BritishRedCross

British Red Cross Needs Assessment of the Wethersfield Site

CONFIDENTIAL TO THE HOME OFFICE

Submitted May 2024

Executive summary

Introduction

The British Red Cross has a recognised status and role as an auxiliary to the UK public authorities in the humanitarian field. In line with this, we were asked to conduct a needs assessment of the Wethersfield site to make recommendations for improvements. Our work is guided by the Fundamental Principles of the Movement, including the principle of Independence, which acknowledges that while we are an auxiliary to public authorities, we must maintain our autonomy. The Red Cross has previously undertaken assessments at two other large-scale accommodation and reception facilities, and this report builds on the findings from those assessments.

Status of the site

The Red Cross conducted an assessment in line with ICRC guidance: *'Determining when a restriction on liberty of movement amounts to deprivation of liberty in the context of migration.'*[1] While the site is classed as initial accommodation and is not an official detention setting, multiple features of detention are present including check points; barbed wire fencing; heavy security presence and close monitoring of residents; rooms of multiple occupancy; lack of privacy, curfews, and restricted entry/exit points at night. Multiple residents have received erroneous letters from the Home Office to 'Wethersfield Immigration Removal Centre' and being refused asylum support due to 'detainees' being ineligible for such support. A common theme in resident feedback is that the site feels like a prison and is dehumanising.

Oversight, accountability and transparency

There are multiple organisations working on the site from the private sector (including subcontractors), local and national public sector, and the voluntary and community sector. There are some examples of good practice, and a multiple agency forum has been established. However, each agency on site has their own safeguarding processes. There does not appear to be a multi-agency approach to safeguarding as would be expected in a community setting in line with statutory guidance. Governance structures for dealing with issues onsite are unclear and three out of four residents reported that not enough or nothing was done about issues they raised.

Induction and vulnerability screening

Essential safeguards aimed at minimising risk of harm to vulnerable people not suitable for this type of accommodation do not appear to be implemented. Since the Wethersfield site was established rapidly in July 2023, hundreds of people have been deemed to be unsuitable and have been relocated from the site. These included children, victims or torture, survivors of modern slavery and people with mental and physical health issues. Most of the people who were relocated from the site were identified by off-site agencies rather than Clearsprings, which raises the question about the effectiveness of the welfare function. Inductions and health screenings witnessed by the Red Cross observers were chaotic and undignified. They were conducted in English without the use of interpreters, or with other residents interpreting, some of whom felt coerced to do so. Inaccurate information was provided such as erroneously linking behaviour onsite and people's asylum claims. This

[1] Not currently published online but available upon request.

discouraged residents from raising issues onsite as they were fearful that it might impact on their asylum application.

Accommodation and facilities

91% of residents reported they rarely or never slept well. The most frequent reason for this lack of sleep is the high number of people in each room and the different sleeping times and habits of people sharing a room. Threats of violence play a role in their sleep, too. Violence is more targeted at ethnic and religious minorities and residents have had possessions stolen. Some struggle to sleep because they feel unsafe while others confine themselves to their room to avoid the conflict. There was also a lack of private space for residents to take important calls for trauma therapy and counselling, legal appointments and personal calls. Nine in 10 residents reported they do not do anything or enough of the things they wanted to do when asked about activities. There are facilities onsite and staff have attempted to organise activities with limited success as it was seen as additional to their core role. Many residents feel that their life during the months they have spent on site have been wasted.

Provision of information

During the induction process new arrivals are given no information about where they are, the nature of the site or how long they will be there. The team found no embedded system for routinely providing essential information. The induction pack was provided in English with no adaptions for communications needs. This raises serious concerns about adherence to equalities legislation and needs to be urgently addressed with the contracted provider. The people we spoke with had no understanding of how the Illegal Migration Act directly impacted them. They believed they were asylum seekers and most spoke of going through the system and getting their ‘papers’ in the future. It is a serious concern that they have not been able to obtain legal advice on their immigration status in the UK.

Healthcare

All new arrivals are given a standard ‘Asylum Seeker Health Check (ASHC) which involves taking their medical history, height, and weight, identifying any medication they are on, checking their vaccinations and taking full bloods. Residents during the induction process were observed to be told they must consent to blood being taken or forfeit access to ongoing medical care. Some residents have been diagnosed with HIV following blood tests as part of the ASHC and have been left to manage the impact of that diagnosis while living on site. While the cases are reported to be low, the impact on individuals and the need for highly sensitive care and support around these issues is clearly critical. Prescriptions were originally sent direct to chemists who would then deliver to site and the medication was handed out by the health team. This was changed to the direct provision to residents with instructions on where to find a chemist, however voluntary sector organisations report residents turning up at their offices with a prescription with no idea how to fill it.

Mental Health

People seeking asylum are recognised to be at an increased risk of mental health problems, particularly if they have experienced traumas of violence, exploitation, torture or sexual violence. To respond to this high level of risk there is a single mental health professional on site for the approximately 600 residents. The onsite health team reported to us that suicidal ideation rate was 10% of the residents they saw. There appeared to be some challenges defining suicidal ideation and attempts and self-harm/injurious behaviour. Examples of incidents provided by the service manager included men walking into a reservoir attempting to drown; the stitching together of lips; slicing legs with a knife and taking overdoses,

however these were not considered to be self-harm incidents or categorised as such. Residents reported witnessing people climbing to the top of buildings with the intention of jumping and the Red Cross were shown videos of these incidents. A Clearsprings staff member shared a distressing experience where they had to talk a man down from jumping out of a window. Residents are witnessing the impact of trauma on men living on the site, with suicidal ideation and attempts occurring regularly. There is little evidence of follow up care following acts of self-harm and suicide attempts.

Safeguarding and welfare

Safeguarding concerns can and should be able to be raised by anyone who has a concern about a resident at Wethersfield. In practice the processes are not clear, with each agency onsite having a different process in place, and off-site agencies or voluntary support onsite lacking clear referral pathways. Barriers to residents disclosing issues directly with Clearsprings include the physical presence of security at all entrances to buildings and at every door of internal rooms including within barrack accommodation blocks and welfare spaces of the Portacabin accommodation area. Residents have reported altercations with security and the Red Cross were shown footage filmed on residents' phones of fights between security and residents where security staff were filmed landing blows and fighting on the floor. Each contractor (Clearsprings; Supreme, Commisceo, Mite) on site operates independently, with their own safeguarding reporting system; processes; training; standards and assurance. The health staff we spoke with believed that safeguarding issues are shared across teams, however, as there are no data sharing agreements in place the health team must get consent forms completed before sharing residents' information with other teams on site. When the Home Office began engagement around establishing the site, assurances were made to Essex Children's Services that mitigations were in place. These included assurances of a robust age assessment at the border, and an 'under-25 policy', dictating if a doubt around young person's stated age was raised as being under 25 the young person would not be suitable for immediate transfer to an ex-military site while fuller age determination took place. However, since the Wethersfield site opened in July 2023 between 30 and 40 referrals have been made to children's services.

Physical safety and protection of minority groups

Physical safety was big concern for residents, with over 75% reporting they did not feel at all safe or safe enough living on the site. In contrast, 80% of people said they felt safe when they left the site and spent time in the community. Staff reported few troubles with bullying or harassment on site, however residents fed back this was a common issue and contributed to their feeling of a lack of safety. This indicates the identification and reporting of incidents should be reassessed, with barriers to disclosure and identification fully explored and understood. Social workers supporting children through the age assessment process report hearing claims of fighting between groups, cultural violence, and threats of sexual violence from the children and young people they spoke with on the site. We have concerns about discrimination against minority groups. As well as tensions and threats of violence between different groups of residents which are reportedly ignored, one resident reported being told by site staff "to pray and that [they] didn't need to go to the doctor because Allah would help [them]."

Staff welfare and capabilities

The Red Cross team spent two days on site speaking with medical, Clearsprings and security staff. Overall, while there were clearly people who did want to improve the situation there was a distinct level of desensitisation amongst the staff working directly with residents, increasing where staff had been working there for several months and since the site opened in the July 2023. This ranged from expressing a limited understanding of the wider context and how traumatic experiences might be impacting the people they were interacting with; failing to see people as individuals with their own needs; displaying a lack of professional curiosity about root causes of behaviours and consistent minimising of the distress of residents. One staff member we spoke with shared they had seen dead bodies of men who had taken their lives by suicide while in the military, insinuating they were immune to such horrors and if the people on site really wanted to kill themselves, they would *'just do it.'*

Conclusion

As a humanitarian organisation we have very serious concerns about the impact the Wethersfield site has on residents, including the high risk that people will take their own lives. Our overarching recommendation is that this site and all large-scale accommodation (ex-MOD sites and barges) are not a safe or appropriate way to house people in the asylum process and should be closed. This was clearly reflected in the assessment and feedback from residents. In the short term, the length of time people are held on the site must be reduced to minimise the impact of mental health and wellbeing. A long list of recommendations has been made to reduce the harm on residents should the site stay open.

For the avoidance of doubt, any legislation, law, act or otherwise, referenced within the report is subject to independent legal advice, and should not be considered or otherwise deemed as a complete statement of the applicable law and protections that may be available to the residents, and other affected parties this report relates to.

Contents

Glossary

AASC: Asylum Accommodation and Support Contract 10

AIRE: Advice, Issue Reporting and Eligibility 10

ASC: Adult Social Care 14

DAPS: Dignity, Access, Protection, Safety 5

ECC: Essex County Council 12

ESOL: English for Speakers of Other Languages 13

GDPR: General Data Protection Regulation 18

ICRC: International Committee of the Red Cross 5

IMB: Independent Monitoring Board 14

IRC: Immigration Removal Centre 11

JRS: Jesuit Refugee Service 54

MAF: Multi-Agency Forum 12

MOD: Ministry of Defence 13

NHS: National Health Service 12

NRM: National Referral Mechanism 14

RAMA: Refugee, Asylum Seeker, and Migrant Action 12

RG: Reasonable Grounds decision 21

SMP: Strategic Migration Partnership 12

TB: Tuberculosis 25

UNHCR: United Nations High Commissioner for Refugees 10

VCS: Voluntary and Community Sector 12

Introduction

The British Red Cross, in common with other Red Cross and Red Crescent National Societies, has a recognised status and role as an auxiliary to the UK government in the humanitarian field. Amongst other things, this auxiliary relationship helps us coordinate with officials to meet humanitarian needs in times of crisis. Our work is guided by the Fundamental Principles of the Movement. The principle of Independence acknowledges that while we are an auxiliary to public authorities, National Societies must maintain their autonomy so that they may be able to act at all times in accordance with our Fundamental Principles. In line with our recognised status and role, the British Red Cross were asked to conduct a needs assessment of the Wethersfield site to make recommendations for improvements.

This is the third piece of work relating to large-scale accommodation and reception facilities we have undertaken. In 2020-21 we conducted an assessment of the Penally Barracks in Wales and made a series of recommendations to the Government. In 2022 we delivered a project providing humanitarian support to reception facilities at Dover and Manston and advised on ways to address risks and vulnerabilities and strengthen processes, shared in February 2023. This Wethersfield report reflects and builds on the findings of the two previous reports. Areas of concern such as weak processes for vulnerability screening and safeguarding, and a lack of information provided to people in the system continue to be a feature of large-scale sites. Concerns that risks are being missed, minimised and mishandled are echoed across all three reports. The British Red Cross welcome the opportunity to carry out this latest assessment and the constructive engagement with Home Office officials and look forward to future engagement on the recommendations.

Approach and Scope:

The assessment framework covered 13 domains that were developed for previous Red Cross assessments at the Dover and Manston sites and augmented with Sphere Standards and a review of the AASC contractual standards. The Red Cross minimum protection standards and the 'DAPS' (Dignity, Access, Protection, Safety) framework for providing humanitarian support in emergencies has provided a lens for analysis. Additional support and framing was provided by the International Committee of the Red Cross (ICRC) in line with its mandate and expertise in working in places of detention. The team visited the site three times and received feedback from 90 residents.

Status of the site

Statutory frameworks

Wethersfield is classed as non-detained Initial Accommodation. It operates under the Home Office 'Asylum Accommodation and Support Contract' (AASC) with management of the site contracted to Clearsprings Ready Homes, the private housing firm with a 10-year contract to supply housing management services to the Home Office across the South of England and Wales until 2029. The Clearsprings model is to sub-contract in the hotels they manage. At Wethersfield there are sub-contracts in place for security, catering and transport services, with agency staff supplementing housing staff.

Migrant Help are contracted to deliver the 'Advice, Issue Reporting and Eligibility' (AIRE) contract for the Home Office across the asylum accommodation estate. The contract includes responsibility for completion of applications for support and the logging of accommodation maintenance issues in line with the contractual KPIs. The contract also provides for advice on the asylum process and signposting to other support agencies.

The Home Office's stated aims of establishing the site are to *provide 'adequate and functional accommodation for asylum seekers and is designed to be as self-sufficient as possible, helping to minimise the impact on local communities and services.'*

The people being placed on the site are newly arrived in the UK, travelling from France to Kent across the Channel. They are therefore likely to fall under provisions of the Illegal Migration Act 2023. Until further guidance is published, their claims are not being progressed in the UK. They are currently unable to regularise their status and integrate, or reunite with their family through refugee family reunification. The Home Office state: *'This cohort was decided as this group comprises the bulk of the small boats arrivals and are the most suitable for a large site as they typically do not have the complex needs that would be found with family groups, for example who are more suited to other forms of accommodation. This group is least likely to place additional strains on local services in a rural area such as Wethersfield.'*

Statutory duties around the Care Act 2014 that set out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect are not fully in place or integrated into processes at Wethersfield. This is discussed in more detail later in the report.

Statutory duties under the Working Together to Safeguard Children guidance published in 2015 on multi-agency working to help, protect and promote the welfare of children guidance are not applied by the authorities at the Wethersfield site. The Essex Children's Services Team are carrying out their duties when they are informed that a child is on site, including duty to conduct Merton-compliant age assessments.

Determining deprivation of liberty

Housing refugees on ex-military barracks, barges and large-scale sites has been contested by specialist organisations supporting victims of torture and trauma and by humanitarian organisations including the UNHCR and the British Red Cross. One of the principal concerns that arise with the use of such sites is that they may turn into places of de-facto detention. In the light of these concerns, The British Red Cross, in conjunction with the International Committee of the Red Cross (ICRC), conducted an assessment of Wethersfield in line with the ICRC guidance: *'Determining when a restriction on liberty of movement amounts to deprivation of liberty in the context of migration: A summary of ICRC practice, March 2024'.*

Some observations are shared below for the purpose of this assessment and further engagement with interlocutors will follow.

The residential component of the site sits within an 800-acre estate of the Wethersfield military barracks. The ‘green zone’ that encompasses accommodation is surrounded by a fence within the wider physical perimeter of the site. While the site is classified as initial accommodation and is not an official detention setting, multiple features of detention are present including check points; barbed wire fencing; heavy security presence and close monitoring of residents via body-worn cameras of security guards and CCTV; rooms of multiple-occupancy; lack of privacy, curfews, and restricted entry/exit points at night.

> *“They lied about what you can do. They said there was Wi-Fi and they said that you can leave whenever you want.”*

Situational indicators are also present that indicate the wider Home Office consider Wethersfield to be a place of detention, for example we were made aware of multiple residents receiving erroneous letters from the Home Office to ‘Wethersfield IRC’ (Immigration Removal Centre) including refusing asylum support due to ‘detainees’ being ineligible for such support. The staff onsite in turn were observed to refer to the site as a ‘prison camp’ and described residents as being eligible for community-based dispersal accommodation only after a period of ‘good behaviour’. Staff were observed to routinely use prison comparisons to benchmark the site and its facilities.

Due to the isolated location, an eight-mile journey to the nearest town, residents must rely on contracted minibus services to access community-based support and services. The timetable is limited allowing residents a short number of hours in the community. The latest service runs back from local towns at 7pm ensuring everyone must be back on the site by 8pm. Security staff are instructed to stop people attempting to leave at night at the gate and call Clearsprings staff to speak with them about why they want to leave and where they are going, on the grounds that the site is surrounded by unlit country lanes and potentially unsafe to walk along. People wishing to stay away overnight are required to leave contact details in line with the approach in wider asylum support accommodation. There are no visitors permitted on the site. Wi-Fi is not available in the residential blocks and is restricted to some communal areas. There are plans for this to be extended although at the time of the assessment nine months on from opening the site, this was not in place.

Residents fed back:

> *“Even though they say it is not a prison, this is how it feels. There is security everywhere. If we want to leave, security take our IDs. The bus we go into town is like a cage. We have not committed a crime, so why are we in prison?”*

> *“I just feel like a prison feel like we did something wrong. Feel like we are not a human being no more feel like we just wanna be in the community. We just wanna be safe. We just want to be happy.”*

> *“I think everyone is as surprised as I am. The place is not prepared to receive immigrants, and the place reminds me of several things I was exposed to in my country of origin.”*

Oversight, accountability, and transparency

Site stakeholders and joint working

The site is managed and run by Clearsprings Ready Homes, a private housing firm who hold an Asylum Accommodation and Support Contract (AASC) with the Home Office to provide accommodation and support to eligible people going through the asylum process. Clearsprings operate across London, the South of England, and Wales, providing Initial Accommodation, 'contingency' accommodation (usually hotel rooms), and community-based dispersal accommodation, typically in houses of multiple occupancy. Clearsprings also run and manage Napier Barracks in Folkstone, run as contingency accommodation since 2020.

Braintree District Council holds the statutory role as the planning regulator including the Special Development Order, with responsibility for clean water and pollution management. The Environment Agency also has a role, for example if toxic substances are found, with joint responsibility with Braintree District Council for the safety of the people living on the site in these cases. Braintree District Council receive and manage the government asylum dispersal grant for the area.

A Multi-Agency Forum (MAF) structure is in place chaired by Braintree District Council with membership from statutory services (See figure 1). They report some challenges due to ongoing litigation happening alongside the engagement structures but report that overall, it is a better functioning MAF than some others. There are several sub-groups including finance; infrastructure; communications; environment, policing and public order; and health and social care. In addition, thematic 'task and finish' groups are in place including for mental health and safeguarding, chaired by the site NHS lead and Essex County Council (ECC) respectively. A future group on advice and signposting is planned once Migrant Help are established on site.

Engagement with the local voluntary and community sector organisations (VCS) happens outside the MAF structure, in a standalone meeting chaired by the Home Office. This differs from Wethersfield's closest comparator, Napier Barracks, where the VCS and wider engagement is coordinated by the Strategic Migration Partnership (SMP). The focus of the VCS meeting is to explore the activities the voluntary sector can provide onsite, and a gap analysis produced by the Home Office has been shared. At the time of the assessment, the voluntary groups regularly attending were Refugee, Asylum Seeker, and Migrant Action (RAMA), based in Colchester, and the British Red Cross. A vicar and a volunteer English teacher also attended. Other organisations providing remote or office-based casework support to residents do not attend the meetings. The criteria for participation needs further clarifying with a clear terms of reference for all the engagement groups. The Red Cross have observed that leadership of the group lacked experience of meeting the needs of people seeking asylum, with gaps in understanding of people's rights or the different roles of Home Office contracted providers. This resulted in blind spots and a lack of tangible progress on actions with issues being 'stuck' for several months. There also seemed to be confusion about available funding which is discussed later in the report.

Key contributors to the wider multi-agency forum structure are Essex County Council. ECC has experience of supporting people seeking asylum in hotels in some areas of the county and there is some good practice of working with the VCS around this. The Adult Social Care (ASC) team attends the site to meet with individuals who may be identified as having care and support needs. They also attend a weekly 'Multi-Disciplinary Team' (MDT) meeting with Clearsprings and representatives from the onsite health team to discuss high-risk individuals for whom mental health or safeguarding issues are a concern. As discussed later in the

report, the MDT could be crucial function in the overall accountability structure for people at risk, however gaps in processes and responsibilities for follow-up actions need to be addressed in order for this to be effective.

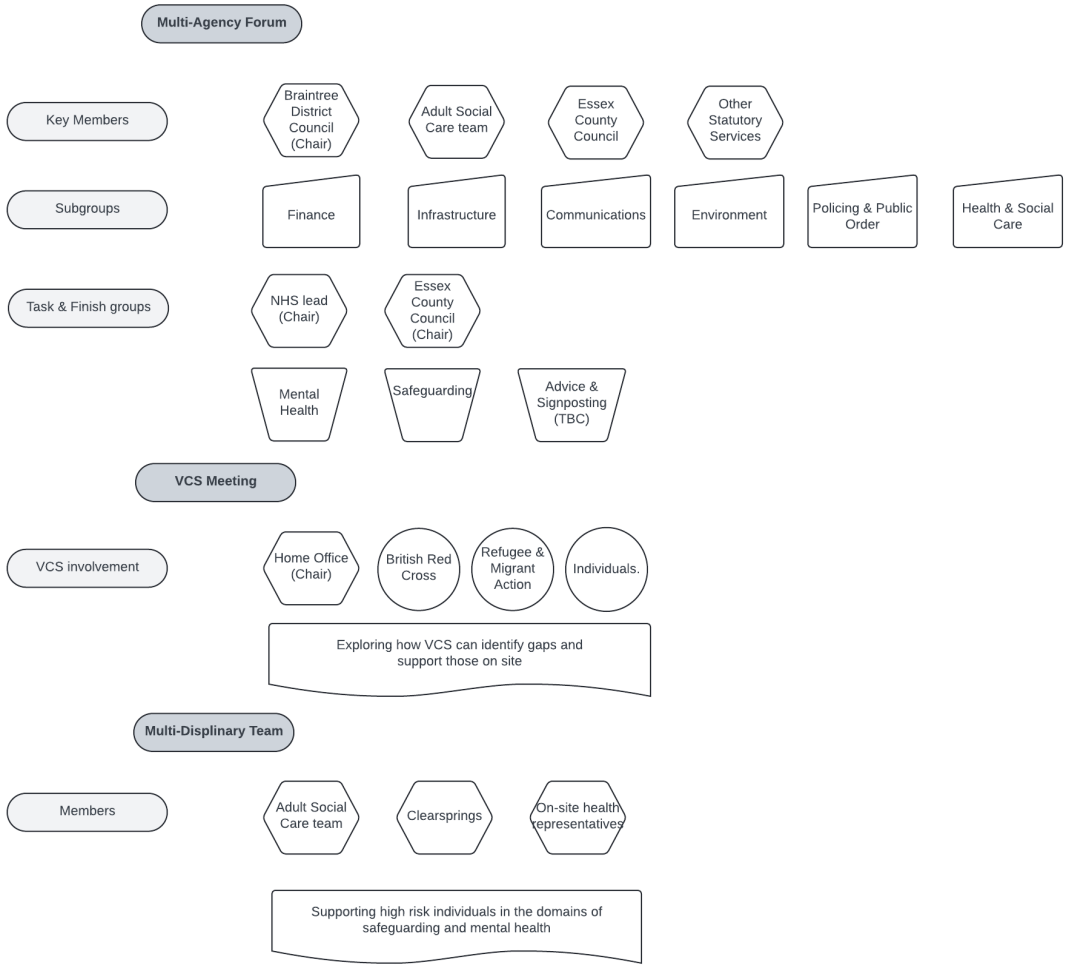

Figure 1: Membership and remit of Multi-Agency Forum, VCS meeting and MDT in supporting Wethersfield site.

The SMP for the East of England has been involved from the outset but lacked capacity to take a coordinating role. Their role has included advising on issues such as the need for legal advice and a dedicated ESOL programme on site. Braintree District Council, while less experienced in meeting the needs of people seeking asylum due to the historically low dispersal rates to the area, also see their role as holding the Home Office to account, for example gaining clarity on roles and responsibilities of the contracted providers. They report a constructive relationship with the Home Office despite some frustrations about barriers to getting things in place and concerns about moving in to fill gaps in Home Office commissioning. The legal team within the Council who are challenging use of the site remains separate from engagement on improvement.

Insights and lessons learned are shared via a ‘large-scale’ sites group including the council leaders from Lincolnshire, where the next large-scale ex-MOD site is being planned. Essex Children’s Services have also met with their Lincolnshire counterparts to share their experiences of supporting children sent to large sites.

Community Cohesion

Community cohesion in the Braintree area has been challenging. The local authority highlighted a need for better proactive and transparent communication from the Home Office from the outset. Unrealistic expectations set by the Home Office about the site being 'self-contained' has resulted in local residents taking issue with seeing people leave the site to access towns. As a result there is a risk of discriminatory attitudes towards site residents needing to access services including getting prescriptions from pharmacies and other basic services such as libraries and shops.

The transportation service provided to residents has also been a source of contention at a time when the local bus service has been restricted due to local authority budget cuts, placing residents at Wethersfield at risk of hostility from the local population through no fault of their own. The worrying sight of emergency services including ambulances regularly having to attend the site has also stirred up local anxieties.

The language used by the Home Office around containment of the site including that it is *designed to be as self-sufficient as possible, helping to minimise the impact on local communities and services* could also exacerbate misplaced concerns about criminality that have the potential to heighten local tensions and are not reflective of the reality of refugee protection and the rights of the men on site.

Accountability

The Chief Inspector or Borders and Immigration (ICIBI) visited the site in December 2023 and February 2024 and a report with recommendations was submitted to the Home Office which has not yet been published. Some of his concerns about the safety and legal status of the site raised in a letter to the Home Secretary were made public. The Home Affairs Select Committee have also set out their intentions to visit the site.

There is no regular independent monitoring currently in place for the Wethersfield site. The Independent Monitoring Board (IMB) have a remit to inspect prisons and places of immigration detention including short-term holding facilities. The Wethersfield site is classed as initial accommodation under the Asylum Accommodation and Support Contracts rather than a place of detention, therefore the IMB remit does not apply.

Data on issues such as National Referral Mechanism (NRM) referrals, age disputed children living on the site, people relocated on grounds of specific vulnerabilities such as being victims of torture is not shared.

Essex Adult Social Care team is in the relatively early stages of structured engagement with the site since it opened in July 2023. A weekly multi-disciplinary team meeting has recently been established to discuss individuals considered to be high-risk, for example due to deteriorating mental health. The attendees include a representative from the onsite health service and a Clearsprings safeguarding lead who does not work on the site. As discussed later in the report, this crucial new structure would benefit from increased rigour and accountability for care plans that are required under statutory risk planning.

Health staff advised us that that health decision-making to identify individuals who may be deemed unsuitable for being placed on a large-scale ex-military site falls to the Home Office doctor and the Commisceo director, both off-site. It was stated by the health team that the site is 'unique' in the approach to care and support.

Each agency on site has their own safeguarding processes. There does not appear to be a multi-agency approach to safeguarding as would be expected in a community setting in line with statutory guidance. The ability of staff to identify and safely respond to safeguarding

issues and disclosures, and to share information to safeguard vulnerable individuals, is limited. Barriers to good practice include siloed methods of working; lack of data-sharing agreements for agencies on site; weak case management and lack of experience of frontline staff in Clearsprings.

Complaints are dealt with according to the process for each contractor on site. Residents are informed they can call the Migrant Help telephone advice line if they wish to raise any issue or concern. On receipt of an issue or complaint, the Migrant Help KPIs state that the issue is immediately logged and passed to the AIRE contract team at Clearsprings, a call centre that manages all contracted issues from across the asylum accommodation estate. An email will then be sent to all Clearsprings managers on the Wethersfield site to take action. As discussed under the physical safety section of the report, the email alerts can include all issues from a resident disclosing bullying and harassment to lower-level concerns about food. 63% of residents we spoke to did not understand the purpose of the Migrant Help telephone number, the process for making a formal complaint or what would happen with their complaint.

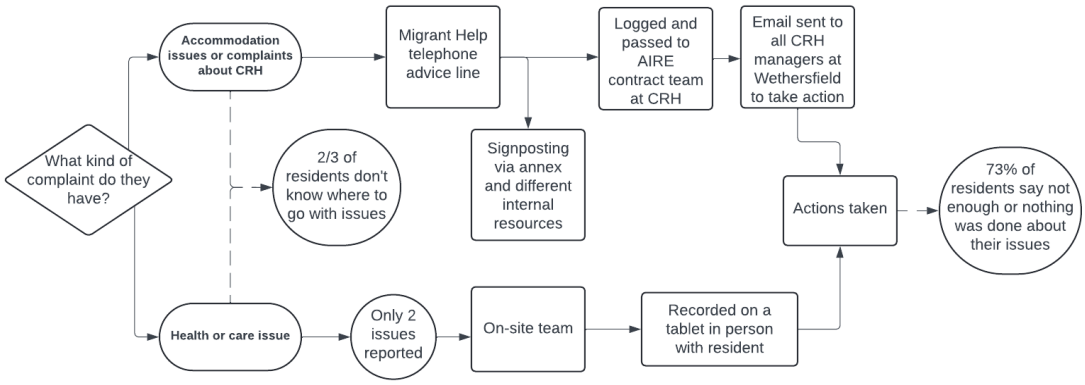

Figure 2: Complaints procedure on site, with many residents not knowing where to go or feeling that anything was done about their issue.

The process for complaints about the health service sits separately. Complaints about care received must be made directly to the onsite team who will record these with the resident on a tablet and take all details in person. The health team report there have only been two complaints made to them since the site opened.

Induction and vulnerability screening

The Allocation of Asylum Accommodation Policy is the guidance used by the Home Office to determine who is not suitable for accommodation at ex-military sites. It is an essential safeguard that when properly implemented should minimise further risk of harm to already vulnerable people. It relies on vulnerabilities being disclosed and recorded either at the border or to staff on site or with support from specialist agencies.

Since the Wethersfield site was established rapidly in July 2023, hundreds of people have been deemed to be unsuitable and have been relocated from the site. These included children, victims of torture, survivors of modern slavery and people with mental and physical health issues.

In February 2024, the Home Office amended the Allocation of Accommodation Policy to remove the strict criteria preventing certain categories of individuals from being placed on ex-MOD sites and room sharing. It has been replaced with a discretion to consider exceptional circumstances, and to ensure suitability of individuals continues to be considered on a case-by-case basis.

The change of policy places a greater emphasis on individuals to provide medical evidence once they have already been placed on the site and does not automatically exclude for example victims of torture or sexual violence. Identifying and responding to these individuals requires robust safeguarding and welfare processes that have found to need improvement on the Wethersfield site. For example, the majority of the people who were relocated from the site before the change of policy were identified by off-site agencies rather than Clearsprings, which raises the question about the effectiveness of the welfare function for recognising and responding to safeguarding concerns and the case-by-case approach.

People struggling with living on the site due to deteriorating mental health or at risk due to specific vulnerabilities must get evidence from the Commisceo health team to support relocation requests. Further understanding of how this process works in practice and is integrated into the mental health support options for residents would be helpful to see.

The induction process

Groups arrive in coaches either directly from Manston or via the London hotel that is used to accommodate people for a few days to carry out checks before they are moved on. On arrival, the group is taken to a dedicated building for an induction meeting to complete the accommodation agreement and carry out a welfare check.

Before arrival at the Wethersfield site there is an initial screening process at Manston. As documented in previous Red Cross reports, the management of initial arrival is process-driven and undertaken in an environment that is not safe or conducive to disclosure of health or vulnerability issues that may place an individual at particular risk of harm. Border Force and Home Office social workers undertake age determination meetings with some children going on to have longer welfare meetings with social workers. There are no Merton-compliant age assessments undertaken at the border. Initial asylum screening, a mandatory part of the legal process, will take place either at Manston or at a hotel in prior to individuals being transferred to Wethersfield.

The team observed initial induction processes wo groups of approximately 15 individuals at each induction. The first coach had arrived from the ‘first stage’ hotels and the people had been there for approximately one week. The second appeared to have arrived directly from Manston as they were carrying blue plastic bags.

The briefing was conducted by a Clearsprings staff member in English. People were asked to raise their hands if they spoke the same language then grouped together and attempts were made to identify someone who spoke enough English to translate for the others. There was little opportunity to refuse this request, the process felt hurried, there were clearly no other interpreters available, giving the impression that people were under pressure to interpret for the group.

There was no explanation of the site, what it was called, or where they were. During the group briefing conducted in English, residents were asked the following questions to the whole room specifically: *“Is everyone feeling healthy, well? Yes? Good.”* They were told *“This is the best site in the UK, this is number 1. Everything is here, I am happy for you being here.”* New arrivals were instructed to: *“Behave well and don’t fight. Any incident report will not complement your asylum application.”*

The Red Cross queried this with the Home Office who confirmed that behaviour management is not linked to the ongoing provision of accommodation and support, and there should be no direct link between 'poor behaviour' on site to asylum claim determination. The exception would be in relation to criminal activity in very specific circumstances, however from the group briefing this detail was not made clear, with the insinuation being that raising or causing issues on site might directly impact on the legal process. Residents reported that people are fearful of being involved in or raising any 'issue' that might impact on their asylum application and there was significant confusion about this.

> *''If you misbehave, they threaten you with a warning letter. If you get more warning letters, they threaten that you will stay at this place longer and it will affect the outcome of your asylum claim."*

In the briefing people were told that they could *"go out at any time"* and if they want to go to "other cities" they can do so and pay cash to get there. They were informed that *"This is not a detention site. If you want to go on holiday, we encourage you to do that, just give us a telephone number."* The language used around going 'on holiday' was considered particularly insensitive given the traumatic journeys and separation from family that many people will have endured. This language was repeated on posters across the site.

The briefing observed by the assessment team concluded with**:** *"Questions and concerns? We want to hear concerns".* No one put their hands up at this question.

The induction observed was during the month of Ramadan and people were then made to put up their hands in front of everyone else to identify themselves if they were fasting. The reason for doing so was not clear and no names were taken down at this point. *"Hands up for Ramadan – no one is eating?"*

Newly arrived people to the site were then called up to three desks in front of everyone to sign their occupancy agreement in English and to go through a 'welfare check' form in English with Clearsprings staff member. The conversations were conducted in English. People were asked*, "Speak English? A little bit? Good"* without pausing for a reply before proceeding with the paperwork. The accommodation agreement appeared to be translated and provided to people to read through and sign. There were no considerations for people who are not literate and no attempts were made to ask about literacy, or whether they understood the document that was in front of them before signing.

All paperwork was completed by hand. The assessment team observed the Clearsprings officer transferring details over to their paperwork from Manston paperwork. Paperwork was disorganised with completed accommodation and welfare forms containing personal data left strewn across the desks and on the floor, raising significant GDPR concerns.

During observations it was noted that multiple spelling mistakes were made on the forms by staff completing them and a resident had to correct the spelling of their name on two occasions. Important questions such as date of entry into the UK were asked in English and was clearly confusing for the residents. These were potentially recorded incorrectly on Clearsprings paperwork.

On leaving the induction briefing an induction pack was provided in English. It included some poorly photocopied pages. The information was densely spaced with small and difficult to decipher text. It appeared not to have been adapted fully for the Wethersfield site and

contained irrelevant information about living in contingency accommodation. The pack contained unexplained acronyms and appeared to be written with professionals rather than the end-user in mind. None of the information created by the Home Office were provided, for example the Physical and Mental Health Support for People Seeking Asylum or the Guide to Living in Initial Accommodation. Given the issues raised by residents about the lack of information provided to them while living on the site, the poor quality of the induction materials represents a missed opportunity and could contribute to misinformation.

The assessment team addressed this point with the Clearsprings lead and the view taken was that new arrivals receive 'too much information' at induction. While people adjusting to their new surroundings may experience information-overload and have limited ability to absorb information at this stage, good practice might include a simple information document with key points of information easily accessed, in a language they understand, that can be referred to throughout their stay. Ideally any written information would have input from people who have sought asylum from a range of backgrounds to inform language, tone, and design. The VCS has provided significant input over several years to inform welcome and induction packs for people entering the asylum system, none of these documents were available to people at Wethersfield by the Clearsprings staff.

Consent

All inductions were carried out in English, including questions about medical consent; consent to share information; to share rooms, and important information about any allergies. One resident being inducted spoke only minimal English and there was no attempt to offer an interpreter or language line. He clearly did not understand anything that was being asked of him or understand the paperwork. There were no adaptions in place for people who were not literate in their own language.

Staff asked residents in English for the consent to *"Share medical information with the Home Office"* and when one resident said no was informed, he *'had'* to consent, and there was no other option. This was confirmed by a team leader:

> *"He must say yes for consent to share information with the Home Office. If he says no, it's up to him but it is good for him to say yes".*

A resident was observed being informed:

> *"You can say no to sharing information with the Home Office if you want, but the doctor will not be able to help you. [It will be] problem for you".*

Screening for vulnerabilities

Clearsprings staff ask questions about physical fitness in English by gesturing at the body *"OK? Problems?"* Staff were not observed to be considering any paperwork that had come from Manston that might indicate vulnerabilities and were focussed on the completion of the immediate form in front of them.

Mental health questions are asked by pointing and gesturing at the head. *"Mentally? Well?"* Questions were asked about mental health in front of the whole room with just a barrier separating each interaction meaning people's replies were clearly audible to the room.

Residents were called on to interpret for these exchanges, one resident we witnessed was interpreting for two welfare checks simultaneously.

A man who spoke a different language from the rest of the group was observed asking three times for an interpreter becoming more agitated each time. When a telephone interpreter was finally called, the call was placed on loudspeaker and the exchange was clearly audible to the entire room. We witnessed staff raising their voices in English and gesturing as a substitute for offering interpreting services. One resident the assessment team observed being inducted told the welfare officer *"next day, I'm going for job".* This was not addressed or even acknowledged. This would be considered to be significant potential for exploitative work.

The mobile phone of one staff member we observed continued to ring loudly throughout induction meeting, including when welfare questions were being asked. There was no explanation of who or what who the 'Home Office' is, but it was referenced regularly throughout the briefing.

The next step of being taken for blood tests was done in English and arrivals were grouped depending on who appeared to have a bag of toiletries which caused confusion. The overall feeling of the induction process was chaotic, and the team noted there were significant gaps in important information being provided and a lack of sensitivity to the needs and dignity of people at this crucial stage of induction to a new place so soon after a potentially traumatic experience.

Overall, the information provided at induction briefing was minimal with no assurances that the arrivals understood what was being asked of them. The initial stages of the induction process were framed around the needs for residents to rest and recover, however people were also asked to sign and consent to processes that they may not understand or fully consent to without interpretation.

Case study: “People are angry at me when I refuse to translate.”

Residents are used by staff to interpret information to people who speak their language. There did not appear to be an understanding of the impact of asking groups of people to interpret official information for each other; the opportunity for exploitation or coercion, or the power imbalance that would make declining the request more difficult. Two residents we spoke to who had arrived a few days previously shared that they were regularly called on to attend the induction when coaches from Manston arrived.

“I speak English and I have to help translate for my community, it leaves me tired, and I do not have the strength to do this. People are angry at me when I refuse to translate. We do not know what is happening,” wrote one resident.

When this was addressed with the Clearsprings lead it was referenced that the Home Office had asked them to stop the practice of asking arrivals to interpret for each other. However, this was understood by Clearsprings to be a negative development as, in their view, people were willing and keen to take on an unpaid interpreter role for the purposes of induction. Feedback shared with the Red Cross from residents was some of those called on to provide interpreting services felt uncomfortable but were under pressure to comply.

Language barriers were a consistent theme in resident feedback, which they say contributed to a lack of information about their situation. They described residents being asked to interpret into their own language as being their only means of understanding information on arrival.

Pressure was placed on people to either speak English or interpret for others, with little understanding of the risks of asking the men to interpret for each other, for example around exploitation. When issues were disclosed, such as the individual who stated they had work lined up the following day, nothing was recorded and there seemed to be no acknowledgment of the risk of exploitation or trafficking.

As with the processes at Dover and Manston highlighted in our previous report, speed was prioritised over ensuring people understood what was happening which gave the process a chaotic feel. There was a lack of confidentiality that could deter people from making any disclosures of vulnerability or risk.

The management of handwritten forms not being securely stored represented a GDPR concern and possible beach of data protection. Multiple references from staff overseeing the induction that people should be “tired” and “fasting” would also be in breach of the requirement for impartiality. It was not clear why people were made to identify themselves if they were fasting. Residents reported to the Red Cross that there were conflicts and harassment relating to fasting and these types of cultural and religious sensitivities should be considered in all interactions with residents.

Identification of children

Experts in supporting child refugees including the Red Cross have long raised concerns about the age determination process carried out on arrival at Dover. An independent report from the Refugee Council Forced Adulthood found that over an 18-month period (January 2022 to June 2023), more than 1,300 children were wrongly assessed to be adults by the Home Office at the border.

This is critical for the Wethersfield site. Given the rapid move of people from Manston to the site, children are likely to be accommodated with adults in a setting that poses significant

safeguarding risks. Essex Children's Services report that 30 – 40 referrals have been received since the site opened.

The reality of the weak processes for identification of children on arrival places greater responsibility on the Home Office to ensure any potential children are swifty identified to the local authority and safeguarded while the statutory processes are undertaken. We would strongly encourage that safeguarding process include relocation to a place of safety for children while they are awaiting the meeting with social workers to minimise the risk of harm on the Wethersfield site, which is deemed by the Red Cross throughout this report to be a high-risk site.

The Clearsprings staff advised that if there are concerns about anyone being underage on arrival they will be transferred to 'isolation' or 'single occupancy' area, described as *very nice accommodation "like a flat even has LED TV."* Single occupancy is also used for anyone with an infectious disease examples provided TB; scabies; Covid-19; HEP A, B or C and STDs. The single occupancy rooms are six contained flats with 28 rooms. They are visited by Clearsprings staff, but the details of these visits are unknown.

Identification of Victims of trafficking and modern slavery

In October 2023 the trafficking-related suitability criteria were amended so that only those potential victims of trafficking who had received a positive Reasonable Grounds (RG) decision via National Referral Mechanism (NRM) would be classified as unsuitable for accommodation at large-scale sites and room sharing. Interviews take place via video call with Home Office on site and it was reported the number of positive reasonable grounds decisions was low.

Given the UNHCR audit of Asylum Screening published in 2023 found that indicators and disclosures are often missed or not acted upon by Home Office staff, it is likely that people are being moved from Manston processing to Wethersfield who would only be identified as potential victims of trafficking by Clearsprings or medical staff on arrival at the site. Concerningly then, the mechanisms for identification and support to victims of modern slavery and trafficking were found to be weak at the Wethersfield site. The induction and screening on arrival at the site is basic and the process is not safe for disclosure. It was wrongly assumed by health and housing staff we have spoken with that survivors of torture or trafficking were moved to other sites, or this was 'screened out' earlier in the process. Requirements under the Home Office's Modern Slavery Statutory Guidance that sets out essentials that must be in place to enable disclosure and identification such as use of interpreters were lacking from induction processes and welfare checks.

As an AASC subcontractor, Clearsprings are not first responders and cannot refer people into the NRM, and there is a lack of clarity as to whether Clearsprings have a duty to notify the Home Office of suspected victims of trafficking and modern slavery. However, Clearsprings do hold a safeguarding responsibility for residents. The AASC contract requires contractors to proactively monitor and identify service users who have specific needs or are adults at risks including potential victims of modern slavery. To fulfil this requirement, we would expect to see awareness materials in appropriate languages; a good level of understanding across all frontline workers and designated focal points to respond to trafficking concerns and other protection issues such as sexual and gender-based violence, with referral pathways into local authorities and specialist services in place.

The Home Office are the first responders for the site; however, the local authority are also first responders and may be better placed to act as a single point of contact for referral to other specialist and independent services. We did not observe the process in relation to potential victims of trafficking and would recommend these are reviewed in line with the requirements of the Statutory Guidance.

Case study: Gaps in Safeguarding processes.

While on site, the Red Cross assessment team were approached by a young man with a piece of paper in his hand. He was confused and was asking where he should go, showing the paper to Red Cross staff. The handwritten note had 'NRM meeting' written on it with a time and name. The team noted the meeting time had passed. Not only did he not know where he could go for this call, but he did not appear to understand the purpose of the meeting, suggesting he was unaware of his rights in the process.

The team attempted to gather more information from site staff about where he should go for his video call with the Home Office. It was clear that site staff were unaware of the NRM meeting taking place and no processes were in place to support this vulnerable individual.

Health screening

All new arrivals are taken across from the induction block to the health block for a general 'Asylum Seeker Health Check'. There was no explanation in English about this stage of the process, arrivals were identified for the health check based on whether they had been provided with a small bag of toiletries. Consent for this stage of the process was observed to be mandatory. The asylum seeker health screening is primarily a blood test to screen for infectious disease. All new arrivals are expected to undergo this following the consent taken in English during the induction. The health leads informed the assessment team that '99%' of patients did not disclose mental health needs at this stage and that this would generally come later after they had been on site for some time. This was interpreted by the health team as residents making false claims about their mental health as a means to a transfer off site and was attributed to a 'copy-cat' type behaviour, rather than an understanding of the negative impact of living of the site itself that residents have fed back as part of this assessment or the challenges presented in the indication process of disclosing information about mental health.

Accommodation and facilities

Accommodation

There are three distinct housing types present on site; barrack blocks, portacabin housing (also referred to as 'the village' by staff) and isolation units.

Barracks

These consist of long two-story buildings with a single central corridor with rooms on either side. A central stairwell leads to the first floor. Within the barracks visited by the Red Cross team there were 28 rooms are present on each floor. Also contained within each of the four barrack blocks currently in use is a small communal space and a small laundry area. The blocks have large fuel oil tanks outside each of them, alongside a boiler that is contained in a shipping container. These new utilities are contained within a securely fenced dedicated area. Each block is supplied with heating and hot water from these units. At the time of the

assessment only four of the eight available barrack buildings contained within the current footprint of the site are operational, with additional building works being reported by several people and witnessed by the Red Cross team on the remaining four buildings. It was reported that each room slept three people.

The fourth operational barracks is the isolation building. This has limited number of individuals at any time and appeared to be individual accommodation units, so is likely to have very different level of occupancy. We did not view these facilities. It was later reported that this accommodation was also used to house potential children on site who were waiting for an age assessment to take place with the local authority.

The remaining other four barrack blocks on site consist of an additional two buildings as described above, and two additional three-story buildings. Laundry is done weekly, and bedding is changed every two weeks. All laundry is done by the onsite cleaning team. The cleaning team reported directly to us that there are currently 24 people per day on the cleaning crew.

A dedicated washing machine for the isolation barracks was witnessed by Red Cross staff, providing some level of infection cross contamination prevention. In the barracks visited, there were facilities to make hot drinks and squash, water, and biscuits available. This was being reported as being replenished a couple of times a day by the catering staff. Security was present in each of these barrack blocks, with two staff based in the entrance hall of each building.

Portacabin Area

A new fenced off series of portacabins that have been built as additional accommodation to house people seeking asylum being placed on the site. These are large grey blocks of eight rooms, with external communal toilets and communal shower cubicles. There are no ensuite facilities available in any of the blocks. Bedrooms were observed to be cramped with up to six in a room and space comprising of single beds with built in storage, bedside cabinet, and wardrobe/locker. All décor is grey and there appeared to be no personalisation in rooms. There are no locks on the doors and blinds are black out blinds only. Rooms are not culture specific although the onsite staff reported that men will change rooms regularly and reference was made by staff of there being designated communities in rooms, but no concerns were raised by staff and each community was reported to being respectful of each other. This was contradicted by the residents we spoke with, who reported regular clashes between different groups and changing their behaviour to avoid conflicts.

Resident feedback about the bedrooms and people's sleep is highlighted later in the report, but the most frequent reason for this lack of sleep is the high number of people in each room and the different sleeping times and habits of people sharing a room. Threats of violence play a role in their sleep, too. Violence is more targeted at ethnic and religious minorities and residents have had possessions stolen and some struggle to sleep because they feel unsafe while others confine themselves to their room to avoid the conflict.

In the portacabin area there is a recreational room although not large enough for all residents to access. Facilities were reasonable but clinical and included table tennis as an activity. Noticeboards had some information about activities including an English class and gym session and some helpline numbers and other useful information about mealtimes, laundry, post etc. Some information was only in English including a notice about the body-worn cameras that all security guards wear. The largest multi-lingual display was observed to be promoting voluntary return.

A welfare room was available to offer health support to residents. There was an ablutions area for Muslim residents on site to support spiritual needs. There was no privacy for telephone calls, the only areas that had privacy were staff offices. All other areas were communal.

Flooding was observed around the accommodation entrances on the second visit to the site. A resident was observed calling a staff member closer to show them the flooded areas. The staff member then took a picture and said that this was a common issue in heavy rain.

Isolation block

The isolation block was not accessed by the Red Cross assessment team, but we observed many aspects of the operation around this accommodation building. It was reported by several staff that cases of Covid-19, scabies and TB etc. would all be accommodated in that block. It was also reported that this was the location that possible children were accommodated while awaiting an age assessment visit from the local authority. Cleaners accessing this block wear full white disposable suits, masks, and shoe covers. It was not established how food was delivered to these isolating individuals including children.

The signage on the isolation block was very minimal – and would not be obvious to anyone that could not read English. It is recommended that additional signage in multiple languages is placed on this building, ensuring that unauthorised access does not occur accidentally.

Cleaning

Overall, at the time of the first Red Cross visit the site was clean and seemed to be well maintained. We observed cleaning crews in operation within the buildings and litter picking taking place on the main road within the site. 24 staff are reported to be on site each day conducting the cleaning and we saw evidence of daily cleaning logs present on some buildings. Residents fed back concerns with cleanliness particularly the toilets.

Other buildings on site include the induction block where all new arrivals are taken directly from the coach for their induction briefing; a canteen; medical centre and smoking areas. There are plans for Migrant Help to be based in an office attached to the induction block in the future.

Fire safety and evacuation

Staff disclosed that they knew of someone who came to site and checked the fire alarms regularly. We saw evidence of in date fire extinguishers and smoke alarms in most spaces. Organisationally, we have recently attended multi agency meetings where the local fire service has also expressed that they have no fire safety concerns about the site. When questioned about fire assembly points in one of the accommodation blocks, the security staff instantly knew where the nearest fire assembly point was.

The level that residents had been briefed around fire safety and evacuations was less clear. All fire related notices that we saw were in English and there was no evidence of a fire safety brief during day one induction of new residents. We did not observe the day two induction process, so there is a potential that evacuation procedures are included within that element of the induction process. A photo was taken by the Red Cross team of a fire evacuation process poster, that made no mention of residents, or how to deal with people who might not understand communications in English.

Food and drink

58% of residents said they were sometimes or often hungry or thirsty. While meals were provided at the canteen, people we spoke with expressed concerns such as fighting and long waiting times as barriers to going to the canteen. Some residents also shared being on the receiving end of abuse from catering staff, for example being told they would be *'sent to Rwanda'*. The Home Office shared there had been problems with running out of food for residents in the earlier months of the site being open due to staff eating at the canteen before all residents had been given their meals. The Home Office had stepped in to stop this practice. Adjustments had also been made to menus following resident feedback. This should be continuous, including regular reviews and menu changes to keep this fresh, and not a point of tension.

Catering provided by Supreme catering, responsible for all food on site. This includes the main canteen for meals, biscuits and hot and cold drinks in the induction area, individual barrack blocks and communal space. There is also a burger van outside the Clearsprings main block. The canteen was broken into two dining 'lines' and corresponding halls – this allowed the catering team to open one or both of the 'lines' depending on the number of people coming to a meal. When people arrived for a meal, they were signed off on a paper sheet, as having arrived. Staff stated that if people were missing for three days and had not eaten in nine meals a welfare visit would be triggered, but not before then. The kitchen had extended its opening hours to respond to Ramadan, outside of fasting periods the kitchen would be starting breakfast at 9am and closing after dinner finished at 7pm. Biscuits were available at the Clearsprings offices alongside the barrack blocks. These were reported to be refreshed a couple of times a day by the catering staff. However, when we visited the barrack block no snacks were present.

Basic Needs

From observation residents are able to keep any belongings they arrive with, although the briefing pack explains that residents are not allowed any electronic devices apart from mobile phones, so they may have items confiscated although this was not something we discussed. People transferred directly from Manston have their blue bags transported with them on the coach.

Money

Everyone accommodated at Wethersfield should be supported to complete an asylum support application and be able to access Section 95 support and an ASPEN card to receive the £8.86 per week. Some residents fed back delays in this process which need to be looked at and timeframes set and monitored as part of wider assurance procedures.

Clothing

The Asylum Accommodation and Support Contract (AASC) does not include the provision of clothing. People arriving via the Western Jet Foil are provided with a tracksuit and basic footwear and must purchase their own clothing from the £8.86 weekly payments provided to people placed in contingency accommodation where meals are provided.

In the winter of 2022-23 in response to the crisis across the asylum estate of people without warm clothing, exacerbated by the widespread outbreak of scabies in hotels, the Red Cross stepped in to provide humanitarian support. Over the last 18 months, the Red Cross has provided clothing to the value of £220,000, drawing on Disaster Funds designated for overseas aid. This was an unprecedented intervention, driven by the scale of need and imperative to prevent human suffering. The response reached over 12,000 people in the asylum system who would otherwise have been left without their most basic human needs being met. Residents at Wethersfield were found to have these same unmet needs with the

additional barrier of being in an isolated location with few community-based groups to provide support and restricted freedom of movement. The ‘dignity shop’ the Red Cross team saw on site, set up to distribute donations from local charities of clothing; underwear and footwear, was observed to be sparsely supplied and on our second visit almost completely unstocked. Clearsprings staff raised concerns that reliance on donated goods was not sustainable resulting in residents lacking in basic items. In response to this, the Red Cross have purchased clothing packs to the value of £8,000 to be delivered to the Wethersfield site; connected with corporate donors to supply further clothing packs and provided clothing vouchers to the most vulnerable residents identified through external agencies. This type of solution to a basic need is not sustainable and must not be instrumentalised. Consideration must be given by the Home Office to meeting the basic needs of people housed on an isolated large-scale site away from community support to ensure their fundamental rights and dignity are upheld.

Privacy, sleep, and rest

> *“Being lonely and isolated is one of the hardest situations a human being can go through, its negative impacts are worse than one could imagine. Puts me in a flashback circle of all the bad things that happened to me and my family which is unbearable to me currently. Being in a room with people whom you don't understand their way of life hinders my peace of mind and sleep, and so many negative thoughts that come into my mind.”*

90% of residents we spoke with said they are never or rarely able to sleep well on site. This was particularly true for people sleeping six to a room. People reported only being able to get to sleep with the help of medication; of not being able to sleep due to the different sleeping habits and patterns of their roommates; disturbances from people calling friends and family during the night due to time differences and bedrooms being the only relatively safe space to speak, and most commonly and concerningly because they simply do not feel safe. Residents referenced cultural differences, particularly acute during Ramadan, and being forced awake to pray against their wishes by other people sharing the room.

> *“There are too many people in one room (six). I haven't slept in three days.”*

Sleep deprivation can contribute to low mood and exacerbate the symptoms of depression and trauma responses. Likewise poor sleep can be symptoms of depression and anxiety, and some residents reported nightmares and flashbacks about traumatic experiences they had suffered or anxiety about the safety of family members. Maintaining good sleep hygiene such as a regular bedtime, control over lighting, noise and comfort is also incredibly difficult when sleeping six to a cramped room.

Lack of privacy is an issue on site given the shared bedrooms and communal spaces. Residents struggle to find a private room for remote counselling or consultations with specialist trauma support such as the Helen Bamber Foundation, or to make calls to family and friends. The Home Office has said they will look at trying to support with establishing private spaces in the site. A sign was seen on one of the notice boards encouraging residents to speak to a staff member if they need a private space to make a call. It was not clear where they were directed to or why they needed to go via a staff member for this in the first instance.

> *"There is too much tension on site, and we are sleeping in the same room with too many people. No privacy."*

Many residents we spoke with highlighted the lack of Wi-Fi across the site as a barrier to being able to maintain contact with loved ones and the lack of private spaces. At the time of the assessment only the communal areas had sufficient connectivity to establish calls, for example to face time with wives and children, or to carry out important legal and advice meetings.

Meaningful activities

Nine in 10 residents we spoke to said they don't do anything or enough of the things they wanted to do when asked about activities. One resident shared:

> *"I spend time in the gym and pool room, but the environment is not ok. There are no regular classes for English. The one they offer is not advanced enough. I would like more formal education and serious about improving language. There are no computers or books."*

Braintree District Council manage the government grant for large-scale sites of £3,500 per person, largely to support local infrastructure including health and policing. This was made available in October 2023. A small ringfenced grant of £50,000 is intended to directly fund enrichment activities on site as part of the wider funding. At time of writing in mid-May the grant had not been fully utilised. The District Council report barriers to commissioning including difficulties buying equipment for group work, Home Office decision-making about access to the site and a lack of consistent contact within Clearsprings to establish the activities. Clearsprings responded with a dedicated role to focus on activities, however this is understood to be a temporary measure and has now been withdrawn.

In the absence of a regular programme, some ad-hoc activities have been trialled. Posters advertising a football tournament; cricket and chess were displayed in the welfare areas. A gym training session 'MOD Wethersfield: Shape your Body' poster invited people to train together for two hours each week. A Clearsprings team leader explained their efforts in introducing activities to keep people engaged and healthy and to address the huge boredom felt by the majority of residents, but struggled with capacity as this work was on top of their role. Another team member shared their detailed plans for establishing a programme of activities based on resident feedback but was blocked from progressing from higher up their own management chain.

> *"I have had to find a routine. We gather as a group, play snooker, go to church, imagine that it is nice here. We have to be creative."*

Setting up and facilitating activities as an additional task rather than core part of their roles also means when individual officers are not working, the activities simply don't happen. As we enter the summer months and warmer weather, activities such as football and athletics will be easier to facilitate, however a focus on non-sporting activities should be maintained to ensure inclusivity. Braintree District Council and Clearsprings have a list of potential activities including a photography and gardening clubs, yet none of these have been successfully implemented. Residents should be more widely consulted with on the programme of activities to ensure a range of suitable options.

The gym is modern and well stocked with a variety of machines. Free weights had recently been reintroduced after initially being removed following a security incident. Pool tables, table tennis and TVs were accessible in the old 'mess' or bar area of the site. There were

consols, games and DVDs that could be used. The Home Office shared the balance between wanting to provide activities to keep people occupied and thus reduce the stress, anxiety, and boredom and some relating behavioural issues, and not wanting to appear over generous for fear of negative media.

Several residents fed back they avoided group activities and sports due to tensions between groups.

> *"I walk to the other side of the camp; I get my food and go back to my room. I do not want to go to the group areas there are other ethnic groups have tension and everyone stays in their group."*

> *"There's a lot of activities I would like to do but when many people gathered on table tennis as we have two and it's by turn. I avoid it because fight start on many occasions. And TV controlled by many ethnic groups with many types of different music. Everywhere crowded. And I can't find quiet place to read as many people and their needs. It depends."*

Residents report improving their language skills is a priority with a view to better integration in the UK once they can leave the Wethersfield site. There was some limited information available indicating an English language session on Monday and Tuesday mornings for an hour. We did not see this in operation and understand it is run by a local volunteer group. Residents we spoke to expressed disappointment at the level of the class that taught very basic words making it less useful to them to gain language skills to navigate life in the UK. One person shared the wasted opportunity of nine months on site and that with proper provision they would have been able to significantly advance their language skills during this time, supporting their integration.

Provision of information

> *"At hotel they wouldn't give me the postcode of where I was going. I was misled and brought here like an animal*".

During the induction process new arrivals are given no information about where they are, the nature of the site or how long they will be there, as detailed elsewhere in report. The team found no embedded system for routinely providing essential information. The induction pack was provided in English with no adaptions for communications needs. This raises serious concerns about adherence to equalities legislation and needs to be urgently addressed with the contracted provider. As reported elsewhere in the report, all verbal induction information is provided through use of other residents interpreting, both people already on site and people who have arrived together. This assumption of trust and safety between individual men who have been grouped together and transported by coach to the Wethersfield site then asked to relay important information to each other is highly problematic and unsafe.

> *"I learned from other people here. We have to use google translate or find someone if we want to speak to the welfare team or the staff."*

> *"Promised things that weren't true. They used other residents to interpret when we arrived. The residents they used told us in our language to stay in the bus and not get off."*

After induction and once on site, the residents we spoke with reported information being provided on request from individual staff members and other residents. From speaking with staff across all agencies, it was clear there was an inconsistent understating of basic facts about the process the residents were going through, leaving open the space for misinformation and abuse. For example, related to health, Clearsprings and security staff all stated they only have sight of their particular roles as cogs in the wider wheel, and all referenced the 'Home Office' as having the bigger picture.

> *"They tell me it's nine months, but my psychological state is getting worse every day. I'm trying to save myself, but I can't control myself."*

Young men we spoke with onsite asked the assessment team direct questions about why they had been taken to an isolated camp and what the government intended to do to them. This uncertainty generated palpable fear amongst the men and should be considered in the context of people who may have suffered or witnessed arbitrary detention and state disappearances.

> *"They say six months, but there is no such thing".*

The system for raising issues or concerns was also found to be weak, residents are informed they can speak to Clearsprings officers but what will happen with issues raised, how and where that information is shared and what outcome they should expect is not made clear to them. The complaints process was also not made clear. These factors combined present opportunity for an information gap to arise and for misinformation to fill the vacuum.

In the main welfare block and secondary welfare area in the portacabin accommodation space there are pin boards with posters and flyers displayed in multiple languages. Translated information about changes to ASPEN cards, some support line numbers in English; a poster about mental health in Kurdish; the Migrant Help phone line and a poster in English advertising a weekly call with the Home Office and some information on laundry. We did not observe anyone stopping to look at the information and it seemed inconsistent. We did not see any information about safeguarding, sexual violence or abuse or trafficking or exploitation.

Access to legal advice

The people we spoke with had no understanding of how the Illegal Migration Act 2023 directly impacted them. Most spoke of going through the system and getting their 'papers' in the future. It is a serious concern that they have not been able to obtain legal advice on their immigration status in the UK, particularly with the operationalising of the Rwanda policy following the passing of the Safety of Rwanda Act 2024, and the likelihood that the majority of residents will fall under the provisions of the Illegal Migration Act, given their arrival dates and mode of arrival. As with many areas of England, the East of England and Essex where the Wethersfield site is located are 'legal aid deserts' suffering from a chronic lack of legal aid funding for advice on asylum and immigration. It is further a cause for concern, and potential security issue, of how the people in Wethersfield will respond when the implications of the Illegal Migration Act are explained to them.

There was a common sentiment of apprehension amongst the men we spoke to about how long they would have to stay at the Wethersfield site. One individual relayed that they had been told by staff that the longest anyone would stay would be nine months. He further said that there is one person who they know has been on the site for eight months and if he is not moved at the nine-month mark 'the place will burn'. One individual said that morale would improve on the site if people were regularly moved out of Wethersfield. They described the

sense of not knowing how long they would be there as anxiety inducing. During the course of the assessment period, a large group of 70 people were moved off the site in a single day which was reported by the Home Office to improve morale on site but also raised questions about the impact on residents left behind and explanations for how people had been selected for relocation.

Healthcare

Staffing

Primary care services are supplied by Commisceo Primary Care Solutions, a private company that sits within NHS England funded by the Home Office. At the time of the assessment, contracted staff roles at the health clinic comprised of a Primary Care Service Manager who oversaw all health services and staffing, made final decisions on further actions including any onwards referrals and relocations; three nurses including a mental health nurse; a community care nurse and three healthcare assistants. An NHS Head of Integrated Care leads on coordination with different health services and chairs the Mental Health sub-group.

Access and presenting issues

The Health Clinic is open 10 am – 6 pm Monday – Friday and operates on an appointment service in line with community GP access. The appointment booking system has until recently been carried out by Clearsprings officers, with the window for making these appointments restricted to one hour each day. Some officers reported that a significant part of their role was phoning the clinic on behalf of residents to try and make an appointment. Residents also shared they can feel uncomfortable disclosing their health issues with the officers and this was a barrier to access. More recently NHS desks have been introduced in the communal blocks to allow residents to make their own appointments.

Outside these hours the routes are the same as community GP practice closure hours, and residents would call 111 or 999. Other non-emergency routes outside of core hours were advised to be speaking to a Clearsprings staff member or calling the general Migrant Help issues reporting line. It was noted there are no clinically trained professionals in the Clearsprings team to provide out of hours support. Security guards are stationed at the entrance to the health centre, as with all buildings on site.

All new arrivals are given a standard ‘Asylum Seeker Health Check’ which involves taking their medical history, height, and weight, identifying any medication they are on, checking their vaccinations and taking full bloods. Residents during the induction process were observed to be told they must consent to blood being taken or forfeit access to ongoing medical care. If any medication is missing on arrival including having been confiscated at Manston, the team report it can be quickly replaced. If medical issues are identified that need follow up, an appointment is made for the next day as it is felt that they are too tired after travel and induction to cope with anything more. Residents with serious health concerns can be placed in isolation. This is voluntary, and residents do not have to consent.

Many new residents arrive with tooth pain and dental problems. This is common for people who have spent many months on the move and who have spent time sleeping rough without resources to meet their basic health needs including dental hygiene. Access to dentistry is subject to the same challenges as the wider population and the immediate care is limited to pain relief. When an appointment is secured, transportation services reported that many people are turned away due to language barriers. To address the structural barriers and levels of need, NHS England have produced a Model of oral healthcare for asylum seekers

and refugees. The seven-step model includes guidance on interpretation services to support equitable access for this vulnerable group that should be referenced by staff supporting with appointments.

The main infections on site were reported to be TB, scabies, Covid-19 and STDs. The health team work closely with TB services and dependent on test results, may follow up with chest x-ray, isolation and treatment as needed.

Some residents have been diagnosed with HIV following blood tests as part of the asylum seeker health check on arrival and have been left to manage the impact of that diagnosis while living on site. While the cases are reported to be low, the impact on individuals and the need for highly sensitive care and support around these issues is clearly critical. The NHS Integrated Care lead was alive to these issues and the imperative for confidentiality, discussed elsewhere in this report, however it raises a significant concern about the wider understanding of the health team given the limited experience of working with people from countries where this is a stigmatising diagnosis. It is also a concern that individuals with an HIV diagnosis are not routinely found more suitable accommodation away from the Wethersfield site which would allow them to more easily manage their diagnosis and treatment.

Health staff advised that all correspondence was available in at least seven languages but there was a need for continual learning. All information presented at the Health Centre is scanned on to an individual's health record and linked to the persons health ID. Language Line telephone interpreting is available although one team member highlighted the lack of privacy in the centre, with telephone interpreters placed on loudspeaker being clearly audible outside consulting rooms when discussing confidential health matters.

The health leads advised that the site was unsuitable for anyone with disabilities or other physical health needs as it was not an accessible site and therefore believed there was no one on site with any physical needs. The Red Cross were told about several cases who should have been deemed unsuitable according to these criteria. One staff member recounted the case of a young man with severe injuries as a result on stepping on a land mine who they had to escalate and make the case to be moved off site. They encountered resistance to this from Home Office decision makers. We were also informed of people arriving with broken bones that had not been deemed serious enough to consider for more suitable accommodation despite the cramped living conditions and Wethersfield and reliance on minibus journeys to local town to access basic services including collecting prescriptions and accessing advice and support services.

Medication

The service manager advised that medication is disclosed by residents at the initial asylum seeker health check. This includes if there is a requirement for medications that may need to be administered by injection. We were informed that any missing medication could be prescribed and collected locally on the same day even out of hours. Processes were described as far better than a local community GP Practice. While some people arrive with medication, the Red Cross understands this is usually removed from them at Manston.

The nearest pharmacy was within a six-mile radius. Prescriptions were originally sent direct to chemists who would then deliver to site and the medication was handed out by the health team. This was changed to the direct provision to residents with instructions on where to find a chemist, reported to be intended as a way to help people integrate. The arrangement works well from the perspective of the health team although voluntary sector organisations report residents turning up at their offices with a prescription with no idea how to fill it.

It was reported that there was no controlled medication on site and at the time of the first Red Cross visit in March it was reported that only 10 prescriptions of diazepam had been issued since the site opened. Anti-depressants are also regularly prescribed including as an outcome of the Global Mental Health Assessment Tool (GMHAT) as well as sleeping tablets. Residents are provided with a maximum of seven days' of their medication to reduce the risk of overdose. This requires people to make weekly journeys on the minibuses to attend the pharmacy which was reported to be a barrier for people struggling with their mental health. The policy is applied uniformly.

The service manager reported they had visited Manston to understand the initial screening health process people go through prior to arrival at Wethersfield. One of the concerns the Red Cross raised about the process for managing medical needs at Dover and Manston was that medication for chronic illness was usually confiscated on arrival. Many people we spoke with who spent time at Manston were worried about this, and there were disclosures of chronic conditions that would require faster access to assessment and medication. If the system at Wethersfield works well, residents could potentially get these needs met faster via the initial health check and get the medication they need. Staff reported if someone is on Methadone or another controlled medication they are not sent to Wethersfield as it is felt that the value of these medications would make them vulnerable on site. Given the focus on rapid processing on arrival there may be gaps that require further consideration. It was mentioned that private medication buying off site to self-medicate was a possibility.

Mental Health

> *'Someone tried to jump yesterday, this is happening all the time. The fighting here ruins everything, I don't want to live in a place like this.'*

During site visits to Penally, Dover and Manston, the British Red Cross adopted a trauma informed perspective to consider the experience of both residents and staff living/working in a highly complex and challenging environment. This has been acknowledged by the Home Office as an important tool for identifying best practice and is one area we hope is given further consideration in our recommendations. However, all concerns highlighted in this current report will impact significantly on the wellbeing and mental health in this client group for whom dislocation from country of origin, trafficking, sexual violence, witnessing and being subjected to torture, to name but a few examples, result in both acute and chronic mental health difficulties, including complex PTSD.

Doctors of the World with Medicine Sans Frontiers have been providing primary care services ancillary to the site since the end of 2023. While their original intention was to focus on physical health, they found the provision on site to be broadly meeting the needs of residents which is positive. Instead, they found the levels of mental health presentation to be extremely high. The clinical team use the 'CORE-10' or "Clinical Outcomes in Routine Evaluation" (CORE) system that comprises tools and advice to support monitoring of change and outcomes in routine practice in psychotherapy, counselling and any other work attempting to promote psychological recovery, health, and wellbeing. They have a variety of measures. The CORE-10 is a 10-item measure asking how a person has felt over the past week. It is a session-by-session monitoring tool with items covering anxiety, depression, trauma, physical problems, functioning and risk to self. the CORE-10 has six problem domain items,

three functioning domain items and one risk item. The total score indicates a persons' level of psychological distress.

Using this assessment tool for people accessing the service who reported a mental health complaint, which was 83% of all users, the data showed:

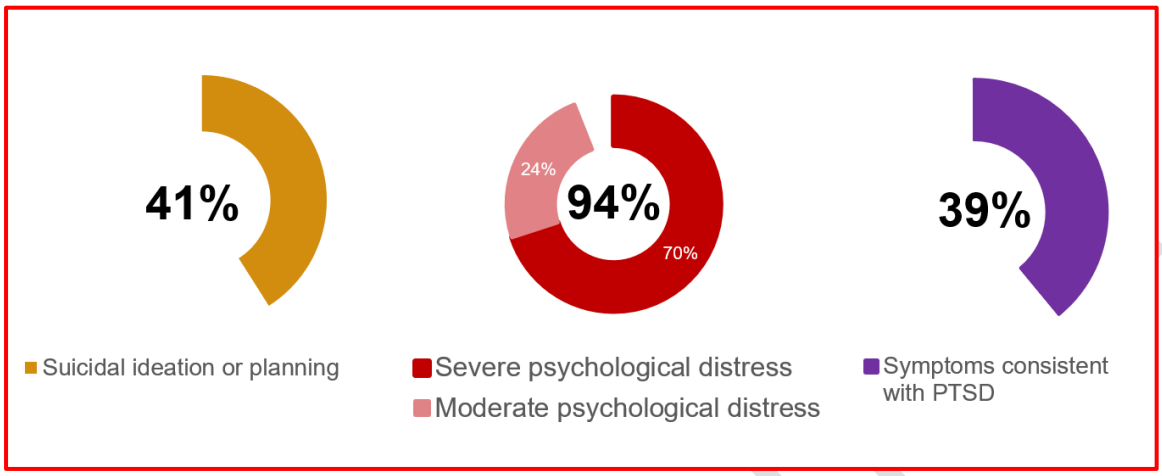

Figure 3: percentage of people accessing the service with a mental health complaint who had suicidal ideation, extreme or moderate psychological distress or symptoms consistent with PTSD.

The clinical team at Doctors of the World escalate concerns into the Clearsprings team, onsite health services, and make adult social care referrals where appropriate.

The onsite health team reported to us that suicidal ideation rate was 10% of the residents they saw. This was later reduced to a much lower rate as it was not clear on the assessment criteria or tool being used. There appeared to be some challenges defining suicidal ideation and attempts and self-harm/injurious behaviour. Examples of incidents provided by the service manager included men walking into a reservoir attempting to drown; the stitching together of lips; slicing legs with a knife and taking overdoses, however these were not considered to be self-harm incidents or categorised as such. Residents reported witnessing people climbing to the top of buildings with the intention of jumping and the Red Cross were shown videos of these incidents. A Clearsprings staff member shared a distressing experience where they had to talk a resident down from jumping out of a window.

Residents are witnessing the impact of trauma on men living on the site, with suicidal ideation and attempts occurring regularly. There is little evidence of follow up care following acts of self-harm and suicide attempts. This is highlighted in elsewhere in this report and in our recommendations as a serious concern.

Case study: “People are trying to kill themselves all the time.”

A resident disclosed that he had witnessed five suicide attempts in the five months he had been at the Wethersfield site. One of the suicide attempts had happened the previous evening, whereby an individual took a surplus of medication. We were advised that it took an hour for the ambulance to arrive. The health team on site were unaware of this event.

The resident wrote about his experience, saying, “I have seen things here that I did not see on my journey to the UK. I have seen things I never thought I would see... People are trying to kill themselves all the time, 5 people since I came… I have seen self-harm and suicide attempts, and it makes me think about doing [it].”

Another individual described seeing a person sew his own mouth shut. The health team confirmed they were aware of this person and treatment had been received to remove the stitches.

The service manager shared that if someone was actively suicidal, they would be sent to hospital with another resident to accompany them, and a ‘care plan’ would be written including welfare checks from Clearsprings, however we found little evidence of such plans being standard practice. Social workers in the Adult Social Care team had also not seen a written plan. It is not clear who would have overall responsibility for these plans.

One man we spoke with had recently made a suicide attempt and had been sent to hospital. When we saw him again three weeks later, he told us he had not received any follow up support, no one from either the health or Clearsprings team had been to see him. This suggests the responses are more ad-hoc than they may first appear, and unwell people are likely to fall through the gaps.

The service manager advised that the health team would not get involved in decision making about relocations from the site if someone was vulnerable due to health or mental health deterioration. This raised concerns in relation to the ‘case-by-case' approach that is now meant to be taken for relocation requests under the updated suitability criteria in the Allocation of Asylum Accommodation Policy, and apparent barriers to key health information being considered under the new policy for Wethersfield residents who required relocation.

They further advised that the Commisceo Director and the Home Office doctor would review cases and provide second opinions. Where medical evidence has also been provided from independent clinicians, this approach should be mindful of the High Court judgement [1] on the ‘second opinion policy’ introduced in June 2022 that related to medico-legal reports submitted by or on behalf of a person in immigration detention, addressing their vulnerability to harm in detention. The policy previously directed Home Office decision-makers to delay consideration of any independent reports in deciding whether a vulnerable person should remain in immigration detention whilst it sought a second medical opinion from a Home Office contracted doctor. The judgement found this policy to be unlawful. While Wethersfield is not classified as an official detention setting, as highlighted throughout this report it meets many of the features of detention - including the experiences of residents, and the views and approaches of staff.

One man with additional vulnerabilities was deemed high-risk and discussed weekly at the Multi-Disciplinary Team meeting, Adult Social Care shared that it took over a month for a decision on relocation with the delay they understand coming from the Home Office team responsible for relocations.

The service manager found no concerns in respect to drug and alcohol use on site, and while there were a few 'problem makers' declared instances were low and not related to mental health issues. Braintree was raised as an area of concern in respect to the risk of supplying drugs to the men on site. The Home Office is considering banning alcohol completely from the site which suggests there are some issues relating to alcohol use and more clarity on this would be helpful in informing any onward actions. There were references made to challenging mental capacity due to intoxication and despite no clear evidence of dementia screening, it had been determined that there was no-one on site with dementia.

Mental health provision on site

People seeking asylum are recognised to be at an increased risk of mental health problems, particularly if they have experienced traumas of violence, exploitation, torture or sexual violence. To respond to this high level of risk there is a single mental health professional on site for the approximately 600 residents. The Home Office leads and most staff we spoke with consider this provision sufficient and even more than might be provided in a community setting. Our assessment found the reverse. For a group of people so highly predisposed to trauma impacting on their mental health plus the absence of any protective factors such as connections with family and friends; meaningful social activity and good sleep routines and nutritious food of their choosing, a higher level of mental health presentation than would be found in the local population of Braintree should be expected. It is also highly likely that an environment that is physically and psychologically unsafe is going to cause and exacerbate mental health difficulties and retraumatise people who have pre-existing experience of trauma.

The Home Office have introduced the Global Mental Health Assessment Tool (GMHAT) for initial assessments. This was reported to be an attempt to manage the high numbers of residents presenting at the hospital emergency units in mental health crisis and the poor pathway between the two. For example, people who were suicidal attending hospital in crisis then being discharged back to the site after acute episode with no onward care plan in place. The tool is used by health care assistants at initial assessment. It is designed to support decision-making on appropriate care plans, including referral to mental health services where required; identify individuals who need more and/or specialist support early in their journey before they deteriorate and present in crisis; and generate data on individual-level mental health, which can then be monitored over time.

The helpfulness and effectiveness of this screening tool is reliant on the training and administrators' cultural sensitivity; appropriate access to the right language or interpreters; privacy; the time to administer, and then clear pathways for follow up to in-depth mental health diagnosis and treatment. The Red Cross mental health and psychosocial team and independent clinicians at Doctors of the World have concerns about whether these fundamental elements are in place at the Wethersfield site.

The tool is due to be evaluated in June 2024 and it is welcome that steps are being taken to manage and monitor mental health outcomes for residents bearing in mind the disproportionately high levels of presentation. Use of the tool should not be seen as the end in itself and the focus must remain on outcomes for patients and the support put in place after the assessment.

It is also unclear how the tool aligns with the suitability criteria for being on the site, or how assessment data is used in the medical evidence required to inform decisions about relocations to more suitable accommodation. Outcomes for people found to have depression, anxiety and other stress-related conditions are referral to primary care mental health services. For severe depression with moderate to severe self-harm patients should be

referred to secondary care mental health services. It is not clear how this is being interpreted on site. The health team report most assessments lead to referrals to talking therapy provided over the phone and/or medication, but that there can be low engagement with the talking therapy that could be in part due to the lack of privacy on the site.

Barriers to accessing mental health services via the Essex Partnership University Trust have been identified by the health team and a mental health working group has been established and led by the NHS lead to strengthen referral pathways and practical cooperation across services. The lead also reflects the view of the adult social care team that cases of diagnosed mental health conditions are lower and there is no one on site that meets the threshold for care and support needs under the Care Act, but that most residents 'fall somewhere in the middle' and have some form of mental health need. The situational driven mental health issues and deterioration could be missed by the assessment and should be considered as part of the evaluation of using this type of assessment in a large-scale barracks setting.

Doctors of the World have provided some limited services to fill the gaps in support alongside their clinical service. They run regular psychoeducation sessions from a location in Braintree. Getting people to sign up has been a challenge and they are assessing ways to increase attendance, including building in time to fully explain the purpose of the sessions. Topics include conflict resolution, boundaries, stress, sleep, basic mental health, and communication are all voluntary separate modules. They emphasise that psychoeducation is non-clinical and should never be seen as a replacement for mental health support. Care should be taken by the Home Office and others in describing the purpose and scope of this provision.

Sessions of psychological first aid have also been successfully delivered on site by Doctors of the World, consisting of a morning and afternoon session provided Tigrinya, Persian, Arabic and Kurdish Sorani. There are no plans to repeat this at present however it has been identified that all staff as well as residents would benefit from these sessions and the Home Office are exploring options. They highlight they will not be able to provide these services permanently and a longer term more sustainable solution needs to be secured as part of the wider range of activities that support residents to manage their mental health while having to live on the site.

The Boloh Helpline, a Home Office-funded service for people in the asylum system run by Barnardo's was listed on a poster in one of the welfare blocks and this is a service the Asylum Mental Health and Wellbeing lead at the Home Office, who has visited the site, is keen to promote. The Helpline offers advice, signposting, emotional support and eight free sessions of therapy by qualified therapist. We understand the mental health nurse provides the number to residents he sees, although staff we spoke with on the site including health managers were not aware of it. The data shared by the Home Office shows that only eight referrals have been received for people at Wethersfield, four self-referrals and the remainder we understand as having been made by Doctors of the World. As with the other telephone-based support, lack of privacy on the site and the fact that most new arrivals do now have mobile phones, or have them confiscated at Manston, could be a barrier for telephone-based therapy that need to be addressed and should be looked at as part of the evaluation of accessibility of the service for people accommodated on large-scale sites. There is also a question about how safe it is to engage in any type of therapy for someone housed at Wethersfield or any large-scale institutional setting with the risks, isolation from community and lack of protective social factors.

Safeguarding and welfare issues

Identification

Safeguarding concerns can and should be able to be raised by anyone who has a concern about a resident at Wethersfield. In practice the processes are not clear, with each agency onsite having a different process in place, and off-site agencies or voluntary support onsite lacking clear referral pathways.

Welfare checks are conducted by Clearsprings officers twice per month to meet the contractual KPIs and the data uploaded to the central Clearsprings system which is not automatically accessible to the team at the site. Group welfare checks are carried out to meet this requirement. For example, the Red Cross team observed two group welfare checks taking place with four or five men in each group in an open plan office with residents interpreting for each other, limiting opportunities for disclosure of sensitive information such as trafficking and modern slavery; sexual violence, mental health deterioration or other risk factors. Outside of the contractual checks we were informed a welfare check would be triggered by someone not signing in for meals at the canteen for three consecutive days or nine meals.

One man we spoke with told us he had left the site due to fears for his safety and travelled to stay with an acquaintance. When this arrangement broke down, he spent over a week sleeping rough and eventually made his way back to Wethersfield on foot, a journey that took him several days. On arrival back at the site he was able to re-enter and learnt that his absence had gone unnoticed.

The Clearsprings guidance on welfare checks is based on room-based checks and sets out the need to use a translation service to avoid miscommunication. As highlighted elsewhere in this report, the use of interpreters has been observed to be absent at crucial stages so assurances should be sought that this is in place during the bi-monthly welfare checks. Questions covered during the check are listed on the online form not seen by the Red Cross assessment team.

If additional concerns are identified, a standard incident report is advised to be completed. There is no explicit guidance that these checks should be carried out on a one-to-one basis although it is implied throughout the guidance and the practice of group welfare checks at Wethersfield is likely an adaption of this guidance specific to the site. A requirement to offer signposting based on the needs of the resident is included in the guidance that would benefit from external oversight, for example monitoring on the routine nature of signposting and quality assurance and updating of the content of the resources.

We were told that if the medical team had a concern about someone's mental health particularly, around suicidal ideation, one of the measures put in place would be additional welfare checks. Given Clearsprings officers lack training in mental health or social work, additional guidance should be provided on this and the limitations of the Clearsprings contractual requirements around this acknowledged by medical staff. Prison guidance such as the Managing Prisoner Safety in Custody rules and guidance for prison staff on managing prisoners who are at risk of harm or death, or who may be a risk to others could be considered as framework given the institutional nature of the Wethersfield site.

Residents who wish to disclose or raise an issue or safeguarding concern are provided with two main pathways to do this: attending the welfare office and asking to speak to a Clearsprings staff member or calling the Migrant Help phone line. It was noted that any issue raised with Migrant Help will be passed back to Clearsprings management by email to

respond to with KPIs in place for this part of the contract. Issues raised in this way range from complaints about the quality of food to complaints of bullying and harassment. The issue is logged with the AIRE team on a separate database not accessible to the onsite team. Some Clearsprings officers we spoke with explained that if someone disclosed a past incident of torture they would book them a medical appointment. There was no automatic requirement to raise a welfare or safeguarding issue, so in this example the information would not be logged on any system. This has implications for any decisions about ongoing accommodation and support; considerations for suitability for accommodation on large-scale sites, and the possibility of re-traumatisation if the disclosure needed to be repeated, recognising the need for consent for any information to be captured and shared and implications fully explained.

The data capture mechanism in place for disclosures outside of the routine welfare checks (with the limitations described above) is the 'Incident Report' that can be uploaded to the Clearsprings portal. Medical staff have noted the generic nature of this reporting framework and its limitations, however while this is the only system in place for out-of-cycle reporting, staff should be encouraged to record such disclosures as an 'incident' for the purposes of recording with full consent of the individual and improved delineation of issues to support better monitoring; actions and outcomes, particularly where welfare issues escalate to more serious safeguarding concerns.

Barriers to disclosure

Barriers to residents disclosing issues directly with Clearsprings include the physical presence of security at all entrances to buildings and at every door of internal rooms including within barrack accommodation blocks and welfare spaces of the Portacabin accommodation area. Residents have reported altercations with security and the Red Cross were shown footage filmed on residents' phones of fights between security and residents where security staff were filmed landing blows and fighting on the floor. Residents have also described being harassed by catering staff in the canteen and being told they would be 'sent to Rwanda' while security staff looked on. These experiences, whether felt directly or witnessed, would undoubtedly undermine confidence in the overall staffing of the site and the ability to disclose sensitive and confidential information to any staff member.

Management shared that if a resident reported a case of bullying or harassment via the Migrant Help phone line, the team on site would go to the person's room and ask them to point out the person who was bullying them, which was considered an effective response.

The lack of use of interpreters risks people being unable to make themselves understood, masked by the culture of 'getting by' with gestures and basic English observed across the site and at crucial points of engagement such as induction and welfare meetings. The lack of confidential space and practice of carrying out group welfare checks are also a clear barrier for someone who has a sensitive issue they would like to talk about. Trust is fundamental to disclosure. Some Clearsprings staff shared WhatsApp messages from residents who had left the site and continued to be in contact intended to indicate a level of trust and positive relationships. At an institutional level, the ability for residents to feel confident in sharing confidential information is a concern. Residents we spoke with shared feelings of frustration that when they did raise an issue it was not acted on, with three in four residents stating that not enough was done to fix problems they raised and 71% of those people saying nothing was done at all.

Examples of problems being reported include discrimination and assault:

> *"My friend was attacked yesterday, and the gang of residents said that they would kill him. I don't feel safe and protected outside of my room. We follow rules and this is maybe why we are being threatened."*

> *"I was once assaulted by someone and one of the staff told me to hit the person back. The staff treat me like an animal."*

And mental health concerns:

> *"I went to the welfare office to ask for a mental health appointment for the doctor. I was told by the office lady to pray and that I didn't need to go to the doctor because Allah would help me."*

We are concerned about the impact of people being told on arrival that they should behave well because *'any incident report will not complement your asylum claim'* which could be interpreted as not raising any issue that will cause a problem for the Home Office or other staff, particularly with the lack of professional interpreters being used for induction.

There appeared to be confusion amongst Clearsprings staff of the process for managing disclosures and a tendency to minimise concerns was apparent and embedded in the culture of the staff on site. This raises concerns about the ability of Clearsprings staff to identify possible safeguarding issues and take the appropriate steps, echoed by many of the professionals interviewed as part of this assessment. We were told for example that most referrals to adult social care were not being made by onsite staff. This would suggest a low level of identification, inadequate response, or both. While not every concern will require a referral into statutory services, the levels of inherent vulnerabilities of the cohort of people housed at Wethersfield, without adequate vulnerability screening, isolated from the community lacking protective factors to managing their mental health suggest higher levels of statutory referrals than are apparent from the staff team responsible for safeguarding. For greater assurance the data on internal safeguards raised via the Clearsprings systems and outcomes to these issues should be reviewed. We would also suggest checks on levels of awareness across the staff team around issues relating to adults at risk; exploitation; abuse; trafficking, trauma and sexual violence including knowledge of indicators and how to recognise and respond.

In recent weeks social workers from adult social care have increased their presence to respond to referrals and in part to have greater visibility on site. This is a positive development, and this more regular contact may help increase awareness across the Clearsprings staff team about when they should be raising a concern. There was some evidence of this reported by adult social care starting to happen informally. If done more systematically, for example ensuring onsite staff can participate in the weekly multi-disciplinary team meetings where safeguarding is discussed, this process could be strengthened, however neither approach is a substitute for having experienced staff who can identify and safely respond to concerns.

Medical staff believed that mental capacity is checked before anyone moves to the site, but that there had been a couple of cases that had *'slipped through the net'*. This was supported by independent organisations who reported at least two cases of capacity concerns that had not been identified while the men were living onsite that had required them to refer to adult social care. It is not clear when mental capacity checks would take place, interactions both at the initial encounter and on arrival at Wethersfield are conducted rapidly and without the routine use of interpreters. The asylum screening would then be the only opportunity for this.

The fact that at least two cases we know of where capacity issues were not picked up before arrival or by any of the staff interacting with the men is a cause of concern, particularly given the higher risk for abuse or harm in these cases.

Response, referrals, and information sharing

Each contractor (Clearsprings; Supreme, Commisceo, Mite) on site operates independently, with their own safeguarding reporting system; processes; training; standards and assurance. The health staff we spoke with believed that safeguarding issues are shared across teams, however, as there are no data sharing agreements in place the health team must get consent forms completed before sharing residents' information with other teams on site. Medical records are stored securely on electronic systems.

There is no central database of safeguarding issues on site. Staff we spoke with believed the Home Office ultimately has oversight of all safeguarding issues but were unclear if anyone on site had the overall picture or whether this was via another offsite system. The risk of undefined pathways means agencies hold different pieces of information and follow different processes, making a multi-agency approach incredibly difficult at the Wethersfield site. This has started to be addressed through the establishment of a multi-disciplinary team (MDT) comprising of the NHS Integrated Care Lead, Clearsprings Safeguarding Lead who works offsite, and Essex Adult Social Care social workers. The group meets weekly to discuss actions to be taken for a list of residents deemed high risk. For a case to be escalated to the group, concerns must be raised by Clearsprings, and further clarity on the criteria and process should be sought to better understand how effectively this is working.

Outside of the contractual bi-monthly welfare checks that were observed to be conducted in groups of up to five residents at a time, the process for identifying ad-hoc welfare and safeguarding issues requires improvement. For example, if someone approaches an officer to raise a concern verbally as they are encouraged to do, it is not clear whether this is automatically recorded on their file. Critical pieces of information are held on emails, the result being things could be missed and escalations not monitored. Where things have reached crisis point, gaps in information about escalating mental health issues would not be easily accessible, such was the case of the man who had to be talked down from a window ledge.

One man we spoke with complained to us that he was unable to get support from the medical centre, as they directed him to Clearsprings, and then Clearsprings directed him back to the medical centre. He was being passed back and forth, without getting the support that he needed for his medical issue. This was very concerning as it indicates an underlying lack of coordination between these two key support services. We also noted a lack of consistency when discussing medical consent and data sharing. This could create illegal sharing of personal data and distrust of medical services on site.

Adult Social Care are now more engaged with the site and report that developing pathways and referrals from the site and onwards has been an area of focus, reflecting that engaging with the site has been *'a huge and steep learning curve'* due to the volume of referrals into their team and the complexities of navigating the roles of the different agencies. This is addressed through a fortnightly safeguarding working group that aims to develop clear pathways for Section 42 Care Act referrals; urgent care and treatment for mental health

episodes, which they believe most cases fall in to, and keeping people safe on site, looking at who is responsible for each of these categories.

Adult Social Care report there is no one with support and care needs that meet Care Act thresholds living on the site and would expect anyone with these needs to be relocated. They do carry out assessments and gave the example of a concern being raised about someone with 'additional needs' that started as a safeguarding concern and moved to completing a Care Act assessment and was ultimately provided with advice. Another resident had issues with his back and was assessed for any additional concerns. He was temporarily provided with alternative accommodation on the site. Adult Social Care hope that people with care and support needs would be seen by the medical team. They considered the prevalence of people onsite meeting this threshold to be low and the greater concern to be safeguarding and mental health management.

The referral route into Adult Social Care has been simplified with a single point of access via the online portal that has been shared with Home Office and Clearsprings. They highlight a lack of ability to deal with mental health, and this will be referred on. If a referral into Adult Social Care determines the concern is a 'Home Office' issue the referral will then be passed back to Clearsprings to respond to. It was not clear whether Adult Social Care will respond to the referrer or simply signpost on and what assurances are in place around this process.

A weekly multi-disciplinary team meeting to individual cases has been more recently established. This includes a Clearsprings safeguarding lead who does not work at the site, a representative from the onsite medical team and a social worker from Adult Social Care. As the safeguarding body the local authority have the overall duty. They engage with Doctors of the World and other independent agencies separately outside of this structure. One of their concerns is around whether appropriate safeguards are being identified and raised, and this concern is part of the reason for adult social care social workers being more present and visible on site. When the Red Cross team visited the site in April the social workers had just started attending. It was clear that Clearsprings and Home Office staff did not fully understand the role of the social workers and were at an early stage of establishing the connection. The social workers remained in a back office of the welfare block for the duration of the time the Red Cross were onsite. One social worker we spoke with commented that when walking around site, they always ensured they were accompanied by a security guard for their own safety. While safety is clearly critical for all people on site, this should also be considered in the context of tensions between security and residents and barriers to disclosure of abuse and other confidential information.

Case study: Most vulnerable slipping through the gaps

The Red Cross assessment team were told by onsite staff about a man who had deteriorated significantly while living on the site, leading to him being unable to manage his basic needs when he was moved offsite.

Staff explained that the man became withdrawn and stopped leaving his room, with roommates bringing him food from the canteen. The man withdrew further, stopped washing and attending to hygiene. The team leader described having to physically support and prop up the man to leave his bed and walk to the health centre to be seen, such was his poor physical and mental state. This decline happened over several weeks.

By the time he was eventually moved off the site, his deterioration was so complete he was unable to independently manage his basic needs. It is not clear why interventions were not made sooner and why he was allowed to deteriorate over the course of several weeks. If the multi-disciplinary team had been functioning well, this should have been immediately brought to their attention with swifter action taken. There are clearly weaknesses in the system that risk the most vulnerable slipping through the gaps.

Statutory services with duties towards the residents of Wethersfield recognise the unique setting and the challenge of delivering a community-based model of social care to a highly institutional setting. The additional risks of the site being managed by a non-specialist private housing firm also need to be acknowledged and considered. Good inroads have been made to establish multi-disciplinary approaches but overall, there is much more to be done and the local authority continue to seek assurances from the Home Office and their contractual providers around safeguarding. There appeared to be an assumption by the statutory services that actions identified around safeguarding people with risk and vulnerabilities including mental health concerns, would be taken forward by the Clearsprings staff. There was an assumption that those staff were responsible for actions flowing from the multi-disciplinary team meetings on high-risk residents such as creating support and risk plans, although social workers admitted that had never seen any written plans. There is a lack of clarity about roles and responsibilities, with Adult Social Care believing Clearsprings should take greater responsibility but also perhaps a misunderstanding of their role, their capabilities, or the limitations of the contract. This might stem in part from the assumption that Clearsprings are a qualified welfare team. There is a need for greater visibility over roles; training and monitoring of actions taken; records kept by Clearsprings and a deeper level of professional curiosity and scrutiny by statutory services.

Adult Social Care highlighted the need for more information sharing across agencies on site. They called for greater assurance about how safeguarding issues are identified and raised by the responsible agencies on site. They also highlight the gaps in whistle-blower policies that should act as another level of assurance in the ability to rase issues.

Children and adolescents on site

Unaccompanied children under the age of 18 should legally not be placed on the Wethersfield site. When the Home Office began engagement around establishing the site, assurances were made to Essex Children's Services that mitigations were in place. These included assurances of a robust age assessment at the border, and an 'under-25 policy', dictating if a doubt around young person's stated age was raised as being under-25, the young person would not be suitable for immediate transfer to an ex-military site while fuller

age determination took place. This assurance was made to minimise the risk of children being placed on site and recognising the difficulties is assessing age at the border to within two or three years. Children's Services were informed that the system at the border was working *'incredibly well'* citing the fact that no children had been identified at Manston.

On operationalising Wethersfield this safeguard was dissolved and there was a steady increase in referrals to children's services. Children's services also became aware that '18-21' was a category captured by the site, for example for health screening, which was found to be lower amongst this residents group, indicating the prevalence of people as young as 18 on site. This was raised as an issue by Children's Servies and the Home Office were found to be responsive, re-implementing the benefit of the doubt under-25 guidance. In policy however, non-age disputed adolescents from 18 years old continue to be deemed suitable for living on large-scale military sites placing them at potentially increased risk of sexual violence; exploitation and abuse from older adults and an impact on their emotional development.

> *"I don't feel safe because of my health. I am not being cared for properly but only given medication. I want to be moved. I am 19-year-old and everyone here is older."*

Since the Wethersfield site opened in July 2023 between 30 and 40 referrals have been made to children's services, the majority between September and December 2023, with 16 in one month alone. The Children's Services Manager met with the Home Office leads to address how the mitigation had broken down and reported a positive change in process form that point. Children's Services have a duty to carry out age assessments. Around half of the people referred have been taken in to care while the full Merton-compliant age assessment takes place, usually over three meetings of several hours. They emphasize the importance of the 'benefit of the doubt' principle and will not put a child through the age assessment process unduly if they clearly look and act like a child. They report the Home Office has challenged their decisions to accept a child's age in the past and have tried to refer to their own age assessment process which they have had to push back on.

Referrals are received from both Clearsprings and external agencies including Doctors of the World. Initially, a lack of detail in the referrals meant that they attended the site multiple times only to see the same child who had already been referred to them but reported this has now improved. Social workers will provide 24 hours' notice before attending the site in the hope that Clearsprings will make arrangements for supporting young people who are not taken into care, and now have two dedicated onsite contacts. They describe one harrowing experience where a young man in a group of friends was found to be older than the others and 'left behind' when his friends were taken off site, becoming incredibly distressed. The social work team were unable to locate any Clearsprings staff to support the young person and the situation became fraught. They hope that support is now in place for young people after the age assessment process and that signposting information to independent organisations for ongoing advocacy would be in place, but they cannot be sure of what happens once their part of the process is completed. Social workers are connected to the relevant Health and Social Care group and feel confident they could raise issues there as needed.

Clearsprings staff we spoke with were able to clearly describe the process once a child identifies themselves on the site.

> *"If an SU says that they are a minor, we put them in the isolation block (1026) in a single room. We note down their claimed DOB,*

room number, and port reference. We go to Danielle at the Home Office who then sets up a social worker from Essex County Council coming to site and age assessing. They come within a week and then provide the age assessment outcome and paperwork. We will photocopy that and put that on their file."

Physical safety and protection of minority groups

General safety and security

"I do not feel safe, I spent 24 years in a camp in Iraq and now I am back in camp again it makes me very scared."

"I find it very difficult to live here. This place reminds me of prisons in Syria I wish other accommodation would be provided."

Physical safety was big concern for residents, with over 75% of the people we spoke to saying they did not feel at all safe or safe enough living on the site. In contrast, 80% of people said they felt safe when they left the site and spent time in the community. One man commented:

"Because this place is like prison; it's a closed environment and there are always fights inside Wethersfield, so feel safe being outside".

Staff reported few troubles with bullying or harassment on site, however residents fed back this was a common issue and contributing to their feelings of lack of safety. This indicates the identification and reporting of incidents should be reassessed, with barriers to disclosure and identification fully explored and understood.

Social workers supporting children through the age assessment process report hearings claims from the children and young people they met of fighting between groups, cultural violence, and threats of sexual violence and coercion.

There was a single image of a homemade knife (shank) displayed in several places. Security reported that people are not searched on arrival or when they come and go, so that items like this are likely to be on site. This obviously increases the risk to all residents, combined with the frustrations and deteriorating mental health that has come out so strongly during this assessment. Additional work would be beneficial to ensure that everyone on site knows what to do if there is a stabbing or injury such as first aid training and bleed control kits. First aid provision was not obvious in many locations around the site, this needs to be followed up on as only one kit was observed on site.

"My friend was attacked yesterday, and the gang of residents said that they would kill him. I don't feel safe and protected outside of my room. We follow rules and this is maybe why we are being threatened."

Clearsprings reported residents complaining about the plates that were used in the canteen. They stated that the plates smelled and as a result were questioning if they were clean. A staff member stated to us that residents preferred the paper plates, and that they had even stated to staff that the current ceramic plates *"are perfect weapons…."*.

Consideration is being given to the practical need for security around the site, versus the appearance of heavy security. The example was given of the guard dog being withdrawn

from service, and other means being explored, given that the dog gave an unnecessary appearance of escalation. This consideration is positive, and any future reductions in unrequired security pressures should be considered. The visibly heavy security presence around the site is constant and mentally very impactful.

Keeping people safe and managing behaviour on a large, isolated site with up to 600 men, with few activities and a high prevalence of trauma and poor mental health presents an enormous challenge that the Home Office and their contracted providers are ill-equipped to safely deal with. The professionals we spoke with painted a picture of a chaotic start when the site began intaking new residents, with panicked staff over-correcting following incidents, for example when gym equipment was used as a weapon in a fight the response was to immediately remove all equipment. The status of a site as initial accommodation clearly does not reflect the reality of the institutional environment and as such no specialist inputs, standards or safeguards are in place. This concern for safety was highlighted by David Neal, then Chief Inspector of Borders and Immigration following a visit to the site.

Protection of vulnerable and minority groups

> *"This site is affecting my physical and mental health. I am not sleeping. I am losing hair and having skin issues. We are Christians and the Muslims on site do not like us and kick our door in and threaten us. My friend attempted suicide, and no one responded quickly when we asked for an ambulance."*

The obligations of the Accommodation Providers in respect of non-discrimination and the treatment of people seeking asylum are set out the Terms and Conditions of the AASC. Providers are obliged to comply with discrimination legislation in the Equality Act 2010 that ensure public authorities cannot discriminate on the basis of age, ethnic origin, nationality, race, religion, culture, gender, sexual orientation, physical and mental ability. As documented under the assessment of the induction process for new arrivals, there are concerns around how this is being implemented, and wider issues about the culture of the site that determines how different minority groups are considered and responded to. For example, when we spoke with residents about how staff treated them a resident shared:

> *"Some are very good and some culturally insensitive. They say if your name is Mohammed, you should not be a Christian."*

> *"I went to the welfare office to ask for a mental health appointment for the doctor. I was told by the office lady to pray and that I didn't need to go to the doctor because Allah would help me."*

Inclusive practices on site for Ramadan were reported to be adjusting mealtimes. The single prayer space which was a dedicated 'faith' block contributed to tension on site. For example, different faith groups with their own practices sharing and vying for space in the solitary faith room for the entre site, which intensified at dedicated Muslim prayer times. These obvious points should be acknowledged and provided for on a site with more than 600 people with a range of faiths and religious practices.

> *"People came into my room and stole my cross and broke things. I reported it but nothing happened. CCTV not working. I am worried it will happen again."*

Case study: “They just told us to leave and to call Migrant Help.”

A protest involving 30-40 residents occurred the day before a Red Cross visit to Wethersfield. The gathering outside of the welfare block was ignited by tensions between Muslim and Christian groups of people. The reason for the protest was reported by both the Home Office and residents to be a feeling of discrimination towards minority Christian groups on site. They complained about the inequitable provision of food and prayer spaces that coincided with the month of Ramadan for practising Muslims on site.

The protest was attributed to a Vicar who was providing faith spaces on site listening to concerns in the canteen about poor dietary options for people then ‘leading a group’ to the welfare office to complain where things became heated. The protest was diffused by conversation and the Vicar was barred from the site in future.

One resident said that nothing was done at all about this problem. They added that, “40 people got together and went to the office to report discrimination. They just told us to leave and to call Migrant Help.”

Residents feel that not enough is done about problems being raised and this exemplifies that. More information about decision making around this incident and how this is approached in future, including admitting, and banning people from the site, would be welcome.

Anchoring to faith practices for people trying to adjust to a chaotic and uncertain environment could be considered a protective factor and should be facilitated. There will also be many people on the site who are fleeing religious persecution; people who are actively avoiding the practices that would usually be associated with their culture or faith; people who have a range of experiences and individual views including having no faith or being at risk because of their protected characteristics. The nature of the population seeking asylum in the UK for religious and political reasons means this wider range of considerations should be included. Health staff and many other professionals we spoke with highlighted that Wethersfield is not safe for everyone, particularly for more vulnerable groups. There did not appear to be any policies or procedures in place for the safety of LGBTQI residents for example. People living with HIV were at risk due to the fear of stigmatisation, without written policies in place to manage this that include more suitable accommodation options. Concern was also raised about the ‘quieter voices’ and those on site that were never seen at the Health Clinic and did not participate and engage. However, no process to identify, support or manage these patients were acted on by the staff due to lack of awareness and knowledge of these vulnerable men.

> *“We have raised issue of our safety, but the people attack us in front of security - they are not scared of anyone. They threaten to kill us. The people just get a warning letter - if you get three letters, we heard you have to stay here longer.*

Clearsprings were unequivocal in the induction briefing that they had no power to transfer people away from the site and that this was a Home Office decision, however no explanation of the circumstances under which a transfer could be considered were provided.

Clearsprings Ready Homes Induction Briefing states:

> *“If you want a transfer you have to speak to Home Office. Home Office have the power; we have no power”.*

We asked about transfer to detention and no one was aware of what this process looked like. The head of security shared that people do get collected from the site and then disappear, but he *"didn't want to know what happens to people"* and felt that it was best for him and his team not to know. Essex County Council may remove children from the site the same day.

72 people were moved off site on a single day during the assessment period. Preparation for the move was found to be minimal, with people not being told where they would go until the day before, or in some cases on the day itself. Residents reported that lists of people to be moved were printed and displayed on the walls of the welfare office that were easily visible to anyone coming in. The names were accompanied by dates of birth and port reference numbers and a note of their new address. If true, this represents a significant GDPR breach.

On 29 April, the Home Office began a programme of detention for people who had been issued notice of intent for Removal to Rwanda. Staff shared that the negative impact on residents could be felt, with some people leaving the site and choosing to sleep rough locally.

Staff welfare and capabilities

Clearsprings Ready Homes

The Home Office hold ultimate responsibility for the welfare and safeguarding of people they are accommodating, with local authority services covering Wethersfield also holding statutory safeguarding responsibilities to children and to adults at risk. The providers contacted by the Home Office, in this case Clearsprings Ready Homes, must uphold the safeguarding duties as the supported accommodation provider and take on this responsibility via the AASC contract. This responsibility is for the day-to-day welfare and safeguarding of residents on site, including the identification, response, reporting and following up on all welfare and safeguarding issues.

Clearsprings employ housing officers across the asylum accommodation estate they manage. Their remit is predominantly to manage the housing side, including responding to accommodation issues. Management shared that all 'welfare' staff employed at Wethersfield were employed as housing officers in line with the AASC contracts and their role title had been informally changed to reflect the higher level of risk and welfare needs that present on the Wethersfield site, however this did not translate to a revised Job Description or requirement for enhanced levels of experience and capabilities. There are several longer-term staff who have been employed at the site since it opened in July 2023. The Red Cross team spoke with housing staff who had been drafted temporarily in from London contingency accommodation for the purpose of conducting contractual welfare checks with groups and supporting with induction of new residents. The staff were observed carrying out group welfare meetings in an open-plan office with up to five men, with residents interpreting for each other. Responses are inputted to the Clearsprings central team. The staff we spoke with had little understanding of the site or the local safeguarding processes outside of the contractual welfare check.

For longer-term staff regularly working on the site it was not clear what structured support was in place to manage the impact of working daily with large numbers of traumatised people. One staff member who covered overnight shifts shared that they were regularly called to emergency situations in accommodation blocks including where a resident might not be breathing and tasked with calling an ambulance or administering basic first aid. No staff we met had any background in mental health or clinical expertise.

Feedback in one case was that the senior managers could provide debriefing and aftercare to their staff following traumatic incidents on an ad-hoc basis because they '*had military backgrounds' and 'understood PTSD'.* Staff we spoke with acknowledged that having trained onsite counsellors would be beneficial to supplement the basic welfare/housing officer role on a day-to-day basis.

Health staff

Experience of health centre staff included previous support to asylum seekers in hotel accommodation, although this was limited. The service manager had experience of working with the traveller community during the Covid-19 pandemic. Staff we spoke with did not reference the specific health needs of people seeking asylum and there was no evidence of applying the Refugee and Asylum Seeker Patient Health Toolkit.

Safeguarding training is reported to be completed by the health team at levels 1/2/3, Care Quality Standards, with their own policies regularly updated. There is a single mental health nurse for the 600 men on site, and it was not clear what prior experience they had to prepare them for this highly unusual situation and what ongoing support is in place.

The health team appeared very clear on their boundaries, with Clearsprings staff expected to pick up a lot of the more routine tasks that support their work. They reported positive practice in observing regular breaks and have a break room within the health building. They reported good peer support between team members, and all have access to psychosocial/counselling support. The service manager shared that female doctors who had previously worked on the site were not 'emotionally equipped' with reference to both being too 'easy going' and it not being the right fit for the environment. It was reported the current team work closely together and have access to welfare and mental health support and the mental health nurse is a 'breath of fresh air' and talks to the team regularly.

The overall impression of the health team is that they are running an efficient service, on their own terms and believe they are doing it well. However, because of this belief, they do not actively seek to explore how their working practices might impact other services and patients. They appear to have an unrealistic expectation of the role of Clearsprings. For example, Clearsprings have no mental health training yet are expected to carry out welfare checks for people who may be self-harming or actively suicidal, including people who have recently survived a suicide attempt and been returned to the site.

Security Staff

Security staff are recruited from Lead Element Security, a UK security company owned and operated by veterans. The Head of Security shared the support in place including a dedicated team for management of PTSD. There was a two hourly security rotation to ensure safety of the team. One security we guard we spoke with was still in active duty and worked at Wethersfield during his leave to make extra money. The security team are only there to provide a general security presence and to step in if there is an issue while police are called. There have been instances of altercations between security staff and residents. The manager at the health team highlighted the underuse of the skills and capacity of the security.

Culture on site

> *"The staff change when the Home Office are here. They start to smile. The next day, completely different."*

The Red Cross team spent two days on site speaking with medical, Clearsprings and security staff. Overall, while there were clearly people who did want to improve the situation there was a distinct level of desensitisation amongst the staff working directly with residents, increasing where staff had been working there for several months and since the site opened in the July 2023. This ranged from expressing a limited understanding of the wider context and how traumatic experiences might be impacting on the people they were interacting with; failing to see people as individuals with their own needs; displaying a lack of professional curiosity about root causes of behaviours and consistent minimising of the distress of residents.

For example, staff in the portacabin area believed that living at Wethersfield was a good option as you *'got everything you needed',* this included all your meals, you didn't need money, your laundry was dealt with, and your accommodation was clean and good quality as well as having the space on site for recreational activities including gym classes.

Several people we spoke to came from prison staff backgrounds and so they found this site very light touch and *"not like a prison at all!".*

The portacabin accommodation area was referred to as 'the village' by staff on site. This was found to be inappropriate as there was no village or community feel; the area is quite desolate; grey and unappealing with poor facilities. A 'welfare block' on site with two welfare offices, an ablution area and two adjoining rooms where residents sat around looking at their phones formed part of 'the village'. Attempts to re-name facilities with more positive terms contribute to the minimisation of the negative aspects and realities of the site. Reference was made to the men on site as being *'The Boys'.* This grouping together of individuals with a wide range of characteristics, backgrounds and ages contributed to the dehumanising effect.

A smaller number of staff we spoke to were more candid about the effect the site was having. A person with experience of Napier Barracks, the only other ex-military site currently being used for asylum accommodation reflected that Wethersfield was *'totally different'* from Napier due to the remote location, in contrast to Napier where residents can access the local community easily on foot. They attributed this fundamental difference to the higher presentation of behavioural issues and difficulties on the Wethersfield site. Despite this, during induction the site was referred to as *"the number one site – you don't need to leave, but you can go on holiday if you like….".* Similar language was observed on posters around the site and contained in the induction pack provided to new arrivals. This is highly concerning language to use when speaking to a group of people who are fleeing their home country and potentially are newly arrived in the UK. They are not here at a holiday camp. Their practical needs might be being met, but it became apparent that 'hope' was the one thing missing from this site, and these men had no idea what would happen next, or when they might be able to move on.

This culture extended to the more harmful practices of minimising self-harming behaviours and the distress of residents. For example, staff shared views including *"We know that they are making a drama!"* with reference to the high presentation of mental health and self-injurious actions of residents and a perceived view that the majority of residents were making these up in order to accelerate their release from the site. This generalisation is highly concerning given the experience of traumatic events including being victim of and witnessing extreme violence and the risk that people with genuine mental health concerns will be dismissed in this way.

75% of residents we spoke with shared they were unhappy with the way staff treated them.

One man shared:

> *"I was called a king Kong (monkey) by one of the welfare workers at the site which didn't go well with me to the extent of missing a meal."*

Another shared:

> *"Security not bad but sometimes they don't talk to respectfully. They talk to us like soldiers. The office don't understand what you need. Even when there is a problem with the room, they promise to come tomorrow but don't come. There are not good systems on site."*

Other people who fed back said their treatment from staff had been good. Many were indifferent. For example, residents shared:

> *"The staff aren't horrible, they just don't care about us at all."*

> *"I do not have a lot of contact with the staff, when they do speak to me, they do not use interpreters."*

We heard a case of a man who had sewed his lips together. Staff spoke about removing the stitches but no acknowledgement of what might have driven him to an act of extreme self-harm and what follow up support was provided. Another episode where a group of residents informed the Red Cross that a man had attempted to jump from a roof the previous evening was met with hostile questioning and a disbelieving attitude when reported to the health team because there was no way this could have happened without the security guards knowing and the information *'only'* came from an *'SU'* (service user). The staff member later apologised for their conduct during this exchange.

These views and the culture that underpins them is closely reflected in similar findings from JRS UK's recent report on Brook House. This described a deep culture of disbelief in relation to mental health, and a prevailing view that people were "making up symptoms" to get out of detention. As with Wethersfield, this view was applied to a population that badly needed psychological support, and where the environment itself specifically had a negative impact on their mental health.

Clearsprings leadership expressed that distress and trauma of Wethersfield residents was somehow less than the trauma they had *themselves* been exposed to as part of military operations overseas and was observed by the Red Cross team as driver for the downplaying of risks and vulnerabilities of Wethersfield residents. We also observed a tendency by Clearsprings leadership to overly associate their own experiences of overseas military operations as evidence they 'knew' or 'understood' the cultures of young refugee men from countries they had been stationed to, displaying a lack of self-awareness or grasp of power dynamics.

One staff member we spoke with shared they had seen dead bodies of men who had taken their lives by suicide while in the military, insinuating they were immune to such horrors and if the people on site really wanted to kill themselves, they would *'just do it.'* The clear insinuation was that any acts of self-harm by residents were somehow less significant. This, again, was mirrored in the recent JRS Brook House report, which detailed a desensitised attitude to suicide and self-harm, including officers remarking that someone who had been saying he would hang himself should "*just do it".* The clear parallels between Wethersfield and Brook House highlight that none of this is new. Our assessment findings mirror those from previous investigations and reviews and demonstrate a prevailing culture of

degradation and disbelief which underpins the treatment of people across these institutional settings.

> *[If I had an issue] "I wouldn't report it to anyone anymore, because they won't listen and they won't do anything about it. I was once assaulted by someone and one of the staff told me to hit the person back. The staff treat me like an animal."*

Security reported that they have a *"quick reaction force"* to deal with any security issues. The head of security stated that the site opened with 15 men and had now increased to almost 600 and therefore there were challenges, and it was important to have relationships with the men so that situations could be de-escalated. There seemed to be a good understanding of this by senior security staff, however reports of conflicts between security staff and residents include incidents of fighting in the canteen area that have been filmed and referenced by some residents, particularly people who are already feeling insecure on the site, as contributing to a lack of trust in the authorities and feeling of unsafety.

The assessment team have concerns about the power structures within and between staffing teams on the site that could deter a more junior staff member from speaking out if they witnessed bad practice. For example, the medical centre is in the main staffed by healthcare assistants and nurses with limited experience of providing healthcare in a large-scale setting with asylum seekers, far removed from care that would be provided in a community setting. There are clearly staff who are committed to the wellbeing of residents and are working to meet their needs, with ideas about how to improve the situation for the men on site. We have found limited opportunities for the implementation of improvements within the wider staffing culture and nature of large-scale sites.

Case study: “I escaped from one prison and am now here in another...”

While some staff expressed views describing the conditions at the site positively, they simultaneously referred to the site as ‘a prison camp’ and ‘a refugee camp’ and recognised the prison-like conditions, a view that residents share.

One resident said, “I left my country after being tortured and left my family. I escaped from one prison and am now here in another prison camp. It is affecting my mental health really bad. I am calm and try to be a calming influence on all the younger men here. But even I am reaching the end of my patience.”

However, staff responsible for the welfare of residents onsite said, “They are given everything”, and “I’d like to move here, three meals a day, a gym and all my cleaning done for me, it’s great”. From multiple interactions with staff these comparisons with a prison setting were common and the further view that all anyone might need was such basic material needs and nothing more was particularly worrying. Little or no reference was made by the many officers we spoke with about the traumatic background of residents as people fleeing conflict and persecution, and there was little understanding of the mental and physical isolation created by this site itself.

This disconnect between recognising the site as a prison-like setting while also saying it was a great place to be and met all the needs of the men accommodated there could be attributed to the de-sensitisation we observed. It may also be in part due to the government approach to increasing the use of large-scale sites, barracks and barges, and the narratives for justifying these policies.

Resident feedback is clear on how they view the site. They describe it as a prison and the overwhelming view was to close it down. “Close this prison. Treat people like humans,” said one person.

Conclusions

Wethersfield is a high-risk site. It was set up rapidly, lacking infrastructure; basic quality frameworks or safety standards; without consideration of the needs of people seeking asylum and the required careful planning to ensure community cohesion. It is not suitable for people with identified vulnerabilities; for people suffering from trauma or mental ill-health - regardless of whether they disclose this during the basic induction process or later in their stay, or for children. It should not be considered suitable for accommodating people seeking asylum for any longer than a maximum of a few weeks. The nature of the site exacerbates trauma, wearing down the resilience of even people who arrive relatively mentally robust.

People seeking asylum who are vulnerable and suffering from poor mental health continue to be sent to Wethersfield. Findings show even when someone may present as fit and well via perfunctory screening processes at the border, there are multiple instances of people with health and mental health needs being sent to the site, and that the site itself contributes to the declining mental health of residents. Onward referrals to health and mental health services are regularly required and barriers to access risk these needs becoming more acute and requiring emergency services and treatment. There are systems gaps in referral and care pathways to meet the needs of men on site. The change of policy towards vulnerable groups in the allocation of accommodation policy has made it more difficult for people for whom the setting is wholly unsuitable to be relocated to more appropriate accommodation potentially causing further harms.

The Red Cross was concerned but not surprised to find that children have been mistakenly sent to Wethersfield. Our last report to the Home Office on findings from our work at the Western Jet Foil in Dover found children are subject to poor age determination processes at the border. The practice of excluding any age disputed person who reasonably might be under 25 from selection for Wethersfield and all large-scale sites must therefore be kept in place and tightly monitored to ensure no more children at put at risk of harm.

There remains a gap between what the Home Office has contracted for support on site and the reality of what is needed to keep residents safe and well that must be addressed with both expertise and dedicated resourcing. Over-reliance on an already stretched voluntary sector and an expectation that core services required to make the site safe and effective will be supplied for free by the VCS need to be reassessed. A stronger, more meaningful partnership with the VCS with the right levels of resourcing in place should be part of any onward planning, and core support around wellbeing and mental health must be built in to commissioning plans, looking ahead to when Doctors of the World must inevitably withdraw their services.

Residents and staff both referred to the site as a 'prison camp'. The risks of operating a detention-like facility for non-detained people, both legally and for the safety and wellbeing of residents have been highlighted in this report. All parties we spoke to as part of the assessment shared their concerns about how safeguarding is being managed on the site. The expertise of Clearsprings to safely identify, respond and record safeguarding concerns was found to be limited, with an urgent need to review systems and processes that are not suitable for this unique environment. Without significant input from specialist organisations with experience of managing similar settings, a high-risk situation for residents and staff persists. The isolated locations of Wethersfield and Scampton require the Home Office to put in place a range of additional services that drive up costs; add pressure for staff on site and ultimately creates a wholly avoidable volatile situation. The Red Cross doubts the social or

economic reasons relied upon to justify housing people who have sought protection in the UK in this way.

The government's asylum accommodation policy over the last few years has increasingly relied upon institutional settings such as hotels and now barracks and barges. People entering the asylum system have become increasingly reliant on the state for support for longer periods of time as their claims are assessed and are isolated from the communities that would have previously been able to support them. Wethersfield undermines the safety and dignity of people who have already been through so much and is a clear example of the harmful impact of this approach. One resident reflected:

> *"I try to be a calming influence on all the younger men here but even I am reaching the end of my patience. They have opened this site as an experiment, they are gaining experience with us. We are a laboratory sample. It's the truth."*

Recommendations

Status of the site

1. Our overarching recommendation is that the site and all large-scale ex-MOD sites and barges are not safe or suitable forms of accommodation for people in the asylum process and should be closed. This was clearly reflected in the resident feedback.
2. In the short term, the length of time people are held on the site must be reduced to minimise the impact of mental health and wellbeing. We suggest 28 days in line previous recommendations on immigration detention time limits.
3. The recent changes to the suitability criteria of the Allocation of Asylum Accommodation guidance must be reversed to prevent people with specific vulnerabilities being taken to the site.
4. Timescales for the provision of financial support under the Initial Accommodation contract should be clarified and upheld.

Oversight, accountability and monitoring.

5. Engage with the interim Independent Chief Inspector of Borders and Immigration as a priority to arrange an independent inspection of Wethersfield. This should include data from providers on safeguarding; oversight of the decision-making of the medical team and ideally feedback from residents.
6. Map and share the governance structures for the different decision-making groups, their terms of reference and how information is shared.
7. Establish quality assurance framework and monitoring of the induction process ensuring accessible information is provided in a trauma-informed way by trained staff.
8. Promote the whistle-blowing procedures for all staff including sub-contractors.
9. Capture and monitor datasets relating to the management of health; risks and vulnerabilities including suicide attempts and hospital admissions; incidents of violence and incidents of harassment or discrimination towards minority groups.
10. Monitor actions taken by staff responsible for safeguarding including referrals to statutory and specialist services and outcomes of actions agreed at multi-agency meetings.
11. Increase meaningful engagement with the VCS to work collaboratively on identifying and meeting the needs of residents beyond the provision of activities, for example on independent and legal advice.

Induction and Vulnerability Screening.

12. Improve the identification of vulnerabilities both at Manston and on arrival in Wethersfield. The recommendations set out in the UNHCR Asylum Screening in the UK report (p41) could be used as a starting point, recognising that identification and screening of vulnerabilities should be carried out by trained and experienced staff. This recommendation was also made in the Red Cross Dover report submitted in February 2022.
13. Provide clear, accessible translated information to all new arrivals including reviewing the induction packs, ideally to be co-produced by people in the asylum system. This must be regularly monitored.
14. Ensure professional interpreters are offered at induction and all critical points including welfare checks. This is linked to the Red Cross Dover report and should be regularly monitored.

Accommodation and facilities

15. Limit room sharing. Lack of sleep and privacy is a major driver in poor mental health of residents and is a concern for physical safety.
16. Private, suitable indoor spaces should be made available across the site for residents to take important calls for trauma therapy and counselling, legal appointments and personal calls.
17. Remove the physical presence of military activity for example fencing and barbed wire.
18. Carry out meaningful engagement with residents about the activities and facilities that meet their needs, taking in to account diversity and equality considerations and making better use of space to address overcrowding and dominance by particular groups.
19. Increase the signage with multiple languages on the isolation building, to ensure no unauthorised access. Consideration needs to be given to avoiding stigmatising people accommodation in the isolation building, and the fact that some will be individuals awaiting an age assessment.
20. Review the minibus timetable to extend the time people can spend in nearby towns.
21. Improve cleaning of communal areas particularly the toilets and shower areas.
22. Home Office to invest in a dedicated activities coordinator for the duration of the site's use as accommodation and work with Braintree District Council to ensure the proper level of funding is made available to set up an embedded programme of activities.

Provision of Information

23. Provide clear information about the legal process residents are in, timescales for decision making and anything that is different about the Wethersfield site.
24. Proactively engage with the Legal Aid Service to prepare for large numbers of people being housed in areas with poor provision.
25. Ensure all new arrivals are provided with International Family Tracing (IFT) information in line with the Welfare Provision in Immigration Removal Centres Guidance

Mental Health

26. Ensure there is appropriate adherence to trauma informed guidance. This includes staff being trained, supervised and supported to realise the high incidence of trauma

experiences in this population and respond helpfully to the effects of trauma. Resist re-traumatisation by following the trauma informed principles to create a safe environment. Help people reliably access the resources that will help them and engage in safe, trustworthy and compassionate relationships.

27. Provide adequate help and support for staff to reduce the potential for vicarious traumatisation or secondary traumatic stress.
28. Ensure people with significant pre-existing vulnerabilities including mental health difficulties, survivors of torture and other forms of cruel and inhumane treatment, including sexual violence and gender-based violence, and suspected and confirmed victims of trafficking are not accommodated at the Wethersfield site.
29. Provide ongoing opportunities for people to be able to access private, confidential, culturally sensitive evidence-based treatment options for mental ill-health.
30. Strengthen the processes for identification of vulnerabilities to recognise mental health and indicators of deterioration including guidance on self-harm, linked to a clear process for relocation to more suitable accommodation.
31. Ensure care plans are in place for anyone who attempts suicide that should include immediate consideration of relocation to more suitable accommodation.
32. Review and strengthen processes in line with the Government's Suicide Prevention Strategy and Action Plan.
33. Revise and strengthen release and onward care pathways including medication to support relocations as a result or worsening mental health and vulnerability.
34. Invest and expand the mental health provision on site by increasing the number of mental health nurses.
35. Evaluate how the GMHAT tool is being used in the context of an institutional setting, specifically how the 'actions for management' are interpreted to reflect the impact of the site on mental health and restricted access to community-based mental health services.

Physical Health

36. Adopt the model of oral healthcare for asylum seekers and refugees and support onsite staff to help facilitate appointments ensuring the right to an interpreter.
37. Ensure the dietary needs of residents are met through the regular revision of the menu with nutritious food and consider the structured monitoring of this.
38. Provide first aid training to staff onsite and ensure that everyone onsite knows what to do in the case of a stabbing or injury. Ensue the provision of first aid kits on the Wethersfield site.

Safeguarding and Welfare

39. Create and share and single safeguarding procedure for all agencies on and off site to raise safeguarding concerns about residents at Wethersfield.
40. Establish named onsite safeguarding leads for each contracted agency with the requisite experience and training in issues relating to adults at risk including trafficking and sexual and gender-based violence.
41. Create a robust information sharing processes between the different agencies on site.
42. Strengthen the multi-agency team structure through ensuring a well-trained, culturally sensitive and competent workforce, who are sensitive to the needs of refugees and migrants, their languages and their unique health problems.

43. Establish quality and assurance measures for risk management, care plans and safety plans recommended by the multi-disciplinary team. Establish clear written responsibilities between Adult Social Care and Clearsprings Ready Homes team.
44. Identify and embed appropriate escalation and referral pathways within staff guidance relating to specialist independent support for victims of trafficking; sexual and gender-based violence, and other specialist services based on resident needs.
45. Children waiting for an age assessment meeting with the local authority should be taken off site. If this is not possible additional guidance should be drawn up for supporting a child on the site pending the age assessment meeting, with input from children's services.
46. A plan should be in place for young people after the age assessment process who are found to be 18 or over to provide additional support and oversight as these young people may be in considerable distress. This should include information about challenging the outcome of and age assessment and signposting to independent advice and support.
47. Welfare checks should be carried out 1:1 in a confidential space and on a fortnightly basis, accompanied by clear guidance setting out processes for welfare concerns that need to be followed, including processes for transfer offsite.
48. Ensure translated information about trafficking and modern slavery, abuse and sexual and gender-based violence and how to disclose is accessible across the site.
49. Quality assure the NRM interview process in line with the Modern Slavery Statutory Guidance.

Physical safety and protection of minority groups.

50. Apply guidance set out in the AASC Statement of Requirements that allows for the transfer to alternative accommodation in cases of bullying and harassment or other safety concerns.
51. Review and strengthen contractual reporting of incidents of violence, harassment and bullying to ensure these are being reported and actions taken to keep residents safe.
52. Ensure an Equality Impact Assessment is completed each time for any substantial changes being considered to site facilities and processes to ensure they are not discriminatory towards people with protected characteristics.
53. Consider working with an experienced organisation to conduct a gender and diversity assessment for the residents on site.

Staff welfare and capabilities

54. Work with the Home Office Asylum Mental Health team to embed trauma-informed approaches across the site, recognising the barriers that must be addressed to do this safely.
55. Consider a rota approach or a cap on overall length of time people can work on the site to manage the desensitisation of staff and risk of vicarious trauma.
56. Quality assure the implementation of training undertaken by staff and consider additional training in anti-discriminatory and anti-racist practice.
57. Bring in more trained and experienced staff for example with social work backgrounds, better knowledge of statutory safeguarding and experience of working with vulnerable groups.