

The Brook House Inquiry Report

Volume II

A public inquiry into the mistreatment of
individuals detained at Brook House
immigration removal centre

Kate Eves, Chair of the Brook House Inquiry

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Inquiries Act 2005

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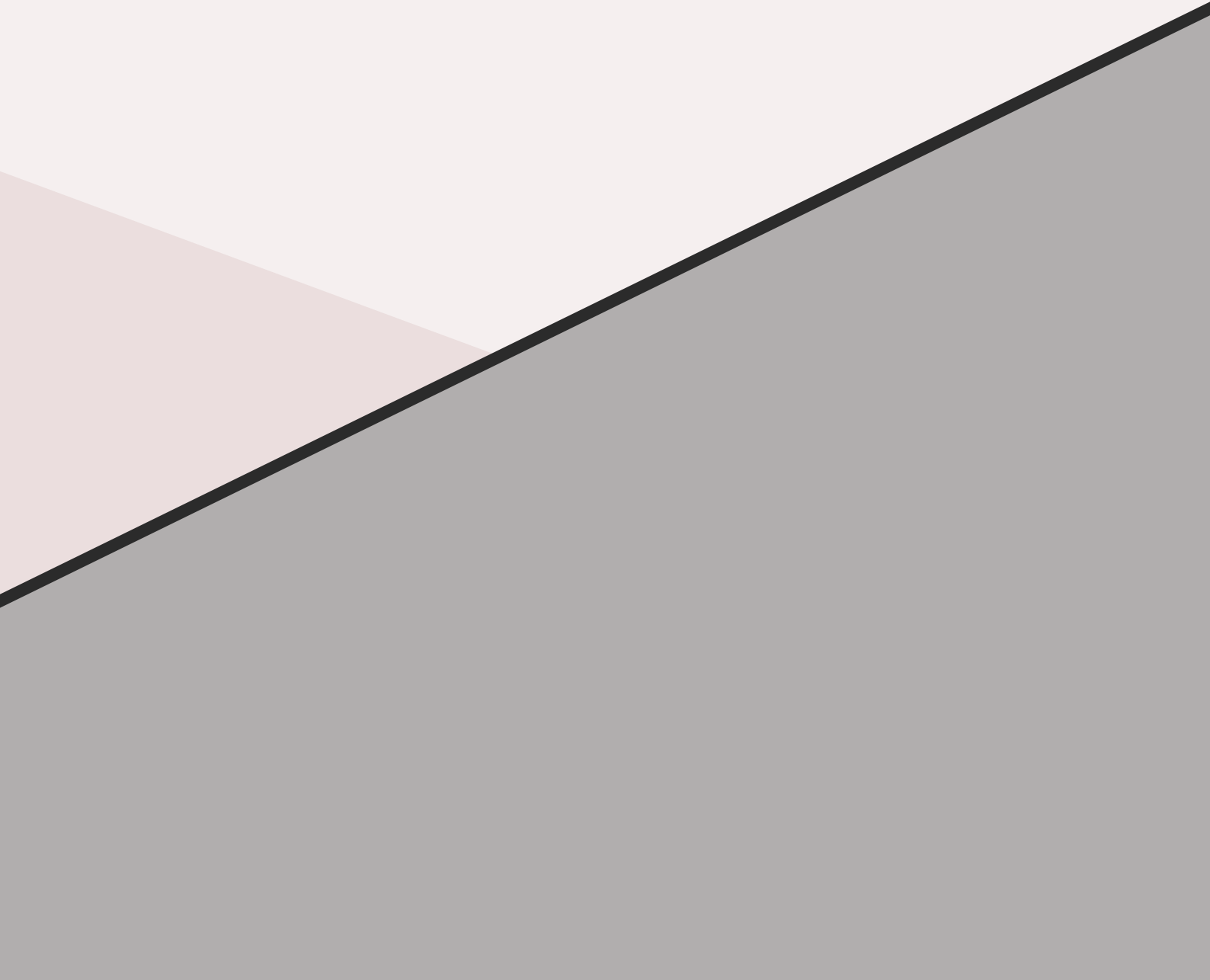
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Part D

Issues at Brook House



Chapter D.1:

Introduction

1. Part D examines in detail 10 key issues identified, on the basis of all the evidence heard and received by the Inquiry, as being the most significant issues affecting the operation of Brook House during the relevant period. The combination of these broader factors contributed to a negative experience for many detained people and, crucially, to conditions where mistreatment was more likely to occur.

- 1.1 The contract to run Brook House:** Brook House, like most immigration removal centres (IRCs) in the UK, was and is managed by a private outsourcing firm on behalf of the Home Office, subject to contractual as well as other legal obligations. The Inquiry identified key issues in relation to the way in which the bidding process for the initial Brook House contract was undertaken, the terms of the contract that was implemented and the monitoring of the contract by the Home Office. In respect of the new contract for the operation of Brook House that is now in place between the Home Office and Serco, evidence of current practice suggests that there are ongoing issues in the Home Office's approach to performance management.
- 1.2 The physical design and environment:** Detention for immigration purposes is not equivalent to a prison sentence. The Inquiry identified a number of issues linked to the design of Brook House and the intention that people be held there only on a short-term basis. In addition, the Inquiry found issues with the operation and provision by G4S of computers and internet access for detained people at Brook House, as well as with a decision to add extra beds to the centre in early 2017.
- 1.3 Detained people's safety and experience:** Those detained at Brook House and elsewhere should be treated humanely and with care. The Inquiry identified a number of issues that adversely affected detained people's safety and experience at Brook House, including drug use, language barriers, inadequate management of risk, a strict lock-in regime, no-notice removals and the impact of the indefinite nature of detention.
- 1.4 Safeguards for vulnerable individuals:** There are critical safeguards to protect the physical and mental health of a detained person. The Inquiry identified significant issues in the operation of Rule 34 and Rule 35 of the Detention Centre Rules 2001 (the Rules) at Brook House, and in the way in which other mechanisms (such as Part C forms) were

used inappropriately by Healthcare staff. In addition, the Inquiry identified a disconnect between the Assessment Care in Detention and Teamwork (ACDT) process and other safeguards for vulnerable people.

- 1.5 Restrictions on detained people:** Detained people can be removed from association or segregated only in strictly defined circumstances set out within Rule 40 and Rule 42. However, the Inquiry found that these Rules were being misinterpreted and misapplied routinely by Brook House staff during the relevant period, and that a misunderstanding about who can authorise use of those Rules persists under Serco's operation of the centre. The Inquiry also identified significant issues with the oversight and monitoring of the use of Rule 40 and Rule 42.
- 1.6 Use of force:** Force may be used by detention staff on detained people only in particular circumstances, as set out in various rules and regulations, and it should be a measure of last resort. Where a use of force is unnecessary, inappropriate or excessive, it plainly has the potential to cause harm. The Inquiry identified serious problems with the way in which force was used at Brook House by G4S staff, as well as with the systems of reviewing and monitoring use of force incidents.
- 1.7 Healthcare:** The delivery of healthcare services in IRCs can be challenging because of high levels of mental ill health. However, inadequacies in the provision of healthcare to detained people (particularly those who are vulnerable) risk a deterioration in their physical or mental health. This, in turn, can affect their behaviour. Too often, Brook House staff misinterpreted this as disruptive conduct. The Inquiry identified key issues with the provision of healthcare at Brook House, the approach to detained people refusing food or fluid, and the healthcare complaints system.
- 1.8 Staffing and culture:** The Inquiry examined staffing and culture at Brook House and found that G4S and the Home Office did not provide a sufficiently caring, secure or decent environment for detained people or staff at Brook House. The Inquiry identified a number of key issues that negatively impacted on staff culture and morale: namely, inadequate staffing; retention and recruitment issues; inadequate development and support of staff; ineffective management and supervision by the G4S Senior Management Team; and a hands-off approach by Home Office staff on the ground. In addition, the Inquiry found that there was a toxic culture among staff, with racism, bullying, bravado and 'macho' attitudes present. There was also a considerable amount of abusive, racist and derogatory language used by staff towards or about detained people.
- 1.9 Complaints and whistleblowing:** Detained people and staff should be able to raise concerns and have those issues resolved satisfactorily, with thorough investigations into alleged wrongdoing and action taken

against any staff responsible for misconduct. However, the Inquiry found that many detained people felt unable to complain about poor treatment, and most staff were either unwilling or unable to raise concerns. When complaints or concerns were raised, there were a number of failures in the responses from G4S, the Home Office and the Home Office's Professional Standards Unit. The Inquiry also identified inadequacies with the whistleblowing procedures in place during the relevant period.

1.10 Inspection and monitoring: The Inquiry examined the adequacy of inspection and monitoring during the relevant period. The Inquiry identified key issues relating to inspection and monitoring, including a problematic over-reliance on external organisations by senior management within G4S and the Home Office.

2. While numerous failings specific to each issue are identified within Part D, there are several common threads. In particular, rules and processes already exist to address the key risks associated with immigration detention, and in many instances the failures identified in this Report were the result of non-compliance with those existing rules and processes. Entire safeguarding mechanisms in a number of areas were shown to be dysfunctional, resulting in a failure to protect those detained as intended.

3. In many cases, the issues identified by the Inquiry had already been raised by oversight bodies and non-governmental organisations, or in previous investigations. The repeated failures to learn lessons and to act on recommendations made are inexcusable.

4. It is the Home Office that ultimately bears the crucial safeguarding responsibility for the welfare of detained people. The significance of that responsibility cannot be overstated and cannot be removed by subcontracting. The Inquiry identified a comprehensive range of failings by the Home Office, spanning all of the key issues set out in this Part of the Report.

5. G4S was responsible for ensuring that it complied with its contract with the Home Office, as well as with the relevant rules and guidance, such as the Detention Centre Rules 2001 and the detention services orders. It failed to do so. The Inquiry identified a comprehensive range of failings by G4S staff at Brook House, but also at a management and ultimately at a corporate level.

6. While this Inquiry was not an investigation into current practice within Brook House or into immigration detention more generally, it is concerning that the Inquiry identified evidence that suggests many of the issues present during the relevant period persist under Serco's management of Brook House.

Chapter D.2:

The contract to run Brook House

Introduction

1. Brook House, like other immigration removal centres (IRCs) in the UK, was and is managed on behalf of the Home Office by private outsourcing firms. The Home Office nevertheless retains ultimate responsibility for the welfare of detained people, and the process of subcontracting cannot remove that responsibility. Contracted-out centres such as Brook House must be operated in accordance with the Detention Centre Rules 2001 (the Rules), which set standards for the safety, care, activities, discipline and control of detained people, as well as with the specific terms of the contract.¹ This includes Rule 3(1), which clearly states:

“The purpose of detention centres shall be to provide for the secure but humane accommodation of detained persons in a relaxed regime with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environment, and to encourage and assist detained persons to make the most productive use of their time, whilst respecting in particular their dignity and the right to individual expression.”²

2. This chapter focuses on the Home Office management of its contracts for Brook House, with G4S Care and Justice Services (UK) Ltd (G4S) from 2009 to 2020, then with Serco Group PLC (Serco) from May 2020.³ It considers the original procurement process, the management of contractual performance (including the operation of contractual penalties), and the impact of these issues on the welfare of detained people at Brook House.

¹ Section 149 of the [Immigration and Asylum Act 1999](#) contains a power for the Secretary of State to contract out management of removal centres. Where that has been done, it specifies that the contracted-out removal centre must be operated in accordance with the rules made by the Secretary of State under section 153 of the Act, ie the [Detention Centre Rules 2001](#)

² [Detention Centre Rules 2001](#), Rule 3(1); see [CJS006120](#)

³ Healthcare services, considered separately in Chapter D.8, were and are delivered at Brook House under a separate contract

The initial contract for Brook House

3. The initial Brook House contract was awarded to Global Solutions Ltd (GSL) in 2008.
4. Bids were received from six private companies, including GSL and G4S. The bids were evaluated by teams from the Home Office in late 2007, based on the operational *“quality”* of each bid and also the commercial element or cost. The evaluation criteria provided that the weighting between these two elements would be 50:50.⁴ A small team of three Home Office staff was tasked with evaluating the bids from an operational perspective, on the basis that Brook House would admit and discharge 2,500 detained people each month.⁵ This involved an initial assessment, and then a final assessment following clarifications from bidders.⁶
5. The assessment of the operational quality included a number of comments of note.
 - 5.1 GSL’s proposal for activities was described in the initial assessment as *“extremely poor”* and it was noted that *“Welfare proposals provided a team of DCOs [Detention Custody Officers] without any clear leadership.”*⁷
 - 5.2 Assessors recorded concerns about GSL’s proposal to reduce staffing levels significantly during lockdown hours.⁸ Only one bidder (Reliance) proposed adequate overnight staffing.⁹ In summary, the assessors recorded that all the other bidders’ overnight staffing levels *“border on the unsafe”*, and that an:

*“ethos of cutting corners ... was evident from much of what we read and we were especially disappointed at the extended lock down hours proposed ... This appears to be a desperate attempt to reduce cost at the expense of welfare.”*¹⁰
 - 5.3 The lockdown period initially proposed by GSL was stated to be *“excessive and not in keeping with the ethos of the rest of the estate”*, with *“no justification for such a lengthy period of non-association”*.¹¹ Mr Philip Schoenenberger, one of a team of three officials tasked with assessing the operational elements of the contractors’ bids in 2007,

⁴ [DL0000140_044](#)

⁵ [DL0000140_078-079](#)

⁶ Initial assessment: [DL0000140_062-069](#); final assessment: [DL0000140_070-079](#)

⁷ [DL0000140_064](#)

⁸ [DL0000140_064](#)

⁹ [DL0000140_065-066](#)

¹⁰ [DL0000140_069](#)

¹¹ [DL0000140_078](#)

was asked by the Inquiry about IRCs being required to provide a secure but relaxed regime, with as much freedom of movement and association as possible. He accepted that there was an apparent contradiction between this and the bids, which involved nearly half the detained people's time being spent in locked cells.¹²

- 5.4** The assessors considered that the initial GSL bid had *“failed to provide a number of commitments including dealing with 2500 admissions and 2500 discharges each month”*.¹³ This does not appear to have been resolved by the final assessment stage.¹⁴

The assessment concluded that a bidder named GEO offered *“the best all round response”*, although it noted that *“the long lockdown period, which is shared with other bidders and tight staffing levels, remain a concern”*.¹⁵

- 6.** A further group within the Home Office (called the Border and Immigration Agency at the time) then considered the operational and financial evaluations together. Taking both factors into account, the GSL bid was recommended. From a cost perspective, this bid was cheapest in terms of both start-up and annual costs.¹⁶

7. It is concerning that proposals with such significant flaws in terms of *“quality”* led to the award of a contract to manage Brook House. Mr Schoenenberger told the Inquiry that the team did not consider the bids to be deficient, although they were *“very concerned”*. He said that by setting out those concerns in the assessment document, his team *“did our best to make sure that people understood that this wasn't what we thought was acceptable”*.¹⁷ He was not aware whether there was any process for evaluators to find out how any concerns or comments raised at the proposal stage played out in real life, although he believed this should be done.¹⁸ If the proposals did not meet the statutory purpose of IRCs – to provide accommodation in a secure but relaxed regime with as much freedom of movement and association as possible, as set out in the Rules – they should have been rejected or at least returned to the bidder for fundamental adjustment.

- 8.** The Brook House tender was noted by the Home Office to have *“delivered significant (35%) cost savings compared to the original budget”*.¹⁹ While it is of course appropriate to consider issues such as cost-effectiveness during tendering, the Home Office's budget allowed for a higher standard.

¹² [Philip Schoenenberger 23 March 2022 15/14-17/15](#)

¹³ [DL0000140_078](#)

¹⁴ [DL0000140_070](#); [DL0000140_078](#)

¹⁵ [DL0000140_073](#)

¹⁶ [DL0000140_047](#)

¹⁷ [Philip Schoenenberger 23 March 2022 22/20-23/16](#)

¹⁸ [Philip Schoenenberger 23 March 2022 31/21-32/15](#)

¹⁹ [DL0000140_047-048](#)

Rather than using the budget to ensure that a suitable operational contract was in place, the primary motivator of the Home Office appeared to be cost-saving, with care and welfare sidelined.

9. Mr Philip Riley, Director of Detention and Escorting Services (DES) within the Home Office, accepted that *“scoring for costs and quality, 50-50”* encouraged bidders *“to put in a cost-efficient bid, because that drives down the cost and pushes up the score”*.²⁰ Mr Gordon Brockington, Managing Director of Justice and Government Chief Commercial Officer at G4S, noted that price was the central concern in such exercises:

“the vast majority of government tendering, regardless of whether it says it’s 50:50 price:quality, it’s price, let’s face facts”.²¹

He told the Inquiry that, while this was true in 2007, there is now a *“far bigger drive ... for value for money and quality”*.²² The Home Office has now *“accepted that the bids at the time appeared to have done all they could to reduce costs against the required specification”*.²³

10. The initial contract to operate, manage and maintain Brook House was awarded to GSL, from March 2009. In addition to provisions requiring compliance with the Rules, the Detention Services Operating Standards Manual and detention services orders, the contract included a lengthy list of high-level requirements set by the Home Office and, at Schedule D, specifications for how these requirements should be met.²⁴

11. In May 2008, G4S acquired GSL and therefore acquired its contract to manage Brook House.²⁵ Mr Riley confirmed that G4S was expected to deliver the contract as agreed with GSL and not to impose its own (rejected) proposal.²⁶

The operation of the contract

12. The total lifetime value of the contract was £137.5 million over 11 years.²⁷ It was recorded in a G4S spreadsheet that G4S had made

²⁰ [Philip Riley 4 April 2022 49/1-3](#)

²¹ [VER000225_010](#) para 121

²² [Gordon Brockington 31 March 2022 76/12-16](#)

²³ [HOM0332165](#) para 96; [Philip Riley 4 April 2022 49/19](#)

²⁴ Extracts at [HOM000798_001](#); [HOM000798_079-080](#); [HOM000798_084-086](#); [HOM000798_146](#); [HOM000798_148](#); [HOM000916_040](#); [HOM000916_180](#); [HOM000916_199](#); see also [DL0000175_013](#) paras 1.7-1.11

²⁵ [DL0000141_023](#) para 68. G4S also acquired the contract to run Tinsley House, another IRC nearby that had been opened in 1996 ([CJS0073709_053](#) para 5.2). The two IRCs are referred to collectively as Gatwick IRCs, and, although subject to separate contracts with the Home Office, were run with one Senior Management Team across both ([CJS0072810_002](#))

²⁶ [Philip Riley 4 April 2022 38/22-25, 41/10-19](#)

²⁷ [DL000175_013](#) para 1.9

cumulative efficiency and clustering savings of £4.05 million from July 2012 to May 2017.²⁸ Mr Peter Neden, G4S Regional President UK and Ireland during the relevant period, said that this did not represent cost savings being prioritised over the welfare of detained people.²⁹ Payment was by way of a monthly fee, which rose with inflation. During the relevant period (1 April 2017 to 31 August 2017), the monthly fee paid by the Home Office to G4S was approximately £1 million, from which G4S paid all staff, running costs and subcontractors.³⁰

13. Ms Stacie Dean, formerly Head of Tinsley House IRC, asserted in a grievance letter and in a meeting in January 2017 that there had been some deliberate under-reporting of incidents to the Home Office, as well as an alleged mistake about the profit margin that led to a need to make savings.³¹ During a subsequent grievance meeting with Ms Dean in January 2017, Mr Jeremy Petherick, Managing Director of G4S Custodial and Detention Services during the relevant period, commented:

“There is nothing to stop us making money, providing we deliver the contract.”³²

14. The National Audit Office, which undertook a review in 2019 of the Home Office’s management of the Brook House contract at the request of the Home Affairs Select Committee, noted the following, based on information from G4S:

“G4S’s annual gross profits ranged between £2.1 million and £2.4 million, representing between 18% to 20% gross profit (Figure 11). G4S spent more on the contract following the Panorama episode in September 2017, and its gross profit fell to £1.3 million (10%) in 2017 and £1.8 million (14%) in 2018 ... It is difficult to say exactly what an appropriate profit would be ... It is not obvious that G4S carries a particularly high level of financial risk on this contract given the low level of financial penalties available, but its profit did fall following Panorama as it spent more on the contract.”³³

15. The monthly fee that the Home Office paid to G4S was subject to performance-related deductions. Schedule G of the contract set out 30 performance measures (key performance indicators or KPIs), examples of which are set out in Table 3, some of which gave rise to a set financial penalty if not met, and some of which incurred points that had a value that varied over time.³⁴

²⁸ [INQ000119_032](#) para 157

²⁹ [Peter Neden 22 March 2022 51/17-52/14](#)

³⁰ [DL000175_016](#) paras 1.12-1.13

³¹ [CJS0073632_003-005](#)

³² [CJS0073633](#)

³³ [DL000175_007](#) para 15; [DL000175_024-025](#) paras 2.16-2.21

³⁴ [HOM000921](#); from April to May 2017, each point incurred a penalty of £1.54. In June 2017, this figure increased to £1.73 ([CJS004578](#))

Table 3: Extract of performance measures under the GSL contract

Failure	Points	Penalty (June 2017 value)
Self-harm resulting in death <i>“any known incident of deliberate self-harm resulting in death which involves any failure to follow laid down procedures”</i>	–	£10,000 per incident
Detainee escaping from IRC (<i>“detention escape”</i>) or while being escorted (<i>“escort escape”</i>)	–	£30,000 per detainee £10,000 per escort escape
Self-harm resulting in injury <i>“Any known incident of deliberate self-harm resulting in physical injury requiring any form of healthcare intervention and involves any failure to follow laid down procedures for the safety of Detainees set out in Schedule D”</i>	400	£692 per incident
Substantiated complaints <i>“Any substantiated complaint against a member of staff (whether specifically identified or not) being either</i>		
<i>Serious complaint</i> <i>Any substantiated complaint of assault, damage to or loss of a Detainee’s property, or racial abuse;</i>	300	£519 per incident
<i>Other complaint</i> <i>Any other substantiated complaint”</i>	100	£173 per incident
Failure to provide the required staffing levels	Variable	

Source: [HOM000921](#)

16. G4S was required to monitor compliance with these measures and report any failures to the Home Office. Fee deductions could be imposed each month, depending on the seriousness of any failures. If grounds of mitigation could be proposed for the failure and were accepted by the Home Office, no penalty was imposed. Only failures in relation to matters listed in Schedule G could attract deductions. For example, while staff training content was set out in a plan approved by the Home Office, no penalties would attach to a failure to follow the plan.³⁵ Neither did specific penalties attach to improper use of force.³⁶ Deductions represented around 1.5 per cent of the monthly fee on average over the life of the contract.³⁷ During the relevant period, G4S incurred 19,245 penalty points, amounting to a financial deduction of £32,154.³⁸

17. Mr Riley considered that, by 2017, the contract was not suitable for what Brook House was being asked to deliver, one issue being that it did not appropriately mandate the deployment of staff within Brook House.³⁹

18. Mr Petherick told the Inquiry that the Home Office set the level of penalty points. While he suggested that he personally believed that the penalty attached to, for example, an escape, versus the death of a detained person, showed misplaced priorities, Mr Petherick said that the various levels of sanction “*didn’t come into the conversation*” with the Home Office once G4S took over the contract.⁴⁰

19. The penalty structure of the contract set by the Home Office emphasised security over care. An escape was penalised at three times that of a death in detention from self-harm involving a failure in procedures.⁴¹ This is indicative of a lack of sufficient prioritisation of the wellbeing of detained people.

Home Office contract performance management

20. Under its contract, G4S was required to monitor compliance with the performance measures and to report any failures to the Home Office. Compliance was monitored by the Home Office during the relevant period in various ways, including:

- quarterly, monthly and weekly meetings;
- weekly and monthly self-declaration;

³⁵ [HOM000921; DL0000175_007](#) para 14

³⁶ [HOM000921; DL0000175_007](#)

³⁷ [DL0000175_018](#) para 2.3

³⁸ [CJS004578](#)

³⁹ [Philip Riley 4 April 2022 44/17-19, 51/8-22](#)

⁴⁰ [Jeremy Petherick 21 March 2022 124/21-125/1](#)

⁴¹ [HOM000921](#)

- reviewing data such as raw staffing level data;
- talking to staff and walking around Brook House; and
- reviewing various forms and other paperwork.⁴²

Reliance on self-reporting by the contractor

21. Self-reporting by G4S was therefore an important feature of the contract. During regular meetings, G4S presented an account recording failures to comply with the performance measures in Schedule G and raised possible grounds of mitigation. Any issues or failings would be discussed at weekly meetings, and performance points would be agreed at monthly contract review meetings.⁴³

22. To illustrate how the reporting system worked in practice, a number of witnesses were asked about the penalty points attached to the ‘self-harm resulting in injury’ performance measure.

22.1 This required reporting of:

*“Any known incident of deliberate self-harm resulting in physical injury requiring any form of healthcare intervention and involves any failure to follow laid down procedures for the safety of Detainees set out in Schedule D”.*⁴⁴

22.2 Data gathered by G4S and the Home Office at the time showed that, during the relevant period, there were 60 acts of self-harm by detained people, of which four required treatment off site.⁴⁵ None gave rise to a performance measure report or penalty.

22.3 There was an apparent lack of clarity over the circumstances in which a self-harm event would need to be reported as a possible contractual failure. For example, on 4 July 2017, D865 was found in his cell unconscious, having placed a ligature around his neck. Detention Custody Manager (DCM) Christopher Donnelly accepted that he failed to check for a ligature, which he should have done immediately, until around two minutes after entering the cell.⁴⁶ The witnesses were divided as to whether, had this failure been reported, it would have amounted to a performance failure by G4S giving rise to penalty points. The view of Home Office Contract Monitor Mr Paul Gasson seemed to be that a reportable failure would be one where contractually required training

⁴² [HOM0332165](#) para 106; see also [HOM0332004_006-007](#) paras 14-17; [HOM0332152_003-006](#) paras 12-25; [Michelle Smith 23 March 2022 114/21-133/6, 143/13-21](#)

⁴³ [Daniel Haughton 16 March 2022 79/2-23](#); [HOM0332004_005-006](#) paras 12-15

⁴⁴ [HOM000921_005](#)

⁴⁵ [IMB000021](#); [IMB000050](#); [IMB000011](#); [IMB000047](#); [IMB000019](#)

⁴⁶ [Christopher Donnelly 23 February 2022 116/3-4](#)

updates had not been met, or where an Assessment Care in Detention and Teamwork (ACDT) plan had not been opened but should have been.⁴⁷ Mr Daniel Haughton, G4S Support Services Manager during the relevant period, felt that an individual error was likely to amount to a failure to follow procedures, potentially giving rise to a penalty that was not reported because it was not declared by Mr Donnelly.⁴⁸ Mr Ben Saunders, Centre Director for Brook House and Tinsley House (Gatwick IRCs) during the relevant period, told the Inquiry that all known self-harm events were reported to the Home Office at Safer Community meetings. Mr Saunders said that he signed off monthly G4S reports to the Home Office, adding: *"I don't know particularly how much scrutiny they paid to incidents. Not a huge amount, I would suggest."*⁴⁹

22.4 There was no real suggestion of an interrogation of the levels of self-harm, or its causes, by Mr Gasson as the contract monitor, or by anyone else at the Home Office. Mr Ian Castle, Home Office Detention and Escorting Services (DES) Area Manager for Gatwick IRCs during the relevant period, managed the Compliance Team. He was unable to say whether the level of self-harm (60 acts over the relevant period) *"was good or bad"*, as he had nothing with which to compare it.⁵⁰ Mr Gasson gave the impression that monitoring of self-harm was done within the quite rigid definitions of the contract, but in any event confirmed that his team would not go back and check for failures that might have led to the event.⁵¹

23. The G4S and Home Office staff tasked with monitoring G4S's compliance with the prevention of self-harm did not take appropriate steps to check for failings, despite significant known levels of self-harm. If this was due to a lack of clarity in the wording of the contract, clarity should have been sought. Mr Castle told the Inquiry that he relied on G4S to accurately report any self-harm event that met the criteria. He did not *"personally"* ensure that performance reports were accurate and could not say with any certainty what, if anything, his monitoring team did to check the information.⁵² He accepted that, in purely financial terms, G4S was disincentivised from reporting its own failures.⁵³ In his view, self-reporting was the only method available under the contract to ensure compliance: *"we did rely on honesty and integrity from G4S"*.⁵⁴ Ms Michelle Smith, Home Office Service Delivery Manager for Gatwick

⁴⁷ [Paul Gasson 15 March 2022 156/3-161/5](#)

⁴⁸ [Daniel Haughton 16 March 2022 87/5-88/7](#)

⁴⁹ [Ben Saunders 22 March 2022 159/18-24](#)

⁵⁰ [Ian Castle 15 March 2022 22/23-23/2](#)

⁵¹ [Paul Gasson 15 March 2022 161/21-162/10](#)

⁵² [Ian Castle 15 March 2022 20/1-4](#)

⁵³ [Ian Castle 15 March 2022 20/19-23, 21/13-20](#)

⁵⁴ [Ian Castle 15 March 2022 21/5-12](#)

IRCs during the relevant period, agreed that, where a contract requires self-reporting, *“it’s a matter of trust”*.⁵⁵

24. The Home Office suggested that the lack of any penalties under the self-harm KPI, despite significant self-harm incidents, was explained by the fact that a penalty was incurred only if procedures were not followed.⁵⁶ The Home Office said that this demonstrated that *“the KPI ... set too high a test for failure”*.⁵⁷ However, in my view, as there was no adequate process by the Home Office to check whether procedures had been followed correctly, it was not possible to tell whether the lack of penalty points was due to the threshold or to a lack of monitoring.⁵⁸

25. Penalties also attached to staffing levels, which were similarly reported by G4S and subject to Home Office monitoring.

25.1 G4S was required to:

“ensure that staffing in the Removal Centre allows at all times for an ordered, controlled, disciplined and safe environment for Detainees, Staff and Visitors and meets the obligations and complies with the provisions of the Contract at all times”.⁵⁹

25.2 The contract between G4S and the Home Office also included a ‘minimum’ or ‘required’ level of staff within the IRC based on the number of detained people at Brook House.⁶⁰

25.3 Failures to achieve contractual minimum staffing levels at Brook House could result in penalties (performance points) for G4S, as set out in Schedule G.⁶¹ The number of performance points would increase with the severity of the shortfall and where a failure was repeated multiple times in one month.⁶²

25.4 During the relevant period, the total Detention Custody Officer (DCO) staffing achieved by G4S often fell short of the minimum requirement. For example, staffing levels gave rise to penalty points on 13 occasions between June and August 2017, almost always at weekends. On four occasions, staffing was 90 per cent of the minimum level or below.⁶³

⁵⁵ [Michelle Smith 23 March 2022 145/16-22](#)

⁵⁶ [HOM0332165_035-036](#) para 110

⁵⁷ [HOM0332165_036](#) para 110

⁵⁸ [Paul Gasson 15 March 2022 161/12-162/10](#); [Ian Castle 15 March 2022 16/25-20/7](#)

⁵⁹ [HOM000798_180](#) clause 19.1

⁶⁰ During the relevant period, G4S should have provided 668 hours of DCO time each weekday (655 hours at weekends) and at least two DCOs should have been on duty on each residential wing during the daytime ([CJS0073709_010](#); [CJS004586_014](#))

⁶¹ [HOM000921_007](#) para 2(iii)(o)(ii); [CJS000524](#); [CJS004452](#)

⁶² [HOM000921_006-007](#) (updated October 2009); [CJS004452](#)

⁶³ Data from monthly performance reports ([CJS004586](#); [CJS004581](#); [CJS004585](#))

Fines for understaffing during the relevant period amounted to £2,205.75.⁶⁴

- 25.5** There were also other related contractual obligations that did not appear to have been met by G4S from time to time. For example, although this varied, three or four DCMs should have been present during the daytime and two at night.⁶⁵ However, Mr Stephen Loughton, a DCM during the relevant period (now Assistant Director), told the Inquiry that *“Every couple of months”* he had been the only DCM looking after four wings.⁶⁶ The Inquiry was told that there was an *“unmanageable workload”* for DCOs working on residential wings, involving such tasks as:

“admitting detainees to the wing, filling out ACDT observations, making property appointments, handing out essentials like toilet roll and soap, checking detainees’ cards as they tried to access the wing, allocating detainees to rooms, resolving detainee disputes, responding to incidents of violence or self-harm on the wing, escorting detainees to the kitchen to work and collecting the food trolley from the kitchen”.⁶⁷

- 25.6** Although the staffing requirements of Brook House fluctuated throughout the day and depended on the needs of the population, monitoring was simply based on the number of DCO hours on site over a 24-hour period. Ms Smith said that this method for calculating compliance was inappropriate, as *“it doesn’t really give you any control over where people are at any given time”*.⁶⁸

The adequacy of Home Office performance management

- 26.** There were insufficient Home Office staff to properly monitor the contract during the relevant period. The National Audit Office concluded that, until 2018, the Home Office did not have sufficient staff to verify or validate G4S’s reported level of performance.⁶⁹ This was accepted by Mr Gasson.⁷⁰ Mr Riley said that the Home Office staff at Brook House were too focused on *“serving of papers and doing the returns-focused work. We should have ... taken more responsibility for monitoring the overall experience of detainees.”*⁷¹ Ms Smith agreed that *“the team ... had limited time to focus on the compliance*

⁶⁴ [CJS0074522_006-007](#) para 28; 1,275 penalty points were incurred at £1.73 per point

⁶⁵ [VER000266](#) paras 138-145; [SER000453](#) para 123

⁶⁶ [Stephen Loughton 1 March 2022 73/23-75/7](#)

⁶⁷ [INQ000052](#) para 71

⁶⁸ [Michelle Smith 23 March 2022 115/13-17](#)

⁶⁹ [DL0000175](#)

⁷⁰ [Paul Gasson 15 March 2022 145/5-25](#)

⁷¹ [Philip Riley 4 April 2022 57/15-1](#)

activity” as a result of engagement work with detained people.⁷² She acknowledged that there was insufficient time to carry out dip sampling of G4S self-audits:

*“there was a KPI within the business plan in detention that required the onsite team to carry out seven hours’ contract monitoring per week, that was the expectation, and an acceptance that, in the main, that didn’t really stretch further than being able to have – attend meetings”.*⁷³

27. Ms Smith also told the Inquiry that there was no contractual requirement on the Home Office team at Brook House to report on the overall welfare of detained people, and that she expected external monitoring bodies to perform this role.⁷⁴ It appears therefore that, during the relevant period, Home Office staff at Brook House paid only superficial attention to welfare standards, which should have been their fundamental concern.

28. In my view, as a result of inadequate performance management by the Home Office, its contractor, G4S, did not face financial sanctions in circumstances where robust monitoring would likely have revealed failures that merited them. Critically, opportunities to improve safety were also potentially missed. As Mr Riley conceded, *“if we had adequately resourced our management of the contract, then I don’t think that the abuse would have happened”.*⁷⁵

29. Following the *Panorama* programme, the Home Office concluded that the behaviour depicted did not constitute evidence of systemic failures or a material breach of the contract, and that it was not necessary to try to terminate G4S’s contract. The Home Office and G4S *“analysed the Panorama programme and counted 84 separate incidents”*, some of which related to different aspects of the same event.⁷⁶ Some related to the inappropriate use of force and language, which were not themselves contractual performance measures. Most of the uses of force by staff against detained people shown in the *Panorama* programme were already known to G4S and the Home Office. Of the 84 incidents, the majority had not been previously reported under the contractual performance and incident reporting, but the Home Office agreed that G4S did not have a responsibility to report most of these incidents, finding that only four required reporting according to the contract.⁷⁷

⁷² [Michelle Smith 23 March 2022 111/20-112/6](#)

⁷³ [Michelle Smith 23 March 2022 114/12-18](#). Along with attending compliance meetings, Home Office representatives would attend ‘detainee forum meetings’ as well as monthly Independent Monitoring Board (IMB) meetings, while other Home Office employees acted as IMB clerks and took minutes (INQ000057 para 37; [Michelle Smith 23 March 2022 110/4-6](#))

⁷⁴ [Michelle Smith 23 March 2022 129/22-24](#)

⁷⁵ [Philip Riley 4 April 2022 94/11-13](#)

⁷⁶ [DL000175_021](#) paras 2.7-2.9

⁷⁷ [DL000175_021](#) paras 2.7-2.9

30. In its Closing Statement to the Inquiry, the Home Office acknowledged that *“the treatment shown in the Panorama Broadcast was completely unacceptable”*.⁷⁸ Mr Riley also conceded that its contract *“did not give the Home Office sufficient ‘leverage’”* to hold G4S to account in delivering services in accordance with the contract or the requirements of the Rules and other guidelines.⁷⁹

Extensions of the contract

31. In 2016, the contract was extended for 15 months until May 2018.

32. The Home Office was due to award a new contract to operate Brook House in late September 2017, but this procurement was paused when the *Panorama* programme aired to facilitate further due diligence work on the bids and was then subsequently cancelled.

33. In August 2018, the Home Office agreed a second extension of the contract to May 2020. Mr Riley told the Inquiry that the purpose of this extension (which he called *“short”*) was:

*“to allow officials time to reflect on the findings of [former Prisons and Probation Ombudsman] Stephen Shaw’s two reviews of vulnerability in detention, and the Verita report. It was only right that these important reports be given full consideration, and that future contract specification be carefully designed in accordance. A ‘knee-jerk’ reaction to change supplier would not, to my mind, have been in the best interests of the welfare of those in detention (which is the single biggest driver in the new contract) and would have risked destabilising the Centre at a time where positive stability was most required.”*⁸⁰

He acknowledged that this decision might be seen as *“questionable”*.⁸¹ Mr Stephen Kershaw, Senior Director of the Immigration Enforcement Board at the Home Office, told the Inquiry that he had advised ministers on the decision to extend the contract so that the Home Office could *“develop and let a very different successor contract”*, taking account also of the findings of the National Audit Office.⁸²

⁷⁸ [HOM0332165](#) para 2

⁷⁹ [HOM0332005_011](#) para 31

⁸⁰ [HOM0332005](#) para 23

⁸¹ [HOM0332005_008](#) para 23

⁸² [HOM0332166](#) para 12; [DL0000175](#)

A new contract

34. In August 2019, the Home Office invited outsourcing companies to bid for a contract worth up to £260 million over 10 years from May 2020 to manage Brook House and Tinsley House.⁸³ G4S did not bid for the contract.

35. In February 2020, Serco was awarded the contract to run the Gatwick IRCs and pre-departure accommodation, following a competitive public procurement process.⁸⁴

36. The Home Office stated that improvements were made in the Serco contract, including: a new staffing model with more staff supporting detained people; a two-hour reduction in the time detained people were locked in their rooms overnight; more welfare staff; more systematic assessments; educational and recreational activities seven days a week; increased assurance; a clearer and firmer approach to sanctions for poor performance; and requirements for the reduction of violence, substance misuse and drug supply. It stated:

“Overall, the new contract has been designed to have a much greater focus on the safety and welfare of those detained.”⁸⁵

37. Mr Riley told the Inquiry that the contract with Serco was not drafted specifically to address concerns arising from the *Panorama* programme or detailed in Mr Shaw’s reviews. He highlighted *“the overall focus on detainee welfare”* within the new contract and the reduced number of KPIs that were *“more clearly focused on outcomes”*.⁸⁶ He also noted KPIs relating to staff misconduct, *“maintaining a healthy staff culture”*, and failure to report serious incidents.⁸⁷ The Inquiry was told that the new contract links KPI failures with profit reduction and that, unlike the G4S agreement, repeated failures could lead to the termination of the contract.⁸⁸ Two *“critical”* failures attract a fixed penalty of £50,000: the escape of a detained person and self-harm resulting in death involving *“any failure to follow laid down procedures”*.⁸⁹ Other failures give rise to payments calculated by reference to the anticipated average monthly profit margin, depending on the level of failure, ranging from 5 per cent for *“severe”* to 0.25 per cent for *“minor”*.⁹⁰

⁸³ [Home Office offers £260m to run Gatwick immigration detention centres](#), [civilserviceworld.com](#), 2 August 2019

⁸⁴ [SER000226](#)

⁸⁵ [HOM0332165](#) para 102

⁸⁶ [HOM0332005_009](#) paras 25 and 26

⁸⁷ [HOM0332051_006-007](#) paras 28-29

⁸⁸ [SER000226_203](#); [SER000226_210-215](#); [HOM0332051_008](#) para 37

⁸⁹ [SER000226_210-215](#)

⁹⁰ [SER000226_0203](#); [SER000226_0210-0215](#)

38. As with the G4S contract, a KPI failure may not give rise to a financial penalty if it is ‘mitigated’. Mr Steven Hewer, the current Director of Gatwick IRCs under Serco, explained that mitigation would require either that there were extraordinary situations outside Serco’s control that had a significant impact on the ability to deliver the contract, or that Serco had introduced new systems or processes to stop the failure from happening again.⁹¹

39. Between May and August 2020 – the initial period of Serco’s management of Brook House – there was a “*relief period*” on all KPIs, meaning that no penalties would be applied for failure to comply.⁹² From July 2021, and continuing at the time when Mr Hewer gave evidence, a “*derogation*” had also been agreed with the Home Office in respect of multiple KPIs, by which any failure to comply would be reported but would not result in a penalty. This was because Serco had been asked by the Home Office to provide staff to immigration asylum hotels near Gatwick, as a result of which Serco could not meet certain requirements of the Gatwick IRCs contract.⁹³ Mr Hewer called this a “*temporary arrangement*” that had “*gone on a bit longer than anticipated, from a Home Office perspective*”.⁹⁴ The KPIs subject to this derogation related to staffing levels, recruitment processes, adherence to the staff culture and conduct policy, and staff training.⁹⁵

40. Compliance continues to be monitored by a combination of self-auditing by Serco and oversight by the Home Office, which has 12 members of staff working across the Gatwick IRCs estate.⁹⁶ Mr Hewer explained that Serco provides data through:

*“an agreed reporting structure, a balanced scorecard on a weekly and monthly basis ... performance is also discussed at the Weekly Operations Review Meeting (‘WORM’) and the Monthly Operations Review Meeting (‘MORM’)”.*⁹⁷

When asked how Serco ensures that serious incidents are now reported, he emphasised that “*it is really about that ethical behaviour ... part of the training of the managers and SMT [Senior Management Team] is to ensure that we report all information*”.⁹⁸

⁹¹ [SER000451_004](#) para 11

⁹² [SER000451_007](#) para 23

⁹³ [Steven Hewer 1 April 2022 35/1-38/2](#)

⁹⁴ [Steven Hewer 1 April 2022 36/23, 37/22-24](#)

⁹⁵ [SER000451_007](#) para 23

⁹⁶ [Daniel Haughton 16 March 2022 90/5-10](#). The Home Office team is split into three groups: Operations (dealing with day-to-day issues), Performance (carrying out the main compliance and performance monitoring) and Assurance (assuring self-reporting and monitoring third-party recommendations) ([INQ000057_003](#) paras 8-9)

⁹⁷ [SER000451_004](#) para 10

⁹⁸ [Steven Hewer 1 April 2022 31/20-32/2](#)

41. Mr Riley’s view was that it was too soon to comment on the effectiveness of the new Brook House contract, as the Covid-19 pandemic and consequential low capacity and limited regime made it difficult to assess whether cultural changes and staffing improvements have been delivered.⁹⁹ The evidence the Inquiry has seen – in particular in relation to current staff culture and the use of Brook House to house vulnerable individuals – suggests that there is still significant room for improvement. I am therefore recommending an active and robust approach to performance management.

Recommendation 1: Robust monitoring of contract performance

The Home Office must actively and robustly monitor the performance of the Brook House contract, including satisfying itself that any self-reported information is accurate. This may include engagement with monitoring bodies and appropriate stakeholders. Penalties must be attached to inadequate self-reporting.

Future Home Office procurement

42. The contract under which G4S managed Brook House during the relevant period was, the Inquiry was told, “likely designed in 2004 or 2005”.¹⁰⁰ Mr Riley told the Inquiry that the Cabinet Office rules for procurement were different at this time and that the ‘Sourcing Playbook’ to be followed in procurements of this type has now been revised.¹⁰¹ The Home Office stated that contracts are now awarded on the basis of value for money, which is defined as:

“securing the best mix of quality and effectiveness for the least outlay over the period of the contract – not minimising up-front costs. The Government recognises the risk of low cost bias, even if evaluation criteria are designed to balance quality and cost.”¹⁰²

For new IRC contracts, the cost element comprises 35 per cent of the assessment weighting, with “quality”, “social” and “value” elements making up the other 65 per cent.¹⁰³ This has replaced the 50:50 weighting applied at the time of the initial Brook House bids.¹⁰⁴

⁹⁹ [HOM0332051_005 para 25](#)

¹⁰⁰ [HOM0332165 para 97](#); [Philip Riley 4 April 2022 34/24](#)

¹⁰¹ [Philip Riley 4 April 2022 35/14-36/23](#)

¹⁰² [HOM0332165 para 99](#)

¹⁰³ [Philip Riley 4 April 2022 35/14-20](#)

¹⁰⁴ [DL0000140_044](#)

43. The tendering process for managing an IRC must ensure minimum welfare standards, as required by the Rules. The process for awarding contracts and any contract itself should include and properly reflect the overriding purpose set out in Rule 3 of the Rules: ie to provide *“secure but humane accommodation”*. Any ‘operational versus cost’ assessment must reflect this, whatever weighting is given to welfare. Standards must be maintained throughout the life of any contract for running an IRC, which can only be achieved by appropriate multi-layered monitoring. I am therefore recommending that contracts awarded by the Home Office for managing IRCs include, at their core, the welfare of those detained within them by expressly requiring compliance with the overriding purpose of Rule 3.

Recommendation 2: Contractual term requiring compliance with the overriding purpose of Rule 3 of the Detention Centre Rules 2001

The Home Office must ensure that each contract for the management of an immigration removal centre must expressly require compliance with the overriding purpose of Rule 3, which is to provide *“the secure but humane accommodation of detained persons in a relaxed regime with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environment, and to encourage and assist detained persons to make the most productive use of their time, whilst respecting in particular their dignity and the right to individual expression”*.

The provisions and operation of each contract must be consistent with and uphold the requirements of the Detention Centre Rules 2001, the Adults at Risk in Immigration Detention policy and the safeguards contained in detention services orders (including those concerning the use of force).

Chapter D.3:

The physical design and environment

Introduction

1. The Detention Centre Rules 2001 (the Rules) state that the purpose of detention centres such as Brook House is to provide:

*“secure but humane accommodation of detained persons in a relaxed regime with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environment, and to encourage and assist detained persons to make the most productive use of their time, whilst respecting in particular their dignity and the right to individual expression”.*¹

2. This chapter considers how the environment at Brook House was influenced by its physical design, facilities and other decisions made by the Home Office and G4S. It was designed to the specification of a Category B prison and to hold detained people for a few days.² This had numerous effects. It contributed to the harshness of the environment for detained people and the toxicity of staff culture, the undervaluing and under-resourcing of activities, and poor conditions inside detained people’s cells, particularly with regards to ventilation and sanitation. A humane and supportive regime appropriate for people in immigration detention was difficult to maintain, partly due to Brook House’s design to hold detained people on a short-term basis, which meant there was insufficient and inappropriate space for suitable activities. A decision by the Home Office in early 2017 to add beds for a further 60 detained people had a significant adverse impact on welfare due to overcrowding. The plan went ahead despite the obvious consequences and the warnings from Brook House staff, HM Inspectorate of Prisons (HMIP) and Mr Stephen Shaw, a former Prisons and Probation Ombudsman.

¹ [Detention Centre Rules 2001](#), Rule 3

² A Category B prison is described as a ‘closed’ prison, having ‘a secure perimeter’ and “providing additional physical and procedural security suitable for managing those identified as presenting a greater level of risk” ([Security Categorisation Policy Framework](#), Ministry of Justice and HM Prison and Probation Service, updated August 2021)

The design of Brook House and its facilities

Design of Brook House

Figure 29: Aerial view of Brook House



Source: *Financial Times*, 14 September 2017

3. The Home Office was responsible for the design and construction of Brook House. The physical environment was described by many witnesses as unfit for purpose as an immigration removal centre (IRC) holding detained people for more than a few days.
4. It was accepted by G4S that Brook House was *"built to the specifications of a Category B prison albeit without the education facilities and space for activities that would be available in such a prison"*.³
5. Mr Philip Riley, Director of Detention and Escorting Services (DES) within the Home Office, did not agree that it was designed as a Category B prison, but his reasons related to its culture and regime rather than the building itself.⁴

³ [CJS0075153_015](#) para 42. A number of witnesses to the Inquiry also agreed with this characterisation: [Jerry Petherick 21 March 2022 55/4-8](#); [Owen Syred 7 December 2021 57/23-58/2](#); [Dr Hindpal Singh Bhui 24 March 2022 177/18-25, 178/3-16](#); [Gordon Brockington 31 March 2022 90/18-21](#); [SER000455_028-029](#) paras 81-83; [INQ000055_002](#) para 8; [D1851 3 December 2021 63/20-64/6](#); [Owen Syred 7 December 2021 57/23-58/2](#); [VER000248_018](#) para 192; [John Connolly 2 March 2022 204/1-23](#); [Stephen Webb 8 March 2022, 138/23-25, 139/1-2](#); [SER000453_011](#); [INQ000056_010](#) para 45; [Dr Hindpal Singh Bhui 24 March 2022 154/2-7](#); [Clayton Fraser 28 February 2022 13/20](#); [VER000257_005](#) para 32; [BHM000031_003](#) para 5b

⁴ [Philip Riley 4 April 2022 60/12-61/7](#)

By contrast, in a 2019 judgment, the High Court described Brook House as having been “modelled on the design of a category B prison”, as did a report by HMIP following a March 2010 inspection.⁵

6. In his 2016 report for the Home Office on the welfare of vulnerable people in immigration detention, Mr Shaw described Brook House as “prison-like in aspect and in terms of security” and observed that it had “a small footprint meaning the facilities are rather cramped”.⁶ He was concerned that the introduction of anti-suicide safety netting had added to the oppressive environment.⁷ He also had some concerns about the multi-purpose use of E Wing to manage detained people with varying needs.⁸ This was a concern that he was to repeat when he returned to Brook House for a 2018 follow-up report.⁹

Figure 30: Safety netting at Brook House



7. In 2018, Ms Sarah Newland, Head of Tinsley House during the relevant period (1 April 2017 to 31 August 2017), and subsequently Deputy Director of Brook House and Tinsley House (Gatwick IRCs), remarked:

⁵ DL0000174_006; DL0000167_005

⁶ INQ000060_045 para 3.3; *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-up Report to the Home Office by Stephen Shaw*, Stephen Shaw, Cm 9661, July 2018

⁷ INQ000060_047 para 3.16

⁸ INQ000060_046 para 3.13

⁹ *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-up Report to the Home Office by Stephen Shaw*, Stephen Shaw, Cm 9661, July 2018, para A7.16

“Brook House is ostensibly a prison. It is built like a prison – it is prison wings. I think the whole environment that that brings, the acoustics, the noise, the numbers can be really overwhelming for people who haven’t experienced it before.”¹⁰

8. Mr Ben Saunders, Centre Director for Gatwick IRCs during the relevant period, described Brook House as:

“a much harsher environment [than Tinsley House], it was designed more like a prison and it felt like a prison. There were four main wings and a much smaller one designed for more vulnerable and challenging individuals. It was a far more oppressive building which we tried to soften but there is only so much you can do with the existing infrastructure.”¹¹

9. Monitoring bodies were also highly critical of the environment.

9.1 In its report following a May–June 2013 inspection, HMIP stated that *“Despite efforts to soften the environment, the centre continued to look and feel like a prison”* and made a recommendation that plans *“to soften the environment should be implemented across the centre”*.¹²

9.2 This was reiterated in the October–November 2016 HMIP inspection report, when it made recommendations concerning the poor ventilation and unsatisfactory sanitary conditions.¹³ When asked about the so-called *“mis-design”* of Brook House, Dr Hindpal Singh Bhui, Inspection Team Leader at HMIP, stated that holding immigration detainees in a centre designed as a Category B prison was *“inappropriate”* and that they should not be accommodated in *“prison-like environments”*.¹⁴

10. There was limited outside space. As noted by Professor Mary Bosworth, the Inquiry’s cultural expert, *“the category B design ... comes with a couple of concrete yards, and there’s ... not enough space”*.¹⁵ Due to its prison specification, Brook House was surrounded by tall razor wire fencing.¹⁶ This must have added to the oppressive feeling for detained people. The prison-like environment was harmful and inappropriate for all detained people, even for those who had served a prison sentence, particularly given the problems with overcrowding and with the facilities discussed in this chapter.

¹⁰ [VER000223_004-005](#)

¹¹ [KEN000001_011-012](#) para 56

¹² [HMIP000311_014](#) para S12; see also [HMIP000311_015](#) para S14; [HMIP000311_033](#) para 2.1; [HMIP000311_033](#) para 2.8; [HMIP000311_058](#) para 5.36

¹³ [CJS000761_018](#) para s36

¹⁴ [Dr Hindpal Singh Bhui 24 March 2022, 177/18-25, 178/3-16](#)

¹⁵ [Professor Mary Bosworth 29 March 2022 33/11-16](#)

¹⁶ [INQ000052_036](#) para 143

11. There was also some dispute about whether Brook House was only ever designed to hold people for 72 hours. Mr Riley described this as “*patently incorrect*” and an “*urban myth*”.¹⁷ However, the 2010 HMIP inspection report on Brook House noted that “*The centre was designed to hold detainees for no more than 72 hours*” and also that there was an “*erroneous assumption that detainees would be staying only a few days*”.¹⁸ G4S senior management and senior managers within Brook House suggested that it was designed for very short-term stays.¹⁹ In addition, the bids to manage Brook House, the assessment of those bids and the assumptions set out in the G4S contract appeared to be premised on the basis that people would be detained there for a matter of days.²⁰

12. I think it likely that Brook House was initially designed to hold detained people for no more than a few days, but that it became clear fairly soon after it opened that, in practice, most detained people stayed for much longer periods.²¹ Despite this, no significant changes were made to the building or how it was used for things such as activities and education.

13. In its first report (for April 2009–March 2010), the Independent Monitoring Board at Brook House (Brook House IMB) expressed “*great concern*” that at least five detained people had been held for nearly a year. The Brook House IMB also noted that the design of Brook House did “*not allow for many activities to occupy the men held there*” and therefore they “*should not be held for an extended length of time*”.²² It also noted that “*the design of the Centre is not adequate for detainees to be held for any protracted length of time*”.²³ Similarly, HMIP noted in its 2010 inspection report:

*“There had been limited investment in activity places as Brook House had been designed on the assumption that detainees would stay for only a short time before removal or release. In reality, many stayed for lengthy periods.”*²⁴

¹⁷ Philip Riley 4 April 2022 45/12-18, 45/12-46/12, 59/22-60/5

¹⁸ *Report on a Full Announced Inspection of Brook House Immigration Removal Centre 15–19 March 2010*, HM Chief Inspector of Prisons, June 2010, pp5-7; see also Dr Hindpal Singh Bhui 24 March 2022 176/12-24

¹⁹ Stephen Skitt 17 March 2022 130/16; SER000455_028; VER000266_005; CJS0074048_022 para 85; INQ000164_054 para 106; Gordon Brockington 31 March 2022 90/25-91/-5; Jerry Petherick 21 March 2022 55/4-56/20; Peter Neden 22 March 2022 68/3-7

²⁰ Reverend Nathan Ward 7 December 2021 134/12-136/14; DL0000141_023-024 paras 67-71; Philip Schoenenberger 23 March 2022 12/1-13/6; HOM000916_040; CJS000768_014

²¹ CJS000768_014; Dr Hindpal Singh Bhui 24 March 2022 176/23-177/-7

²² INQ000249_006

²³ INQ000249_005

²⁴ *Report on a Full Announced Inspection of Brook House Immigration Removal Centre 15–19 March 2010*, HM Chief Inspector of Prisons, June 2010, p5

14. The proportion of people detained at Brook House for less than a week has ranged from 11.7 per cent in 2010 to 23.3 per cent in 2017 and to 9.9 per cent in 2022.²⁵

Conditions inside Brook House

15. The prison-like, short-term specification for Brook House had consequences for the environment in which detained people lived.

16. Professor Bosworth commented:

“The design of Brook House Immigration Removal Centre is inappropriate for its purpose. The half doors of showers are undignified, while the toilets in the bedrooms and the inability to open the windows create unpleasant living spaces. Men on the footage ... report that their living spaces became uncomfortably hot in the summer months. These claims are reinforced by details in the IMB minutes. There is limited access to natural light and outdoor space as well as only a small area for activities. The daily schedule is punctuated by roll calls during which men are locked back in their rooms.”²⁶

Cells

17. Detention Custody Officer (DCO) Callum Tulley told the Inquiry that most DCOs referred to detained people’s rooms as cells since they “were so obviously cells”.²⁷ They were small, with two single beds. There was no handle on the inside of the door which would enable detained people to leave freely, the window was unopenable, and there was a toilet in the cell that caused it to smell.²⁸

²⁵ [Report on a Full Announced Inspection of Brook House Immigration Removal Centre 15–19 March 2010](#), HM Chief Inspector of Prisons, June 2010, p90; [CJS0073709_060](#); [INQ000225_003-004](#)

²⁶ [INQ000064_043](#) para 9.8

²⁷ This was the case for most of Brook House’s existence but, as discussed below, there were three beds in 60 cells for a period from 2017 to 2018

²⁸ [Callum Tulley 29 November 2021, 37/6-13, 39/6-17](#)

Figure 31: Cell at Brook House



18. There was a toilet with a privacy screen (a waist-high partition) and sometimes a curtain (although this was not always available) that separated the toilet from the rest of the cell.²⁹ Detained people vividly described the humiliation they felt about having to use the toilet in front of their cell mates.³⁰ Mr Tulley told the Inquiry that he would visit cells with unscreened toilets “*on a weekly if not daily basis*” and that detained people would often complain to him about the smell in their cells and the lack of fresh air after they had been locked in for long periods of time.³¹ It was humiliating for detained people to use the toilet without a curtain in very close proximity to others, particularly where the ventilation was poor. There was no reason why, at the very least, adequate partitions could not have been provided between the toilet and the rest of the cell.

19. HMIP highlighted these and other issues about poor conditions in every inspection report since 2010 (discussed in Chapter D.11). Following its 2016 inspection, one of HMIP’s main recommendations was that:

“Concerted action should be taken to soften the prison-like living conditions. Showers and toilets should be adequately screened, and toilets deep cleaned. Units should be well ventilated and detainees should have more control over access to fresh air.”³²

20. The lack of ventilation in cells was described in 2018 as the “*chief complaint among detainees*” by Mr Jeremy Petherick, Managing Director of G4S Custodial and Detention Services.³³ In his evidence to the Inquiry in

²⁹ [DL0000143_017-018](#) paras 63 and 65; [DL0000228_044](#) para 160

³⁰ [DL0000149_008](#) para 29; [DL0000228_044](#) para 160

³¹ [INQ000051_029](#) para 6; [INQ000051_030](#) para 9

³² [CJS000761_018, 049](#)

³³ [VER000117_031](#) para 2.2

March 2022, Mr Petherick said that “we were doing our best to alleviate many of the inherent problems” with the design of the building, which included unopenable windows.³⁴ Mr Lee Hanford, Business Change Director at G4S during the relevant period, also recognised that ventilation was an “issue” even before the introduction of 60 additional beds.³⁵ He said that the windows were worse than prison windows because prison windows had a “triple vent”. The Brook House windows did not have such vents in order to reduce the sounds from Gatwick Airport, which is located next to Brook House.³⁶ Mr Petherick, in his evidence to the Inquiry, stated that the toilets were difficult to clean because their construction materials required particularly abrasive chemicals to be used (cleanliness had to be balanced against the health risks associated with the use of those cleaning materials).³⁷

21. However, the Inquiry heard no evidence that specific action was taken by G4S in response to HMIP’s recommendations. Poor conditions remained during the relevant period. Issues with the lack of ventilation and unscreened and unclean toilets in small cells, partly a product of the prison-like design, led to humiliating experiences for many detained people.

22. Many witnesses also referred to the internal noise levels, with the banging of heavy doors putting people “on edge”.³⁸ The noise inside Brook House was obvious from the *Panorama* programme. There was also external noise. Professor Bosworth noted:

*“Brook House is right next to the runway at Gatwick, so it’s extremely noisy, you hear the planes landing and taking off all the time. It’s a very, very harsh environment to be in.”*³⁹

The proximity to Gatwick Airport and the noise impact on detained people were also noted by a local authority planning officer in 2006, who stated that “insulation of the development has been agreed with colleagues in the Environmental Health Division based upon limited time occupation of the building by individual detainees”.⁴⁰

23. In its Closing Statement to the Inquiry, the Home Office conceded that standards of cleanliness and hygiene at Brook House during the relevant period were “not acceptable”.⁴¹ It highlighted the fact that G4S’s Service Improvement Plan (in response to HMIP’s 2017 recommendation) was partially accepted due to

³⁴ [Jeremy Petherick 21 March 2022 98/5-7](#)

³⁵ [VER000266_004](#) para 32

³⁶ [VER000266_004-005](#) paras 34 and 38

³⁷ [Jeremy Petherick 21 March 2022 99/25-100/7](#)

³⁸ See, for example, [DPG000021_011-012](#) para 36

³⁹ [Professor Mary Bosworth 29 March 2022 33/11-16](#)

⁴⁰ [Planning Register, Crawley Borough Council, Officer Report](#), para 23

⁴¹ [HOM0332165_052](#) para 170

the limitations of the building design.⁴² This was because the building management system did not allow for individuals to control air access in their cells.⁴³ However, the plan stated that a review of the effectiveness of the ventilation system would take place (with a time frame of six months) and that a “*continuous programme of cleaning*” cells and toilet areas was being implemented.⁴⁴ Mr Riley pointed to improvements made since the relevant period, which include a cleaning and maintenance programme, refurbishments and redecorations commencing in October 2017, and improvements to toilet and shower screening.⁴⁵

24. Despite these actions, HMIP has remained critical of the current environment provided to detained people under Serco’s management of Brook House from May 2020. The May–June 2022 HMIP inspection report stated that a “*priority concern*” was that:

“The centre did not provide an open or relaxed environment suitable for immigration detainees. The centre was crowded and noisy, ventilation in cells was inadequate and the prison-like environment was one of the main reasons that detainees gave for feeling unsafe.”⁴⁶

Increases in the capacity of Brook House

25. The capacity of Brook House was increased in March 2013 by 22 beds, from 426 to 448 beds.⁴⁷ Mr Petherick told the Inquiry that these additional beds were added not to increase profits but “*to increase operational efficiency*”, for example by having a pre-departure unit and increasing the number of cells designed for constant watch.⁴⁸ I did not find this explanation convincing. A 360-degree contract review produced by Mr Saunders in June 2014 demonstrated that G4S did make an additional profit of £28,000 per year by adding the extra beds.⁴⁹ Mr Petherick also told the Inquiry that it did not necessarily follow that staffing would increase as a result, and that he felt that the staffing ratios remained appropriate following the increase in beds.⁵⁰

26. In 2014, the Home Office requested an increase in the population at Brook House. Mr Hanford told the Inquiry that there was no resistance to this

⁴² [VER000116_001](#) ref 5.2

⁴³ [VER000116_001](#) ref 5.2

⁴⁴ [VER000116_001](#) ref 5.2

⁴⁵ [HOM0332005_018-019](#) para 56

⁴⁶ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022, p5 para 2; see also pp3 and 64 and paras 1.11, 1.17, 2.27, 2.34, 3.5 and 3.7-3.8

⁴⁷ [CJS0074047_009](#) paras 41-46; [CJS000768_027, 044](#)

⁴⁸ [CJS0074047_009](#) para 45

⁴⁹ [CJS000768_027](#)

⁵⁰ [Jeremy Petherick 21 March 2022 41/4-42/15](#); [CJS0074047_009](#) para 43

from a G4S perspective and that it was an “*opportunity*” for the company.⁵¹ Mr Saunders confirmed in the June 2014 360-degree contract review that it was estimated that the introduction of an additional 60 beds would increase overall revenue by £1.5 million per year, with a profit margin of £91,000 per year.⁵² This confirmed that G4S’s profits would benefit from the increase in beds.

27. Reverend Nathan Ward, former Head of Tinsley House, told the Inquiry that he raised concerns with Mr Saunders about the increase to three-person cells and its effect on detained people’s welfare, particularly due to the lack of ventilation and privacy in cells. However, Mr Saunders did not consider that these concerns should be shared with the Home Office. Reverend Ward understood that the idea for the increase in beds came from both G4S and the Home Office.⁵³

28. In early 2017, the Extra Beds Programme was introduced and an additional 60 beds were installed in Brook House by converting some cells from two-person to three-person cells.⁵⁴

29. These plans were criticised by external sources before and after the changes were implemented, because of the effect that overcrowding would have on detained people’s welfare.

29.1 In the 2016 Shaw report, Mr Shaw said: “*Given the pressure on the other facilities, I do not believe this should go ahead.*”⁵⁵ In the 2018 Shaw follow-up report, he expressed disappointment that the Home Office had rejected this advice and suggested that it was “*unacceptable*” that cells contained toilets separated only by a curtain.⁵⁶ He commented: “*I did not find conditions in those rooms remotely acceptable or decent.*”⁵⁷ Mr Shaw recommended again that these practices ceased.⁵⁸

29.2 HM Chief Inspector of Prisons, Mr Peter Clark, warned in his introduction to the 2016 HMIP inspection report that the proposal to bring into use third beds installed in two-person cells “*has the potential to adversely*

⁵¹ [CJS0074048_021](#) para 79

⁵² [CJS000768_027](#)

⁵³ [Reverend Nathan Ward 7 December 2021 146/10-148/21](#)

⁵⁴ [CJS0074048_020](#) para 74

⁵⁵ [INQ000060_045](#) para 3.5

⁵⁶ *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-up Report to the Home Office by Stephen Shaw*, Stephen Shaw, Cm 9661, July 2018, paras 2.75 and 2.77

⁵⁷ *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-up Report to the Home Office by Stephen Shaw*, Stephen Shaw, Cm 9661, July 2018, p32

⁵⁸ *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-up Report to the Home Office by Stephen Shaw*, Stephen Shaw, Cm 9661, July 2018, recommendations 7 and 8

affect the conditions in which some detainees are held". He added that inspectors shared the view of many staff and detained people that it *"would lead to a decline in living standards"*.⁵⁹ Dr Singh Bhui explained to the Inquiry that a formal recommendation from HMIP was not appropriate because the change had not yet happened:

*"As third beds were installed but not yet being utilised, we had no evidence regarding the impact of a third bed on the experiences of detainees. No recommendation was made because inspections do not make recommendations about potential future outcomes, only about evidenced current outcomes."*⁶⁰

29.3 A meeting with Dr Singh Bhui, carried out as part of the external investigations company Verita's investigation into Brook House, recorded him saying in October 2017 that *"having three detainees in a cell is 'playing with fire' but means G4S will make more money from the contract"*.⁶¹

30. Concerns about the additional beds were also raised by G4S staff.

30.1 In relation to the impact of three-men cells, Mr Owen Syred, a DCO and Welfare Officer during the relevant period, told the Inquiry:

*"what was clear was that, actually, just a cell with two people in it was stuffy, the air was stale, it smelt, there was no access to fresh air, there was no real privacy when they were using the toilet, and, therefore, if – if the system doesn't work with two people in a room, adding a third person only increases the detrimental impact on living in there. If you're having to medicate people in order to sleep with two people in the room, then actually adding a third person isn't going to make it any better. In fact, it will make it demonstrably worse. These are concerns which I actually raised at the time, and I drew the facts of some of the policies which were in existence around minimum sizes that should be given for cell space to Ben Saunders at the time, and suggested that, in fact, we weren't meeting those with two people, let alone three people."*⁶²

30.2 When asked whether there was a noticeable change once the three-men cells were introduced, DCO Daniel Small replied:

*"Oh, 100 percent. If you were going to increase the capacity of detained persons at that facility, then surely you would increase the capacity of officers ... The environment is horrific in that place."*⁶³

⁵⁹ [CJS000761_005](#)

⁶⁰ [HMIP000697_006](#) para 18

⁶¹ [VER000193_001](#)

⁶² [Owen Syred 7 December 2021 147/21-25, 148/1-12](#)

⁶³ [Daniel Small 28 February 2022, 114/8-12, 115/21, 147/19-23](#)

31. Mr Hanford told the Inquiry that a joint assessment of risk (by the Home Office, Ministry of Justice and G4S) concluded that the Home Office’s proposal to increase capacity was viable when it was made in 2014.⁶⁴ However, he said that negotiations took a significant amount of time and, by the time the additional beds were added in 2017, the detained population had changed (the percentage of time served foreign national offenders – known as TSFNOs – had increased), the average stay had increased, and there was a significant drug problem concerning a new psychoactive substance known as ‘spice’.⁶⁵ However, if the change in the detained population was likely to cause difficulties for the Extra Beds Programme, Mr Hanford did not offer any explanation as to why G4S did not raise concerns in late 2016 or early 2017.

32. By contrast, Mr Julian Williams, Residential Manager, commented in a Senior Management Team (SMT) meeting on 13 April 2017:

“There has been no impact with addition[al] beds. Some detainees [do] not want to share but others are happy to have three detainees in a room.”⁶⁶

33. G4S and the Home Office eventually agreed in May 2018 that, *“having experienced managing the facility with the additional places”*, the Extra Beds Programme ought to be discontinued.⁶⁷

34. I agree with Mr Shaw that capacity in the immigration estate should never again be increased by adding extra beds to cells designed for fewer occupants.⁶⁸ When asked if he considered the introduction of the additional beds to be a mistake, Mr Riley said that he did not know what the *“options”* were at the time, and it may or may not have been the best option considering that extra capacity was needed.⁶⁹ The adverse impact of accommodating an additional 60 detained people was not given sufficient priority by the Home Office or by G4S, despite the availability of ample information on the risks to detained people’s welfare. Since the Covid-19 pandemic, when statistics have been published, there have been fewer than 200 people detained at Brook House.⁷⁰

⁶⁴ [Lee Hanford 15 March 2022 99/18-100/6](#)

⁶⁵ [Lee Hanford 15 March 2022 94/19-100/24](#)

⁶⁶ [CJS000582_002](#)

⁶⁷ [CJS0074048_021](#) para 79

⁶⁸ [CJS0074048_021](#) para 79

⁶⁹ [Philip Riley 4 April 2022 70/3-7](#)

⁷⁰ [Immigration System Statistics, year ending March 2023 \(Detention – Summary Tables\)](#), Home Office, May 2023, table 3a. The latest statistics show the number of people at Brook House on 31 March 2023

The detrimental impact on detained people

35. The physical environment and the conditions at Brook House had a significant detrimental impact on detained people, particularly those with mental ill health or other vulnerabilities.

35.1 D790 gave evidence that Brook House was overcrowded, leading to long queues to use the welfare office and IT equipment.⁷¹ He said that the cells were small and cramped.⁷²

35.2 D687 described being:

*“constantly on edge because of the toxic environment at Brook House and ... [the] noise [of officers slamming cell doors shut] was almost painful”.*⁷³

35.3 D801 described the environment as like a prison, which made it:

*“frightening and intimidating. I did not feel safe and I do not think it was safe for someone with my mental health problems.”*⁷⁴

36. Tellingly, senior Home Office officials accepted a causative link between the environment at Brook House and the deterioration of detained people’s mental health. The Home Office DES Area Manager for Gatwick IRCs, Mr Ian Castle, told the Inquiry:

*“I think, if you spend more than 24 hours in Brook House, you’re going to develop mental health issues. It’s not a nice place to be.”*⁷⁵

Not only is this a serious indictment generally of Brook House during the relevant period, but it is also very concerning that a Home Office manager perceived Brook House in this way.

37. Some of those currently working at Brook House also recognised the serious limitations of Brook House and its design. Mr Steven Hewer, current Director of Gatwick IRCs under Serco, recognised that the building and the restrictions that went with it posed challenges for the delivery of a *“human[e] regime”*.⁷⁶ Efforts must be made to allow more free movement around Brook House, to continue to provide diverting and beneficial activities, and to soften its appearance (as previously recommended by the Brook House IMB, HMIP and Verita).⁷⁷

⁷¹ [D790 21 February 2022 48/20-21](#)

⁷² [D790 21 February 2022 49/12](#)

⁷³ [DPG000021_025](#) para 78

⁷⁴ [BHM000034_028](#) para 84

⁷⁵ [Ian Castle 15 March 2022 38/16-18](#)

⁷⁶ [Steven Hewer 1 April 2022 87/3-7](#)

⁷⁷ [HMIP000613_020](#) para S36; [HMIP000613_028](#) para 1.59; [HMIP000613_045](#) para 3.16; [IMB000156_005](#); [CJS0073709_039-40](#) paras R17 and R23

38. Providing a humane regime at Brook House was difficult due to the design of the building. However, these issues and more were exacerbated while the additional beds were in use. I am therefore recommending a limit on the maximum number of detained people sharing each cell at Brook House.

Recommendation 3: Limit on cell sharing

The Home Office must ensure that a maximum of two detained people are accommodated in each cell at Brook House.

Activities

39. The Rules provide that a comprehensive range of activities must be provided so that detained people's "*recreational and intellectual needs*" are met and "*boredom*" is relieved.⁷⁸ It is important that attention is paid to providing detained people with sufficient activities and to ensuring that appropriate resources are available.

40. The G4S Regimes and Activities Policy reflected the requirements set out in the Rules on access to activities at Brook House. It stated that detained people should have access to three periods of daily activity (in the morning, afternoon and evening).⁷⁹ Available facilities provided by Brook House's Activities Centre included cardio fitness areas, IT rooms, internet access, a library, educational classes, a music room, a pool table and games on the wings, outdoor sports in courtyards, a shop and multi-faith rooms.⁸⁰ A gym was to be accessible in five pre-bookable sessions per day. There was also a 'cultural kitchen' to enable detained people to plan their own meals, cook and engage with each other.⁸¹

41. However, in the 2016 IMB report, the Brook House IMB commented that there was a "*noticeable shortage of space for activities*" at Brook House.⁸² During its inspection in May–June 2022, HMIP found that, although there was a reasonable range of activities available, the number of places was not sufficient to occupy the population of Brook House, and the facilities such as classrooms,

⁷⁸ Rule 17 of the Detention Centre Rules 2001 specifies that the development of skills and of services to Brook House and the community should be encouraged; detained people should be able to take part in paid activities; and educational activities and classes, physical education or recreation, and a library should be provided

⁷⁹ CJS000680_005-006

⁸⁰ CJS000680_005-006

⁸¹ CJS0074048_022 para 86

⁸² IMB000121_006 para 3.7

the gym and the cultural kitchen were too small.⁸³ Thirty-seven per cent of detained people told HMIP that there was not enough to do to fill their time.⁸⁴

42. The limitations imposed by the physical environment at Brook House were recognised by staff.

42.1 Mr Stephen Skitt, Deputy Director of Brook House during the relevant period, recognised the effect on activities for detained people. He said that since Brook House was built to a Category B security standard:

“[it] is restricted to the confines of the building. It would always be nice to have more open space or a bigger gym, greater activity areas and more recreational areas, but this is not possible in terms of the space available.”⁸⁵

42.2 Mr Hanford told the Inquiry that Brook House was *“not designed to accommodate people for long periods of time”* and that this affected the activities provided for detained people. There was *“not enough space to provide activities for so many people for long periods”*.⁸⁶ In his view, there were insufficient activities in Brook House for 448 detained people, *“let alone 508”* (after 60 additional beds were introduced in early 2017).⁸⁷

43. In addition, the Inquiry heard evidence from staff that activities were substantially limited during the relevant period due to understaffing.

43.1 DCO Edmund Fiddy said that the Activities Centre should have had three members of staff but there were many occasions when there were only two, and therefore only the IT suite and library would be staffed.⁸⁸

43.2 Mr Small, an Activities officer, told the Inquiry in his witness statement that Activities staff were required to cover staff breaks on the wings as well as staff sickness, and to accompany detained people to hospital.⁸⁹ He said that the consequence of this was that the Activities team was short-staffed and detained people could not go outside or have access to equipment.⁹⁰

43.3 DCO Kye Clarke said that there ought to have been more staff to run activities, particularly football and cricket, which were very popular.

⁸³ [*Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)*](#), HM Chief Inspector of Prisons, September 2022, para 4.1

⁸⁴ [*Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)*](#), HM Chief Inspector of Prisons, September 2022, para 4.1

⁸⁵ [SER000455_029](#) para 83

⁸⁶ [CJS0074048_0022](#) para 84

⁸⁷ [VER000239_016](#) para 172

⁸⁸ [MAR000002_007](#) para 58

⁸⁹ [BDP000003_011-012](#) para 34

⁹⁰ [BDP000003_011](#) para 34

Unnecessarily early night-time lock-ins meant that detained people would have to stop watching televised sporting events halfway through.⁹¹

44. The 2018 Verita report also found that activities were “*under-resourced, poorly managed and further compromised by long-standing staffing problems*”.⁹² The report stated:

*“Activities available to detainees at Brook House do not meet the standard prescribed by rule 17(1) of the Detention Centre Rules 2001. The lack of activities and opportunities for exercise present a risk to detainees’ welfare and wellbeing and to the general safety and security of the centre.”*⁹³

45. Mr Saunders accepted that staff should have been more proactive and should have organised activities better during G4S’s management of Brook House, but he said that staffing issues made it difficult.⁹⁴

46. This appeared to have been, in part, because activities were not seen as important by the Home Office or by G4S for detained people who were only supposed to be accommodated at Brook House for very short periods of time. This was demonstrated by the lack of space allocated, understaffing and issues regarding general resourcing.⁹⁵ The lack of activities led to an impoverished regime, which is likely to have contributed to the boredom and frustration felt by many detained people.

47. The Inquiry was told, as discussed in Chapter D.2, that recent increased staffing levels and new contractual provisions permit a wider range of activities to take place under Serco’s management. Serco stated that there had been significant investment in the physical environment, including redecoration and refurbishment, as well as the installation of biometric turnstiles to control access to different parts of Brook House and of information kiosks with multiple language options.⁹⁶ Mr Steven Dix, a Detention Custody Manager during the relevant period and now Assistant Director of Brook House, said that the numbers of Activities staff had increased since Serco took over the contract, and this had led to improvements for detained people.⁹⁷

48. Activities have been undervalued and under-resourced by G4S and the Home Office, so these are welcome developments. These efforts should continue in order to ensure that, as required under the Rules, detained people

⁹¹ [INN000012_020-021](#) paras 82, 86 and 87

⁹² [CJS0073709_015](#) para 1.50

⁹³ [CJS0073709_016](#) para 1.56

⁹⁴ [KEN000001_027](#) para 152

⁹⁵ [IMB000121_006](#) para 3.7; [CJS0073709_015](#) para 1.50

⁹⁶ [SER000451_012](#) para 47

⁹⁷ [SER000436_011](#) para 52

have “an opportunity to participate in activities to meet, as far as possible, their recreational and intellectual needs and the relief of boredom”.⁹⁸ Activities are essential for detained people’s welfare, particularly where they are held for longer periods than those for which Brook House was designed.

Internet access

49. The Rules do not contain any reference to computer or internet access, only to the use of telephone and post.⁹⁹

50. However, rights regarding the internet are reflected in Detention Services Order 04/2016: Detainee Access to the Internet (the Internet DSO), which states that detained people should have “reasonable and regulated access to the internet whilst ensuring that the security of the detention estate is not undermined”.¹⁰⁰ Consequently, detention centres:

*“must ensure that internet access enabled computer terminals are available to detainees 7 days a week for a minimum of 7 hours a day, though individual time slots may be limited if there is excessive demand”.*¹⁰¹

51. Computer and internet access at Brook House was poor and did not meet these requirements.

52. There were problems with computer and internet speed, blocked websites and access to working computers. D687 told the Inquiry:

*“I was trying to contact solicitors to get help with my case but the email provider I used was blocked on the computers in the IT suite. Staying in contact with people whilst detained at Brook House to [sic] be very difficult. The phones we were given weren’t smart phones and the reception at Brook House was awful. All this limited the ways you could contact people – friends, family, solicitors or charities supporting you. For people who didn’t have family in the UK, this was extremely difficult as the internet was the only way they could stay in touch with them.”*¹⁰²

53. Internet access was restricted to the IT room and was supervised by DCOs.¹⁰³

⁹⁸ [Detention Centre Rules](#), Rule 17(1)

⁹⁹ [Detention Centre Rules](#), Rule 31 and Rule 32

¹⁰⁰ [Detention Services Order 04/2016: Detainee Access to the Internet \(HOM002593\)](#), Home Office, May 2016 (updated [January 2020](#)), para 2

¹⁰¹ [Detention Services Order 04/2016: Detainee Access to the Internet \(HOM002593\)](#), Home Office, May 2016 (updated [January 2020](#)), para 4

¹⁰² See, for example, [DPG000021_031](#) para 93

¹⁰³ [CJS000680_007](#)

54. In a conversation recorded by Mr Tulley, DCO Daniel Lake, another Activities officer, described the slowness of the computers as a *“fucking joke”* and was concerned that detained people would *“kick off”* as a result.¹⁰⁴ Several anonymous complaints were made in July 2017 by detained people about slow and intermittent internet access.¹⁰⁵ On 24 July 2017, G4S found the complaints *“unsubstantiated”* and stated that the internet speed was *“satisfactory”*.¹⁰⁶ However, minutes from a Gatwick IRCs security meeting in August 2017 noted that they were *“Still having issues with IT and slow speed of the detainee internet”* and, having checked with Virgin and Openreach, that some of the problems were caused by detained people downloading films and due to the distance that Brook House was from the *“hub”*.¹⁰⁷

55. The Inquiry also heard from detained people who stated that internet access failed shortly before they or other detained people were deported on charter flights, which made it difficult for them to contact their lawyers.¹⁰⁸ Mr Syred said that he did not notice *“a pattern”* to the intermittent internet access that was available at Brook House.¹⁰⁹ Mr Riley was asked about this in his evidence to the Inquiry and he said that he had no knowledge of how that would even be possible.¹¹⁰ There was evidence that, in September 2017, the internet went down for a considerable period (four days) and that this was reported to the internet provider.¹¹¹ However, the Inquiry did not hear enough evidence to determine whether or not internet access did fail before charter flights or, if it did, the reasons for this.

56. The Internet DSO states that access to *“any personal internet based email accounts will be provided to detainees, subject to the detainee signing up to the individual centre’s acceptable use policy for internet use”*.¹¹² However, Mr Lake told the Inquiry that the IT room was *“useless as most websites were blocked and detainees couldn’t even access the documents they needed for their court hearings most of the time”*.¹¹³ Only certain categories of website should have been prohibited, as set out in the Internet DSO, such as social networking, pornographic material, and extremist and radicalisation

¹⁰⁴ [TRN0000083_031-034](#). Mr Lake told the Inquiry that, on one occasion, detained people smashed the computers up so that they would get sent away, but that the result was simply that there were fewer computers available for detained people ([Daniel Lake 1 March 2022 23/5-012](#))

¹⁰⁵ [CJS001591_001-002](#); [CJS001591_009](#)

¹⁰⁶ [CJS001591_003-004](#)

¹⁰⁷ [CJS000913_001](#)

¹⁰⁸ See, for example, [DL0000228_078](#) para 250; [DL0000143_027-028](#) paras 100-104

¹⁰⁹ [Owen Syred 7 December 2021 127/13](#)

¹¹⁰ [Philip Riley 4 April 2022 86/18](#)

¹¹¹ [HOM015395_001](#)

¹¹² [Detention Services Order 04/2016: Detainee Access to the Internet \(HOM002593\)](#), Home Office, May 2016 (updated [January 2020](#)), para 5

¹¹³ [BDP000002_010](#) para 32

material.¹¹⁴ Personal email accounts should not have been blocked.¹¹⁵ Despite this, D687 gave evidence that several websites were blocked, including his email provider, which made it very difficult for him to contact his solicitor.¹¹⁶

57. Mr Lake, in conversation with Mr Tulley in June 2017, said that he had told a member of the Brook House IMB about internet and computer speed and they said *“it’s a bit hit and miss”*, to which he responded, *“It’s a joke. They can’t even access their emails, let alone anything to do with their case.”*¹¹⁷ Mr Lake thought that the Brook House IMB did not take it seriously, because *“nothing was ever done about it”*.¹¹⁸

58. Bail for Immigration Detainees (BID), a charity that provides advice and assistance to people in immigration detention, surveyed detained people at Brook House every six months from 2016 and found that, in the majority of its surveys, more than half of respondents who tried to use the internet to research their legal cases complained of blocked websites. The blocked websites included BID’s own website, which offers free representation for immigration bail applications, and other websites offering advice on immigration matters, including those of solicitors’ firms.¹¹⁹ Mr Pierre Makhlouf, Legal Director of BID, noted that detained people’s personal email accounts were blocked, making it difficult for them to communicate with advisors.¹²⁰ This is particularly concerning since, in some cases, it appears to have had the effect of reducing access to justice.

59. Detained people also confirmed to the Inquiry that the computers themselves were often broken. D393 told the Inquiry that the computers *“never worked”*, and very often this meant that he was unable to communicate with his solicitors.¹²¹ D1851 told the Inquiry that there were *“always issues with the internet and with fax”* that meant he needed to see an immigration officer in person to hand over documents that his caseworker had asked him to provide.¹²² However, his requests to see an immigration officer were not followed up.¹²³ Mr Lake handed in a petition to senior managers from 30 detained people complaining about poor computer facilities, but he suggested

¹¹⁴ [Detention Services Order 04/2016: Detainee Access to the Internet \(HOM002593\)](#), Home Office, May 2016 (updated [January 2020](#)), para 11

¹¹⁵ [Detention Services Order 04/2016: Detainee Access to the Internet \(HOM002593\)](#), Home Office, May 2016 (updated [January 2020](#)), para 5

¹¹⁶ [DPG000021_031](#) para 93

¹¹⁷ [TRN0000083_031-032](#)

¹¹⁸ [Daniel Lake 1 March 2022 23/2-4](#)

¹¹⁹ [DPG000038_019](#) para 54

¹²⁰ [DPG000038_019](#) para 54

¹²¹ [DPG000023_010](#) para 38

¹²² [DL0000143_007-008](#) para 31

¹²³ [DL0000143_007-008](#) para 31

that the senior managers threw it away before the complaint could be considered by the Home Office.¹²⁴

60. It is unsatisfactory that, despite issues concerning blocked websites and access to working computers being complained about by detained people and advocacy groups during the relevant period, these issues were not resolved by G4S. This is particularly concerning as this failure to provide an adequate facility meant that it was difficult for some detained people to participate fully in their immigration cases.

61. Detained people (as well as some others working or visiting IRCs) are not permitted to have internet-enabled devices such as smartphones.¹²⁵ They must therefore be able to easily access computers and the internet in order to, among other things, obtain legal advice and representation. I am therefore recommending that reasonable access to computers and the internet be provided, reflecting the requirements of the Internet DSO.

Recommendation 4: Ensuring computer and internet access

The Home Office and its contractors must ensure reasonable access to computers and the internet.

Contractors must comply in full with Detention Services Order 04/2016: Detainee Access to the Internet, in particular:

- Computers and the internet provided for detained people's use must be maintained and fixed, if broken, within a reasonable time period, in order to allow detained people to access the internet for a minimum of seven hours per day, seven days per week.
- Websites containing personal internet-based email accounts must not be blocked, since this is not a prohibited category of website.
- Websites facilitating the provision of legal advice and representation must not be blocked, as this is not a prohibited category of website.

¹²⁴ [Daniel Lake 1 March 2022 23/13-24/22; TRN0000083 032](#)

¹²⁵ [Detention Services Order 05/2018: Mobile Phones, Internet Enabled Devices, and Cameras, Home Office, December 2018](#)

Chapter D.4:

Detained people's safety and experience

Introduction

1. Detention for immigration purposes should be *“used sparingly, and for the shortest period necessary”*.¹ Even former prisoners were not in Brook House to serve a prison sentence. People who were detained at Brook House were entitled to be treated humanely and with care, and to reside in an environment that ensured their safety and security. These principles are reflected in the Detention Centre Rules 2001 (the Rules) as well as the G4S contract.²

2. The evidence received by the Inquiry revealed several issues – such as drug use, language barriers, inadequate management of risk, the lock-in regime, no-notice removals and the indefinite nature of detention – that had a detrimental impact on the quality of life of detained people at Brook House during the relevant period (1 April 2017 to 31 August 2017).

Drugs

3. There was a significant drug problem during the relevant period at Brook House, particularly with the new psychoactive substance known as spice, a synthetic drug that mimics the effect of the active ingredient in cannabis.³

4. The number of detained people requiring medical assistance as a result of drug use fluctuated significantly, with 1 in April 2017, 15 in May 2017, 33 in June 2017 and 7 in July 2017.⁴ Evidence received by the Inquiry demonstrates the significant impact that the use of spice could have on detained people.

4.1 D1851 described seeing *“spice, drugs, people collapsing, emergencies, people looking like zombies every day, piling on each other”*.⁵ He said it was *“not uncommon to see people wetting themselves, collapsing and*

¹ [Detention: General Instructions](#), Home Office, January 2022, p7

² [Detention Centre Rules 2001](#), Rule 3; see also, for example, [HOM000916_040](#); [HOM000916_199](#)

³ See [Anton Bole 8 December 2021 128/15-131/4](#); [HOM0331981_011](#) para 41

⁴ [CJS0074244](#)

⁵ [D1851 3 December 2021 104/1-15](#)

frothing at the mouth" due to spice.⁶ Others described seeing or experiencing bad reactions to spice.⁷

- 4.2** On 13 May 2017, both D232 and D1667 collapsed and suffered seizures, apparently after smoking spice. They were both moved to E Wing for monitoring but later that day were able to smoke spice for a second time, requiring a further medical response. One member of the medical team and another staff member remarked that it was only a matter of time before a detained person died as a result of taking spice.⁸ This was echoed by Detention Custody Manager (DCM) Shane Farrell in his evidence to the Inquiry.⁹
- 4.3** On 15 June 2017, D149 suffered a severe response to spice, leading to an ambulance being called.¹⁰ There were four medical responses to spice attacks that day, three of which took place simultaneously.¹¹ On other occasions in June 2017, detained people suffered a bad reaction to spice, to which some managers and nurses responded unprofessionally by making jokes or mocking comments.¹²
- 4.4** Both D852 and D1275 were suspected by staff of being used as drug guinea pigs by other detained people.¹³ Mr Anton Bole, a team leader at the Forward Trust (a substance misuse charity), also told the Inquiry about vulnerable detained people being used in this way, but said he did not think it happened often.¹⁴
- 5.** This was not a problem unique to Brook House – it arose at other immigration removal centres (IRCs) as well as within the prison estate.¹⁵ However, Professor Mary Bosworth, the Inquiry's cultural expert, considered the extent of the drug problem at Brook House to be "*shocking*", referring to the "*number of times that the footage showed people having medical emergencies as a result of having taken spice*". She considered that "*one of*

⁶ [DL000094_012](#) para 74

⁷ [DL0000232_020](#) paras 48-51; [DL0000233_020](#) paras 92-96; [BHM000039_010](#) para 49

⁸ [INQ000052_059](#) para 223; [BBC000059_017-018](#); [KENCOV1016 - V2017051300006](#); [TRN0000095_009-017](#)

⁹ Shane Farrell 8 March 2022 85/15-18

¹⁰ [TRN0000069_007](#); [KENCOV1036 - V2017061500014](#); [KENCOV1036 - V2017061500015](#); [KENCOV1036 - V2017061500016](#); [TRN0000093_009-023](#); [CJS0074268](#)

¹¹ [SXP000075_002](#)

¹² [CPS000025_032](#); [TRN0000068_018](#); [CJS005937_008](#); [KENCOV1035 - V2017061400015](#); [Day 8 PM 2 December 2021 00:49:20-00:53:53 \(KENCOV1035 - V2017061400016\)](#); [HOM001503](#); [HOM005830](#); [CJS0073011](#); [TRN0000083_005](#)

¹³ [Callum Tulley 1 December 2021 43/1-25](#); [BBC000059_015](#); [INQ000052_058-059](#) para 222; [CJS005347](#); [CJS001127](#); [Day 8 PM 2 December 2021 00:33:00-00:49:02 \(KENCOV1035 - V2017061400015\)](#) and [00:49:20-00:53:53 \(V2017061400016\)](#)

¹⁴ [Anton Bole 8 December 2021 133/23-136/10](#)

¹⁵ See, for example, [Professor Mary Bosworth 29 March 2022 156/7-14](#); [Ian Castle 15 March 2022 78/1-4](#); [SER000455_012](#) para 42

the very basic aspects of the institution had failed, which was to provide a secure institution".¹⁶ In its report following an October–November 2016 inspection, HM Inspectorate of Prisons (HMIP) observed: *"The supply and misuse of drugs was the most significant threat to security."*¹⁷

6. There appeared to be a lack of training on dealing with spice attacks.¹⁸ Detention Custody Officer (DCO) Darren Tomsett said that his approach would be to get Healthcare to attend as quickly as possible and put the person in the recovery position and make sure they were comfortable in the meantime.¹⁹ He was recorded describing a detained person who had taken spice as a *"fucking idiot"* in a conversation with DCO Callum Tulley.²⁰ Mr Tomsett told the Inquiry that this was because he *"didn't think that they should be taking and using the spice and the different drugs that were in the centre"*, adding that he thought people took spice *"as a crutch"* and *"an escape ... from ... the realities of having to reside in Brook House"*.²¹ There was also some evidence of staff acting in a caring manner, and a large number of detained people were referred by staff to the Forward Trust for specialist support regarding substance misuse.²²

7. G4S told the Inquiry about various steps it took to prevent drugs from entering Brook House, including searching individuals, communal areas and property.²³ One difficulty in detecting spice was that it could be sprayed onto paper and sent in the post.²⁴ It is clear that visitors (including families and non-governmental organisations (NGOs)) were subject to searches, in accordance with G4S policy.²⁵ Despite this, several witnesses believed that this was the primary way in which drugs were being brought into Brook House.²⁶ This may have been, at least in part, due to staff being insufficiently trained to identify drug transfers during visits.²⁷ Similarly, some detained people and their cells were searched, particularly from June 2017 onwards.²⁸ However, DCO Daniel Lake told the Inquiry that staffing levels did not enable the challenge of individuals or searching of cells, as there were often only two staff on a wing, while he understood that searches required three officers.²⁹

¹⁶ [Professor Mary Bosworth 29 March 2022 9/13-20](#)

¹⁷ [HMIP000613_027 para 1.46](#)

¹⁸ [Darren Tomsett 7 March 2022 36/17-37/9](#); [Luke Instone-Brewer 8 March 2022 16/23-24](#)

¹⁹ [Darren Tomsett 7 March 2022 36/17-37/9](#)

²⁰ [TRN0000081_007](#)

²¹ [Darren Tomsett 7 March 2022 36/7-16](#)

²² [TRN0000083_006](#); [TRN0000083_009](#); [TRN0000083_011](#); [CJS0074239](#)

²³ [CJS0074041_031 para 148](#)

²⁴ [Anton Bole 8 December 2021 128/18](#)

²⁵ [INN000007_017 para 73](#); [INQ000027_019 para 76](#); see also [CJS000714_014-015](#)

²⁶ [Luke Instone-Brewer 8 March 2022 73/19-24](#); [Stephen Skitt 17 March 2022 73/11](#); [Owen Syred 7 December 2021 68/12-73/20](#); [CJS000917_002](#); [FWT000001_014 para 77](#)

²⁷ [Anton Bole 8 December 2021 150/7-12](#); [Aaron Stokes 9 March 2022 177/15](#)

²⁸ [Anton Bole 8 December 2021 152/7-20](#)

²⁹ [Daniel Lake 1 March 2022 20/6-24](#)

- 8.** There was also a G4S policy to carry out random searching of staff, based on intelligence and directed by the Head of Security.³⁰ A staff search record showed only one set of random searches during the relevant period – on 4 May 2017.³¹ Most staff asked by the Inquiry indicated that they either were not subject to random searches or were searched very rarely.³²
- 9.** The Inquiry received evidence alleging that staff members brought drugs into Brook House. For example, D393 said that spice was openly used at Brook House and that he heard other detained people talking about staff supplying it to them.³³ This was echoed by D180, D1876 and D1538.³⁴ DCO Shayne Munroe suggested that senior management and DCMs were aware that drugs were being brought into Brook House but said that *“it didn't appear like much was being done to fix the problem”*.³⁵
- 10.** There were specific allegations against individual staff members, to which the response from G4S was slow and inadequate.
- 10.1** Between October 2016 and February 2017, a large number of Corruption Prevention reports were logged, reflecting reports that DCO Luke Instone-Brewer – among others – was smuggling drugs and smartphones into Brook House and supplying them to detained people in exchange for money.³⁶
- 10.2** Ms Stacie Dean, Head of Tinsley House, also told the Inquiry that she had seen and submitted security reports about Mr Instone-Brewer and DCO Babatunde Fagbo dealing spice, and that it was *“a common talking point and was widely acknowledged”*.³⁷
- 10.3** In January 2017, Ms Dean informed Mr Jeremy Petherick (Managing Director of G4S Custodial and Detention Services) that Mr Instone-Brewer and Mr Fagbo were *“known to be supplying spice to detainees”*.³⁸

³⁰ [CJS000714_018](#)

³¹ [CJS0074289_019-032](#)

³² [Babatunde Fagbo 4 March 2022 85/2-20](#); [Callum Tulley 1 December 2021 35/23-37/22](#); [Ryan Bromley 7 March 2022 86/21-24](#); [Shane Farrell 8 March 2022 86/20-23](#); [Daniel Lake 1 March 2022 68/3-11](#); [Stephen Loughton 1 March 2022 128/4-21](#); [Shayne Munroe 4 March 2022 8/15-9/2](#); [CJS0073679](#). On the other hand, Mr Owen Syred said that staff were subject to random searches ([INN000007_017](#) para 73)

³³ [DPG000023_009](#) para 32

³⁴ [DPG000040_017-018](#) paras 72-75; [DPG000039_030-032](#) paras 116-120; [DL0000231_039-040](#) paras 145-151

³⁵ [Shayne Munroe 4 March 2022 9/17-10/13, 11/17-12/15](#)

³⁶ [CJS0073688_003-004](#)

³⁷ [INQ000172_004](#) para 10. Although not reported at the time, D687 told the Inquiry that he was told by two other detained people that Mr Instone-Brewer was bringing in drugs for them, in exchange for £500 ([DPG000021_027-029](#) paras 86-89). D687 had previously made similar allegations about 'Ginger' in his interview with the Professional Standards Unit in January 2018 ([HOM002453_038-039](#); [HOM002453_054-055](#))

³⁸ [CJS0073679_002](#)

She noted: *“there has not been a single staff search since this information has been known, Steve [Mr Stephen Skitt, Deputy Director of Brook House during the relevant period] constantly fobs off decisions”*.³⁹ The Inquiry saw no record of Mr Petherick taking any action upon receipt of this information.

- 10.4** Both Mr Instone-Brewer and Mr Fagbo denied the allegations of smuggling drugs or other items into Brook House or supplying them to detained people, and said that they had no knowledge of these accusations prior to the Inquiry.⁴⁰ Mr Fagbo thought that the accusation that he was bringing in drugs was related to the fact that he is a person of colour.⁴¹ He recalled that two other officers were investigated for bringing in drugs, but he could not remember their names.⁴²
- 10.5** A limited investigation was conducted at some stage after Mr Instone-Brewer resigned in July 2017, but ultimately the *“Police did [a] financial background check and [there was] nothing in [his] bank”*.⁴³ Mr Skitt said that Mr Fagbo and Mr Instone-Brewer had been *“looked at from a Corruption Prevention point of view”* and that *“We involved the Police and they were doing some work on it”*, but nothing came of it and the intelligence dried up.⁴⁴ He told the Inquiry that intelligence suggested that staff members were bringing in drugs, but the evidence to prove it had not been obtained.⁴⁵ Mr Skitt accepted that there were some failures with staff searches but said that he preferred targeted rather than routine searching.⁴⁶
- 10.6** However, there does not appear to have been much targeted searching. Mr Instone-Brewer was recorded as having been searched only twice.⁴⁷ The first search took place in May 2017, six months after the first intelligence was received about him, and the second was in July 2017, five days before he resigned.⁴⁸ The six months during which G4S knew of allegations about Mr Instone-Brewer but took no steps to carry out searches or any other monitoring undermine their position that:

³⁹ [CJS0073679_002](#)

⁴⁰ [Luke Instone-Brewer 8 March 2022 48/10-65/13](#); [Babatunde Fagbo 4 March 2022 84/1-86/2](#)

⁴¹ [Babatunde Fagbo 4 March 2022 86/3-88/20](#)

⁴² [Babatunde Fagbo 4 March 2022 86/15-87/3](#)

⁴³ [CJS0073809_004](#); see also [CJS0073688_001-002](#)

⁴⁴ [CJS0073682](#)

⁴⁵ [Stephen Skitt 17 March 2022 75/6-76/8](#)

⁴⁶ [Stephen Skitt 17 March 2022 146/22-147/13](#); [VER000256_021](#)

⁴⁷ [CJS0073688_004](#)

⁴⁸ [CJS0073688_004](#)

*“when staff members became suspicious about their monitoring, they would resign before any/sufficient evidence could be obtained to refer the matter to the police [or] to commence formal disciplinary proceedings”.*⁴⁹

11. Ms Michelle Brown, a member of the Senior Management Team (SMT) at the time, also said that if she received information about staff bringing in unauthorised items she reported it via the Security Information Report (SIR) process.⁵⁰ She recalled that when she started as Head of Security at Brook House in June 2017 she found a large volume of SIRs *“locked in a safe”*, all of which related to *“staff issues in terms of corruption including alleged drug usage, particularly around steroid use or conveyance”*.⁵¹ Ms Munroe also told the Inquiry that she would write SIRs to record when she was told names of staff bringing in drugs.⁵² Despite this, the Inquiry received only one SIR that possibly related to staff members smuggling or supplying drugs; this was produced by a DCO and was vague and speculative.⁵³

12. It is clear that G4S and the Home Office were aware that drugs were available in Brook House.⁵⁴ The frequent use of drugs and the consequences, as set out above, suggest that there was a failure to take sufficient or adequate steps to control the availability and use of drugs, both prior to and during the relevant period. This failure likely contributed to an environment that felt unsafe to detained people, as discussed, for example, in Chapter C.11 in Volume I. There appeared to be a sense of defeat from staff in how to address the spice problem, while the additional demands that drug use by detained people placed on staff likely impacted their morale and their attitudes to the people in their care.

13. Mr Bole suggested that, after the *Panorama* programme in September 2017, there was an improvement in security, with increased searches and fewer drugs coming in.⁵⁵ Mr Skitt told the Inquiry that various measures were taken that led to a notable reduction in drugs within Brook House by 2018.⁵⁶ By the time of HMIP's 2019 inspection, a drug and alcohol strategy had been introduced and HMIP found improvements in reducing the supply of drugs into Brook House.⁵⁷ HMIP's report following a May–June 2022 inspection (after the

⁴⁹ [CJS0074041_031](#) para 150

⁵⁰ [INQ000164_029](#) para 45

⁵¹ [INQ000164_001](#) para 2; [INQ000164_049](#) para 90

⁵² [Shayne Munroe 4 March 2022 10/14-11/16](#)

⁵³ [CJS0074159](#), which referred to a detained person saying that a colleague could be bringing spice into Brook House

⁵⁴ As is shown by, among other things, attendance at and receipt of minutes of SMT meetings and security meetings (for example, [CJS000536_002](#); [CJS000575_002](#); [CJS000911_001-002](#); [CJS000917_002](#); [CJS000915_003](#))

⁵⁵ [Anton Bole 8 December 2021 119/9-11, 152/12-20](#)

⁵⁶ [Stephen Skitt 17 March 2022 73/10-74/4](#)

⁵⁷ [HMIP000674_030](#) paras 1.52-1.54

conclusion of the Inquiry’s hearings) noted some misuse of drugs but no evidence of a high prevalence. It also noted that suitable measures were being taken to prevent supply, such as mail testing, and that “*Very few detainees had seen any use of drugs or alcohol*”.⁵⁸

Language barriers

14. A large proportion of people detained at Brook House did not have a good understanding of English, creating additional difficulties during their detention.⁵⁹ D2077, for example, referred to the fear of not knowing what was going to happen to him, as he did not speak the same language as “*the guards*”, and to his anxiety about people speaking English around him.⁶⁰ Professor Bosworth considered that language barriers were a “*key contributing factor to the anxiety and frustration of the detained population*”.⁶¹ There was an average of 30 different languages spoken at Brook House.⁶²

15. The G4S contract stated that a fellow detained person could be invited to interpret where communication was part of a general conversation, but other instances required the use of interpreters or computer software.⁶³ Staff were able to use telephone or in-person interpreters via language services companies (LanguageLine or thebigword) to communicate with detained people who did not speak English.⁶⁴ The report of the Independent Monitoring Board at Brook House (Brook House IMB) for the reporting year 2017 recorded 150 to 300 LanguageLine calls made each month, with the majority used by Healthcare, Reception and the welfare office.⁶⁵ Ms Jacqueline Colbran, Chair of the Brook House IMB during the relevant period, thought that DCMs were “*very good*” at using LanguageLine.⁶⁶ There may, however, have been a lack of awareness among some staff of the services they could use. DCO Daniel Small, for example, told the Inquiry that he was not aware of a telephone translation service and would use Google Translate on a computer in the IT suite or

⁵⁸ [INQ000227_023](#) para 2.37; [INQ000227_064](#) Appendix V

⁵⁹ In 2013, 29 per cent of detained people surveyed by HMIP said that they did not understand spoken English and 36 per cent said that they did not understand written English ([HMIP000613_82](#)). The figures in 2016 were 18 per cent and 30 per cent respectively ([HMIP000613_072](#)). In 2019, only 55 per cent of survey respondents answered yes to ‘Do you understand either spoken or written English very/quite well?’ ([CJS0073825_089](#))

⁶⁰ [DL0000226_031-032](#) paras 120-123

⁶¹ [Professor Mary Bosworth 29 March 2022 17/5-6](#)

⁶² [VER000138_011](#) para 5.2

⁶³ [HOM000798_012](#) para 1.1.5. This was also reflected in the G4S Single Equality Policy, which noted that “*Any detainee may translate for another on a voluntary basis ... detainees do not have to translate if they do not wish to do so*” ([CJS000705_037-038](#)); see also [SER000455_039](#) para 115

⁶⁴ [Anton Bole 8 December 2021 163/1-20](#). For healthcare matters, LanguageLine was to be used for confidential interpretation or an interpreter was to attend ([HOM000798_057](#) para 6.1.3)

⁶⁵ [VER000138_011](#) para 5.2

⁶⁶ [Jacqueline Colbran 25 March 2022 88/15-16](#)

library. He said that otherwise he would not be able to communicate with people who did not speak English.⁶⁷

16. Professor Bosworth noted that staff did not seem to use the telephone translation service in everyday interactions. Instead, they relied on other detained people as translators or the use of dictionaries.⁶⁸ She also found little evidence to suggest that most staff spoke languages other than English, unlike at other IRCs.⁶⁹ Her view was that interactions with staff often depended on a detained person's ability to speak English.

17. There were a number of consequences for detained people as a result of language barriers.

17.1 Understanding and communicating generally: Day-to-day impacts of language barriers included detention paperwork not being translated, detained people not understanding their induction, and detained people seeing others struggling to understand their situation and being unable to communicate.⁷⁰ D1876 said that he was rarely provided with an interpreter and, when he was, many of them were "*not good*" and would not allow him to communicate fully. He had to find other detained people to interpret for him, reducing his privacy and sometimes requiring him to pay them.⁷¹ In 2019, HMIP found that there was not enough use of professional interpreting by Reception staff and observed new arrivals being interviewed without interpreters when they did not understand the questions they were being asked.⁷²

17.2 Healthcare: Communicating about health issues and with medical professionals was a particular difficulty. Some detained people said that they never had an interpreter when speaking to healthcare staff.⁷³ It was also difficult to communicate complex issues and accurately convey all of the details.⁷⁴ D2158, for example, found it difficult to communicate with the doctor during Rule 35 interviews, even when a telephone interpreter was used. He told the Inquiry that the interpreter did not sound fluent in his language and appeared to be struggling to understand him.⁷⁵

⁶⁷ [Daniel Small 28 February 2022 124/16-125/9](#)

⁶⁸ [INQ000064_037](#) paras 7.14 and 7.15; [TRN0000026_005-009](#); [TRN0000031_006-007](#)

⁶⁹ [Professor Mary Bosworth 29 March 2022 16/12-15](#); [INQ000064_036](#) para 7.12

⁷⁰ [BHM000029_004](#) para 12; [DL0000229_016-017](#) paras 62-66; [DL0000229_019-020](#) para 73; [DL0000229_020](#) para 74; [DL0000229_021](#) para 79; [DL0000229_022](#) para 83; [DL0000229_022-023](#) para 85; [BHM000039_008](#) para 40

⁷¹ [DPG0000039_008-010](#) paras 32-39

⁷² [CJS0073825_020](#) para S42; [CJS0073825_023](#) para 1.6

⁷³ [DL0000149_009-010](#) para 34; [DL0000149_027](#) para 80; [DL0000229_016-017](#) paras 62-66; [DL0000229_019-020](#) para 73; [DL0000229_020](#) para 74; [DL0000229_021](#) para 79; [DL0000229_022](#) para 83; [DL0000229_022-023](#) para 85

⁷⁴ [DL0000231_005](#) paras 20-21; [DL0000231_008](#) paras 36-37; [CJS007239_001](#)

⁷⁵ [BHM000029_007](#) para 24

Ms Christine Williams, Clinical Lead at Brook House, acknowledged that interpreters were not always readily available for healthcare appointments, leading to appointments being rescheduled.⁷⁶ She also said that some interpreters did not know the medical terms being used.⁷⁷ Yet Ms Karen Churcher, a Registered Mental Health Nurse, said that interpreters were nearly always available within two to three minutes of calling.⁷⁸

17.3 Complaints: D2953 made numerous complaints about having been hit by a staff member. His English language skills were “*not good*” and, on several occasions, he did not have the use of an interpreter. As a result, his allegations were not clearly understood by staff.⁷⁹ When he did have the use of an interpreter, he was able to convey that he had been punched.⁸⁰ While complaint forms were provided in multiple languages, the Brook House IMB’s forms were available only in English and required people to write in English, which the Brook House IMB accepted was a barrier.⁸¹ (This was the case at the time of the relevant period and continued at least until the Inquiry’s hearings.) In 2019, HMIP observed that G4S’s complaint responses were written in templates, making them especially difficult to understand for those with little English.⁸²

17.4 Communicating with visitors: There were no telephones in the visits area to enable the use of telephone interpreters and there was no Wi-Fi to facilitate electronic translation. Mr Jamie Macpherson, a Gatwick Detainees Welfare Group visitor, told the Inquiry that he visited an Iranian man who spoke no English and spent an hour with a dictionary picking out odd words.⁸³ However, Ms Colbran said that she personally never had a problem speaking to someone at Brook House because, if she could not use her own language skills to speak with a detained person in a language other than English, the detained person “*would almost always have a friend*” who would translate for them.⁸⁴

18. This evidence suggests that language barriers reduced the ability of detained people to interact with staff, access healthcare, make complaints and communicate with visitors. Insufficient steps were taken by G4S during the relevant period to reduce these barriers, and there was an over-reliance on

⁷⁶ [Christine Williams 10 March 2022 93/16-94/12](#)

⁷⁷ [DWF000020_019](#) para 106

⁷⁸ [DWF000003_011-012](#) paras 78-80

⁷⁹ [HOM032609_002](#); see also [HOM032609_011](#); [CJS001506_033](#) para 7.1.5; Chapter D.10 and Chapter C.10 (in Volume I) regarding D2953’s complaints more generally

⁸⁰ [HOM032609_013](#)

⁸¹ [CJS000705_037](#); [Mary Molyneux 25 March 2022 110/16, 111/21](#)

⁸² [CJS0073825_035](#) para 2.17

⁸³ [Jamie Macpherson 8 December 2021 207/12-210/3](#)

⁸⁴ [Jacqueline Colbran 25 March 2022 88/2-11](#)

informal translation. Such language barriers contributed to conditions where poor treatment was more likely to occur.

19. In June 2022, the Home Office introduced Detention Services Order 02/2022: Interpretation Services and Use of Translation Devices (the Interpretation and Translation DSO). This recognises that:

“Entering detention, changing detention locations and/or being in a detained environment can be a stressful time for individuals. It is the responsibility of Home Office and supplier staff operating in these facilities to take all reasonable steps to ensure that all processes and communications between staff and the detained individual are fully understood.”⁸⁵

The Interpretation and Translation DSO therefore makes clear that in-person or telephone interpretation services should be used for all essential interactions where accuracy is of significant importance. The use of other detained people for translation should be limited to general questions and non-essential interactions, with the agreement of all parties.

20. However, in its report following a May–June 2022 inspection, HMIP identified that application forms for health appointments and medicines information were available only in English and only 63 per cent of those with no understanding of English said that interpreters were used during healthcare assessments.⁸⁶ Detained people who were interviewed identified concerns that staff could be dismissive or not interact well with detained people, particularly those who did not speak English.⁸⁷ A substantial number of detained people did not know how to make complaints or were not confident in doing so. This was particularly the case for people who did not speak fluent English.⁸⁸ On the other hand, HMIP noted that the welfare team made good use of interpretation and that there was good provision of health and wellbeing information in different languages within the Healthcare department.⁸⁹

Assessment and management of risks

21. To ensure the safety and welfare of anyone detained at Brook House, staff should have assessed their needs and any potential risks to their wellbeing. Proper assessment and management of any risks, throughout their time in detention, were necessary in order to keep detained people safe.

⁸⁵ [Detention Services Order 02/2022: Interpretation Services and Use of Translation Devices](#), Home Office, June 2022, para 5

⁸⁶ [INQ000227_032](#) para 3.19; [INQ000227_035](#) para 3.40; [INQ000227_038](#) para 3.60

⁸⁷ [INQ000227_064-065](#)

⁸⁸ [INQ000227_066](#)

⁸⁹ [INQ000227_015](#) para 1.32; [INQ000227_035](#) para 3.37

Reception and induction

22. Upon arrival at Brook House, all detained people should have received a reception and induction that familiarised them with their surroundings, answered any questions, and provided key information regarding the IRC, its regime and other factors relating to safety and decency.⁹⁰ This was important in order to provide detained people with essential information about Brook House while continuing the process of assessing risks surrounding their detention, welfare needs, any vulnerability issues and their proficiency in English.⁹¹

23. The reality was different: many detained people did not receive a proper reception or induction.⁹² The 2022 HMIP inspection report suggested that some of these issues persisted under Serco's management of Brook House. Although detained people received a good one-to-one induction, HMIP had a key concern: *"The identification and management of risks on arrival was not good enough."* It noted:

*"Not all detainees were offered a private interview on arrival and staff did not always spend enough time enquiring into detainees' risks."*⁹³

24. The induction policy also required new admissions to be accommodated on B Wing (the wing designated as a First Night and Induction Unit) for at least 24 hours. This was to ensure that newly arrived detained people could receive a full induction and were not immediately mixed with those who had already been detained for a long time.⁹⁴ This often did not happen because B Wing was being used to house other detained people.⁹⁵ As noted in the 2018 Verita report:

*"The failure to house detainees in an induction wing where they could be properly assessed and any concerns about them identified presented a risk to their welfare and wellbeing."*⁹⁶

⁹⁰ [CJS006042_004-007](#) p4, sections 1-2

⁹¹ [CJS006042_004](#); [Detention Services Order 06/2013: Reception, Induction and Discharge Checklist and Supplementary Guidance \(CJS000681\)](#), Home Office, July 2016, paras 11-15, 19-20 and 26 (updated [August 2021](#), paras 28, 30-37, 41-42 and 48)

⁹² [D643 22 February 2022 4/17-5/21](#); [CJS0073709_158](#) para 10.35; [VER000269_017-018](#); [BHM000018_005](#) para 21 (D1713); [DPG000040_002-003](#) paras 7-11 (D180); [CJS0074154_003](#)

⁹³ [INQ000227_006](#) para 7; [INQ000227_011](#) para 1.7

⁹⁴ [CJS006042_004](#); [CJS006042_010](#)

⁹⁵ [D1618 3 December 2021 12/24-13/8](#); [Darren Tomsett 7 March 2022 6/8-7/17](#); [CJS0073709_019](#) para 1.73; [CJS0073709_158](#) para 10.35; [INN000024_007](#) para 22

⁹⁶ [CJS0073709_019](#) para 1.74

Cell sharing

25. There also appears to have been an inadequate process for assessing risk when allocating detained people to cells.

26. In accordance with Detention Services Order 12/2012: Room Sharing Risk Assessment, staff were required to carry out a room-sharing risk assessment for each detained person to identify those who posed a risk to others. They were also required to record any additional precautionary measures where cell sharing was unavoidable.⁹⁷

27. Proper risk assessment is crucial to avoid detained people being placed at unnecessary risk. However, the operation of this process appears to have been deficient. For example, D1876 was placed with a cell mate who subjected him to violence, although he indicated that he had told staff beforehand that there was a war between their countries of origin and that he did not want to share a cell with him, but *"nobody listened"*.⁹⁸ D2033's cell mate made him feel *"very afraid"* after he saw that his cell mate had *"destroyed and broken everything in the room"*, *"was always shouting and screaming"* and threatened him with what he thought was a plastic knife. This was after D2033 had *"pleaded with the officers that I should be kept somewhere safe and transferred back to the first wing where I had a room by myself"*.⁹⁹ In both cases, the Inquiry did not receive any record of a room-sharing risk assessment being created or amended during the relevant period.¹⁰⁰

28. There were also problems with allocation regardless of risk assessment. Some staff felt under pressure from the Home Office not to allocate detained people to single occupancy cells.¹⁰¹ Others said that they co-located potentially unsuitable detained people in cells together because Brook House was full.¹⁰²

29. There was an inadequate process for assessing risk when allocating detained people to cells and there were problems with allocation arising from capacity pressures. Risk assessment must be conducted properly and capacity issues should not be prioritised over the welfare of detained people. I am therefore recommending steps to assess and manage risks related to cell sharing.

⁹⁷ See [Detention Services Order 12/2012: Room Sharing Risk Assessment \(CJS000710\)](#), Home Office, August 2012 (updated [September 2016](#)); [CJS006042_022](#). See examples at [CJS001148_013-014](#); [HOM004135](#)

⁹⁸ [DPG000039_028](#) para 108

⁹⁹ [DL0000149_005](#) para 19; [DL0000149_006](#) paras 20-21; [DL0000149_007](#) paras 25-26

¹⁰⁰ Although, for D1876, there is a record of such an assessment in 2018, when D1876 was placed in single occupancy ([HOM032510](#))

¹⁰¹ [CJS0073709_156](#) paras 10.29-10.30

¹⁰² [SER000447_009](#) paras 45-46

Recommendation 5: Undertaking and complying with cell-sharing risk assessment

The Home Office must ensure that adequate risk assessment for cell sharing is carried out by contractors in relation to every detained person. This must be done at the outset of detention and then repeated at reasonable intervals (at least every 14 days) or following any relevant change in circumstances.

In the event that an immigration removal centre is unable to detain someone in accordance with the outcome of a risk assessment (due to capacity or for other reasons), the Home Office must ensure that the individual does not remain at that centre.

Staff response to bullying or intimidation among detained people

30. Violence and bullying among detained people were undoubtedly part of life at Brook House during the relevant period.¹⁰³ There were 32 reports of bullying, 28 recorded fights and 31 recorded assaults on detained people. In June 2017, around 10 per cent of detained people were recorded as being involved in physical violence, which dropped to around 4 per cent in July 2017 and 3 per cent in August 2017. For some detained people, it is likely that this had an impact on whether they felt safe at Brook House.

31. G4S had procedures for addressing bullying among detained people.¹⁰⁴ However, these were not always followed and the Inquiry saw evidence that instances of bullying and violence were not consistently, or promptly, investigated.¹⁰⁵ Some detained people also told the Inquiry of a lack of intervention from staff when they or other detained people were being bullied or assaulted.¹⁰⁶

32. The ability of staff to prevent and respond to violence and bullying was affected by insufficient staffing levels, and their inability had a negative impact on life at Brook House for detained people.¹⁰⁷

¹⁰³ [CJS0073709_188](#)

¹⁰⁴ [CJS000015_001-004](#); [CJS001127_001-007](#). Bullying was defined as “Conduct motivated by a desire to hurt, threaten or frighten someone. It can be physical, verbal, psychological, emotional or economical and often very subtle. It is usually repeated behaviour, unprovoked and intended to cause fear or harm to the victim” ([CJS001127_001](#))

¹⁰⁵ [CJS0073709_198](#) paras 12.39-12.40; [CJS000625_002](#); [CJS000637_002](#)

¹⁰⁶ [DL0000228_041](#) para 146 (D643); [INQ000055_005-006](#) paras 28-29 (D1618)

¹⁰⁷ [CJS0073709_189](#) para 12.12; [CJS0073709_195](#) para 12.30; [CJS0074154_007-008](#)

The mixing of time served foreign national offenders with other detained people

33. During the relevant period, approximately one-third of the detained people at Brook House were foreign nationals who had served a sentence in a UK prison having been convicted of a criminal offence (known as time served foreign national offenders (TSFNOs)) and were due to be deported as a result.¹⁰⁸ There were also individuals whose applications for asylum had been rejected or were still being considered. Others were thought to have entered or remained in the UK illegally, sometimes referred to as 'overstayers'. The mixing of these groups was identified as a potential issue in the *Panorama* programme and in the 2018 Verita report.¹⁰⁹ Some staff criticised the mixing of TSFNOs and others at Brook House, describing it as "very difficult" and "dangerous" as well as causing significant issues for staff and vulnerable detained people.¹¹⁰ Others were less concerned.¹¹¹

34. There was some evidence to suggest that TSFNOs were disproportionately involved in incidents of violence or threatening behaviour. However, this may have been because a few individuals were responsible for a large number of incidents.¹¹² The Inquiry is also aware that TSFNOs detained in Tinsley House did not appear to present the same degree of problematic behaviour as those at Brook House. This suggests that behaviour was affected by the environment at Brook House rather than by the mixing of different groups.¹¹³ In my view, there is insufficient evidence to suggest that either the numbers of TSFNOs or the mixing of TSFNOs with others caused or contributed to conditions in which poor treatment was more likely to occur.¹¹⁴ There is no positive evidence of such a link, and the individual differences between detained people make it impossible to assess, in any event. If anything, as a group, TSFNOs might well have been more vulnerable than others at Brook House and might have had greater unmet needs.¹¹⁵

¹⁰⁸ The average proportion of detained people at Brook House who were TSFNOs during the relevant period was 33–36 per cent (CJS000905; CJS000908; CJS000914; CJS000910; CJS000619; IMB000021; IMB000050; IMB000011; IMB000047; IMB000019). See also CJS0073709_060 para 6.1 and CJS0073709_192, which show that the number of TSFNOs was higher in the period from December 2017 to May 2018

¹⁰⁹ CJS0073709_054 para 5.8

¹¹⁰ VER000226_021; Callum Tulley 1 December 2021 14/21-16/10; Charles Francis 3 March 2022 20/2-22; Stephen Webb 8 March 2022 136/16-139/7; HOW000001_005; INN000007_048 para 193; IPA000001_012 para 92; CJS0074154_011

¹¹¹ SER000453_040 para 182; SER000436_013 para 62; INQ000166_032 para 94

¹¹² CJS0073709_063 para 6.10; CJS0073709_191-193 paras 12.21-12.22; VER0000226_009-010

¹¹³ CJS0073709_063 para 6.10; VER000225_012

¹¹⁴ This view is supported by both G4S (CJS0074153_034-035 para 101) and solicitors representing detained people (BHM000046_164-165 paras 400-402)

¹¹⁵ BHM000030_050-051 paras 115-118

The lock-in regime

35. Before and during the relevant period, detained people at Brook House were locked in their cells from 21:00 to 08:00 every day, and during two daily roll calls, each lasting approximately 30 minutes.¹¹⁶

36. This lock-in regime had a detrimental impact on detained people, which was likely exacerbated by the poor conditions in cells (discussed in Chapter D.3 of this Report). Several detained people described how lock-ins damaged their mental health.¹¹⁷ Others described the lock-in regime as oppressive, “humiliating” and “really hard to cope with”.¹¹⁸ For D1538, it made him feel like a prisoner, while the feeling of being trapped in a small space reminded him of his experiences before coming to the UK.¹¹⁹ D1618 said that he “suffered a lot” during lock-in periods, as this was when his “mental health symptoms were particularly bad”. He would be scared and would struggle to sleep, with “nothing to do other than think about what might happen to me and about my fears of being returned to Afghanistan”. He described lock-ins as “the hardest time of each day”.¹²⁰

37. The harshness of this regime was flagged during the procurement process prior to the opening of Brook House.¹²¹ As recognised in 2007 by Home Office staff assessing bids to manage Brook House, the 11-hour lock-in was “a desperate attempt to reduce costs at the expense of welfare”.¹²² Those assessors also noted that the lock-in period was:

*“excessive and not in keeping with the ethos of the rest of the estate ... The proposals give no justification for such a lengthy period of non-association.”*¹²³

Nonetheless, the contract awarded by the Home Office (which G4S did not seek to vary) included a lock-in of 11 hours.¹²⁴

38. Concerns about the length and timings of the lock-in period were also raised repeatedly by HMIP.

¹¹⁶ [DL0000174_007](#) para 17. The lock-in period could be longer when the roll count was wrong ([INQ000064_042](#) para 9.4; [INQ000051_031](#) para 13)

¹¹⁷ [DL0000094_012](#) para 74; [DL0000228_044](#) para 157; [DL0000233_006-007](#) paras 28 and 35; [DL0000229_030](#) para 112

¹¹⁸ [DL0000226_021-022](#) paras 75-76 (D2077); [BHM000018_005](#) para 22 (D1713); [BHM000029_005](#) para 17 (D2158)

¹¹⁹ [DL0000231_007](#) paras 31-32

¹²⁰ [INQ000055_004-005](#) paras 21-24

¹²¹ [DL0000140_069](#); [DL0000140_078-079](#); see also Chapter D.2

¹²² [DL0000140_069](#). This echoes a point made by Reverend Nathan Ward ([DL0000141_036](#) para 108)

¹²³ [DL0000140_078-079](#)

¹²⁴ [HOM000916_180](#); [DL0000140_052](#); [DL0000140_062](#); [DL0000140_065](#); [DL0000167_052](#)

- 38.1** In its report following a March 2010 inspection, HMIP referred to the 11-hour lock-in period as being *"longer than in most other IRCs"* and the 21:00 start as *"inappropriately early"*. It recommended that Brook House reduce the length of the lock-in period and institute a later lock-in.¹²⁵
- 38.2** This recommendation was repeated by HMIP in its reports following its September 2011 and May–June 2013 inspections.¹²⁶ The latter report also queried *"why detainees needed to be locked in their rooms at all"*.¹²⁷
- 38.3** In its report following an October–November 2016 inspection, HMIP described detained people being locked in their cells overnight as *"inappropriate"*.¹²⁸ It recommended: *"Detainees should not be locked in cells and should be allowed free movement around the centre until later in the evening."*¹²⁹
- 39.** The Home Office failed repeatedly to engage adequately with the issues at the heart of these recommendations. In response to the three earliest reports, the Home Office stated that the lock-in regime timings were determined by the G4S contract and changing the timings would require additional resourcing.¹³⁰ It rejected the 2016 recommendation, stating:
- "At Brook House open access to the centre's regime is provided for all detainees between 8 am and 9 pm each day. Detainees are only confined to their rooms overnight."*¹³¹
- 40.** Dr Hindpal Singh Bhui, Inspection Team Leader at HMIP, told the Inquiry that this was *"deeply unimpressive"*.¹³² He noted:
- "there are several reasons normally given. One is security. It means that, overnight, if detainees are locked in cells, it means that they can't come out and there needs to be less staff around to supervise ... the obvious response to that will be to say, have more staff who are able to supervise, and then you can maintain security without locking people up overnight ... it is, fundamentally, a staffing issue."*¹³³
- 41.** Although not deployed in response to any of the HMIP recommendations, in December 2018 the Home Office introduced the Detention Services Order

¹²⁵ [DL0000167_052](#) para 6.5; [DL0000167_055](#) para 6.29

¹²⁶ [DL0000171_051](#) para 6.3; [HMIP000311_046](#) para 3.9

¹²⁷ [HMIP000311_016](#) para S23

¹²⁸ [HMIP000613_016](#) para S8

¹²⁹ [HMIP000613_027](#) para 1.49; [HMIP000613_053](#) para 5.23

¹³⁰ [DL0000270_065](#) para 92; [DL0000007_190](#); [DL0000007_195](#)

¹³¹ [VER000116_007](#)

¹³² [Dr Hindpal Singh Bhui 24 March 2022 175/4-7](#)

¹³³ [Dr Hindpal Singh Bhui 24 March 2022 176/2-11](#)

04/2018: Management and Security of Night State (the Night State DSO). This suggests that a night state or lock-in:

*“creates a clearly defined day/night routine and offers detainees the opportunity to rest in a quiet and private space in contrast with the constructive activities available during the day time”.*¹³⁴

Given the issues identified in 2007 during the procurement process, I think it is likely that this explanation for the lengthy lock-in regime is an attempt retrospectively to justify a situation that was understood to be unjustifiable at the outset.

42. In reality, I consider that one of the drivers of this highly restrictive regime was financial.¹³⁵ Variations to the G4S contract could have been sought by either party, if necessary. This would have been likely to require increased staffing and therefore increased costs for G4S as well as a demand for further Home Office funding. I consider that the lock-in regime up to and during the relevant period conflicted with Rule 3 of the Rules, which requires as much freedom of movement and association as possible.¹³⁶

43. The 2019 HMIP inspection report stated that *“detainees spent too much time locked in their cells”* under ‘Key concerns and recommendations’.¹³⁷ HMIP repeated its recommendation that *“detainees should not be locked in cells and should be allowed free movement around the centre until later in the evening”*. The response by G4S asserted that lock-in arrangements had been agreed with the Home Office and *“assessed as balancing the need to maintain safety and security with the dignity and welfare of detainees”*.¹³⁸ G4S referred to the forthcoming reduction, from May 2020, of the period during which individuals would be locked in their cells overnight by two hours.¹³⁹ In my view, this nine-hour period remained excessive.

44. In August 2020, the High Court ruled that the lock-in regime operated at Brook House under G4S’s management was neither unlawful under general public law provisions nor in breach of Articles 5, 8, 9 and/or 14 of the European Convention on Human Rights.¹⁴⁰ However, this Inquiry did not consider the lawfulness of the regime, but instead looked at its impact on detained people’s experience at Brook House.

¹³⁴ [Detention Services Order 04/2018: Management and Security of Night State](#), Home Office, December 2018, para 3; see also [DL0000082_007-009](#)

¹³⁵ [Dr Hindpal Singh Bhui 24 March 2022 175/2-11](#)

¹³⁶ [Philip Schoenenberger 23 March 2022 16/7-17/15](#)

¹³⁷ [HMIP000674_005](#); [HMIP000674_020](#) para S46; [HMIP000674_028](#) para 1.46

¹³⁸ [CQC000026_004](#)

¹³⁹ [SER000226_137](#) para 1.3.1; [CQC000026_004](#)

¹⁴⁰ [R \(Soltany & others\) v Secretary of State for the Home Department and G4S \[2020\] EWHC 2291 \(Admin\)](#)

45. HMIP concurred in its 2022 inspection report, maintaining that a 'key concern' was that:

*"Detainees were inappropriately locked in cells overnight. They could have been left unlocked if they had been given a key to their cell and if there had been sufficient staffing at night."*¹⁴¹

The response from Serco did not properly engage with the recommendation, noting simply:

*"Staffing levels have been agreed with the Home Office in line with the new supplier contract which has decreased the period of time a resident is locked within their room since Serco were awarded the contract."*¹⁴²

46. Detained people in Brook House are subject to the administrative process of immigration detention and are not in prison under a criminal justice procedure. This is reflected in the purpose set out in the Rules.¹⁴³ Even if the Home Office seeks to justify the lock-in regime as providing a quiet place for rest at night, I agree with HMIP that the practice at Brook House of locking adults in cells was a *"disproportionate restriction for a detainee population"*.¹⁴⁴ Similar lock-in regimes were in operation at other IRCs, although there was no uniformity regarding the duration or nature of the lock-in.¹⁴⁵

47. Detained people were and continue to be locked in their cells overnight for an excessive period of time. They are not prisoners and are entitled to as much freedom of movement and association as possible. Any time during which they are locked in their cells must be justified by the strongest reasoning. I am therefore recommending this practice be reviewed, to allow greater free movement.

Recommendation 6: Review of the lock-in regime

The Home Office, in consultation with the contractor responsible for operating each immigration removal centre, must review the current lock-in regime and determine whether the period of time during which detained people are locked in their cells could be reduced.

The Inquiry does not consider cost alone to be a sufficient justification for extensive lock-in periods.

¹⁴¹ [HMIP000702_006](#) para 10

¹⁴² [HMIP000704_003](#)

¹⁴³ [Detention Centre Rules 2001](#), Rule 3 and Rule 39

¹⁴⁴ [HMIP000674_020](#) para S46

¹⁴⁵ [R \(Soltany & others\) v Secretary of State for the Home Department and G4S](#) [2020] EWHC 2291 (Admin), paras 117-124

No-notice removals

48. ‘No-notice removals’ is a term that was usually used to describe a three-month window given to detained people when, after an initial short period (of 72 hours, including two working days) during which there was no risk of removal, they could be removed from the UK with no further notice.¹⁴⁶ It was a deliberate element of this policy, which was in place from 2015 onwards, that details such as the time and date of the removal would not be given.¹⁴⁷ In 2020, the Court of Appeal found the policy to be unlawful on the basis that it posed an “*unacceptable risk of interference with the right of access to court*”.¹⁴⁸

49. The use of this approach during the relevant period appears to have had a detrimental impact on detained people, increasing levels of uncertainty, fear and the use of force. Mr Alan Gibson, Head of Operations within the Home Office’s Detention and Escorting Services (DES), said that detained people would be told “*a few hours*” before they went.¹⁴⁹ He added:

*“G4S thought ‘No notice, that means we can’t tell them’ ... the first thing the person knew when they were leaving was when the room door was opened and three officers in full personal protection kit stepped in and they were taking them down to reception. That was just a very grisly, unnecessary set of circumstances and failed communications.”*¹⁵⁰

Ms Clare Checksfield, Director of DES, accepted that the Home Office “*collectively mishandled it very badly*”.¹⁵¹

50. There were a number of effects of this policy at Brook House.

50.1 Distress and uncertainty for detained people: D1851 was subject to a no-notice removal in May 2017 that did not proceed but that he described as a “*distressing and alarming experience*”.¹⁵²

50.2 Impact on relationships between staff and detained people: Mr Lee Hanford, Business Change Director during the relevant period, described the use of no-notice charters as “*so detrimental to the*

¹⁴⁶ Immigration and Asylum Act 1999, section 10(1) as amended by section 1 of the Immigration Act 2014. See *R (FB (Afghanistan)) and Medical Justice v Secretary of State for Home Department* [2020] EWCA Civ 1338, paras 2 and 36-39ii

¹⁴⁷ *FFT000011*; see *R (FB (Afghanistan)) and Medical Justice v Secretary of State for Home Department* [2020] EWCA Civ 1338, para 36

¹⁴⁸ See *R (FB (Afghanistan)) and Medical Justice v Secretary of State for Home Department* [2020] EWCA Civ 1338, paras 56, 170 and 193

¹⁴⁹ *VER000264_016*

¹⁵⁰ *VER000264_016*

¹⁵¹ *VER000264_016*

¹⁵² *DL0000143_008-009* paras 32 and 33

relationships within the centre" because they undermined trust between detained people and staff, who were required to be evasive about when removal flights were to take place.¹⁵³ Mr Hanford raised concerns about these issues at Brook House IMB meetings in late 2017.¹⁵⁴ This led to the Brook House IMB flagging these issues in its 2017 report as an area of concern, saying that no-notice removals "*can lead to inhumane treatment*" and left "*detainees in a limbo of uncertainty with the psychological stresses that brings*".¹⁵⁵

50.3 Impact on use of force: Mr Hanford observed that no-notice removals were a "*significant contributing factor to the number of uses of force we have observed*".¹⁵⁶ Mr Gordon Brockington, Managing Director of Justice and Government Chief Commercial Officer at G4S, agreed. He said that, as a result of no-notice removals, "*a large number of both planned and unplanned use of force incidents became necessary to remove detainees from their cell and onto the HO [Home Office] escort vehicle*".¹⁵⁷ Mr Jonathan Collier, the Inquiry's use of force expert, believed that the policy was also part of the reason for there being a large number of restraints of detained people who were naked or near-naked.¹⁵⁸

51. The evidence suggests that the increase in stress and in the frequency of use of force against detained people caused by this policy adversely impacted their experience at Brook House during the relevant period. It is likely that no-notice removals contributed to conditions where ill treatment was more likely to occur.

The indefinite nature of detention

52. Individuals should have been detained at Brook House only if there was a realistic prospect of removal from the UK within a reasonable period of time.¹⁵⁹ However, there was and is no fixed or maximum period of time for which someone may be detained at Brook House or at any other IRC.¹⁶⁰ This is sometimes referred to as indefinite detention.

¹⁵³ [Lee Hanford 15 March 2022 85/1-87/10](#)

¹⁵⁴ [IMB000025_002](#)

¹⁵⁵ [VER000138_023](#) para 11.2

¹⁵⁶ [Lee Hanford 15 March 2022 87/7-8](#)

¹⁵⁷ [CJS0074041_035](#) para 176

¹⁵⁸ [Jonathan Collier 30 March 2022 61/1-62/3](#)

¹⁵⁹ This is a summary of what are known as the Hardial Singh principles, from the case of *R (Hardial Singh) v Governor of Durham Prison [1983] EWHC 1 (QB)*

¹⁶⁰ With the exception of pregnant women and families ([INQ000064_014-015](#) para 3.9)

53. Despite being designed to detain people on a short-term basis, the average stay at Brook House in July 2017 was 44 days. Five people had been there for one to two years.¹⁶¹

Table 4: Length of time in detention

Date*	Average length of time in detention, including at other IRCs	Average length of detention at Brook House	Proportion of people detained at Brook House for more than 28 days	Source
2010	Almost 6 months	Around 3 months	67.4%	<i><u>Report on a Full Announced Inspection of Brook House Immigration Removal Centre 15–19 March 2010</u></i> , HM Chief Inspector of Prisons, 2010, pp90, 92
2011	Not available	Around 3 months (93 days)	59.4%	<i><u>Report on an Unannounced Full Follow-up Inspection of Brook House Immigration Removal Centre 12–23 September 2011</u></i> , HM Chief Inspector of Prisons, January 2012, pp5, 29, 35, 92

¹⁶¹ CJS0073709_060 para 6.2

Date*	Average length of time in detention, including at other IRCs	Average length of detention at Brook House	Proportion of people detained at Brook House for more than 28 days	Source
2013	Not available	28 days	37.5%	<i>Report on an Unannounced Inspection of Brook House Immigration Removal Centre 28 May–7 June 2013</i> , HM Chief Inspector of Prisons, October 2013, pp29, 80-81
2016	Approximately 3 months	48 days	47.6%	HMIP000613_029 HMIP000613_069
January 2017	93 days	54 days	41.6%	CJS0073709_060
July 2017	78 days	44 days	37.6%	CJS0073709_060
December 2017	99 days	49 days	50.3%	CJS0073709_060
2019	44 days	Not available but stated by HMIP to have " <i>markedly declined</i> " since the previous inspection in 2016	32.6%	CJS0073825_005 CJS0073825_031 CJS0073825_067

Date*	Average length of time in detention, including at other IRCs	Average length of detention at Brook House	Proportion of people detained at Brook House for more than 28 days	Source
2022	72 days	Not available	20.9%	<p><i>Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 (HMIP000702), HM Chief Inspector of Prisons, September 2022, p25</i></p> <p>INQ000225_003-004</p>

* Note: Years do not relate to the whole year but are a snapshot.

54. Mr Philip Riley, Director of DES within the Home Office, contended that “*We don’t have indefinite detention*” on the basis that the Home Office detained people only for the shortest period possible and maintained detention only under certain conditions.¹⁶² I disagree with this characterisation. Whether or not the Home Office complied with its legal obligations regarding the initial decision to detain and subsequent decisions to maintain detention was irrelevant to the fact that there was no maximum period for which someone could be detained. It is also unclear, when an individual is detained, for how long detention will last. Thus, detention is indefinite. Mr Riley gave the sense of the Home Office trying to avoid the reality of how people experienced being detained by refusing to characterise the practice as one of indefinite detention.

55. It was clear from the evidence of detained people, those who worked at Brook House, NGOs, and inspection and monitoring bodies that indefinite detention caused uncertainty, frustration and anxiety for detained people, with a negative impact on their health and wellbeing.

¹⁶² Philip Riley 4 April 2022 61/23-62/17

55.1 D1538 said:

*"The thing is, when you are in detention you are in a constant state of not knowing and uncertainty. I was taken to detention, I did not know when I was leaving, or if I was leaving, and where I would be going. It is like a forgotten prison, with forgotten prisoners. You don't know what is happening or what will happen. And so many people stay there for so long, for so many years, in this state."*¹⁶³

55.2 D687 said:

*"I don't know why the Home Office decide to detain people indefinitely like this, like they're animals, instead of treating them with respect and dignity. I would understand being detained for a short period of time, for the purposes of removal if that was immediately possible. But there has to be a limit on how long that can be allowed."*¹⁶⁴

55.3 D1527 said:

*"It is so upsetting and stressful to not know how long you'll be detained for. You could be there from one day to several years. I've seen that with my own eyes. I've seen people there for years, who have no idea when or if they will ever be released. If they knew the maximum time they will be there for, they will have hope, they will know when they will be released. They will be much less likely to want to kill themselves. Not knowing when I would be released, and being told that I was being kept in detention longer because I was suicidal, made me want to kill myself more."*¹⁶⁵

56. These effects were reinforced by other witnesses.**56.1** Professor Bosworth agreed that the lack of time limit created:

"an enormous amount of anxiety for people who are detained, which affects their mental health, and their mental health deteriorates for the longer that they are detained".¹⁶⁶

56.2 Some DCOs and DCMs expressed significant concerns about the impact of indefinite detention. For example, DCM Nathan Ring described it as the *"root of all problems"*, DCM Stephen Webb regarded it as *"quite cruel"* and Mr Tulley viewed it as *"the most destructive element of detention"*.¹⁶⁷ They and those working in Healthcare also described the negative impact on detained people's mental health. For example,

¹⁶³ [DL0000231_044](#) para 174; [DPG000021_008](#) para 26; [DL0000144_059-060](#) para 145

¹⁶⁴ [DPG000021_009](#) para 26

¹⁶⁵ [DL0000144_059-060](#) para 145

¹⁶⁶ [Professor Mary Bosworth 29 March 2022 15/7-12](#)

¹⁶⁷ [Stephen Webb 8 March 2022 139/11-18](#); [Callum Tulley 30 November 2021 55/1-3](#); [INQ000199_008](#) para 6(1)

Mr Webb's view was that *"if you lock people in what is effectively a prison for an indefinite amount of time then ultimately, however good the care is, they are going to suffer, particularly in respect of their mental health"*.¹⁶⁸ Dr Husein Oozeerally, lead GP at Brook House during the relevant period and at the time of the Inquiry's public hearings, thought that the uncertainty of detention rather than detention itself adversely affected health. Ms Sandra Calver, Head of Healthcare during the relevant period and at the time of the Inquiry's public hearings, explained that the lack of an end date to detention was *"what can often play on their mental health"*.¹⁶⁹

56.3 These concerns were also expressed by senior management at Brook House, who described the frustration caused by indefinite detention as well as the physical and mental impact of the uncertainty. Mr Skitt expressed the view that uncertainty about the length of the period of detention was responsible for *"a lot of the frustrations"* and left some detained people in *"ever-spiralling circles"*.¹⁷⁰ Mr Petherick suggested that uncertainty was the *"main issue"* that had an impact on detained people's wellbeing and mental health, while Mr Hanford referred to indefinite detention being *"very frustrating"* for detained people.¹⁷¹ Senior G4S managers also referred to difficulties with detained people being held on a long-term basis at Brook House when this was not what it was designed for.¹⁷²

56.4 Witnesses from NGOs had a similar perspective on the impact of indefinite detention on detained people. They contended that a time limit should be introduced.¹⁷³ For example, Mr Macpherson told the Inquiry:

*"Detained people find it very hard to be faced with indefinite detention. You can see people's kind of mental health unravelling over time, so I think a clear limit, so they know how long they will be held, the maximum they will be held, in detention would go a long way to help the situation."*¹⁷⁴

¹⁶⁸ MIL000003_022 para 107

¹⁶⁹ Dr Husein Oozeerally 11 March 2022 107/11-19; DRO000001_013 para 115; Sandra Calver 1 March 2022 186/25-187/5

¹⁷⁰ Stephen Skitt 17 March 2022 48/8-17

¹⁷¹ Lee Hanford 15 March 2022 82/10-11; INQ000164_054 para 106; Jeremy Petherick 21 March 2022 98/17-99/6

¹⁷² Lee Hanford 15 March 2022 96/12-19; Peter Neden 22 March 2022 68/3-7. The 2018 Verita report expressed similar concerns (CJS0073709_016 para 1.57; CJS0073709_140 para 9.55; CJS0073709_253 para 15.3)

¹⁷³ BHM000030_023 para 46; BHM000030_032 para 64; BHM000030_034 para 67; BHM000030_044 para 96; DPG000002_026-027 para 69; DPG000002_079-080 para 228; DPG000020_030 para 90a; see also CJS0073865_001. See also INQ000204_158-167 paras A6.5-A6.44 regarding the Association of Visitors to Immigration Detainees, the British Medical Association and Liberty

¹⁷⁴ Jamie Macpherson 8 December 2021 230/15-22

- 56.5** Both the IMB and HMIP recommended a time limit be introduced.¹⁷⁵ (The IMB did so on several occasions, and reiterated the recommendation in its Closing Statement to the Inquiry.) Following its May–June 2019 inspection, HMIP noted: *“There was evidence that lengthy and indefinite detention affected feelings of safety and wellbeing.”*¹⁷⁶
- 57.** The Inquiry also heard evidence about the detrimental impact of lengthy periods of detention, which was likely exacerbated by the design of the building and the particular environment at Brook House.
- 57.1** For example, as discussed in Chapter D.3, the 2018 Verita report concluded that the physical constraints and lack of facilities at Brook House made it *“an unsuitable environment in which to hold detainees for more than a few weeks”*.¹⁷⁷
- 57.2** As noted in its 2022 inspection report, HMIP remained concerned that *“the length of detention remained unacceptably long in some cases”*, with one person detained at Brook House for 16 months and five cases where people had been held in different places of detention for over 1,000 days.¹⁷⁸ Over 20 per cent of people had been at Brook House for more than four weeks, and the average continuous time spent in detention (including in other centres) was 72 days.¹⁷⁹
- 58.** Professor Bosworth considered that *“the lack of clarity about the duration that anybody is going to be in their care makes it pretty easy for [staff] to not care”*.¹⁸⁰ She added that the introduction of a time limit on immigration detention would:
- “significantly reduce the kinds of distress shown in the video footage and would make the purpose of these institutions clearer. This, in turn, would bolster a professional staff culture and help to prevent a recurrence of the events of 2017.”*¹⁸¹
- 59.** Indefinite detention had a negative impact on the health and wellbeing of detained people and therefore contributed to conditions where mistreatment could occur more easily.
- 60.** The Inquiry noted that a time limit on immigration detention had previously been recommended by various organisations, including:

¹⁷⁵ [IMB000221_006](#) para 18d; [IMB000222_040](#) para 98c

¹⁷⁶ [HMIP000674_020](#) para S45

¹⁷⁷ [CJS0073709_140](#) para 9.55

¹⁷⁸ [INQ000227_005](#) para 1

¹⁷⁹ [INQ000227_025](#) para 2.51; *Immigration Detention – Sixteenth Report of Session 2017–19*, Joint Committee on Human Rights, January 2019

¹⁸⁰ [Professor Mary Bosworth 29 March 2022 40/12-16, 154/14-18](#)

¹⁸¹ [Professor Mary Bosworth 29 March 2022 39/7-40/16; INQ000064_011](#) para 2.28

- the All Party Parliamentary Group on Refugees and the All Party Parliamentary Group on Migration;¹⁸²
- the Joint Committee on Human Rights;¹⁸³
- the Home Affairs Committee;¹⁸⁴
- the British Medical Association;¹⁸⁵
- the Bar Council;¹⁸⁶ and
- the Equality and Human Rights Commission.¹⁸⁷

The Government rejected these recommendations, as well as an attempt to introduce a time limit by means of an amendment to legislation in 2020, which the House of Commons voted against.¹⁸⁸ Various United Nations bodies had also called for a time limit on immigration detention in the UK.¹⁸⁹ As discussed in Part B in Volume I, the legal situation remains largely as it was during the relevant period. There is still no time limit on an individual's detention.

¹⁸² *The Report of the Inquiry into the Use of Immigration Detention in the United Kingdom*, All Party Parliamentary Group on Refugees and All Party Parliamentary Group on Migration, 2015, pp18, 33-34

¹⁸³ *Immigration Detention – Sixteenth Report of Session 2017–19*, Joint Committee on Human Rights, January 2019, para 68

¹⁸⁴ *Immigration Detention – Fourteenth Report of Session 2017–19*, House of Commons Home Affairs Committee, 21 March 2019, paras 224-228

¹⁸⁵ *Locked Up, Locked Out: Health and Human Rights in Immigration Detention*, British Medical Association, November 2017, p4

¹⁸⁶ *Bar Council press release*, November 2017; *Injustice in Immigration Detention: Perspectives from Legal Professionals*, Anna Lindley, SOAS, November 2017, p3 para 9

¹⁸⁷ See *Protecting Human Rights: Key Challenges for the UK's Third Universal Periodic Review*, Equality and Human Rights Commission, December 2016, p21; *Immigration and Social Security Co-ordination (EU Withdrawal) Bill 2019–21*, Equality and Human Rights Commission briefing, May 2020

¹⁸⁸ *Immigration Detention: Government Response to the Committee's Sixteenth Report of Session 2017–19: Second Special Report of Session 2019–20*, Joint Committee on Human Rights, October 2019, p14; *Letter from the Minister of State for Immigration to the Chair of the Committee, 23 July 2019*, para 38; *Immigration and Social Security Co-ordination (EU Withdrawal) Bill – New Clause – Time Limit on Immigration Detention for EEA and Swiss Nationals – 19 Oct 2020 at 21:15* (cross-party amendment to the Immigration and Social Security Co-ordination (EU Withdrawal) Bill). See *Hansard* columns 806, 807 and 823 for the parliamentary debates on the issue; see also *Hansard* columns 867-870 for voting figures

¹⁸⁹ *Report of the Committee against Torture*, UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2013, para 30c; *Concluding Observations on the Seventh Periodic Report of the United Kingdom of Great Britain and Northern Ireland*, UN Human Rights Committee, 2015, para 21a; *Written Evidence Submitted by the UNHCR – The UN Refugee Agency (IDD0018)*, April 2018; *Concluding Observations on the Sixth Periodic Report of the United Kingdom of Great Britain and Northern Ireland*, UN Committee against Torture, June 2019, paras 54-55; *Visit to the United Kingdom of Great Britain and Northern Ireland undertaken from 9 to 18 September 2019: Recommendations and Observations Addressed to the State Party*, UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, May 2021, para 56; *United Kingdom of Great Britain and Northern Ireland: Compilation of Information Prepared by the Office of the United Nations High Commissioner for Human Rights*, UN Human Rights Council, August 2022, para 63

61. In my view, the introduction of a time limit on detention would constitute a significant improvement to the treatment and wellbeing of those detained in IRCs.

62. I note that the Home Office guidance states that removal can be said to be imminent where, among other things, "*removal is likely to take place in the next four weeks*".¹⁹⁰ Based on the evidence the Inquiry heard, and in accordance with many of the previous recommendations to which I have referred above, I consider that 28 days is a reasonable time limit, although I acknowledge that there is no magic to the specific number of days.

Recommendation 7: A time limit on detention

The government must introduce in legislation a maximum 28-day time limit on any individual's detention within an immigration removal centre.

¹⁹⁰ Home Office Enforcement Instructions and Guidance, Chapter 55.3.2.4, Application of the factors in 55.3.1 to criminal casework cases

Chapter D.5:

Safeguards for vulnerable individuals

Introduction

1. There are a number of provisions that seek, collectively, to provide safeguards for those individuals who may be vulnerable to suffering harm in detention.
 - 1.1 Rule 34 and Rule 35 of the Detention Centre Rules 2001 (the Rules) require a physical and mental examination by a medical practitioner within 24 hours of admission to a detention centre, as well as a report where the health of a detained person is likely to be injuriously affected by continued detention or any conditions of detention, where the medical practitioner suspects that a detained person has suicidal intentions or where there is a concern that a detained person may have been a victim of torture.¹
 - 1.2 The Home Office's statutory *Guidance on adults at risk in immigration detention* (Adults at Risk policy) specifies the matters to be taken into account in accordance with section 59 of the Immigration Act 2016 when determining the detention of vulnerable people.²
 - 1.3 Detention Services Order 08/2016: Management of Adults at Risk in Immigration Detention (the Adults at Risk DSO) includes mandatory guidance for Home Office staff and suppliers operating in immigration removal centres (IRCs) on the care and management of detained people deemed to be adults at risk while in detention.³
 - 1.4 Detention Services Order 01/2022: Assessment Care in Detention and Teamwork (ACDT) (the ACDT DSO) provides mandatory operational guidance for all Home Office, centre supplier and healthcare staff

¹ Detention Centre Rules 2001. These provisions are reinforced in the Detention Services Operating Standards Manual for Immigration Service Removal Centres, January 2005, pp38-39

² Immigration Act 2016: Guidance on Adults at Risk in Immigration Detention, Home Office, August 2016 (first published May 2016 and subsequently updated, most recently in March 2022); see Adults at Risk policy; section 59 of the Immigration Act 2016

³ Detention Services Order 08/2016: Management of Adults at Risk in Immigration Detention (CJS000731), Home Office, February 2017 (updated August 2022)

working in IRCs, to implement “a holistic approach to self harm and suicide prevention within the broader context of decency and safety”.⁴

2. The purpose of these safeguards is to consistently identify those who may be vulnerable and at risk of harm:

“The clear presumption is that detention will not be appropriate if a person is considered to be ‘at risk’ ... detention will only become appropriate at the point at which immigration control considerations outweigh this presumption. Within this context it will remain appropriate to detain individuals at risk if it is necessary in order to remove them.”⁵

3. The safeguards provided by the Rules and policies recognise in this way that vulnerable people should not be detained inappropriately. The safeguards put in place by the Home Office must be implemented properly. Failure to do so is a breach of the legal requirements and will likely cause harm to some detained people.

4. The healthcare service was and is an NHS-commissioned service on behalf of the Home Office, provided entirely separately from the contract to manage Brook House.

5. G4S Health Services (UK) Ltd (G4S Health Services) held the contract for the provision of healthcare services in Brook House from September 2014 until 31 August 2021, including during the relevant period (1 April 2017 to 31 August 2017).⁶ Practice Plus Group (PPG) took over this contract in September 2021.⁷

6. GP services in Brook House were provided by Doctor PA Ltd under a subcontract with G4S Health Services in the relevant period and with PPG from 1 September 2021.⁸

Examination after admission (Rule 34)

Legal and policy framework

7. Rule 34 of the Rules requires that there should be a medical examination of every detained person by a medical practitioner within 24 hours of their

⁴ [Detention Services Order 01/2022: Assessment Care in Detention and Teamwork \(ACDT\) \(INQ000214\)](#), Home Office, October 2022, p5

⁵ [CJS007082_004](#)

⁶ [CJS0074040_002](#) paras 6-11. The contract was initially held by G4S Medical and Forensic Services (UK) Ltd, which changed its name to G4S Health Services (UK) Ltd in October 2016

⁷ [PPG000182](#)

⁸ [CJS0073870](#); [PPG000040](#). The Inquiry was told that PPG intends to move towards an employed GP model ([PPG000169_010](#) paras 43 and 44)

arrival in a detention centre. This must be a “*physical and mental examination*”.⁹ The Rules also state that a medical practitioner is someone “*vocationally trained as a general practitioner*” and registered with the General Medical Council.¹⁰

8. There is a dual purpose to Rule 34.

8.1 It functions to identify the immediate health needs of a detained person upon arrival at an IRC.¹¹ This is particularly significant given that the Home Office does not medically screen individuals to identify vulnerabilities before they are detained.¹² Dr James Hard, the Inquiry’s medical expert, stated that Rule 34 is:

*“inherently important for the early identification of ongoing health needs of an individual on arrival in a place of detention and is crucial for the planning of the detained person’s care whilst in Brook House or any other secure or detained setting”.*¹³

8.2 The Rule 34 examination on arrival in detention is essentially the first opportunity to prevent a vulnerable detained person from being exposed to a risk of harm. It functions as an important safeguard to identify vulnerable people who should not be in detention. Dr Rachel Bingham, clinical advisor to Medical Justice (a charity that provides medico-legal reports and advice to detained people), described the functions of Rule 34 as being:

*“to identify the need for a Rule 35 report, but also to undertake a physical and mental state examination to determine what, if any, treatment is required and capable of being provided within immigration detention. The absence of proper Rule 34 medical examinations leads to belated identification of physical health issues, and consequential delays to treatment. It also means an important piece of clinical evidence relevant to the consideration of decision-making concerning the exercise of detention powers is missing.”*¹⁴

This reflects the important role of Healthcare in an IRC to provide both primary healthcare and also clinical safeguards that identify who is vulnerable to harm in detention.

9. Where criteria are met, a Rule 35 report should be completed by the GP and raised with the Home Office “*without delay*”.¹⁵ The form might be

⁹ [Detention Centre Rules 2001](#), Rule 34(1)

¹⁰ [Detention Centre Rules 2001](#), Rule 33(1)

¹¹ [Dr James Hard 28 March 2022 10/12-12/2](#); [Dr Rachel Bingham 14 March 2022 27/5-28/2](#)

¹² [Dr James Hard 28 March 2022 20/15-21/10](#); [Theresa Schleicher 14 March 2022 83/4-20](#)

¹³ [INQ000112_056](#)

¹⁴ [BHM000033_028](#) para 80; [Dr James Hard 28 March 2022 12/3-24](#)

¹⁵ [Detention Centre Rules 2001](#), Rule 35

completed at a Rule 34 examination, so that detention can be reviewed at a very early stage. This enables the Home Office to review an individual's continued detention promptly and, unless there are exceptional circumstances, to remove them from detention.¹⁶ In this way, the two rules are designed to work together as a safeguard for vulnerable detained people at the start of detention.¹⁷ In my view, this is the only way to interpret the Rules correctly, given the policy background – as the Home Office appeared to accept.¹⁸ The aim of the policy is that those who may be vulnerable and at risk of harm should be consistently identified to ensure that their detention is reviewed by the Home Office and their release considered.

The application of this framework at Brook House

10. It is, however, abundantly clear from the evidence received by the Inquiry that there were a number of deficiencies in the way in which Rule 34 was operating at Brook House in the relevant period (1 April 2017 to 31 August 2017), and indeed in the way in which it is currently operating.

11. Although this is not reflected in Rule 34, health screening of a detained person on arrival operated in two parts at Brook House.

11.1 On immediate arrival, a nursing screen – sometimes referred to as an initial reception health screen – was to be carried out within two hours.¹⁹ This comprised a questionnaire designed to elicit information that would enable the immediate needs of the detained person to be met (such as obtaining medication) and to identify any vulnerabilities. The initial reception screenings were carried out 24 hours a day and the aim was for the screening to be completed within two hours of the detained person's arrival.²⁰ It was designed to elicit information from the detained person about their physical and mental health, background and any history of self-harm. Its purpose was to safeguard the detained person and to find out whether ongoing care was needed. This was described by Ms Sandra Calver, Head of Healthcare at Brook House during the relevant period and at the time of the Inquiry's public hearings, as the first part of the two-part screening.²¹

11.2 The second part of the screening was undertaken by a GP within 24 hours of the detained person's arrival.

¹⁶ [Dr James Hard 28 March 2022 6/20-8/24](#)

¹⁷ [Dr James Hard 28 March 2022 12/25-13/15](#); [Theresa Schleicher 14 March 2022 62/4-17](#)

¹⁸ [HOM0332160](#); [HOM0332165_0008](#) para 122

¹⁹ [Sandra Calver 1 March 2022 157/5-9, 158/16-22](#)

²⁰ [DWF000020_013](#) para 72

²¹ [Sandra Calver 1 March 2022 159/1-160/4](#)

12. However, in practice, the nursing screen was sometimes the only appointment that occurred.²² It was effectively treated as the examination required under Rule 34. On its own, it could not fulfil the requirements of a mental and physical examination by a GP within 24 hours. It was also not a mental and physical examination, which was required. Instead, it involved the use of a proforma designed to elicit a basic history and medical information. Effectively, it was a tick box exercise.²³ For example, D1538's screening in June 2017 by a nurse did not elicit a history of torture, instead noting that his scars were from fights and accidents.²⁴ D1538 was not provided with an interpreter during this assessment. D1538 was subsequently provided with a Rule 35(3) report on 24 July 2017 in Harmondsworth immigration removal centre which detailed his history of torture.²⁵

13. Detained people were entitled to refuse the appointment with a GP, and sometimes did so.²⁶ However, the nature of the appointment was not routinely explained to them, ie that it was a safeguard to identify any health needs or vulnerabilities that may lead to a Rule 35 report, a review of their detention and consideration of their release.²⁷ Refusals were therefore not likely to have been an informed choice.²⁸ Dr Hard noted:

*"I haven't seen anything so far that explains what is advised of the detainee of the purpose of those subsequent appointments or the potential appointment with the GP the following day ... I do think it's the healthcare provider's responsibility to explain the importance of attending that appointment."*²⁹

This is a deficiency that could easily have been remedied.

14. When GP appointments were ostensibly provided under Rule 34, they were often not provided within 24 hours of a detained person's arrival.³⁰ This was in breach of Rule 34.

15. Those GP appointments that did take place within the first 24 hours of a detained person's arrival were scheduled to last for five minutes during the relevant period.³¹ This is not sufficient time to complete an adequate mental

²² [BHM000032_015](#) para 49

²³ [Dr James Hard 28 March 2022 13/25-15/6](#); [BHM000033_028-030](#) para 80

²⁴ [CJS007239](#)

²⁵ [CJS003632](#)

²⁶ [Sandra Calver 1 March 2022 214/8-12](#)

²⁷ [BHM000032_015](#) para 51

²⁸ [Dr James Hard 28 March 2022 16/4-12](#)

²⁹ [Dr James Hard 28 March 2022 15/18-16/3](#)

³⁰ [Dr James Hard 28 March 2022 15/7-16/12](#); [Sandra Calver 1 March 2022 210/24-212/7](#); [BHM000032_015](#) para 49; [DPG000002_038](#) para 103

³¹ [Sandra Calver 1 March 2022 207/4-11](#)

and physical examination in compliance with Rule 34.³² It is also insufficient time to complete a Rule 35 report, if required.³³ Dr Husein Oozeerally, lead GP at Brook House during the relevant period and at the time of the Inquiry's public hearings, accepted that it was not possible to perform the sort of physical and mental health examination required at this initial GP appointment. His evidence was: *"It's almost like a triage."*³⁴ There was also only provision for one Rule 35 assessment to be carried out per day.³⁵ In contrast, there were 641 new admissions to Brook House in April 2017, 702 in May, 531 in June, 593 in July and 603 in August.³⁶

16. Even when the nursing screening identified vulnerabilities, such as when an individual disclosed that they were a victim of torture, it did not always lead to a Rule 35 assessment or report, when it should have done so in every such case.³⁷ Ms Calver told the Inquiry:

*"It is now a mandatory question, asking about torture, and if it prompts 'Yes', there is a prompt that comes up to say make the appointment."*³⁸

Often mental health was not properly assessed or recorded.³⁹ This left detained people at risk of harm in detention, as their vulnerabilities were not notified to the Home Office for their detention to be reviewed.

17. A practice also arose whereby Rule 35 reports were not written – or, indeed, considered – at the Rule 34 GP assessment.⁴⁰ Instead, a second assessment appointment under Rule 35 was booked if something was flagged initially through screening or in that initial appointment. There was sometimes a considerable delay before the Rule 35 assessment.

17.1 During D1538's Rule 34 appointment, for example, Dr Saeed Chaudhary recorded nothing about D1538's history of torture despite scars on his body consistent with torture and a history recorded in the nurse's screening of having run away from his family at the age of eight. Dr Chaudhary decided that D1538's other complaints were to be discussed in a separate appointment.⁴¹ Those complaints related to

³² [Sandra Calver 1 March 2022 208/16-209/15](#); [Dr James Hard 28 March 2022 18/12-20/5](#); [Theresa Schleicher 14 March 2022 62/18-63/12](#); [DPG000002_038](#) paras 104 and 105

³³ [Dr James Hard 28 March 2022 18/12-20/5](#); [Sandra Calver 1 March 2022 207/4-209/6](#)

³⁴ [Dr Husein Oozeerally 11 March 2022 9/9-20](#)

³⁵ [Dr James Hard 28 March 2022 35/14-36/20](#)

³⁶ [IMB000021_001](#); [IMB000050_002](#); [IMB000011_002](#); [IMB000047_002](#); [IMB000019_002](#)

³⁷ [Dr James Hard 28 March 2022 21/15-22/6](#)

³⁸ [Sandra Calver 1 March 2022 214/23-215/10](#)

³⁹ [Dr James Hard 28 March 2022 21/15-22/6](#); [Theresa Schleicher 14 March 2022 62/18-64/7](#); [BHM000032_015-016](#) paras 49, 50 and 52

⁴⁰ [Dr Husein Oozeerally 11 March 2022 13/9-17](#)

⁴¹ [CJS007239_002](#)

physical symptoms such as headaches and backache as a result of previous assaults amounting to torture.

- 17.2** The Rule 34 process did not adequately identify D1914’s physical health issues either. He suffered from a serious heart condition and had a complex clinical history. He was taken to A&E by ambulance while he was at Brook House on multiple occasions after he complained of chest pains and palpitations and also following a blood test result indicating a possible blood clot. He did not receive a Rule 35(1) report until almost four months into his detention. Those medical vulnerabilities should have been identified far earlier.⁴²

Consequently, in 2017, the safeguard was not operating effectively at the start of detention. The Inquiry heard evidence from a number of witnesses that this remained the case at the time of the Inquiry’s hearings.⁴³

- 18.** Disconnecting Rule 34 and Rule 35 in this way was inappropriate. As Ms Theresa Schleicher, Casework Manager for Medical Justice, told the Inquiry:

“The whole purpose of the two rules taken together is to identify people immediately and route them out of detention. So if, instead, a period is a – a waiting period is allowed, that means people may deteriorate in the meantime.”⁴⁴

The identification of any one of the criteria set out in Rule 35 in a Rule 34 appointment should have triggered automatically the immediate creation of a Rule 35 report. The detained person should not have been placed on a waiting list for a later Rule 35 appointment.⁴⁵

- 19.** In my view, the Rules, operating together, require a proactive approach to the identification of vulnerabilities and require any such vulnerabilities to be acted upon without delay.

20. The Inquiry also received evidence that a practice seemed to have developed that a detained person would have to ask for a Rule 35 report to trigger an assessment.⁴⁶ Such a practice is entirely inappropriate. It was not for detained people to have to advocate for or request a report. The responsibility and obligation rested with the Healthcare staff and GPs to ensure that these reports were completed when necessary. Some detained people may not have been aware of the system, and so they would not have known to request a report. They would, therefore, have fallen through the cracks.

⁴² [Dr Rachel Bingham 14 March 2022 44/3-45/19](#); [BHM000033_030 para 80c](#)

⁴³ [Dr James Hard 28 March 2022 16/13-17/20](#); [Sandra Calver 1 March 2022 208/16-21](#); [Dr Husein Oozeerally 11 March 2022 13/18-16/14](#); [Dr Rachel Bingham 14 March 2022 26/25-28/8](#)

⁴⁴ [Theresa Schleicher 14 March 2022 63/13-21](#)

⁴⁵ [Theresa Schleicher 14 March 2022 63/5-12](#)

⁴⁶ [Theresa Schleicher 14 March 2022 65/11-25](#)

This also led to a perception that detained people who asked for a report were “demanding” or somehow abusing the system.⁴⁷

21. These were significant deficiencies in the operation of Rule 34 (in conjunction with Rule 35) to properly protect vulnerable detained people at Brook House.⁴⁸ Not having a functional way of identifying whether someone is at risk of harm in detention at the first opportunity is a serious concern. This is likely to have caused detained people to suffer actual harm – for example, through a deterioration in their mental or physical health. (See, for example, the cases of D1914 in Chapter D.8 and Chapter C.6 (in Volume I) and D1527 in Chapter C.4 (in Volume I)). The situation left vulnerable detained people in particular at risk of mistreatment, such as the inappropriate use of segregation and the rapid resort to use of force to manage incidents of self-harm and mental health crisis.⁴⁹ It also meant that vulnerable people were detained when detention was not appropriate for them.⁵⁰

22. PPG, the contractor providing healthcare at Brook House, told the Inquiry of various improvements made to the provision of healthcare services since it took over the contract in September 2021.⁵¹ These are considered in more detail in Chapter D.8. At the time of the Inquiry’s public hearings, in significant respects the arrangements remained substantially the same as in the relevant period. For example, Rule 34 GP appointments were scheduled to last 10 minutes; this remained inadequate, as it provided insufficient opportunity to perform the requisite physical and mental examination.⁵² The 2022 HM Inspectorate of Prisons (HMIP) inspection report found that nursing staff and healthcare assistants completed a healthcare screening of detained people when they first arrived at the centre, but that the screening was not carried out consistently well. HMIP considered this to be a key concern.⁵³

23. A key contributing factor to the failure of the safeguards is likely to have been the unacceptable lack of training on Rule 34 and Rule 35 (and on the Adults at Risk policy) in Brook House, which appears still to be the case.⁵⁴

23.1 Nurses did not routinely receive such training, despite their crucial role in identifying the need for Rule 35 reports and in referring detained

⁴⁷ [Dr James Hard 28 March 2022 22/7-19](#); [Theresa Schleicher 14 March 2022 65/9-66/10](#); [Dr Husein Oozeerally 11 March 2022 103/23-108/9](#)

⁴⁸ [Dr Rachel Bingham 14 March 2022 44/3-45/19](#); [Dr James Hard 28 March 2022 84/8-85/82, 113/8-114/12](#); [HOM000644](#); [INQ000075_053](#) para 5.78; [INQ000075_80-81](#) para 5.147

⁴⁹ [Dr James Hard 28 March 2022 177/14-179/9](#); [Dr Rachel Bingham 14 March 2022 54/15-55/15](#)

⁵⁰ [Dr James Hard 28 March 2022 20/15-21/10](#); [Theresa Schleicher 14 March 2022 60/6-61/142](#)

⁵¹ [PPG000204_007](#) para 30

⁵² [Sandra Calver 1 March 2022 208/16-209/15](#); [Dr James Hard 28 March 18/12-20/5](#); [Theresa Schleicher 14 March 2022 62/18-63/12](#)

⁵³ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022, para 3.38 and p49, para 7

⁵⁴ [Sandra Calver 1 March 2022 151/14-152/5](#); [Dr James Hard 28 March 2022 24/14-26/11](#)

people to GPs to complete such reports.⁵⁵ This contributed to a lack of understanding of Rule 35.⁵⁶ The Inquiry understands that further training is planned by PPG.⁵⁷

23.2 Such training as was available from the Home Office (primarily for GPs) was inadequate. The Home Office ceased to provide it in 2016. Such training as was available from G4S Health Services during the relevant period, and from PPG more recently, was also inadequate. There was an inappropriate focus in the training on Rule 35(3) and the identification of victims of torture, to the exclusion of Rule 35(1) (health would be injuriously affected by continued detention) and Rule 35(2) (there is a suspicion of suicidal intentions).⁵⁸ There was also a lack of training on identifying symptoms of torture.⁵⁹ The provision of such training is ultimately the responsibility of the Home Office.⁶⁰

24. The Home Office should have prioritised the delivery of a comprehensive mandatory programme of training for relevant staff in Brook House, to ensure that they understood how to apply properly the policy and their obligations under the Rules. The Inquiry received evidence of current practice that indicates that problems persist.⁶¹ In October 2022, Mr Philip Riley (Director of Detention and Escorting Services within the Home Office) stated that a Rule 35 training package for medical practitioners working in the immigration removal estate had been developed by the Home Office. The Home Office was consulting with PPG on how this could be delivered in conjunction with further training that PPG was developing to improve the standard of reporting on medical issues. It was clear from Mr Riley’s statement that this had not yet been delivered at Brook House.⁶² In its response to the *Third Annual Inspection of ‘Adults at Risk in Immigration Detention’* by the Independent Chief Inspector of Borders and Immigration (ICIBI), the Home Office accepted a recommendation that within three months it would “ensure that planned training on Rule 35 for doctors draws on feedback from the Rule 35 team” and is “tailored to the identified needs of doctors, to enable the production of consistent and high quality Rule 35 assessments and reports”.⁶³

⁵⁵ [Sandra Calver 1 March 2022 151/14-152/5](#); [Dr James Hard 28 March 2022 24/14-26/11](#)

⁵⁶ [Sandra Calver 1 March 2022 229/1-230/25](#)

⁵⁷ [PPG000204_007](#) paras 29 and 30

⁵⁸ [Dr James Hard 28 March 2022 27/18-29/6, 30/8-24](#)

⁵⁹ [Sandra Calver 1 March 2022 186/6-187/18](#)

⁶⁰ [Dr James Hard 28 March 2022 25/22-26/11](#)

⁶¹ [PPG000207](#); [Theresa Schleicher 14 March 2022 85/17-86/9](#); [Sandra Calver 1 March 2022 234/23-236/18](#); [Dr Sarah Bromley 1 April 2022 195/18-201/22](#)

⁶² [HOM0332184_004](#) para 15

⁶³ [Third Annual Inspection of ‘Adults at Risk in Immigration Detention’](#), Independent Chief Inspector of Borders and Immigration, January 2023; [Home Office Response to the Third ICIBI Inspection of Adults at Risk in Immigration Detention](#), Home Office, 12 January 2023

25. Based upon the evidence available to the Inquiry, it is not clear what training has been delivered, and I am therefore recommending that a comprehensive training programme be rolled out as a matter of urgency to ensure the immediate safety of detained people. This is of such significance that I am recommending that this apply across the immigration detention estate, not just to Brook House.

Recommendation 8: Mandatory training on Rule 34 and Rule 35 of the Detention Centre Rules 2001

The Home Office (in collaboration with NHS England as required) must ensure that comprehensive training on Rule 34 and Rule 35 of the Detention Centre Rules 2001 is rolled out urgently across the immigration detention estate. Staff must be subject to refresher training, at least annually.

Attendance must be mandatory for all staff working in immigration removal centres and those responsible for managing them, as well as GPs and relevant Home Office staff. Consideration must be given as to whether such training should be subject to an assessment.

Reports by a medical practitioner (Rule 35)

Legal and policy framework

26. Rule 35 is a key safeguard for those in detention. It requires a medical practitioner (GP) to report to the centre manager where:

- it is likely that a detained person's health would be injuriously affected by continued detention (Rule 35(1));
- the medical practitioner suspects that a detained person has suicidal intentions (Rule 35(2)); or
- there is a concern that a detained person may have been a victim of torture (Rule 35(3)).

On receiving such a report, the manager must inform the Home Office "*without delay*". It is then mandatory for the Home Office to review the detained person's detention and consider whether the detained person should be released.

27. The Adults at Risk policy sets out the process for determining whether an individual would be particularly vulnerable to harm in detention and, if so,

whether they should nevertheless be detained for the purpose of immigration removal.⁶⁴ It was and is necessary for the Home Office to ascertain the reasons why a person might be vulnerable to harm in detention, and to weigh those risk factors of harm to the detained person against immigration control considerations.⁶⁵ These considerations included:

- the length of detention;
- public protection issues, including any criminal offending history and risk to the public if the individual was not detained; and
- compliance issues, such as the risk of the person absconding, based upon their history of keeping to immigration bail conditions or immigration reporting requirements.

28. There was a presumption that adults at risk would not be detained. Detention would be appropriate only where immigration control considerations outweighed the risk factors identified.⁶⁶ In other words, unless it was strictly necessary to detain the person, the default position was that a vulnerable person would not be detained or would be removed from detention once they were classified as an adult at risk.

29. The Adults at Risk DSO sets out a number of factors or experiences that indicate that an individual may be particularly vulnerable to harm in detention. These include, among others, having a mental health condition or impairment or having been a victim of torture.⁶⁷

30. The Adults at Risk policy provided for evidence in support of vulnerability to be categorised at three levels. These were then used to assess the likely risk of harm to a detained person:

- A self-declaration by the detained person of being an adult at risk was regarded as level 1 evidence and was afforded limited weight.
- Professional evidence (such as from a social worker, medical practitioner or non-governmental organisation) stating that the individual was at risk was afforded greater weight and considered level 2 evidence.
- Professional evidence stating that the individual was at risk and that a period of detention would be likely to cause harm, such as an increase in the severity of symptoms or a condition that led to the individual being regarded as an adult at risk, was accorded significant weight and regarded as level 3 evidence.⁶⁸

⁶⁴ [CJS007082](#)

⁶⁵ [Adults at Risk in Immigration Detention](#), Home Office, updated 16 March 2022, para 4

⁶⁶ [CJS007082_007](#) para 13

⁶⁷ [CJS000731_007](#) para 11

⁶⁸ [CJS007082_006](#) para 9

31. The presumption set out in the Adults at Risk policy – that once an individual was regarded as being at risk, they should not be detained – was reiterated in the Adults at Risk DSO. However, immigration factors could then be balanced against that risk in making decisions as to whether to detain the individual.⁶⁹

The application of this framework at Brook House

32. In a 2019 report, the Home Affairs Select Committee set out that, according to Home Office statistics, the number of Rule 35 reports across the immigration detention estate ranged from 420 to 816 in each quarter between 2015 and 2018, resulting in between 13 per cent and 39 per cent of detained people being released.⁷⁰ In 2019, the number of Rule 35 reports ranged from 503 to 657 in each quarter, in 2020 from 50 to 584, in 2021 from 150 to 337, and in the first two quarters of 2022 from 290 to 544, resulting in between 31 per cent and 55 per cent of detained people being released.⁷¹

Table 5: Reports made by a medical practitioner under Rule 35 from 2017 onwards

	Brook House				Total across the immigration detention estate			
	R35(1)	R35(2)	R35(3)	Total	R35(1)	R35(2)	R35(3)	Total
Q1 2017	2	0	105	107	22	3	693	718
Q2 2017	3	0	66	69	25	2	657	684
Q3 2017	2	0	56	58	31	3	688	722
Q4 2017	1	0	92	93	21	4	680	705
Q1 2018	0	0	62	62	17	2	526	545
Q2 2018	2	0	50	52	33	0	633	666
Q3 2018	1	0	57	58	13	6	535	554
Q4 2018	0	0	50	50	23	0	504	527
Q1 2019	2	0	43	45	12	1	490	503

⁶⁹ CJS000731_005 para 4

⁷⁰ *Immigration Detention – Fourteenth Report of Session 2017–19*, House of Commons Home Affairs Committee, 21 March 2019, p46; see also *Immigration Enforcement Transparency Data Q2 2022*, Home Office, 25 August 2022, DT_04: Reports made by a medical practitioner under Rule 35 by place of detention and level (1, 2 and 3)

⁷¹ *Immigration Enforcement Transparency Data Q2 2022*, Home Office, 25 August 2022

	Brook House				Total across the immigration detention estate			
	R35(1)	R35(2)	R35(3)	Total	R35(1)	R35(2)	R35(3)	Total
Q2 2019	0	0	55	55	7	0	547	554
Q3 2019	0	0	59	59	9	1	648	658
Q4 2019	1	0	51	52	8	3	573	584
Q1 2020	0	0	62	62	5	1	578	584
Q2 2020	0	0	10	10	0	1	49	50
Q3 2020	2	0	125	127	6	2	207	215
Q4 2020	0	0	243	243	5	2	516	523
Q1 2021	0	0	13	13	4	1	143	148
Q2 2021	0	0	30	30	2	2	200	204
Q3 2021	0	0	89	89	2	2	333	337
Q4 2021	2	0	57	59	6	0	204	210
Q1 2022	2	0	77	79	3	2	286	291
Q2 2022	5	3	120	128	11	10	524	545
Q3 2022	7	6	131	144	16	12	546	574
Q4 2022	3	1	94	98	10	4	459	473
Q1 2023	2	2	89	93	8	3	456	467

Note: R35(1): health concerns; R35(2): suicide risk; R35(3): torture allegation

Source: Immigration Enforcement Transparency Data Q1 2023, Home Office, 25 May 2023, DT_04: Reports made by a medical practitioner under Rule 35 by place of detention and level (1, 2 and 3)

33. At Brook House in quarters 2 and 3 of 2017 (which cover the relevant period from 1 April 2017 to 31 August 2017), only five Rule 35(1) reports were completed and no Rule 35(2) reports were completed. Only one detained person was released as a result. In the whole of 2017, only eight Rule 35(1) reports were completed.⁷² No Rule 35(2) reports were completed in 2017, or indeed in 2018, 2019, 2020 or 2021.⁷³

⁷² See also [BHM000032_050-053](#) paras 146-151

⁷³ [BHM000032_050-053](#) paras 146-151

34. The vast majority of reports completed in the relevant period were Rule 35(3) reports relating to a concern that a detained person might have been a victim of torture. Based on his review of Rule 35(3) reports, Dr Hard considered that around 75 per cent of those reports were completed inadequately.⁷⁴ In particular, he noted that there was either no conclusion regarding the possibility of previous ill treatment (namely torture) or no conclusion on the impact of ongoing detention.⁷⁵ Many of the reports also failed to identify mental health consequences of torture or mental health symptoms experienced by the individual.⁷⁶ On occasion, such as in relation to D1524 and D2287, the GP sought to explain a conclusion that there was no concern regarding prolonged detention by reference to the absence of “acute mental health issues” or “psychotic features or acute deterioration”.⁷⁷ However, the Inquiry heard that psychotic symptoms are not core diagnostic features of post-traumatic stress disorder (PTSD), depression or anxiety, which were the most prevalent conditions among detained people. The absence of psychotic symptoms therefore could not be taken to be an indicator that harm was less likely.⁷⁸

35. Dr Bingham agreed that, where Rule 35 reports were written, the quality was often inadequate. Often, important issues were left out that should have been covered:

“For example, mental health symptoms. Sometimes comments are made that are really easily misinterpreted, like ‘no severe mental health issues’ when there clearly are significant mental health issues, or recently we have seen the term ‘stable in detention’ very frequently, which I think just means no issues so acute as to require hospitalisation. It doesn’t mean no mental health issues that are likely to deteriorate.”⁷⁹

36. It is difficult to understand the reasons why mental health conditions and symptoms were not considered, given that the Rule 35 report directs such consideration. Dr Bingham told the Inquiry:

“The reasons, I think, for missing this safeguard, it’s not, therefore, that there’s a lack of clarity in the form that needs to be filled in, but it’s that it’s not done. So to answer that question, I think we need to look at a bigger picture of systemic failures to implement these safeguards and to fully understand their importance.”⁸⁰

⁷⁴ [INQ000075_027](#) paras 5.47 and 5.48; [Dr James Hard 28 March 2022 37/20-40/11](#)

⁷⁵ [Dr James Hard 28 March 2022 44/13-46/20](#); [Theresa Schleicher 14 March 2022 64/14-16](#)

⁷⁶ [Dr James Hard 28 March 2022 38/5-39/13](#)

⁷⁷ [CJS000859_003](#); [CJS000860_003](#)

⁷⁸ [Dr James Hard 28 March 2022 41/18-42/24](#)

⁷⁹ [Dr Rachel Bingham 14 March 2022 64/14-25](#)

⁸⁰ [Dr Rachel Bingham 14 March 2022 9/8-24](#)

37. The Inquiry received a number of examples of inadequate reports, two of the most significant of which involved D1914 and D687.

37.1 On 17 July 2017, Dr Oozeerally completed a Rule 35(1) report for D1914 which stated that he had “*no mental health issues*”.⁸¹ This was despite the fact that D1914 had recently attempted suicide. It should have recorded mental ill health leading to self-harm. Given that significant omission, I agree with Dr Hard that the report was both inaccurate and inadequate.⁸²

37.2 On 15 April 2017, Dr Oozeerally completed a Rule 35(3) report for D687 but there were a number of flaws in his conduct and in the subsequent report:

- D687 had shown Dr Oozeerally fresh scars from self-harming two days earlier, but the report makes no mention of any recent self-harm.⁸³
- Dr Oozeerally did not provide an opinion on the impact of ongoing detention as he should have done, and there is nothing in the clinical record to indicate whether Dr Oozeerally considered opening an ACDT document at that time.⁸⁴
- The Home Office concluded that D687 met the threshold to be classified as an adult at risk but decided to maintain his detention at that time.⁸⁵
- D687 indicated that the Rule 35 report did not properly reflect his interaction with Dr Oozeerally on 15 April 2017.⁸⁶
- On 5 May 2017, it was noted that D687’s condition had deteriorated and an ACDT document was opened as a result of a reported intention to take an overdose. No subsequent Rule 35(2) report was provided to the Home Office to notify it of D687’s apparent suicidal ideation. Additionally, there was no Rule 35(1) report notifying the Home Office of the apparent worsening impact on D687 of his ongoing detention.⁸⁷
- D687 missed an appointment on 10 May 2017 but this was not followed up as it should have been.⁸⁸
- On 13 May 2017, during a planned transfer to The Verne immigration removal centre, while still at Brook House, D687 placed a ligature

⁸¹ [CJS001024_002](#)

⁸² [Dr James Hard 28 March 2022 100/4-101/2](#)

⁸³ [DPG000021_054-057](#) paras 151-158

⁸⁴ [INQ000112_025-026](#); [CJS000848](#)

⁸⁵ [Dr James Hard 28 March 2022 101/18-24](#); [HOM000013](#)

⁸⁶ [DPG000021_047](#) para 138

⁸⁷ [Dr James Hard 28 March 2022 100/25-105/12](#); [INQ000112_025-027](#)

⁸⁸ [Dr James Hard 28 March 2022 102/15-106/20](#)

around his neck. This was subsequently removed during a use of force. Having been successfully transferred to The Verne, an ACDT document was opened in relation to D687. The ACDT document and Rule 35(2) report should have been completed at Brook House following the attempted use of the ligature.⁸⁹

37.3 By the time D687 was involved in the self-harm incident on 13 May 2017, he had been presenting with deteriorating mental health symptoms for almost three months.⁹⁰ D687 described multiple incidents in which he expressed suicidal ideation, having given up on life, having lost hope and feeling worthless, which all contributed to his self-harming in that incident.⁹¹ Dr Oozeerally's failures – particularly his failure to report D687's mental health deterioration to the Home Office – meant that D687's mental state and the incident of self-harm were not factored in to the Home Office's decision regarding his transfer to The Verne. Nor was the Home Office given the opportunity to consider this information in a review of his detention. He remained in detention, where he deteriorated, and was then subject to the use of force.

38. These were not isolated incidents. In preparing his two written reports for the Inquiry, Dr Hard reviewed in detail all the available contemporaneous documents in relation to five individuals – D1914, D687, D1527, D720 and D1538 – who were detained at Brook House during the relevant period. In these five case studies, he considered the effectiveness of the assessment of vulnerability, the suitability of healthcare provision, the clinical management of self-harm and of food and fluid refusal, and the extent to which mental ill health played a part in the treatment to which they were subjected. Dr Hard noted the apparent disconnect between the information known by Healthcare staff and their ability to ensure that a review by a GP was timely and that it prompted the provision of Rule 35(1) and Rule 35(2) reports where appropriate. This was particularly the case where there was an apparent deterioration in a detained person's mental health or there had been an episode of self-harm or attempted suicide.⁹²

39. I agree with Dr Hard that the cases of D1914, D687 and D1527 illustrate various deficiencies within the system that are of serious concern.⁹³

39.1 First, it appears that there was no system in place for the automatic review of a detained person's health and welfare where there was self-

⁸⁹ [Dr James Hard 28 March 2022 103/11-104/10](#)

⁹⁰ [CJS007109](#)

⁹¹ [DPG000021_069-075 paras 195-213](#)

⁹² [Dr James Hard 28 March 2022 49/6-21](#); [INQ000112_029-030](#)

⁹³ [Dr James Hard 28 March 2022 59/4-11](#)

harm, a suicide attempt or an apparent deterioration in their mental health.⁹⁴

39.2 Second, it appears that, when the GP was asked to review detained people where there was self-harm, a suicide attempt or an apparent deterioration in their mental health, there was no systematic approach to using Rule 35(1) or Rule 35(2) reports in order to notify the Home Office of these changes in presentation to enable their detention to be reviewed.⁹⁵

39.3 Third, there does not appear to have been any mechanism by which the detained person's circumstances were systematically reviewed by the GP in order to consider whether or not their condition had changed over time and whether detention was having an impact.⁹⁶ A failure to carry out Rule 34 examinations properly at the start of detention – and the lack of completed Rule 35 reports as a result – also led to an absence of any measure against which to assess whether there had been a deterioration.

40. GPs and other Healthcare staff did not flag to the Home Office a lack of time as a reason for the failure. In any event, this would have been an insufficient excuse. Instead, as Dr Bingham noted, it is likely that there was and remains a failure to recognise the importance of the safeguards, the risks of detention and the responsibilities of Healthcare staff.⁹⁷

41. In my view, this was caused, in part, by the complete absence of a consistent mechanism for the routine follow-up of detained people who were considered to be victims of torture or adults at risk. The failure to complete Rule 35 reports in appropriate circumstances resulted in the deterioration in the mental health of detained people and an increased risk of self-harm and suicide. It therefore left them more vulnerable to harm.⁹⁸ Deterioration was not detected or monitored adequately. More importantly, the person remained in detention and there was the potential for the risk to materialise, causing harm.⁹⁹ The Home Office was not informed as it should have been and therefore did not review detention or consider release, as it ought to have done. These were serious systemic failures, indicating a wholesale breakdown in the system of safeguards designed to protect vulnerable detained people.¹⁰⁰

⁹⁴ [Dr James Hard 28 March 2022 49/22-50/15](#)

⁹⁵ [Dr James Hard 28 March 2022 50/910-51/4](#)

⁹⁶ [Dr James Hard 28 March 2022 51/6-52/8](#)

⁹⁷ [Dr Rachel Bingham 14 March 2022 42/8-43/4](#)

⁹⁸ [Dr James Hard 28 March 2022 177/14-179/9](#); [Dr Rachel Bingham 14 March 2022 54/15-55/15](#)

⁹⁹ [Dr James Hard 28 March 2022 54/8-57/8](#); [Theresa Schleicher 14 March 2022 65/3-19](#)

¹⁰⁰ [INQ000112_081](#)

- 42.** PPG has changed some arrangements.
- 42.1** It has increased the number of Rule 35 appointments available per week from 10 to 17. Despite this, there remained a backlog at the time of the Inquiry’s hearings.¹⁰¹ Without further changes to the arrangements, in my view the risk of a backlog occurring remains.
- 42.2** Dr Sarah Bromley, National Medical Director for Health and Justice at PPG, told the Inquiry that temporary measures had been put in place to address concerns about the Rule 35 safeguards. For example, when an ACDT document is opened, a Rule 35(1) appointment is booked for that day or the following day. All patients are also reviewed by the mental health team when an ACDT document is opened. Nevertheless, it is unclear whether Doctor PA Ltd, which provides GP services at Brook House, or the individual GPs have been instructed to undertake Rule 35(2) assessments for all patients on constant supervision.¹⁰²
- 42.3** Mr Luke Wells, Service Line Director for Health in Justice at PPG, told the Inquiry that other steps were being taken to improve the situation, including the design of a new pathway and the allocation of separate times for Rule 35(1), Rule 35(2) and Rule 35(3) appointments.¹⁰³
- 42.4** The Serco Vulnerable People Strategy does not address Rule 35 and refers to the use of Part C forms by detention custody staff to inform the Home Office of vulnerabilities.¹⁰⁴ As discussed below, Part C of the IS91 form primarily relates to the risk detained people pose to others. It does not relate to the risk of harm to detained people posed by detention and was not designed to notify the Home Office of vulnerabilities. It is therefore likely that detention custody staff do not understand the role of Rule 35. It is important that they understand Rule 35 and their role in the process. Without an adequate understanding of this role, detention custody staff will not be referring detained people to the Healthcare department or to GPs as they should for consideration of vulnerabilities under Rule 35. Instead, they will inappropriately be completing only Part C forms.¹⁰⁵
- 43.** In its report for the reporting year 2021, the Independent Monitoring Board at Brook House noted:

¹⁰¹ [PPG000204_006](#) para 27

¹⁰² [Dr Sarah Bromley 1 April 2022 201/11-17](#); [PPG000205_001](#) para 3b; [PPG000204_002](#) para 8

¹⁰³ [PPG000169_003-004](#) para 15; [Luke Wells 31 March 2022 183/1-184/12](#)

¹⁰⁴ [SER000038_006](#) para 5.4

¹⁰⁵ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022, paras 1.8, 2.13 and 2.14, and p49, para 8

“Brook House is not a safe or appropriate environment for the few men who have arrived in 2021 with severe mental health issues or have significantly deteriorated while in detention. The Board is concerned that the Home Office Detention Gatekeeper is not adequately preventing the detention of men whose mental health needs make such detention inappropriate or inadvisable (section 4.4).”¹⁰⁶

The Home Office Detention Gatekeeper is an official who makes decisions about whether to detain an individual.¹⁰⁷

44. During the relevant period in Brook House, there was no adequate oversight of the operation of Rule 35. The Inquiry heard evidence of four particular failures.¹⁰⁸

44.1 There was no quality assurance of Rule 35 reports by either G4S Health Services or the Home Office.¹⁰⁹ There was no system or mechanism for feedback or review by the Home Office on the quality of the Rule 35 reports it had received. Mr Riley, who gave evidence on behalf of the Home Office, told the Inquiry that there was a dedicated team that reviewed Rule 35 reports and returned them if a decision could not be made about whether to release or maintain detention because the reports were incomplete.¹¹⁰ In my view, this remains insufficient as a system of oversight regarding the quality of Rule 35 reports.

44.2 There was no attempt by the Home Office to analyse whether Rule 35 was adequately achieving its stated aims and, if not, what needed to be changed. Mr Philip Schoenenberger, Head of the Home Office Detainee Escorting and Population Management Unit during the relevant period, gave evidence, for instance, that he was unaware of the practice of completing Part C forms (discussed below) instead of Rule 35 reports.¹¹¹

44.3 There was no system to identify training needs or the reasons for inadequate reports.¹¹² Mr Riley told the Inquiry that there was a planned roll-out of training on Rule 35 that had been trialled recently in one IRC.¹¹³ The Inquiry was not provided with any further details of the training.

¹⁰⁶ *Annual Report of the Independent Monitoring Board at Gatwick IRC: For Reporting Year 1 January–31 December 2021*, IMB, June 2022, section 4.4

¹⁰⁷ *Detention Services Order 08/2016: Management of Adults at Risk in Immigration Detention (CJS000731)*, Home Office, February 2017 (updated August 2022), para 11

¹⁰⁸ *Dr James Hard 28 March 2022 47/2-48/1*

¹⁰⁹ *Dr James Hard 28 March 2022 42/15-44/12*

¹¹⁰ *Philip Riley 4 April 2022 112/15-24*

¹¹¹ *Philip Schoenenberger 23 March 2022 93/4-22*

¹¹² *Dr James Hard 28 March 2022 44/1-12; INQ000112_031; INQ000112_035-036*

¹¹³ *Philip Riley 4 April 2022 119/14-19*

44.4 There was no specific system in place, either as part of the operation of Rule 35(1) and Rule 35(2) or in addition to Rule 35, for the re-evaluation of detained people who had been identified as possible victims of torture, in order to ascertain whether ongoing detention was having a negative impact on them.¹¹⁴ D13 was identified as a victim of torture and a Rule 35(3) report was completed.¹¹⁵ He subsequently deteriorated in detention, leading to periods of food and fluid refusal, referral to the mental health team and a long period of management subject to an ACDT process due to suicidal ideation. No Rule 35(1) or Rule 35(2) report was completed in relation to him. There was no other follow-up or re-evaluation of him. The Home Office was not informed of his deterioration and so his detention was not reviewed or his release considered.¹¹⁶

45. There is no oversight mechanism in the Home Office for the quality of Rule 35 reports being completed by GPs in Brook House.¹¹⁷ There is also no oversight, by the Home Office or by any other organisation, of the reasons why so many Rule 35 reports do not lead to the release of the detained person.¹¹⁸

46. The Inquiry heard evidence that the Home Office Detention Gatekeeper is not an effective safeguard against the detention of vulnerable individuals at risk of harm in detention. This is because the Detention Gatekeeper lacks independence and does not have access to independent sources of information on individuals. Independent pre-detention screening should be coupled with effective clinical screening on arrival in detention – in other words, the proper operation of Rule 34.¹¹⁹

Inappropriate use of other mechanisms

47. The system of safeguards provided by Rule 34 and Rule 35 and the Adults at Risk policy failed those detained people who were vulnerable to suffering harm in detention. Instead of fulfilling their obligations under the Rules, Healthcare staff resorted to the inappropriate use of alternatives that were not designed for – and not capable of – adequately fulfilling the purposes of ensuring the safety and wellbeing of detained people and of notifying the Home Office of their vulnerabilities to ensure that their detention was reviewed.

¹¹⁴ [Dr James Hard 28 March 2022 46/8-47/1](#)

¹¹⁵ [CJS000887](#)

¹¹⁶ [Dr Rachel Bingham 14 March 2022 22/8-23/14](#)

¹¹⁷ [Theresa Schleicher 14 March 2022 101/1-15](#)

¹¹⁸ [Theresa Schleicher 14 March 2022 67/11-68/22](#)

¹¹⁹ [Theresa Schleicher 14 March 2022 93/19-95/4; Dr Husein Oozeerally 11 March 2022 16/9-14](#)

Part C forms

48. By the time of the relevant period, an inappropriate practice had developed of Part C forms being completed, primarily by GPs, to inform the Home Office of vulnerabilities or risk, instead of Rule 35 reports being used. Part C forms were not designed to notify the Home Office of a vulnerability or risk factor that would place someone at risk of suffering harm in detention and therefore would classify them as an adult at risk.¹²⁰ An appropriate use might be, for example, to notify the Home Office of an altercation between detained people.¹²¹

49. It was entirely inappropriate to use Part C forms instead of Rule 35 reports to inform the Home Office of concerns about a detained person, thereby bypassing the system of safeguards designed for this purpose. This was particularly the case in circumstances where the form did not achieve the purpose for which it was being used: namely, a review by the Home Office of a vulnerable person's detention and consideration of their release. The fundamental difference between Part C and Rule 35 is that only Rule 35 requires the Home Office to review a detained person's detention and consider whether they should be released. Rule 35 thus operates as a safeguard for individuals who are vulnerable to harm caused by detention. The important feature of a safeguard is that it requires a response.¹²² In the circumstances, the system of safeguards in place to protect vulnerable people from harm in detention became less robust and all the more likely to expose them to harm. Ms Calver was aware – or ought to have been aware – of the development of such an inappropriate practice among the GPs and should have reported it to her line manager. There is no evidence that she did so or that she raised any concerns at the time. Indeed, there is evidence that she, too, occasionally took part in this practice.¹²³

50. Dr Oozeerally said that the reason for using Part C forms instead of Rule 35 reports was that it was a more dynamic way of informing the Home Office of concerns. Part C forms would get a quicker response and, in his experience, the receipt of a Part C form would lead the Home Office to review detention and, indeed, release detained people, even though there is no statutory requirement for the Home Office to do so.¹²⁴ These assertions were not backed up by any evidence or by any reference to identified individuals. Dr Oozeerally was unapologetic about his failure to fulfil his obligations under Rule 35, and he was intransigent in his view that Part C forms were an effective method of securing a Home Office review of detention, despite

¹²⁰ [Dr Rachel Bingham 14 March 2022 37/9-16](#)

¹²¹ [BHM000033_047](#) para 124

¹²² [Dr Rachel Bingham 14 March 2022 36/9-41/17](#); [Dr James Hard 28 March 2022 70/10-71/5, 75/23-77/19](#)

¹²³ [Sandra Calver 1 March 2022 201/24-203/4](#)

¹²⁴ [Dr Husein Oozeerally 11 March 2022 51/1-52/23](#)

evidence to the contrary.¹²⁵ He did not demonstrate insight into his actions and omissions. Upon publication of this Report, a copy will be provided to the General Medical Council.

51. In contrast, Dr Bingham told the Inquiry that, in the experience of Medical Justice, Part C forms did not lead to a review of detention, as a Rule 35 report would and should have done.¹²⁶ This was reflected in evidence received by the Inquiry.

51.1 D801 was detained in Brook House from 1 March 2017 to 3 April 2017 (for 35 days).¹²⁷ During this time, four Part C forms were completed by GPs and by Ms Calver in relation to his mental health and self-harm or suicide attempts (on 1 March, 13 March, 19 March and 31 March 2017). These did not result in a review of his detention by the Home Office or in his release.¹²⁸ D801 was instead managed using an ACDT document.¹²⁹ A Rule 35(1) report was completed in relation to D801 only on the day of his release from detention, when the Home Office had already made the decision to release him as a result of correspondence from his legal representatives.¹³⁰

51.2 During D1914's detention in Brook House, nine Part C forms were completed between 11 April and 13 July 2017.¹³¹ Despite this, none led to a review of his detention or his release. Notably, the Part C form completed on 13 July expressed Dr Chaudhary's concern that D1914's condition was deteriorating, but Dr Chaudhary did not complete a Rule 35(1) report at that time.¹³² D1914 was released in August 2017 as a result of the Rule 35(1) report completed by Dr Oozeerally on 17 July 2017.¹³³

52. Dr Bingham also told the Inquiry that there were cases where Part C forms were not completed, even though there were concerns.¹³⁴

53. On 1 April 2022, the Inquiry was provided with a letter from Mr Riley and Ms Kate Davies CBE, Director of Health and Justice, Armed Forces and Sexual Assault Referral Centres for NHS England. This directed staff working in IRCs to fulfil their obligations under Rule 35 and to cease the inappropriate use

¹²⁵ [Dr Husein Oozeerally 11 March 2022 92/15-23](#)

¹²⁶ [Dr Rachel Bingham 14 March 2022 36/9-37/8](#)

¹²⁷ [Dr Rachel Bingham 14 March 2022 37/17-43/4](#)

¹²⁸ [HOM029119](#); [HOM028624_035](#); [HOM029010](#); [HOM025316_012](#)

¹²⁹ [Sandra Calver 1 March 2022 201/24-203/4](#); [Dr Rachel Bingham 14 March 2022 37/17-43/4](#)

¹³⁰ [Dr Rachel Bingham 14 March 2022 41/2-7](#)

¹³¹ On 11 April, 19 April, 27 May, 28 May, 3 June, 5 July, 6 July, 7 July and 13 July 2017 ([HOM007159_002](#); [HOM007159_004](#); [HOM007159_012](#))

¹³² [HOM010916](#)

¹³³ [CJS001024](#)

¹³⁴ [Dr Rachel Bingham 14 March 2022 36/9-37/8](#); [Dr James Hard 28 March 2022 77/20-78/6](#)

of Part C forms.¹³⁵ The letter arrived one working day before Mr Riley was due to give evidence to the Inquiry. In my view, this is indicative of the superficial and cursory approach of the Home Office to addressing serious deficiencies in a dysfunctional system for which it is responsible.

Assessment Care in Detention and Teamwork

54. The ACDT process, which was drawn from the corresponding process in prisons, is primarily a tool for managing those at risk of self-harm and suicide in detention, through constant supervision.¹³⁶ The ACDT DSO states:

“Any individual identified as at risk of suicide or self-harm must be managed using the ACDT procedures. ACDT is a detained individual centred, flexible care-planning system which, when used effectively, can reduce the distress of those in detention and mitigate the risk of self-harm or suicide.”¹³⁷

55. The process involves a series of actions to be carried out and documented in order to care for the detained person and manage and minimise their risk to themselves.

- 55.1** An ACDT document could be opened by any member of staff in an IRC where there was a concern that a detained person was at risk. Initially, an ‘Immediate Action Plan’ was created, setting out where the detained person was to be located and what level of support they required, including what level of observation was to be carried out and documented by staff members (either intermittently or constantly, depending on the level of risk).
- 55.2** An assessment interview would take place within 24 hours of the concern being raised. This interview addressed both the detained person’s history and their current mental state and intentions.
- 55.3** The interview also triggered engagement by staff with the detained person, including setting a level at which they would be observed. These observations ranged from daily contact or intermittent observations at regular intervals (such as hourly) to constant observations for those at high risk of suicide. Constant observations involved a member of staff observing the detained person, often while they were confined to their cell, on a constant basis – in other words, they watched them all the time.¹³⁸

¹³⁵ [HOM0332160](#)

¹³⁶ [Dr James Hard 28 March 2022 113/8-16](#)

¹³⁷ [Detention Services Order 01/2022: Assessment Care in Detention and Teamwork \(ACDT\) \(INQ000214\)](#), Home Office, October 2022, para 8

¹³⁸ [Sandra Calver 1 March 2022 163/9-23](#)

- 55.4** There was then a process of periodic case reviews by the case manager and detention custody staff.
- 55.5** There was a requirement to record these steps in the ACDT document, which was used to review the levels of risk and observations and to decide on any actions.
- 56.** A total of 248 ACDT documents were open during the relevant period, with 195 new ACDT documents opened in that time.¹³⁹ In the relevant period, there was an average of 456 individuals per month detained in Brook House.¹⁴⁰
- 57.** D1914's case is illustrative of the disconnect between the ACDT process and Rule 35 for a vulnerable individual, as well as of other deficiencies in the safeguards.
- 57.1** D1914 had a serious cardiac condition, having undergone a double coronary artery bypass graft. He had cardiac symptoms in Brook House and abnormal blood results, was hospitalised on four occasions during his four months there and required a further cardiac procedure that was planned for August 2017. He also experienced mental ill health and had a history of episodes of serious self-harm and a suicide attempt while at Brook House. There were multiple indicators to flag up his risk in detention.¹⁴¹
- 57.2** D1914 was not identified at the outset as being vulnerable to harm in detention and his case was not notified to the Home Office as it should have been.¹⁴² This is particularly the case under Rule 35(1), as actual harm is not required to trigger completion of a report, only the likelihood of harm. Given his history, D1914 fulfilled those criteria at the outset of his detention – and all the more so when he demonstrably started to deteriorate, both physically and mentally.¹⁴³
- 57.3** D1914 was made subject to an ACDT process between 11 and 17 April 2017 *"after suggesting he would die if returned to Romania"*.¹⁴⁴ Throughout April and May 2017, he became more agitated and frustrated by his detention and by his inability to access the treatment he required. His mental and physical condition deteriorated as a result of

¹³⁹ [IMB000021_001](#); [IMB000050_001](#); [IMB000011_001](#); [IMB000047_001](#); [IMB000019_001](#)

¹⁴⁰ [IMB000021](#); [IMB000050](#); [IMB000011](#); [IMB000047](#); [IMB000019](#)

¹⁴¹ [Dr Rachel Bingham 14 March 2022 44/3-45/19](#)

¹⁴² [Dr Rachel Bingham 14 March 2022 44/3-45/19](#); [Dr James Hard 28 March 2022 84/8-85/82](#)

¹⁴³ [Dr James Hard 28 March 2022 85/20-22](#); [Dr Rachel Bingham 14 March 2022 44/14-45/19](#); [BHM000033_098](#)

¹⁴⁴ [CJS001043](#)

the stress he suffered in detention.¹⁴⁵ His mental ill health was mischaracterised as refractory or wilfully disobedient behaviour.¹⁴⁶

- 57.4** D1914 was subject to a planned use of force for the sole reason that he could be removed from the UK on 27 May 2017 (as discussed in Chapter C.6 in Volume I).
- 57.5** On 5 July 2017, it was noted that D1914 had self-harmed by making severe cuts to his arms and neck and that he had taken an overdose of his medication. This was regarded by both detention and Healthcare staff as a suicide attempt. A second ACDT document was opened but no corresponding Rule 35(2) report was created to notify the Home Office of a suspicion of suicidal intentions.¹⁴⁷ Additionally, no Rule 35(1) report was created to notify the Home Office of D1914's apparent deterioration, demonstrated by his act of self-harm on 5 July.¹⁴⁸ In my view, on any occasion when there was a serious act of self-harm or an attempted suicide, a report under Rule 35(1) and Rule 35(2) should have been completed, including on 5 July.¹⁴⁹
- 57.6** A Rule 35(1) report should also have been completed on 13 July 2017, given Dr Chaudhary's concerns on that date about the risk of D1914's condition worsening in detention. Instead, on 13 July, Dr Chaudhary completed only a Part C form in relation to D1914 in order to relay those concerns to the Home Office.¹⁵⁰ A Rule 35(1) report on D1914 was completed by Dr Oozeerally on 17 July 2017.¹⁵¹ Only then was the Home Office required to review his detention and consider his release. In the intervening four days, he was at further risk of deterioration in his physical and mental health.
- 58.** The ACDT process is not a clinical response and does not include any therapeutic interventions. It is not a process through which any treatment is given, nor is there clinical input into the management of a detained person.¹⁵² As such, it was not a mechanism to address the underlying causes of a detained person's risk of self-harm or suicide. Dr Bingham explained:

¹⁴⁵ [Dr James Hard 28 March 2022 85/23-86/20](#)

¹⁴⁶ [Dr James Hard 28 March 2022 86/21-87/1](#); [Dr Rachel Bingham 14 March 2022 48/18-50/4](#); [BHM000033_056](#) para 145

¹⁴⁷ [CJS000990_018](#)

¹⁴⁸ [Dr James Hard 28 March 2022 82/14-86/20](#); [INQ000112_024-025](#); [Dr Rachel Bingham 14 March 2022 48/18-50/4](#)

¹⁴⁹ [INQ000112_024-025](#); [Dr James Hard 28 March 2022 59/4-11, 82/14-84/7](#)

¹⁵⁰ [HOM010916](#)

¹⁵¹ [Dr James Hard 28 March 2022 82/14-86/20](#); [INQ000112_024-025](#)

¹⁵² [Dr Rachel Bingham 14 March 2022 11/14-12/16](#)

“ACDT is a prison-style response, not at all suited to clinical presentations in immigration detention. Because it doesn’t address the underlying psychological symptoms, because it doesn’t relieve distress and because it doesn’t provide any therapeutic input, it is not only an inadequate response to those things, it is just not a response to them.”¹⁵³

59. The opening of an ACDT document in relation to a risk of self-harm, including after an act of self-harm or a suicide attempt, did not trigger the consideration of Rule 35. Nor did it trigger the completion of a Rule 35 report to inform the Home Office of the risk that the detained person may suffer harm or was already suffering harm in detention. That risk or suffering of harm was demonstrated by the necessity to manage them using an ACDT process. That is a significant concern. As noted by Dr Hard:

“this almost speaks back to that issue of desensitisation and normalisation, that, my population is likely to do self-harm at this sort of level and we will just manage it with an ACDT rather than considering our founding principles of what’s embodied within the rule 35.”¹⁵⁴

60. PPG told the Inquiry that, in the period between January and October 2022, there were 184 ACDTs, 104 episodes of constant watch (in relation to 94 detained people), 73 incidents of self-harm (in relation to 57 detained people), and 63 periods of food and fluid refusal (in relation to 59 detained people).¹⁵⁵ Despite extremely low numbers of Rule 35(1) and Rule 35(2) reports, there were relatively high numbers of ACDTs, incidents of self-harm and incidents of detained people on constant watch under the management of Serco and PPG. The Inquiry did not receive any satisfactory explanation for this discrepancy. I remain deeply concerned by these figures. In my view, they are indicative of a continuation of the serious failure in the safeguards under Rule 34 and Rule 35 for those detained people vulnerable to harm in detention. The figures are also indicative of clear disconnects between the ACDT process and Rule 35, and between food and fluid refusal and Rule 35.

61. The 2022 HMIP inspection report noted with concern that, in the six months prior to its inspection, there was only one Rule 35(2) report that referred to suicidal ideation, despite 60 detained people being subject to a constant watch because of concerns about self-harm during the same period.¹⁵⁶ The report recorded a key concern:

¹⁵³ [Dr Rachel Bingham 14 March 2022 12/17-13/9](#)

¹⁵⁴ [Dr James Hard 28 March 2022 78/7-80/14](#)

¹⁵⁵ [PPG000207](#)

¹⁵⁶ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022, para 2.13

“The Rule 35 report process was not being used to its fullest extent to protect detainees who had conditions that might have been worsened by detention. Nearly all reports related to potential victims of torture and very few were prepared for detainees with health problems or suicidal ideation.”¹⁵⁷

HMIP also noted that the recommendation from its previous report – that “Doctors should submit a rule 35 report to the Home Office on any detainee they suspect of having suicidal ideation” – had not been achieved.¹⁵⁸

62. Dr Bromley told the Inquiry that the Rule 35 process was still failing “at various points throughout the system” and that Rule 35(1) and Rule 35(2) in particular appeared to have been “a little lost along the way”.¹⁵⁹ She sought to explain that ACDTs and acts of self-harm are not always indicative of suicidal ideation and therefore may not warrant the completion of a Rule 35(2) report in each case.¹⁶⁰ This does not address the very low numbers of Rule 35(1) reports completed, which she sought to explain as a matter of clinical judgement. She also suggested that risks would be increased because those most vulnerable would be hidden among high numbers of reports if there were a:

“literal interpretation of the rules resulting in a requirement for a Rule 35(1) assessment potentially for everyone, or for a Rule 35(2) for anyone placed on an ACDT ... It is arguable that detention has the potential to be injuriously detrimental to anyone’s physical or mental health and therefore in theory everybody coming into a detention centre could be eligible for assessment under Rule 35(1).”¹⁶¹

I consider this explanation deficient and a further indication of an abdication of corporate responsibility.

63. There was no recognition by the GPs or Healthcare staff at Brook House that a holistic view needed to be taken in relation to self-harm and suicide risk. Nor did they recognise that the various processes should be complementary, working together to protect and care for vulnerable people in detention. This undoubtedly exposed vulnerable people to a risk of harm and caused actual harm to be suffered in some cases, as well as leaving certain individuals susceptible to mistreatment. D1851 was one such example whose mental health deteriorated, who was subject to unjustified use of force and who was

¹⁵⁷ *Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 (HMIP000702)*, HM Chief Inspector of Prisons, September 2022, p49

¹⁵⁸ *Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 (HMIP000702)*, HM Chief Inspector of Prisons, September 2022, p51

¹⁵⁹ Dr Sarah Bromley 1 April 2022 168/11-23, 172/10-18, 193/3-194/2, 194/23-195/5

¹⁶⁰ PPG000204_002 para 6

¹⁶¹ PPG000204_002 para 8; PPG000204_001 para 3

left susceptible to mistreatment (see Chapter C.8 in Volume I). In my view, this risk remains.

64. In my view, the disconnect between the ACDT process and the other safeguards for vulnerable people is symptomatic of wider and deeply rooted problems. It is indicative of a system not fit for purpose.

‘Satisfactory management in detention’

65. In 2016, Mr Stephen Shaw, a former Prisons and Probation Ombudsman, recommended removing the test of ‘satisfactory management in detention’. This had been the practice in place under the guidance prior to the Adults at Risk policy.¹⁶² Mr Shaw considered the term to be vague and lacking in clinical meaning. He stated:

*“it is perfectly clear to me that people with serious mental illness continue to be held in detention and that their treatment and care does not and cannot equate to good psychiatric practice (whether or not it is ‘satisfactorily managed’). Such a situation is an affront to civilised values.”*¹⁶³

The practice resulted in a ‘wait and see’ approach, where a detained person could be left to deteriorate: that is, waiting for harm to be suffered to the point where the person could no longer be satisfactorily managed in detention.

66. It is apparent from the evidence in relation to the lack of use of Rule 35(1) and Rule 35(2) reports that there remained a reliance on the ability of Healthcare to ‘satisfactorily manage’ the ill health of the detained person in detention, despite this not forming part of the Adults at Risk policy as a result of Mr Shaw’s recommendation that it be removed.¹⁶⁴ For example, Dr Oozeerally told the Inquiry that the reason for the lack of Rule 35(1) reports was that Healthcare was able to manage people in the detention environment. As a result, he considered that the threshold for a Rule 35 report was not met.¹⁶⁵

67. This practice was wholly inappropriate and, to the extent that it is continuing, it should cease immediately. The placing of further informally adopted obstacles to the operation of the safeguards under Rule 35 resulted in failures to make proper use of those safeguards and to ensure that those who were vulnerable to harm in detention were notified to the Home Office to have their detention reviewed and release considered. This was likely to have caused actual harm to have been suffered by detained people when they were allowed to deteriorate in terms of their mental or physical health. Further, they were

¹⁶² [Dr James Hard 28 March 2022 59/12-61/5](#); [Ian Cheeseman 16 March 2022 190/4-193/8](#)

¹⁶³ [INQ000060_090](#) para 4.36

¹⁶⁴ [Dr James Hard 28 March 2022 59/12-61/52](#); [INQ000112_024-025](#); [INQ000112_029-030](#); [Theresa Schleicher 14 March 2022 73/3-74/25](#)

¹⁶⁵ [Dr Husein Oozeerally 11 March 2022 59/23-60/19](#)

subjected to the inappropriate use of segregation and the quick resort to use of force to manage incidents of self-harm and mental health crises. In this way, the practice left vulnerable detained people exposed to the risk of incidents of mistreatment.¹⁶⁶

Further changes required

68. The Inquiry has not heard evidence of any fundamental changes to the system of safeguards since 2017. There has been no amendment to Rule 34 or Rule 35, nor any significant change in relation to their application in practice. There have been no material changes to the Adults at Risk policy, although in 2018 the definition of torture was amended and, since 2018, there have been weekly Adult at Risk review meetings at Brook House with the attendance of Healthcare and Home Office staff.¹⁶⁷

69. The Home Office told the Inquiry that it had made some improvements in the operation of the system of safeguards under Rule 35. In September 2019, the Rule 35 team was introduced. The team was there to provide a consistent and objective assessment of Rule 35 reports for any individual held in immigration detention managed by any detained casework command, by balancing the evidence within the Rule 35 report (and any other indicators of risk that fall within the Adults at Risk in Immigration Detention policy) against immigration factors.¹⁶⁸ The number of Home Office staff in IRCs was increased through the Detention Engagement teams (introduced in late 2017 in London IRCs and in early 2019 nationally).¹⁶⁹ Case progression panels were introduced to consider whether continued detention is appropriate, considering specific issues in relation to any changes in the vulnerability of detained people.¹⁷⁰ Following the 2018 Shaw follow-up report, these panels included independent members. However, despite these improvements, the arrangements remain substantially the same in significant respects.

70. Concerns in these areas were not raised for the first time in this Inquiry. They have been repeated in several reports over many years, such as those by

¹⁶⁶ [Dr James Hard 28 March 2022 178/20-25, 179/7-9](#)

¹⁶⁷ [HOM0332050](#)

¹⁶⁸ [HOM0332174_002-004](#) paras 8-16

¹⁶⁹ [HOM0332174_004](#) para 15

¹⁷⁰ [INQ000156_94-101](#) paras 11.6-11.35

Mr Shaw, by Medical Justice, and in litigation, and they have prompted further action.¹⁷¹

70.1 NHS England commissioned a mental health needs analysis of IRCs in England from the Centre for Mental Health, a think tank.¹⁷² This identified a significant need for low-level interventions (such as relaxation and talking therapies) to enable detained people to manage living with the everyday stress of their uncertain situations. It concluded that there was:

*“limited support available for trauma across the IRCs and the majority of mental health staff we spoke with did not feel confident in assessing or intervening in trauma”.*¹⁷³

The Centre for Mental Health made a range of recommendations, including regular mental health reviews for detained people after 30 days, mandatory induction and annual refresher training in mental health awareness for all IRC staff, and *“robust clinical supervision”* for mental health practitioners working in IRCs.¹⁷⁴

70.2 The Home Office introduced its Adults at Risk policy in September 2016. This was intended to respond to a call by Mr Shaw in a 2016 report for a more dynamic understanding of vulnerability.¹⁷⁵ Mr Shaw identified a number of shortcomings in the way in which the policy was operating and made further recommendations to address them. These included ongoing oversight and monitoring of the policy, a function that was passed to the ICIBI.¹⁷⁶ In a 2018 follow-up report, Mr Shaw noted very little progress on Rule 35:

¹⁷¹ The 2016 Shaw report included a recommendation to replace the Rule 35 process with a new mechanism that would be more reflective of and responsive to the dynamic nature of vulnerability ([INQ000060_102-109](#) paras 4.92-4.121 and recommendation 21). Mr Shaw also noted inconsistencies between different parts of the Home Office overseeing detained people in its assessment of their vulnerability, recommending the introduction of a ‘gatekeeper’ to provide consistency across all directorates with responsibility for detention ([INQ000060_100-101](#) recommendation 20). [BHM000032_047-048](#) paras 139-140

¹⁷² *Immigration Removal Centres in England: A Mental Health Needs Analysis*, Dr Graham Durcan, Jessica Stubbs and Dr Jed Boardman, January 2017

¹⁷³ *Immigration Removal Centres in England: A Mental Health Needs Analysis*, Dr Graham Durcan, Jessica Stubbs and Dr Jed Boardman, January 2017, p35

¹⁷⁴ *Immigration Removal Centres in England: A Mental Health Needs Analysis*, Dr Graham Durcan, Jessica Stubbs and Dr Jed Boardman, January 2017, p39

¹⁷⁵ See *Government Response to Stephen Shaw’s Review into the Welfare in Detention of Vulnerable Persons*

¹⁷⁶ *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-up Report to the Home Office*, Stephen Shaw, July 2018, paras 2.135 and 2.136 and recommendation 14

“In my first report I argued that Rule 35 did not do what is [sic] intended to do, and that the Home Office did not trust the mechanisms it had created to support its own policy (in particular, that there was a lack of trust placed in GPs to provide independent advice). Despite improved training for clinicians, and improved monitoring of the process, nothing I have seen has suggested any fundamental change to this position.”¹⁷⁷

He went on to recommend the introduction of a new body – independent of the casework decision-maker – to oversee Rule 35 decisions.¹⁷⁸

- 70.3** In response to concerns about Brook House, the Home Affairs Select Committee launched its own inquiry into immigration detention. Its recommendations included the abolition of the three levels of risk for adults at risk and a reversion to the previous policy of a presumption not to detain individuals except in very exceptional circumstances.¹⁷⁹
- 70.4** In his 2018 follow-up report, Mr Shaw had recommended that the ICIBI report annually to the Home Secretary on the working of the Adults at Risk process, which the ICIBI agreed to do.¹⁸⁰ By the time of its second annual inspection, covering the period from July 2020 to March 2021, the ICIBI found that the Adults at Risk policy had become embedded.¹⁸¹ However, it considered that there was a widespread tendency within the Home Office to view claims of vulnerability and the use of safeguarding mechanisms as spurious and as a misuse of process.¹⁸² Overall, the ICIBI found that progress on addressing previous recommendations had been slow, with no progress of note in addressing the shortcomings in the application of Rule 35. Recommendation 4.1 called upon the Home Office *“without further delays”* to implement the recommendations in relation to adults at risk that had been set out in previous reports by Mr Shaw, the ICIBI and other statutory bodies. It also asked the Home Office to produce a timetable for this work.¹⁸³ The ICIBI made four recommendations in respect of Rule 35, including rolling out training to GPs, reviewing the effectiveness of Rule 35(1) and Rule 35(2) as

¹⁷⁷ *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-up Report to the Home Office*, Stephen Shaw, July 2018, para 2.145

¹⁷⁸ *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-up Report to the Home Office*, Stephen Shaw, July 2018, paras 2.137-2.149 and recommendation 15

¹⁷⁹ *Immigration Detention – Fourteenth Report of Session 2017–19*, House of Commons Home Affairs Committee, 21 March 2019, p88

¹⁸⁰ *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-up Report to the Home Office*, Stephen Shaw, July 2018, recommendation 14

¹⁸¹ [INQ000156](#)

¹⁸² [INQ000156_012](#) para 3.3

¹⁸³ [INQ000156_016](#) para 4.1

safeguarding mechanisms and widening the list of those medical practitioners qualified to conduct a Rule 35 assessment to include psychiatrists.¹⁸⁴

- 70.5** In January 2023, following a third annual inspection, conducted between June and September 2022, the ICIBI stated: *“the Rule 35 process needs to be called out for what it is – ineffective”*.¹⁸⁵ It noted a focus on torture:

*“From a total of 538 reports received by the Home Office between April and June 2022, 517 were R35(3) (torture), 10 were R35(2) (suicidal intention) and 11 were R35(1) (physical health).”*¹⁸⁶

The report also rejected the *“perception that the Rule 35 process was being abused by detainees”*, referring to *“limited evidence provided to support this assertion”*.¹⁸⁷ Its 10 recommendations – all of which were accepted or partially accepted by the Home Office – included *“an independent review to develop an in-depth, robust understanding of the abuse of Rule 35”*, training *“on the purpose and process of Rule 35”* and expedition of *“the planned review of the Detention Centre Rules which includes the review of Rule 35”*.¹⁸⁸ In relation to training, the Home Office responded that *“elements of this recommendation are already in place with wider training on Rule 35 being a regular component of existing training programmes”* and that it *“has reminded all staff within immigration removal centres (IRC) about the Rule 35 process”*. The Home Office also stated that it:

“has restarted work to review the Adults at Risk in Immigration Detention (AAR) policy and Detention Centre Rules 2001 ... after this was put on pause in 2021 to allow for a wider review of the immigration system ... with the intention of work commencing by the end of the 2022/23 financial year”.¹⁸⁹

- 71.** Regardless of any local improvements that might have been made by healthcare providers and the improvements referred to above made by the

¹⁸⁴ [INQ000156_018](#) para 4.10

¹⁸⁵ *Inspection Report Published: Third Annual Inspection of ‘Adults at Risk in Immigration Detention’, June–September 2022*, Independent Chief Inspector of Borders and Immigration, January 2023; see *Third Annual Inspection of ‘Adults at Risk in Immigration Detention’*, Independent Chief Inspector of Borders and Immigration, January 2023

¹⁸⁶ *Third Annual Inspection of ‘Adults at Risk in Immigration Detention’*, Independent Chief Inspector of Borders and Immigration, January 2023, para 3.5

¹⁸⁷ *Third Annual Inspection of ‘Adults at Risk in Immigration Detention’*, Independent Chief Inspector of Borders and Immigration, January 2023, p2

¹⁸⁸ *Third Annual Inspection of ‘Adults at Risk in Immigration Detention’*, Independent Chief Inspector of Borders and Immigration, January 2023, recommendations 1, 4, 5 and 7 (p3); see also *Home Office Response to the Third ICIBI Inspection of Adults at Risk in Immigration Detention*, Home Office, 12 January 2023

¹⁸⁹ *Home Office Response to the Third ICIBI Inspection of Adults at Risk in Immigration Detention*, Home Office, 12 January 2023

Home Office, in my view there is clearly a deep-rooted, systemic problem in relation to the adequacy of the operation of the safeguards under Rule 35.¹⁹⁰ This reflects the conclusions of the ICIBI in its most recent inspection report, discussed above.¹⁹¹ At Brook House specifically, this was exacerbated by individual poor practice by GPs in the completion of Rule 35 reports.

72. It is clear that the Home Office was aware of the way in which the safeguards in relation to Rule 34 and Rule 35 were operating at Brook House during the relevant period.

72.1 Ms Calver, Head of Healthcare in Brook House during the relevant time and at the time of the Inquiry’s public hearings, told the Inquiry that, as a result of the IRC forum (meetings attended by the Home Office and representatives from IRCs around the country), the Home Office was aware of the approach being taken to Rule 35 reports, including the thresholds being applied for their completion.¹⁹² Ms Calver confirmed the Home Office’s knowledge of the low numbers of Rule 35 reports, alongside 248 ACDTs indicating levels of self-harm and possible suicidality. No concerns were ever raised by the Home Office with Ms Calver concerning the lack of reports under Rule 35(1) and Rule 35(2).¹⁹³ The Home Office took no action. Dr Hard described the number of open ACDTs, the low number of Rule 35(1) reports and the absence of Rule 35(2) reports as “*shocking*”.¹⁹⁴ I agree.

72.2 Dr Oozeerally said that he (and Dr Chaudhary) had raised issues about the Rule 35 process with the Home Office. Dr Oozeerally met with Mr Ian Cheeseman, a policy advisor in the Home Office unit responsible for policy, concerning people deemed to be vulnerable in detention.¹⁹⁵ The Inquiry received emails from Dr Oozeerally to Mr Cheeseman that referenced discussion regarding Rule 35.¹⁹⁶ The Home Office never raised any concerns with Dr Oozeerally concerning the absence of reports under Rule 35(1) and Rule 35(2).¹⁹⁷

72.3 Ms Schleicher told the Inquiry that Medical Justice had repeatedly raised concerns with the Home Office concerning the quality of Rule 35 reports and the subsequent detention reviews. It also raised concerns about the

¹⁹⁰ [Dr Rachel Bingham 14 March 2022 34/4-13](#); [Dr James Hard 28 March 2022 69/3-70/9, 72/17-19](#)

¹⁹¹ [Third Annual Inspection of ‘Adults at Risk in Immigration Detention’](#), Independent Chief Inspector of Borders and Immigration, January 2023, recommendations 1, 4, 5 and 7 (p3); see also [Home Office Response to the Third ICIBI Inspection of Adults at Risk in Immigration Detention](#), Home Office, 12 January 2023

¹⁹² [Sandra Calver 1 March 2022 174/3-175/2, 219/8-220/19, 222/15-21](#)

¹⁹³ [Sandra Calver 1 March 2022 228/23-25](#); see also [Dr James Hard 28 March 2022 81/4-16](#)

¹⁹⁴ [Dr James Hard 28 March 2022 57/17-58/7](#)

¹⁹⁵ [Dr Husein Oozeerally 11 March 2022 108/10-109/20](#)

¹⁹⁶ [DRO000005](#)

¹⁹⁷ [Dr Husein Oozeerally 11 March 2022 61/9-18](#)

risk that having three separate forms (in relation to each of the individual sub-paragraphs of Rule 35) would deter doctors from completing each one; that the forms may mislead doctors into applying too high a threshold; and about the training on Rule 35. Ms Schleicher said that the Home Office response was generally dismissive and no action was taken.¹⁹⁸

73. These examples demonstrate, in my view, an unjustifiable rejection by the Home Office of any criticism or concerns raised. Obvious indications of processes not working as intended, policies not being followed and deficiencies in the operation of the safeguards were ignored. GPs and Healthcare staff in Brook House and Home Office staff failed to apply the safeguards, but the system itself was also dysfunctional. This undoubtedly led to vulnerable people who were at risk of harm being in detention when they should not have been, and without review. Mental and physical health will have deteriorated, and there will have been increased risk of self-harm and suicide, as well as actual distress and harm. Vulnerable people were, accordingly, left susceptible to treatment and abuses of the type seen on the *Panorama* programme, such as inappropriate use of custodial interventions, segregation, use of force, a culture of disbelief and the mischaracterisation of distressed behaviour as refractory (ie deliberate behaviour that has become difficult or impossible to manage on a residential wing). In my view, it is impossible to separate the treatment from the failures in the safeguards. This situation was completely unacceptable.

74. Safeguarding the vulnerable involves the operation of a complex, technical, legal and policy framework. I do not consider that immigration detention practices have significantly or sufficiently evolved to strengthen safeguards for the vulnerable or to detain people only where there is no other option. As these are matters of significant concern, notwithstanding the issuing of a similar recommendation by the ICIBI in January 2023, I am recommending a review of the implementation of Rule 35 across the immigration detention estate.

¹⁹⁸ [Theresa Schleicher 14 March 2022 68/23-70/25](#)

Recommendation 9: Review of the operation of Rule 35 of the Detention Centre Rules 2001

The Home Office must, across the immigration detention estate, assure itself that all three limbs of Rule 35 of the Detention Centre Rules 2001 (reports by a medical practitioner where: (i) it is likely that a detained person's health would be injuriously affected by continued detention (Rule 35(1)); (ii) it is suspected that a detained person has suicidal intentions (Rule 35(2)); or (iii) there is a concern that a detained person may have been a victim of torture (Rule 35(3))) are being followed, are operating effectively, and are adequately resourced, in recognition of the key safeguarding role that the Rule plays.

The Home Office must also regularly audit the use of Rule 35 in order to identify trends, any training needs and required improvements.

Chapter D.6:

Restrictions on detained people

Introduction

1. The Detention Centre Rules 2001 (the Rules) contain powers that restrict the rights of detained people, segregating them from others to some degree.

2. Rule 40 allows the removal of a detained person from association where *“it appears necessary in the interests of security or safety”*. It restricts a detained person’s ability to associate with others in the way usually permitted at a centre. The initial period of authorisation for removal from association can be up to 24 hours, but may be extended to a maximum of 14 days.¹ The Rule 40 power was used on 241 occasions at Brook House during the relevant period (1 April 2017 to 31 August 2017), as recorded by the Home Office and G4S in their combined reports to the Independent Monitoring Board at Brook House (Brook House IMB), when there were, on average, around 450 people detained there.² Detained people were removed from association in situations where, for example, they had been involved in a protest, assaulted a member of staff, refused to leave their cell, damaged property, refused to share a cell, or assaulted or fought with other detained people.³

3. Rule 42 contains a power to confine a *“refractory or violent detained person”* in *“special accommodation”*. Although it is not defined within the Rules, ‘refractory’ is ordinarily understood to refer to someone who is difficult to control or unwilling to obey authority. The power must not be used as a punishment or after a detained person has ceased to be refractory or violent. A detained person cannot be confined under Rule 42 for more than 24 hours without a written direction from an officer of the Secretary of State, who must state the grounds for the confinement and the time during which it may continue (which must not exceed three days).⁴ This power was used twice at

¹ [Detention Centre Rules 2001](#), Rules 40(3) and 40(4)

² As recorded in IMB/G4S combined reports April–August 2017: [IMB000021](#); [IMB000050](#); [IMB000011](#); [IMB000047](#); [IMB000019](#). Average population calculated using the occupancy on the last date of each month reported in those IMB/G4S combined reports

³ [CJS001710](#); [CJS001744](#); [CJS001671](#); [CJS001664](#); [CJS001689](#); [CJS001692](#); [CJS001667](#); [CJS001681](#); [CJS002021](#); [CJS001670](#); [CJS001839](#); [CJS001758](#)

⁴ [Detention Centre Rules 2001](#), Rules 42(3) and 42(4)

Brook House during the relevant period, as recorded by the Home Office and G4S.⁵

4. The purpose of Rule 40 and Rule 42 is to maintain safety (either of the detained person or of others) or security. Their use must, however, be balanced with *“the need to have due regard to the dignity and welfare of the individual”*.⁶ In addition, Rule 40 and Rule 42 *“must be used only as a last resort, when all other options have been exhausted or are assessed as likely to fail or to be insufficient as an effective means to address the risk considered to be presented”* by the detained person.⁷

5. Rule 40 and Rule 42 impose significant restrictions on detained people’s liberty. Accordingly, the Rules strictly define who can authorise their use and in what circumstances they can and cannot be used. Minimum requirements relating to the use of the Rules are set out in the Detention Services Operating Standards Manual for Immigration Service Removal Centres (the Operating Standards Manual, January 2005).⁸ In addition, Detention Services Order 02/2017: Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42) (the Restrictions Detention Services Order (DSO), dated July 2017 and updated in September 2020) sets out further detail about the operation of both Rules.⁹

6. In this chapter, I consider issues relating to the use of Rule 40 and Rule 42 during the relevant period, with a greater focus on removal from association, which was used more frequently at Brook House.

The impact on the detained person

7. The use and misuse of these powers can have very harmful consequences for detained people, particularly those who were already vulnerable or experiencing mental health issues.

8. Dr Rachel Bingham, clinical advisor to Medical Justice (a charity that provides medico-legal reports and advice to detained people), told the Inquiry:

⁵ As recorded in IMB/G4S combined reports April–August 2017: [IMB000021](#); [IMB000050](#); [IMB000011](#); [IMB000047](#); [IMB000019](#)

⁶ [CJS000676_005](#) para 2

⁷ [CJS000676_009](#) para 19

⁸ [Detention Services Operating Standards Manual for Immigration Service Removal Centres](#), January 2005

⁹ [Detention Services Order 02/2017: Removal from Association \(Detention Centre Rule 40\) and Temporary Confinement \(Detention Centre Rule 42\) \(CJS000676\)](#), Home Office, July 2017 (updated September 2020)

“segregation has been associated with worsening symptoms of depression, severe anxiety, psychotic symptoms and exacerbation of post-traumatic stress disorder [PTSD]. Suicidal thoughts and risks of suicide are also increased. In the context of asylum seekers suffering from PTSD, for instance, it can precipitate or intensify the traumatic memories of flashbacks of their past mistreatment and increase their feelings of powerlessness.”¹⁰

9. A number of detained people gave evidence about the severe impact that the use of Rule 40 had had on them.

9.1 D313 was held subject to Rule 40 the night before a proposed deportation flight. He said:

“It was really frightening to be held in isolation at this point. I felt like harming myself ... I was by myself and I was just walking up and down. I had no one to talk to. I was very upset and I was in tears.”¹¹

9.2 D1473 was held subject to Rule 40 after refusing to share a cell with someone he did not know. He said:

“Being segregated made me feel vulnerable and scared again.”¹²

9.3 D1538 was diagnosed with a severe major depressive disorder with psychotic features and dissociative disorder after being released from detention. In relation to Rule 40, he said:

“I hated being put in isolation ... it made me feel like an animal. All you have is the cell – the four walls ... It was very cold. You are alone.”¹³

9.4 D1914 began suffering with serious health issues in 2016 due to a heart condition. Referring to being held subject to Rule 40 the night before his planned removal, he said:

“it made me feel like I had no value, like no-one cared about me or my life”.¹⁴

Authorisation

10. In non-urgent circumstances at a contracted-out immigration removal centre (IRC) such as Brook House, Rule 40 and Rule 42 provide that authorisation may only be granted by the Secretary of State. However, it is well established that the Secretary of State may delegate their functions to an

¹⁰ [BHM000033_062](#) para 157

¹¹ [DL0000233_005](#) para 25

¹² [BHM000039_015](#) para 73

¹³ [DL0000231_008](#) para 34

¹⁴ [DL0000229_044](#) para 159

appropriate Home Office official.¹⁵ While not defined by the Rules, in my view non-urgent circumstances would include, for example, situations where it is known in advance that a detained person would need to be managed under Rule 40 or Rule 42 and so there is time to seek the requisite authority.

11. In cases of urgency, Rule 40 and Rule 42 state that “*the manager of a contracted-out removal centre may assume the responsibility of the Secretary of State*” and authorise the use of those Rules, although they must notify the Secretary of State as soon as possible after making the necessary arrangements.¹⁶ Rule 2 states that “‘*manager*’ means, in relation to any detention centre, the person appointed under section 148(1) of the *Immigration and Asylum Act 1999*”.¹⁷ During the relevant period, the manager of Brook House for these purposes was Mr Ben Saunders, Centre Director for Brook House and Tinsley House IRC (Gatwick IRCs).¹⁸ An urgent use of Rule 40 or Rule 42 might be required where, for example, a fight breaks out or a detained individual or member of staff is assaulted.¹⁹

12. Rule 65 states that the manager of a removal centre may, “*with the leave of the Secretary of State*”, delegate any of their powers under the Rules to another officer of that centre.²⁰ I have not heard or received any evidence to suggest that Mr Saunders ever sought or was granted leave by the Secretary of State to delegate his powers to authorise the use of Rule 40 and Rule 42 to anyone else. Mr Philip Riley (Director of Detention and Escorting Services (DES) within the Home Office) confirmed that the Home Office had been unable to locate any evidence that any such delegation was ever sought by anyone at Brook House under Rule 65 during the relevant period.²¹ I also note that the definition of ‘the manager’ in the *Immigration and Asylum Act 1999* refers to a person in the singular being specifically appointed to undertake that role.²² Taking all of this into account, there does not appear to me to be any basis within the Rules by which anyone other than the manager of Brook House, Mr Saunders, could have authorised urgent use of Rule 40 and Rule 42 at Brook House during the relevant period.

¹⁵ Detention Centre Rules 2001, Rules 40(1) and 42(1). In *TM (Kenya) v Secretary of State for the Home Department* [2019] EWCA 784, the Court of Appeal held that it was lawful for a Home Office Contract Monitor to perform this function

¹⁶ Detention Centre Rules 2001, Rules 40(2) and 42(2)

¹⁷ Detention Centre Rules 2001, Rule 2

¹⁸ KEN000001_001-002 para 3; HOM0332182_003 para 13

¹⁹ Detention Services Order 02/2017: Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42) (CJS000676), Home Office, July 2017 (updated September 2020), p13 footnote 4

²⁰ Detention Centre Rules 2001, Rule 65

²¹ HOM0332174_005-006

²² See section 148 of the Immigration and Asylum Act 1999, which states that “*a manager*” must be appointed for every centre and that person must be a Detention Custody Officer whose appointment has been approved by the Secretary of State

13. Given all the evidence before the Inquiry, and having regard to the wording of the Rules, I consider that use of Rule 40 and Rule 42 should only have been authorised in the following circumstances during the relevant period:

- in normal circumstances, by the Secretary of State (or an appropriate Home Office official to whom the Secretary of State had delegated their powers, such as Mr Paul Gasson, who was the Home Office Contract Monitor at Brook House during the relevant period²³); and
- in cases of urgency, by the G4S Centre Manager (Mr Saunders) where it was impracticable to seek the normal authority in advance.

14. However, the following documents – all of which were issued or agreed by the Home Office – did not appear to me to be consistent with the wording of Rule 40 and Rule 42.

14.1 Between 25 October 2016 and 17 July 2017, an interim instruction issued by the Home Office regarding Rule 40 and Rule 42 was in place.²⁴ It stated:

“Authority for the initial use of Rule 40 or 42 must be granted by an appropriate Home Office Immigration Enforcement Manager of EO [Executive Officer] grade or above in the first instance.”²⁵

This suggested that only Home Office officials could authorise use of the Rules, even in cases of urgency.

14.2 The Operating Standards Manual states that authorisation *“must be with the authority of the contract monitor (in contracted out centres) or the centre manager (in directly managed centres)”*.²⁶ It does not distinguish between cases of urgency and non-urgency, and it may suggest, when taken at face value, that only the Home Office contract monitor could authorise use of the Rules in contracted-out centres, even in cases of urgency.

²³ [HOM0332162_003](#)

²⁴ This interim instruction was issued by the Home Office to provide guidance to IRC managers and Home Office managers in IRCs while a new DSO was being drafted (see [HOM0332182_002](#) para 7; [HOM0332163](#))

²⁵ [HOM0332163](#)

²⁶ [Detention Services Operating Standards Manual for Immigration Service Removal Centres, January 2005, p51](#)

14.3 In July 2017, the Restrictions DSO was introduced, which stated:

“In cases of urgency and if the circumstances are such that it is impracticable to seek the authority required in paragraph 31 in advance, the centre/duty manager ... can make the emergency authorisation so that the authority is considered to begin at that point. In such circumstances, the DES manager (or the DES on-call manager if out of hours) must be notified immediately.”²⁷

This suggested that, in urgent circumstances, the Duty Manager (ie someone other than Mr Saunders in the case of Brook House) could authorise use of the Rules.

14.4 Schedule D of the G4S contract stated:

- In respect of Rule 40: *“In cases of urgency, the Duty Manager may assume the responsibility of the Secretary of State under paragraph (1).”²⁸*
- In respect of Rule 42: *“Temporary Confinement accommodation will only be used for refractory or violent Detainees on the authority of the Secretary of State or, if used in cases of urgency, by the Duty Manager.”²⁹*

This Schedule did not purport to be a formal delegation in accordance with Rule 65, nor did the Home Office seek to suggest that it had this effect.³⁰ The provision suggests that a Duty Manager (ie someone other than Mr Saunders in the case of Brook House) could authorise use of the Rules in cases of urgency. G4S, in its closing submissions to the Inquiry, asserted that the Restrictions DSO provided the leave of the Secretary of State for the purposes of Rule 65.³¹

15. The Inquiry heard and received evidence that gave the impression of widespread confusion and apparent misunderstanding at an organisational level about who could authorise use of the Rules, even among senior managers (who should have had the most comprehensive knowledge of the Rules), at both the Home Office and G4S.

16. Many witnesses believed that Duty Managers and Detention Custody Managers (DCMs) were permitted to authorise use of the Rules. The documents referred to above may have contributed to this confusion.

²⁷ [CJS000676_0012](#) para 32

²⁸ [HOM000798_131](#)

²⁹ [HOM000798_134](#)

³⁰ [HOM0332174_005-006](#)

³¹ [CJS0074153_0066](#) para 188

- 16.1** On behalf of the Home Office, Mr Riley stated that in urgent circumstances, if Mr Saunders was unavailable to provide authorisation, this could be done by the Duty Manager instead.³² His evidence was that, both before and after the introduction of the Restrictions DSO, Duty Managers could authorise urgent use of Rule 40 and Rule 42 where Mr Saunders was unavailable; the Restrictions DSO simply “*further clarified*” that position.³³ This does not appear to be consistent with the content of the various policy documents set out above. In relation to the interim instruction, although its wording suggests that only Home Office officials could authorise use of the Rules, even in cases of urgency, Mr Riley stated that this was not the case and that this instruction did not alter the position as set out in the Rules.³⁴ I consider this to be at odds with the wording of the instruction.
- 16.2** Mr Gasson said that, in cases of urgency, use of Rule 40 could be authorised by a G4S DCM.³⁵ In contrast, Mr Riley accepted that if that was happening, and the DCM was not also the Duty Manager, it was a failure of the system.³⁶ The Inquiry sought clarification of the Home Office’s position in relation to who could authorise use of Rule 40 and Rule 42. Correspondence was exchanged between the Home Office and the Inquiry, yet the responses did not address the inconsistencies between the Home Office’s approach and the wording of Rule 40 and Rule 42; nor did the Home Office’s Closing Statement.³⁷
- 16.3** G4S witnesses also demonstrated a widespread confusion and apparent misunderstanding about who could authorise use of the Rules. For example, Ms Sarah Newland, Head of Tinsley House and a Duty Director at Brook House during the relevant period, told the Inquiry that a Duty Director could authorise use of Rule 40 if it had arisen as a result of a “*spontaneous incident*”, but any planned use “*had to be agreed with the Home Office*”.³⁸ Mr Gordon Brockington, Managing Director of Justice and Government Chief Commercial Officer at G4S, said that Duty Managers would authorise use of Rule 40.³⁹ Mr Saunders and Mr Stephen Skitt (the Deputy Director of Brook House during the relevant period) said that, in cases of urgency, the Duty Manager or Duty Director would grant the authorisation.⁴⁰

³² [HOM0332182_003](#) para 13

³³ [HOM0332182_004](#) para 14

³⁴ [HOM0332182_002](#) para 8

³⁵ [Paul Gasson 15 March 2022 202/10-204/12](#)

³⁶ [Philip Riley 4 April 2022 84/19-22](#)

³⁷ [HOM0332162](#); [HOM0332161](#); [Home Office Closing Statement](#), paras 147-152

³⁸ [Sarah Newland 21 March 2022 212/5-13](#)

³⁹ [Gordon Brockington 31 March 2022 89/20-90/8](#)

⁴⁰ [Ben Saunders 22 March 2022 185/17-18](#); [Stephen Skitt 17 March 2022 183/1](#)

17. Although ‘Duty Manager’ and ‘Duty Director’ were sometimes used interchangeably by witnesses, my understanding is that they refer to different positions. ‘Duty Manager’ referred to the DCM in charge on the particular shift (also known as the designated ‘Oscar 1’), whereas the term ‘Duty Director’ referred to the on-call member of the Senior Management Team responsible for the management of Brook House on a particular shift.⁴¹

18. In any event, a number of witnesses told the Inquiry that DCMs authorised the use of Rule 40 during the relevant period. Mr Saunders, Mr Skitt and Mr Steven Dix (a DCM during the relevant period and now Assistant Director of Brook House) all said that this was the case.⁴² Mr Daniel Haughton, G4S Support Services Manager at Brook House during the relevant period, stated that this was “*standard working practice*”.⁴³

19. This was reflected in documentation reviewed by the Inquiry in respect of 236 uses of Rule 40 during the relevant period. Only four instances were authorised by Mr Gasson.⁴⁴ None was authorised by Mr Saunders.

20. Instead, uses of Rule 40 and Rule 42 were routinely authorised at Brook House by Duty Managers other than Mr Saunders, and by DCMs who were not acting as Duty Managers. For example:

- On 21 June 2017, DCM Michael Yates authorised use of Rule 40 when he was not the Duty Manager.⁴⁵
- On 16 July 2017, DCM Nathan Harris authorised use of Rule 40 when he was not the Duty Manager.⁴⁶
- On 29 August 2017, Mr Dix authorised use of Rule 40 when he was not the Duty Manager.⁴⁷

21. In addition, the Inquiry heard evidence that Rule 40 might have been used in Brook House without Home Office authorisation on the basis of urgency, even where there would have been sufficient time to seek it. For example, following an investigation into an allegedly urgent use of Rule 40 on 3 June 2017 in relation to D1538 (discussed in Chapter C.9 in Volume I of this Report), the Home Office Professional Standards Unit (PSU) concluded that “*sufficient time existed*” on that occasion to allow input into the Rule 40 decision by the Home Office. Its report recorded an action point that

⁴¹ [Sarah Newland 21 March 2022 152/8-17](#)

⁴² [Ben Saunders 22 March 2022 191/14-23](#); [Stephen Skitt 17 March 2022 185/5-7](#); [Steven Dix 9 March 2022 57/21-23, 58/4-15](#)

⁴³ [Daniel Haughton 16 March 2022 121/18](#)

⁴⁴ [CJS001707](#); [CJS001662](#); [CJS001720](#); [CJS001797](#)

⁴⁵ [CJS001232_001](#); [CJS004247](#); [CJS001652_002](#)

⁴⁶ [CJS001704_039](#); [CJS004228](#)

⁴⁷ [CJS001279](#); [CJS001734_004](#)

consideration should be given to clarifying what constitutes cases of urgency.⁴⁸ The PSU report also recorded a Home Office employee saying that they “*would not be involved in the decision*” to place D1538 subject to Rule 40 because he was displaying “*quite aggressive, abusive and threatening behaviour towards centre staff*”.⁴⁹ This showed a misunderstanding of the Rules and led the PSU to conclude:

“Home Office officers appear to be unsure of their responsibility to act as a prime authority in authorising Rule 40 in all circumstances where time allows.”⁵⁰

22. The evidence above suggests to me that Rule 40 and Rule 42 were poorly understood and were being misinterpreted and misapplied routinely at Brook House during the relevant period. The Inquiry has not identified any basis by which Duty Managers or DCMs at Brook House were able to authorise use of Rule 40 and Rule 42 during the relevant period. Given the restrictions that the use of Rule 40 and Rule 42 impose on the liberty of detained people, and the potentially harmful impact of their use on detained people, it is extremely concerning that the strict authorisation criteria were apparently not understood or being adhered to at Brook House.

23. As described above, the belief that Duty Managers and DCMs were permitted to authorise use of Rule 40 and Rule 42 may in part have been perpetuated or contributed to by the terms of the interim instruction, the Operating Standards Manual, the Restrictions DSO and Schedule D of the G4S contract. However, it appears that G4S, including senior members of its staff, did not question or take any steps to address the apparent inconsistency between the wording of those documents and the Rules themselves, or to identify or seek to reconcile the different understandings within G4S of who could authorise use of the Rules.

24. The widespread lack of understanding about who could properly authorise use of the Rules appears to have been perpetuated by inadequate training in that regard. Detention Custody Officer (DCO) Callum Tulley said that in his training they were “*told about rules 40 and 42*” but that he “*didn’t understand why or when they would be applied*”.⁵¹ Mr Haughton said that he gained his understanding of Rule 40 “*in general knowledge of sort of conducting the rule*” and explained that when moving into a more senior role:

“we needed to sort of upskill ourselves slightly in it ... I had no formal training when I moved into the role of DD [Duty Director] on the sort of use of rule 40.”⁵²

⁴⁸ [CJS003348_026](#) para 9.3.2; [CJS003348_026](#) para 9.4.1

⁴⁹ [CJS003348_025](#) para 9.1

⁵⁰ [CJS003348_026](#) para 9.3.2

⁵¹ [Callum Tulley 29 November 2021 56/6-8](#)

⁵² [Daniel Haughton 16 March 2022 121/5-11](#)

25. In terms of present-day practice, Mr Steven Hewer, the current Director of the Gatwick IRCs, stated that any use of Rule 40 is agreed in advance by the Home Office, save in urgent cases, when the use of Rule 40 would be immediately reported to the Home Office to obtain authorisation.⁵³ In urgent circumstances, he considered that a Detention Operations Manager (DOM, formerly DCM) or the relevant assistant director or deputy director could authorise use of Rule 40.⁵⁴ He thought that a “*larger percentage*” of uses of Rule 40 were pre-authorised by the Home Office now, as compared with the relevant period.⁵⁵ At present, authorisation of use of Rule 40 and Rule 42 is informed by the September 2020 edition of the Restrictions DSO.⁵⁶ However, the essential requirements for authorisation, as set out in the Rules, have remained the same since the relevant period. The Inquiry did not receive evidence of any delegation having been sought by Mr Hewer or on behalf of Serco under Rule 65 to enable DOMs (or anyone else) to authorise use of the Rules.

26. While the Inquiry did not examine any recent individual uses of Rule 40 and Rule 42, it is concerning that Mr Hewer’s evidence appears to show the persistence of misunderstandings about who can authorise use of Rule 40 and Rule 42 under Serco, which continue to be perpetuated by the terms of the Restrictions DSO in particular. It is concerning that Serco, like G4S, appears not to have questioned, or taken any steps to address, the apparent inconsistency between the wording of documents produced by the Home Office (including the Restrictions DSO) and the wording of the Rules themselves.

27. It is extremely important that both the Home Office and Serco take steps to ensure that Rule 40 and Rule 42 are used only where permitted by law, which includes proper authorisation. It is also concerning that new management personnel and a new contractor do not appear to have led to correction of the poor institutional understanding of these restrictive powers. Evidence received by the Inquiry suggests that widespread confusion and misunderstanding as to who can authorise use of the Rules persist today, and I am therefore recommending that the Home Office clarify the authorisation process as a matter of urgency.

⁵³ [Steven Hewer 1 April 2022 96/6-23](#)

⁵⁴ [Steven Hewer 1 April 2022 152/1-11](#). The DCM role is now known as DOM by Serco: [Steven Hewer 1 April 2022 12/23-24](#)

⁵⁵ [Steven Hewer 1 April 2022 97/13-16](#)

⁵⁶ [Detention Services Order 02/2017: Removal from Association \(Detention Centre Rule 40\) and Temporary Confinement \(Detention Centre Rule 42\) \(CJS000676\)](#), Home Office, July 2017 (updated [September 2020](#))

Recommendation 10: Clarification on the use of Rule 40 and Rule 42 of the Detention Centre Rules 2001

The Home Office must amend, as a matter of urgency, Detention Services Order 02/2017: Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42) and, if necessary, the Detention Services Operating Standards Manual for Immigration Service Removal Centres, to clarify who can authorise use of Rule 40 and Rule 42 of the Detention Centre Rules 2001, in both urgent and non-urgent circumstances, including providing a definition of the term ‘manager’ in Rule 40(2) and Rule 42(2).

In anticipation of the update to Detention Services Order 02/2017, the Home Office must issue an immediate instruction to communicate this clarification to staff and contractors operating immigration detention centres.

Inappropriate use

28. The Inquiry also received detailed evidence about the ways in which Rule 40 and Rule 42 were used in Brook House. My concerns fall into four key themes:

- the multi-purpose use of E Wing;
- use as a punishment;
- use for administrative convenience; and
- use to manage mental health.

Multi-purpose use of E Wing

29. When a detained person is held under Rule 40 or Rule 42, they must be accommodated in a room designed and certified for that purpose.⁵⁷

30. At Brook House, that was within the Care and Separation Unit (CSU) or the E Wing.⁵⁸ E Wing, which has 13 cells, was also used to house detained people during their first and last nights at Brook House, those at high risk of self-harm, those with medical or mental health concerns and those with a particular vulnerability. Within E Wing, the CSU was behind a steel gate and contained a further six cells.⁵⁹

⁵⁷ [Detention Services Order 02/2017: Removal from Association \(Detention Centre Rule 40\) and Temporary Confinement \(Detention Centre Rule 42\) \(CJS000676\)](#), Home Office, July 2017 (updated September 2020), para 16

⁵⁸ [CJS006043_004](#)

⁵⁹ [Stephen Loughton 1 March 2022 101/8-17; Callum Tulley 30 November 2021 141/5-9](#)

Figure 32: E Wing and entrance to CSU



31. The Inquiry heard conflicting evidence about where detained people subject to Rule 40 were accommodated. DCO David Webb told the Inquiry that if someone was being managed through Rule 40 or Rule 42, they would be in the CSU and not E Wing.⁶⁰ However, his evidence was contradicted by that of Mr Dix, who confirmed that detained people subject to Rule 40 could be placed on E Wing rather than in the CSU.⁶¹ In addition, in its report for the reporting year 2020, the Brook House IMB noted that detained people subject to Rule 40 could be located in the CSU and on E Wing.⁶² In my view, detained people being managed through Rule 40 were housed on E Wing as well as within the CSU.

32. Housing detained people who were being temporarily removed from association or confined as a result of their behaviour under Rule 40 on E Wing resulted in them living alongside vulnerable detained people who were suffering from mental health disorders or who required protection from other detained people. While Sandra Calver (Head of Healthcare at Brook House during the relevant period and at the time of the Inquiry’s public hearings) described E Wing as the “*calmer wing*”, that description was undermined by other evidence to the contrary.⁶³ For example, Reverend Nathan Ward (former

⁶⁰ [David Webb 3 March 2022 100/21-101/2](#)

⁶¹ [Steven Dix 9 March 2016 56/17-20](#). See also, for example: [CJS001753](#); [CJS001643](#)

⁶² [Annual Report of the Independent Monitoring Board at Brook House: For Reporting Year 1 January–31 December 2020](#), IMB, May 2021, p19

⁶³ [Sandra Calver 1 March 2022 166/2](#)

Head of Tinsley House) described a “toxic cocktail” where “the most vulnerable and the most violent” were inhabiting the same space.⁶⁴ Mr Owen Syred (a DCO and Welfare Officer during the relevant period) told the Inquiry that a conflict arose from the multi-purpose use of E Wing and that “people down there didn’t feel safe”.⁶⁵ He said that housing the most vulnerable detained people next to those being managed through Rule 42 “prevented them sleeping, it made them anxious”.⁶⁶ D2033 described being held on E Wing on his first night (not subject to Rule 40 or Rule 42):

“When I arrived at the wing on my first night I realised that the wing I had been placed in was where the troublemakers or disturbed people were, those who were fighting and causing trouble. It was clear that this was an exceptional wing for exceptional people. The reason why I say this is that when I was taken to my room the troublemakers were shouting and banging on the doors to their rooms. The person just next to my room was constantly kicking the door throughout the night. This was very alarming.”⁶⁷

I also consider a number of events that occurred on E Wing in Part C in Volume I of this Report.

33. In my view, there was a failure by G4S to properly consider the impact of this approach on detained people. It appears that this practice continues under Serco’s management of Brook House, as Mr Dix also confirmed that people placed subject to Rule 40 might be put on E Wing rather than in the CSU.⁶⁸ I am therefore recommending that the multi-purpose use of E Wing be reviewed.

Recommendation 11: Review of the use of E Wing at Brook House

The Home Office and the current operator of Brook House must keep under review the appropriateness of the multi-purpose use of E Wing, particularly in relation to its suitability as a location to detain vulnerable people.

⁶⁴ [Reverend Nathan Ward 7 December 2021 171/4-6](#)

⁶⁵ [Owen Syred 7 December 2021 51/9-10](#)

⁶⁶ [Owen Syred 7 December 2021 53/22](#)

⁶⁷ [DL0000149_005](#) para 19

⁶⁸ [Steven Dix 9 March 2016 85/9-18](#)

Use as a punishment

34. As set out in Rule 42 itself and in the Restrictions DSO, neither Rule 40 nor Rule 42 can be used as a punishment.⁶⁹ They must only be used *“as a last resort, when all other options have been exhausted or are assessed as likely to fail or to be insufficient as an effective means to address the risk considered to be presented by the detained individual”*.⁷⁰

35. However, this does not reflect the evidence received by the Inquiry about the use of Rule 40 at Brook House.

35.1 Mr Skitt said that Rule 40 was the *“only policy”* in place to deter poor behaviour.⁷¹

35.2 DCM Nathan Ring described Rule 40 as a *“repercussion”* for misbehaviour by detained people. He initially offered it as an example of an available punishment, although he then added that he did not personally see it in this way.⁷²

35.3 Mr Tulley explained that people would be held subject to Rule 40 for *“refusal to transfer or to be deported or to go down to E wing, or ... non-compliant behaviour, violent behaviour, fighting, protesting ... it was used as a form of punishment”*.⁷³ He said they were explicitly told in their training that *“it was not to be used as a form of punishment, but it was quite obvious that it was”*.⁷⁴

36. There is evidence that suggests that Rule 40 was used as a form of punishment at Brook House during the relevant period.

36.1 D2553 was placed subject to Rule 40 in May 2017 after hiding in another room and causing a delay to a roll count.⁷⁵

36.2 D728 had been placed subject to Rule 40 due to his assessed high risk of self-harm. DCO Charles Francis, attending his cell, said:

⁶⁹ Detention Centre Rules 2001, Rule 42(1); CJS000676_009 para 20. This guidance was expanded in Detention Services Order 02/2017: Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42) (CJS000676), Home Office, July 2017 (updated September 2020), paras 20-26

⁷⁰ CJS000676_009 para 19

⁷¹ SER000455_085 para 322

⁷² Nathan Ring 25 February 2022 18/13-19/1. By contrast, in his witness statement, Mr Ring stated that Rule 40 and Rule 42 were not used as a punishment: MIL000002_009 para 24p

⁷³ Callum Tulley 30 November 2021 143/1-8

⁷⁴ Callum Tulley 30 November 2021 143/10-12

⁷⁵ CJS001753

“Right. If I have to come back here again. You won’t be going anywhere today. You’ll be staying down here permanently. You understand?”⁷⁶

- 36.3** D114 was placed subject to Rule 40 in June 2017 after stealing a box of coffee. Although the reason for removal from association is recorded as being *“to maintain good order within the centre”* after he admitted taking the coffee, it is unclear why that was necessary.⁷⁷
- 36.4** On 4 May 2017, D1527 climbed onto the safety netting and refused to engage with staff members.⁷⁸ After a short while, he agreed to come off the netting and went to his cell to calm down. As recorded in his incident report, Mr Dix later went to D1527’s cell and explained that *“due to his behaviour he would need to comply and go to the CSU on rule 40”*.⁷⁹ However, D1527 had already come off the netting and returned to his cell. There appears to be no basis for Rule 40 being used to justify moving D1527 to the CSU. Mr Dix’s note stated that the move was *“due to his behaviour”*. It suggests that D1527 was moved to the CSU as a punishment. Indeed, this is consistent with Mr Dix’s erroneous belief that Rule 40 was a *“disciplinary process”*.⁸⁰
- 37.** It is clear, therefore, that Rule 40 was improperly used as a punishment by some members of staff at Brook House, even in response to minor behavioural issues, notwithstanding the fact that this was not a permissible use of the Rule. Some staff at Brook House did not have a clear understanding of when Rule 40 could be used, while others may have used Rule 40 because they felt they had no other means of dealing with poor behaviour.⁸¹

Use for administrative convenience

38. While it was permissible, according to G4S policy, to use E Wing to accommodate detained people on their last night in Brook House where it was suspected that they may attempt to disrupt a transfer or removal, the Inquiry received evidence that suggested that some detained people were moved to E Wing and additionally placed subject to Rule 40 seemingly for reasons of pure administrative convenience. This is significant because a detained person held on E Wing under Rule 40 would be restricted in their ability to associate

⁷⁶ [Day 2 PM 24 November 2021 00:38:58-00:53:30 \(KENCOV1044 - V2017070600007\)](#). This incident is discussed in Chapter C.14 in Volume I

⁷⁷ [CJS001690](#)

⁷⁸ An example of what the safety netting looks like can be seen in [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022, p1

⁷⁹ [HOM000319_003](#)

⁸⁰ [SER000455_087](#) para 331

⁸¹ [DL0000141_099](#) para 282

with others and move around the centre.⁸² By contrast, a detained person held on E Wing for other reasons would have full freedom of movement and association within the wing and the remainder of Brook House.

39. DCM Stephen Webb referred to considering using Rule 40 on a detained person as *“killing two birds with one stone”*.⁸³ He explained that this was because the detained person had threatened to self-harm and had a flight the following day.⁸⁴ This appears to suggest the fact that the convenience of placing the detained person subject to Rule 40 the day before the flight was part of the decision to authorise Rule 40.

40. D1914 described being forcibly removed to E Wing and placed subject to Rule 40 in preparation for his planned removal the following day.⁸⁵ It is not clear from the records why D1914 was placed subject to Rule 40. The records state that D1914 was placed subject to Rule 40 for *“refusing to relocate to E Wing”* and to *“maintain good order and discipline of the centre”*.⁸⁶ However, the IS.91RA Part C form records: *“he stated that he would kill himself rather than return to Romania, because of this threat he has now been placed onto ACDT [Assessment Care in Detention and Teamwork] constant supervision and is now on Rule 40”*.⁸⁷ While it may be justifiable in certain circumstances to relocate a detained person to E Wing ahead of their imminent removal, it is not appropriate for that detained person additionally to be managed through Rule 40 while on E Wing where they do not separately satisfy the criteria for Rule 40.⁸⁸ If there was a genuine concern that it was necessary to place D1914 subject to Rule 40 for his own protection (due to the risk of suicide), that should have been made clear in the records. In my view, the documentation gives the distinct impression that D1914 was inappropriately placed subject to Rule 40 as a first response to his suicide threat and/or for the administrative convenience of staff.

41. Similarly, D313 described being held subject to Rule 40 before his proposed flight on 30 May 2017.⁸⁹ It is unclear why this was done.

42. The 2020 IMB report stated that Rule 40 had been simultaneously used on 45 detained people in February 2020 (when Brook House was run by G4S) to manage removals for a charter flight to Jamaica, despite some of these detained people not being scheduled to fly and others having not given any indication that they would resist removal. The Brook House IMB *“questioned*

⁸² [CJS006043_005](#)

⁸³ [CJS004722](#)

⁸⁴ [MIL000003_021](#)

⁸⁵ [DL0000229_040-044](#) paras 142-160

⁸⁶ [CJS001768_002](#)

⁸⁷ [CJS001768_002](#)

⁸⁸ [CJS006043_0004](#)

⁸⁹ [DL0000233_005](#) para 24

whether this pre-emptive use of Rule 40 was justified and unnecessarily inclusive".⁹⁰

43. Mr Hewer's evidence to the Inquiry was that Rule 40 is no longer used pre-emptively in advance of charter flights. He said that it is only used in advance of charter flights as a last resort and, where required, where "*it is appropriate and affects the good order and stability of the centre*".⁹¹ However, the 2021 IMB report concerning both the Gatwick IRCs noted that "*on nine occasions, men have been held in separation to facilitate their removal ... The Board questions the necessity, appropriateness and legality of using Rule 40 as a blanket approach in such circumstances.*"⁹² This appears to question the accuracy of Mr Hewer's evidence on this point. The report also referred to:

*"several instances of men remaining in the CSU after expiry of Rule 40 separation because it has been difficult to determine where, given Covid related restrictions, they could be returned to. While we understand the constraints and have not received any specific complaints from men thus detained, the Board is concerned by this consequence of COVID-19 management. The Home Office and Serco have developed the custom of calling this 'Rule 15', referring we believe to Detention Centre Rule 15, which in fact only concerns the certification of rooms for particular purposes. It does not grant any power to Home Office or Serco to detain a man separate from the facilities of the centre (as the CSU does). We are concerned that keeping men in CSU on 'Rule 15' can amount to de facto separation – for example the gate between CSU and E wing has been locked when Board members have visited men in CSU on 'Rule 15'. 'Rule 15' has also been used to place men in CSU for a short time prior to leaving for a charter flight."*⁹³

44. This more recent evidence indicates that there may be continuing problems with the use of segregation for the convenience of staff under Serco's management of Brook House.

Use to manage mental health

45. It is clear that Rule 40 and Rule 42 should not be used as "*a normal means to manage detainees with serious psychiatric illness or presenting with mental health problems*".⁹⁴

⁹⁰ *Annual Report of the Independent Monitoring Board at Brook House: For Reporting Year 1 January–31 December 2020*, IMB, May 2021, p19

⁹¹ *Steven Hewer 1 April 2022 95/8-96/5*

⁹² *Annual Report of the Independent Monitoring Board at Gatwick IRC: For Reporting Year 1 January–31 December 2021*, IMB, June 2022, p31

⁹³ *Annual Report of the Independent Monitoring Board at Gatwick IRC: For Reporting Year 1 January–31 December 2021*, IMB, June 2022, p8

⁹⁴ *CJS000676_009 para 22*

46. Where detained people are vulnerable:

“Special care and caution is needed in relation to decisions to use Rules 40 and 42 ... Specific account must be taken of any adverse effect that use of the Rules may have on the individual in light of their circumstances and steps should be taken to mitigate any adverse effects.”⁹⁵

The use of Rule 40 and Rule 42 in such cases will be “exceptional”, where it is “justified on the basis of the risk presented”.⁹⁶ This is because particular care is needed to ensure that “the general requirements that use of the Rules is for the shortest time possible and only as a last resort are met in these cases”.⁹⁷

47. Where a detained person is at risk of suicide or self-harm, Rule 40 and Rule 42 should only be used in “exceptional circumstances”, for the “shortest time possible” and “as a last resort where all other options for managing the behaviour have been considered and exhausted, or considered to be inappropriate”.⁹⁸

48. Despite this clear mandatory guidance, there was evidence that Rule 40 and Rule 42 were used inappropriately by some members of staff to manage detained people with mental ill health during the relevant period. Mr Syred said that Rule 42 was used by staff to manage detained people suffering from mental health issues, and he thought that this was because those detained people were inherently difficult to manage.⁹⁹ Dr Bingham noted that there was evidence, for example, that D1255 was moved to the CSU for three days under Rule 40 for his “own protection” after he displayed “strange behaviour” and self-neglect, which was causing issues with other detained people.¹⁰⁰ DCO Ryan Bromley admitted that he was “quite possibly” aware that it was common for people who were at risk of self-harm to be moved to E Wing under Rule 40, rather than just being moved there.¹⁰¹

49. Dr Bingham said it was not only that segregation was not a mental health treatment, but also that it was “worse than nothing, because it’s actually something that would harm [their] mental health”.¹⁰² Nonetheless, Dr Bingham noted that:

⁹⁵ [CJS000676_009](#) para 22

⁹⁶ [CJS000676_009](#) para 22

⁹⁷ [CJS000676_009](#) para 22

⁹⁸ [CJS000676_010](#) para 25

⁹⁹ [Owen Syred 7 December 2021 59/19-24](#)

¹⁰⁰ [BHM000033_065](#) para 165; [CJS001665](#)

¹⁰¹ [Ryan Bromley 7 March 2022 109/16](#)

¹⁰² [Dr Rachel Bingham 14 March 2022 54/5-8](#)

*“a recurrent pattern that emerges on the available evidence is the use of segregation, both under the rule 40 and 42 safeguards and held on E wing, as a mechanism to manage detainees suffering from mental illness or risk of suicide and harm”.*¹⁰³

Dr Hindpal Singh Bhui, Inspection Team Leader at HM Inspectorate of Prisons (HMIP), agreed that Rule 40 was not appropriate for people with mental health difficulties.¹⁰⁴

50. It is particularly concerning that this approach was still pervasive during the relevant period, as the 2016 IMB report specifically noted:

*“the use of the CSU for detainees with mental health issues continues to reflect a worrying lack of specialist accommodation within the detention estate and the wider NHS ... The IMB remains clear in its view that the CSU is not an appropriate location for detainees with mental problems. It simply represents the least worst option.”*¹⁰⁵

The following year, the Brook House IMB noted that this inappropriate use of the Rules persisted.¹⁰⁶

51. Mr Riley accepted that repeated comments of this nature by the Brook House IMB were *“a concern”*.¹⁰⁷ I would go further. It is unacceptable that concerns about the use of Rule 40 on detained people with mental health issues were specifically raised in two consecutive Brook House IMB reports, and yet the Home Office and G4S failed to adequately address those concerns.

52. In addition, the monitoring of detained people under Rule 40 by healthcare staff at Brook House was itself also inadequate. Healthcare staff failed to adequately identify concerns about detained people’s suitability for being subject to the continued use of those Rules.

53. Paragraph 88 of the Restrictions DSO clearly states:

*“Healthcare staff must assess the physical, emotional and mental wellbeing of the detainee and whether any apparent clinical reasons advise against the continuation of separation.”*¹⁰⁸

Despite this, Dr Husein Oozeerally, lead GP at Brook House during the relevant period and at the time of the Inquiry’s public hearings, told the Inquiry that his role when doing a daily visit to assess a detained person for continued use of Rule 40 was *“not to run an entirely clinical and full assessment especially if*

¹⁰³ [BHM000033_063](#) para 158

¹⁰⁴ [Dr Hindpal Singh Bhui 24 March 2022 181/5-12](#)

¹⁰⁵ [IMB000121_016](#) para 5.7.5

¹⁰⁶ [VER000138_014](#) para 6.5

¹⁰⁷ [Philip Riley 4 April 2022 78/23-24](#)

¹⁰⁸ [CJS000676_025](#) para 88

[the detained person] *had no clinical issues they were raising*".¹⁰⁹ He added that he had never advised that a detained person should be taken off Rule 40 on medical grounds, although he said that if he noticed someone was getting worse, he "*might speak with the security team*" or the Home Office.¹¹⁰ Dr Saeed Chaudhary, also a GP at Brook House, admitted that he did not recall making himself aware of Rule 40 and Rule 42 before he started work there, and he took the lead from Dr Oozeerally in terms of the processes to be followed.¹¹¹

54. Dr Bingham considered that there was a failure by healthcare staff to identify concerns about unsuitability for detention on E Wing in relation to people with mental illness.¹¹² Ms Calver disputed this and stated that E Wing would be the best environment for those detained people.¹¹³ However, she accepted that this would not be the case where E Wing also held violent or refractory detained people or those resisting their removal.¹¹⁴ As is set out above, the Inquiry found that this was often the case.

55. Mr Hewer's evidence was that under Serco's management of Brook House, Rule 40 is "*not particularly*" used for detained people with mental health problems.¹¹⁵ He said that E Wing or the CSU would be used to hold such people on a case-by-case basis, depending on the circumstances and the vulnerabilities of the individual, although the CSU would rarely be used for this purpose.¹¹⁶ He said that there are circumstances where a detained person has not been violent but, because of their vulnerabilities, they are taken to E Wing or the CSU and assessed on a case-by-case basis, because those wings are quieter areas of Brook House.¹¹⁷ It is unclear if the practices in relation to segregation of those with mental health problems have materially changed since 2017. To the extent that Rule 40 and Rule 42 are still being used to manage detained people with mental ill health in a manner that is not in accordance with the Restrictions DSO, that remains inappropriate. The Home Office and Serco should seek to assure themselves that the practice is not continuing. In my view, the use of segregation in the management of those vulnerable to a risk of self-harm and suicide, and those with mental health issues – whether informally on E Wing or formally under Rule 40 or Rule 42 – should urgently be reviewed by the Home Office and Serco. The Inquiry also heard evidence of inadequate monitoring of those who had been segregated

¹⁰⁹ [Dr Husein Oozeerally 11 March 2022 165/8-10](#)

¹¹⁰ [Dr Husein Oozeerally 11 March 2022 167/13-168/5](#)

¹¹¹ [Dr Saeed Chaudhary 11 March 2022 182/22-183/16](#)

¹¹² [BHM000033_063](#) para 158

¹¹³ [Sandra Calver 1 March 2022 170/6-14](#)

¹¹⁴ [Sandra Calver 1 March 2022 170/17-21](#)

¹¹⁵ [Steven Hewer 1 April 2022 97/23](#)

¹¹⁶ [Steven Hewer 1 April 2022 97/25-98/3](#)

¹¹⁷ [Steven Hewer 1 April 2022 98/10-20](#)

during the relevant period by healthcare staff, including by GPs who, at the time they gave evidence to the Inquiry, still worked at Brook House and still did not have an adequate understanding of their duties and obligations under the Rules.¹¹⁸

Conclusion on the inappropriate use of Rule 40 and Rule 42

56. The Inquiry received evidence that suggested that Rule 40 and Rule 42 were poorly understood, misinterpreted and routinely misapplied. I consider that those working at Brook House – under G4S and Serco – did not have a clear understanding of the circumstances in which these Rules could be used and who could authorise their use. This was widespread, extending even to senior staff. The attitude of some was cavalier.

57. While Rule 40 and Rule 42 serve a legitimate purpose when used correctly, the Inquiry received evidence that they have been used to inappropriately deal with those with mental health conditions. Rule 40 appears to have been used to punish detained people and for the administrative convenience of staff. The Inquiry also received evidence of the harmful impact that the multi-purpose use of E Wing had on detained people. A further concern about the use of Rule 40 is the fact that, at times, detained people were forcibly moved to the CSU or E Wing, and so the use of Rule 40 created a situation where force was used, when it may not otherwise have been required.¹¹⁹ This further demonstrates why it is so important that Rule 40 and Rule 42 should only be used where appropriate. I am therefore recommending that action be taken to improve the understanding of staff, both from the Home Office and from contractors, about the proper operation of these Rules.

¹¹⁸ [KENCOV1034 - V2017061100005](#); [Dr Husein Oozeerally 11 March 165/8-165/10, 167/3-168/5](#); [Dr Saeed Chaudhary 11 March 182/22-183/16](#); [BHM000033_063](#) para 158

¹¹⁹ See, for example, [CJS005614](#); [CJS005623](#); [CJS005530](#); [CJS005589](#); [CJS005650](#); [CJS005575](#)

Recommendation 12: Training in relation to Rule 40 and Rule 42 of the Detention Centre Rules 2001

The Home Office and contractors operating immigration removal centres must provide regular training, at least annually, on the operation of Rule 40 and Rule 42 of the Detention Centre Rules 2001, which must include:

- that Rules 40 and 42 are the only powers under which detained people in immigration removal centres can be removed from association and/or located in temporary confinement;
- who is permitted to authorise use of those Rules and in what circumstances they may be authorised;
- that Rules 40 and 42 cannot be used as a punishment or solely for administrative convenience before a planned removal or transfer; and
- the need to assess any adverse effect that use of Rule 40 or Rule 42 could have on a detained person's physical or mental health, and to consider any steps that could be taken to mitigate those effects.

Attendance must be mandatory for all staff working in immigration removal centres and those responsible for managing them. The training must be subject to an assessment.

Reporting and oversight

58. The use of Rule 40 and Rule 42 must be “recorded” and also notified to the Secretary of State, as well as “without delay” to “a member of the visiting committee [the IMB], the medical practitioner and the manager of religious affairs”.¹²⁰ The Restrictions DSO clarifies that notification to those listed in the Rules must take place “no later than 2 hours after a detainee is located under Rule 40 or 42 accommodation”.¹²¹ It also states that “centre suppliers must notify” the Home Office Detainee Escorting and Population Management Unit (DEPMU) of any instance of a detained person being managed under Rule 40 or Rule 42.¹²² The detained person should also be provided with reasons for that decision in writing within two hours of being relocated under either Rule.¹²³

¹²⁰ Detention Centre Rules 2001, Rules 40(3), 40(8), 42(6) and 42(7)

¹²¹ CJS000676_017 para 55

¹²² CJS000676_018 para 57. The DEPMU is responsible for determining whether those involved in deportation cases should be detained in prison or in IRCs

¹²³ CJS000676_016 para 52; Detention Centre Rules 2001, Rule 40(6)

Contractor monitoring

59. The contractor of Brook House, formerly G4S and now Serco, has a responsibility under the Restrictions DSO to report on the use of Rule 40 and Rule 42. The Restrictions DSO states that each IRC must “*have in place arrangements for monitoring the use of Rules 40 and 42 accommodation*”.¹²⁴ Contractors must submit daily reports on the use of Rule 40 and Rule 42 accommodation, which must be summarised and escalated by the Home Office service delivery manager of each IRC to the Home Office’s Head of Detention Operations every week. Contractors are also required to compile monthly summary data on the number of individuals managed in Rule 40 and Rule 42 accommodation, the number of occasions on which Rule 40 and Rule 42 were used and the length of time spent in Rule 40 and Rule 42 accommodation.¹²⁵ Since the latest edition of the Restrictions DSO was published in September 2020, an annual self-audit of the Restrictions DSO must now also be undertaken by contractors to ensure that the Restrictions DSO processes are being followed.¹²⁶

60. Mr Brockington’s evidence was that G4S was satisfied that:

*“it had systems in place during April to August 2017 for monitoring Rule 40 and 42 and that they were used appropriately by staff. Senior and Duty Managers engaged with Home Office staff as these were the only grades able to authorise Rule 40 and 42, and this was subject to daily scrutiny and appropriate challenge from IMB members.”*¹²⁷

Notwithstanding Mr Brockington’s evidence, I consider that G4S’s monitoring of the use of Rule 40 and Rule 42 was plainly inadequate because G4S failed to identify and act upon any of the significant issues identified by the Inquiry in relation to the use of Rule 40 and Rule 42, set out above. In addition, the fact that the Inquiry has identified a number of areas where issues in the operation of Rule 40 and Rule 42 may be persisting under Serco suggests that there is likely to be room for improvement in Serco’s internal monitoring of Rule 40 and Rule 42.

¹²⁴ [CJS000676_026](#) para 98; [Detention Services Order 02/2017: Removal from Association \(Detention Centre Rule 40\) and Temporary Confinement \(Detention Centre Rule 42\) \(CJS000676\)](#), Home Office, July 2017 (updated [September 2020](#)), para 108

¹²⁵ [CJS000676_026-027](#) para 98; [CJS000676_027](#) para 99; [Detention Services Order 02/2017: Removal from Association \(Detention Centre Rule 40\) and Temporary Confinement \(Detention Centre Rule 42\) \(CJS000676\)](#), Home Office, July 2017 (updated [September 2020](#)), paras 108 and 109

¹²⁶ [Detention Services Order 02/2017: Removal from Association \(Detention Centre Rule 40\) and Temporary Confinement \(Detention Centre Rule 42\) \(CJS000676\)](#), Home Office, July 2017 (updated [September 2020](#)), para 113

¹²⁷ [CJS0074041_040](#) para 199

Home Office

61. Mr Philip Schoenenberger, Head of the DEPMU during the relevant period, confirmed that the DEPMU was told when Rule 40 or Rule 42 were used, with individual entries recorded on its computer system. However, he added that the DEPMU would “*absolutely not*” have been able to spot any trends in the way that Rule 40 was being used.¹²⁸ He explained that there were no means of collating Rule 40 statistics or analysing trends on its system.¹²⁹ It is unclear what purpose the notification of use of the Rules to the Home Office served, because it did not have a system to undertake any generalised monitoring. This was a systemic failure in the Home Office’s oversight function.

62. Mr Riley explained that, in October 2017, the DES Head of Operations reminded centre managers at each IRC of the requirement to compile monthly data on Rule 40 and Rule 42. A review of Rule 40 and Rule 42 in February 2018 by the DES Audit and Assurance Team found that the processes set out in the Restrictions DSO were not always being followed across the immigration detention estate. As a result, in April 2018, the DES Head of Operations wrote to centre managers and Home Office service delivery managers to remind them of their responsibilities.¹³⁰

63. In addition, Mr Riley told the Inquiry that he had seen correspondence from as recently as July 2019 in which colleagues from DES and Home Office Commercial decided to penalise G4S for basic, fundamental failings in the operation of Rule 40 and Rule 42, including the inaccurate completion of records.¹³¹ This demonstrates that known failings in the operation of Rule 40 and Rule 42 had not been adequately addressed by G4S, or indeed by the Home Office, as late as July 2019.

64. Although the Home Office identified failings in compliance with Rule 40 and Rule 42 and related guidance, very little substantive action was taken and the Home Office undertook no generalised monitoring. Oversight and monitoring by the Home Office should have been an important means of protecting the rights of detained people, but it was not undertaken with the required rigour by individual members of staff or, more significantly, at an institutional level within the Home Office. This was a significant failing on the part of the Home Office.

65. Under the Serco contract, there is a key performance indicator regarding compliance with DSOs and the Rules, which would allow the Home Office to impose a financial penalty in the event of a breach of such requirements.¹³²

¹²⁸ [Philip Schoenenberger 23 March 2022 95/22-97/1](#)

¹²⁹ [Philip Schoenenberger 23 March 2022 97/3-10](#)

¹³⁰ [HOM0332005_015](#) para 44

¹³¹ [HOM0332005_015](#) para 45

¹³² [SER000226_218](#)

Independent Monitoring Board

66. Whenever a detained person is held subject to Rule 40 or Rule 42, the Rules currently require that the IMB should be given notice and visit them within 24 hours.¹³³ The requirement is important because visits provide an opportunity to detect issues with the treatment of detained people and the administration of Rule 40 and Rule 42. The IMB also has a right to report directly to the Secretary of State if it finds conditions within the IRC or the treatment of detained people to be unsatisfactory.¹³⁴

67. Ms Jacqueline Colbran, Chair of the Brook House IMB during the relevant period, said that there were “*very, very few instances*” during the relevant period where it was not informed of a use of Rule 40, and that those “*would have been raised with management*”.¹³⁵ However, she admitted that the Brook House IMB did not check any individual uses of Rule 40, for example, to satisfy itself that it had been appropriate to use the Rule. She said:

*“We wouldn’t ... look into the decision, no. We would ideally see the person and there was an opportunity there for them to tell us things, but, no, we didn’t check that out.”*¹³⁶

Ms Colbran could recall only one instance where a colleague from the Brook House IMB challenged an individual decision to invoke Rule 40, as well as an occasion in February 2017 where she questioned the increased use of Rule 40 at a meeting of the Brook House IMB.¹³⁷

68. Despite the lack of scrutiny of individual uses of Rule 40, in its report for the reporting year 2017, the Brook House IMB concluded:

*“The increase in the use of Rule 40 is potentially worrying, but we have no evidence that this rule has been used indiscriminately or inappropriately. From the reasons recorded for the use of Rule 40, reporting suggests that its use has been reserved for occasions on which detainees have behaved in a clearly unacceptable way. Other aspects of our monitoring, such as conversations with detainees and officers involved, support this finding.”*¹³⁸

Ms Colbran conceded that the conclusion that Rule 40 had been reserved for detained people behaving in a clearly unacceptable way was not entirely accurate, because the Rule was very occasionally also used for detained people who were at risk. It is unclear whether Ms Colbran condoned the use of Rule 40

¹³³ [Detention Centre Rules 2001](#), Rule 62; [IMB000183_014](#); [IMB000203_026](#) para 82

¹³⁴ [IMB000183_006-007](#)

¹³⁵ [Jacqueline Colbran 25 March 2022 63/1-11](#)

¹³⁶ [Jacqueline Colbran 25 March 2022 64/14-21](#)

¹³⁷ [Jacqueline Colbran 25 March 2022 66/9-127](#); [IMB000026_003](#); [IMB000204_035](#) para 105; [IMB000062_002](#)

¹³⁸ [IMB000135_0013](#) para 6.3

on detained people who were at risk.¹³⁹ In any event, it is difficult to see how the Brook House IMB could consider that its monitoring supported a conclusion that Rule 40 was reserved for occasions when detained people were behaving in a clearly unacceptable way, in light of Ms Colbran’s admission that the Brook House IMB did not look into individual decisions to use Rule 40.¹⁴⁰

69. Ms Mary Molyneux (subsequent Chair of the Brook House IMB and current member of the Gatwick IRCs IMB) stated that now, when it receives a call to say that Rule 40 has been exercised, it will ask for more information. However, she said that this was not at *“the level of analysis, but there is certainly more information gathering or trying to understand what’s happened”*.¹⁴¹

70. Visits to detained people who were the subject of these Rules were not always carried out within 24 hours, as Ms Molyneux explained:

“given the number of instances of Rule 40 being used, the number of IMB volunteers, and the fact that these notifications came several times a week at all hours of the day and night, it was not possible to visit every man placed on Rule 40 within 24 hours”.¹⁴²

She emphasised that, even today, it was not possible to visit all the detained people managed under Rule 40 and Rule 42, although she was aware that it was a legal requirement to do so.¹⁴³

71. The Home Office and G4S were both aware that the Brook House IMB was not always able to visit every detained person placed subject to Rule 40 and Rule 42 within 24 hours, and the Home Office has declared its intention to update the Rules in this regard.¹⁴⁴ However, no new rules have been laid before Parliament by the Government and it is entirely unclear why important legislation governing the IMB’s safeguarding role has not been updated for so long. This issue is analysed further in Chapter D.11 of this Report.

HM Inspectorate of Prisons

72. HMIP is an independent arm’s-length body sponsored by the Ministry of Justice.¹⁴⁵ It aids HM Chief Inspector in meeting the responsibility to report on the treatment of detained people and conditions of detention, including in IRCs.¹⁴⁶ HMIP’s role is to ensure independent inspection of places of detention,

¹³⁹ [Jacqueline Colbran 25 March 2022 70/13-23](#)

¹⁴⁰ [Jacqueline Colbran 25 March 2022 63/20-24](#)

¹⁴¹ [Mary Molyneux 25 March 2022 137/8-138/20](#)

¹⁴² [IMB000203_026](#) para 82

¹⁴³ [Mary Molyneux 25 March 2022 136/7-18](#)

¹⁴⁴ [IMB000199_006-007](#) para 17; [IMB000199_015](#) para 44

¹⁴⁵ [HMIP000683_003](#) para 6

¹⁴⁶ [HMIP000683_002](#) para 5

report on conditions and treatment, and promote positive outcomes for those detained and the public.¹⁴⁷

73. Dr Singh Bhui told the Inquiry that when HMIP conducted inspections, it considered *“a sample of cases to work out whether or not separation has been justified”*.¹⁴⁸ He said he was sure that HMIP would have considered whether, in those cases, the detained person was put on Rule 40 with the correct authority. He assumed that, because the issue of authorisation of uses of Rule 40 was not raised in the October–November 2016 HMIP inspection report, it was not a concern for the inspector.¹⁴⁹ Despite the significant body of evidence demonstrating that authorisation of the use of Rule 40 and Rule 42 was a serious issue at Brook House during the relevant period (which was only five months after HMIP’s 2016 inspection), no such issue was identified by HMIP.

74. The HMIP 2016 inspection report commented:

*“The regime for separated detainees remained poor: they did not have televisions, radios, books or other means of distraction. The unit was austere with dirty toilets and cells which required painting.”*¹⁵⁰

The May–June 2019 HMIP inspection report noted that conditions *“were reasonable. It was clean and reasonably bright and rooms were appropriately furnished.”*¹⁵¹ However, it also recorded that:

*“Cells had no televisions and, although we were told that detainees were given a radio on request, we saw no record of this or of detainees being given books or other means of distraction. Detainees were assessed for access to the regime; however, there was little evidence in records that separated detainees had received a significant regime.”*¹⁵²

75. In HMIP’s latest report, following its inspection of Brook House in May–June 2022, it was noted that:

*“It was a concern that the [CSU] had held a number of detainees with poor mental health, including at least one who was considered unfit for detention.”*¹⁵³

¹⁴⁷ HMIP000683_003 para 7

¹⁴⁸ Dr Hindpal Singh Bhui 24 March 2022 179/13-19

¹⁴⁹ Dr Hindpal Singh Bhui 24 March 2022 180/10-17; HMIP000613

¹⁵⁰ *Report on an Unannounced Inspection of Brook House Immigration Removal Centre 31 October–11 November 2016*, HM Chief Inspector of Prisons, March 2017, para S10

¹⁵¹ *Report on an Unannounced Inspection of Brook House Immigration Removal Centre 20 May–7 June 2019*, HM Chief Inspector of Prisons, September 2019, para 1.65

¹⁵² *Report on an Unannounced Inspection of Brook House Immigration Removal Centre 20 May–7 June 2019*, HM Chief Inspector of Prisons, September 2019, para 1.68

¹⁵³ *Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 (HMIP000702)*, HM Chief Inspector of Prisons, September 2022, para 2.45

“Most paperwork we reviewed showed reasonable grounds for separation and reviews were thorough. However, we looked at two cases where the justification for separation was weak – both cases involved segregating the victims of an assault.”¹⁵⁴

“There was little oversight of segregation, with no regular meetings or analysis of data to look into its use.”¹⁵⁵

It therefore appears that many of the concerns noted by the Inquiry still persist under Serco’s operation of Brook House.

76. While the HMIP 2022 inspection report demonstrates that greater consideration is being given by HMIP to the inspection of the use of Rule 40 and Rule 42, this remains an area where greater scrutiny by HMIP would be beneficial. In particular, the HMIP 2022 inspection report did not identify the apparent ongoing misunderstandings among Serco staff in relation to the authorisation of use of Rule 40 and Rule 42 about which the Inquiry heard evidence.¹⁵⁶

Improving oversight

77. In addition to ongoing monitoring by the contractor of an IRC in a contracted-out centre, with oversight by the Home Office, the IMB and HMIP are important safeguards to ensure the proper operation of Rule 40 and Rule 42 and to protect those subject to them. I consider that there is room for improvement in the operation of these critical oversight functions, and I am therefore recommending that steps be taken to facilitate that improvement.

Recommendation 13: Audit of use of Rule 40 and Rule 42 of the Detention Centre Rules 2001

The Home Office must regularly (and at least quarterly) audit the use of Rule 40 and Rule 42 across the immigration detention estate, in order to identify trends, any training needs and required improvements.

In addition, HM Inspectorate of Prisons and the National Chair and Management Board of Independent Monitoring Boards must review processes to consider how they fulfil their oversight role in respect of Rule 40 and Rule 42, and report on the monitoring of the use of Rules 40 and 42 going forward.

¹⁵⁴ *Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022* (HMIP000702), HM Chief Inspector of Prisons, September 2022, para 2.46

¹⁵⁵ *Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022* (HMIP000702), HM Chief Inspector of Prisons, September 2022, para 2.49

¹⁵⁶ *Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022* (HMIP000702), HM Chief Inspector of Prisons, September 2022

Chapter D.7:

Use of force

Introduction

1. The term ‘use of force’ has a particular meaning in the context of immigration detention.¹ Force is only allowed to be used by officers on detained people in particular circumstances, and as a last resort. The legal and policy framework surrounding the use of force is technical, but this should not detract from the human impact it has on those who are subject to it, even when used legitimately. Where force is used unnecessarily, inappropriately or excessively it clearly has the potential to cause serious harm and has, therefore, been a critical focus of this Inquiry.

2. The Inquiry heard evidence that an unauthorised and potentially highly dangerous technique was used on several occasions during the relevant period from 1 April 2017 to 31 August 2017. In addition, there was considerable evidence that, during many incidents, officers were too quick to employ force. Attempts to de-escalate incidents were often non-existent. This included the unnecessary use of Personal Protective Equipment (PPE). Furthermore, on occasions, detained people were faced with officers wearing balaclavas. These are not approved PPE for local interventions.² There was no apparent justification or consideration of the impact of wearing inappropriate PPE on detained people. Most concerning, force was routinely used on mentally unwell and vulnerable detained people.

3. The serious problems with the way force was used at Brook House were neither identified nor rectified, because the system of reviewing and monitoring use of force incidents was completely ineffectual. There is no specific detention services order (DSO) that governs use of force in immigration removal centres (IRCs). Use of force in IRCs is governed in part by a prison service order (PSO), Prison Service Order 1600: Use of Force (the Use of Force PSO).³ The Use of Force PSO was developed for use in the prison estate and does not appear to have been drafted for the purpose of governing use of force in the immigration detention estate.⁴ This, in my view, is inappropriate. IRCs are not prisons and there are fundamental differences between the two environments and the needs of the people held within them.

¹ [Detention Centre Rules 2001](#), Rule 41

² [Jonathan Collier 30 March 2022 79/21-80/18; INQ000111_40](#) para 153

³ [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005

⁴ [INQ000250](#) paras 6-7

4. This chapter will address:

- how, when and why force should be used (the legal and policy framework);
- how, when and why force was in fact used at Brook House (the evidence considered by the Inquiry); and
- concerning themes arising from the evidence.

Legal and policy framework

5. Rule 41 of the Detention Centre Rules 2001 states that force must not be used:

*“unnecessarily and, when the application of force to a detained person is necessary, no more force than is necessary shall be used”.*⁵

It also provides that no officer shall act deliberately to provoke a detained person.

6. There are specific situations within an IRC where force is allowed.

6.1 The Detention Services Operating Standards Manual states that *“no more force than necessary will be applied”*, and:

*“The Centre will ensure that force is used only when necessary to keep a detainee in custody, to prevent violence, to prevent destruction of the property of the removal centre or of others and to prevent detainees from seeking to prevent their own removal physically or physically interfering with the lawful removal of another detainee.”*⁶

It should *“only be used as a measure of last resort”*.⁷

6.2 The Use of Force PSO also states that force is justified and lawful only if:

- it is reasonable in the circumstances;
- it is necessary;
- no more force than necessary is used; and
- it is proportionate to the seriousness of the circumstances.⁸

⁵ [Detention Centre Rules 2001](#), Rule 41

⁶ [INQ000050_076](#) standard and para 1 (see [Detention Services Operating Standards Manual for Immigration Service Removal Centres](#), January 2005)

⁷ [INQ000050_076](#) para 2 (see [Detention Services Operating Standards Manual for Immigration Service Removal Centres](#), January 2005)

⁸ [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, para 2.2

- 6.3** The Use of Force PSO states that ‘control and restraint’ (often referred to as C&R) techniques – a type of use of force – are *“used as a last resort in order to bring a violent or refractory prisoner under control. The techniques are applied for as short a time as is possible.”*⁹
- 6.4** The training on use of force provided to staff is the same training provided to prison officers. It is set out in the Use of Force Training Manual, produced by the National Offender Management Service.¹⁰
- 7.** There must also be a system for recording use of force and monitoring its use.¹¹
- 8.** The Use of Force PSO states: *“Prior to intervention in a planned incident the supervisor must ... consider the use of a video camera to record the intervention and relocation.”*¹² Use of a surveillance camera system, including body worn cameras (ie cameras worn on the body in an overt capacity by a user for the primary purpose of recording video and audio material), must be in accordance with all relevant legislation.¹³ Further guidance is also contained in Body Worn Video Cameras (Prison Service Instruction 04/2017) and Detention Services Order 04/2017: Surveillance Camera Systems (February 2018), as discussed below.

The evidence considered by the Inquiry

Types of evidence

- 9.** The Inquiry reviewed a wide range of documentation concerning use of force incidents, including:
- Use of Force reports completed by Detention Custody Officers (DCOs) that detailed their accounts of what had happened;
 - debrief forms in which an officer reflected on what had happened;
 - electronic logbooks in which G4S recorded and summarised each incident by month;
 - Use of Force review meeting forms, which were handwritten single-page forms in which Detention Custody Manager (DCM) Stephen Webb (a C&R instructor and coordinator) reviewed the documentation for each use of force;

⁹ [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, pp9-10

¹⁰ [Use of Force Training Manual \(NOM000001\)](#), National Offender Management Service, December 2015

¹¹ [INQ000050_076](#)

¹² [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, Annex F

¹³ [Detention Services Order 04/2017: Surveillance Camera Systems](#), Home Office, February 2018, paras 2, 4. Relevant legislation includes the Data Protection Act 1998, the Regulation of Investigatory Powers Act 2000, the Freedom of Information Act 2000, the Human Rights Act 1998 and the Protection of Freedoms Act 2012

- complaints by detained people and investigations carried out in response; and
- contemporaneous footage of incidents, including covert footage taken by DCO Callum Tulley, and video evidence from body worn cameras, handheld cameras and CCTV.

10. The Inquiry instructed an expert on the use of force, Mr Jonathan Collier, to review 43 use of force incidents and consider:

- whether force was necessary, reasonable and proportionate in each incident;
- general themes on the use of that force (including the adequacy of the recording and reviewing of incidents); and
- the suitability of the current use of force model, particularly for vulnerable detained people.¹⁴

Evidence of training at Brook House

11. The Initial Training Course (ITC), which staff were required to complete before the Home Office allowed them to engage in DCO duties, included 32 hours of training on C&R and personal protection.¹⁵ All DCOs and DCMs were required to complete annual C&R refresher training of eight further hours, and were not allowed to undertake frontline operational duties without this refresher training.¹⁶ A video was shown during training which emphasised that certain actions carry particular medical risks, such as putting pressure on the throat and neck area during a restraint.¹⁷

12. The Inquiry heard evidence from members of staff who felt that the quality of the training they received on use of force was good.¹⁸ However, as discussed below, some staff were rightly concerned that there was a particular gap in the training concerning using force against people with mental ill health.¹⁹

¹⁴ [INQ000111](#), [INQ000158](#) and [INQ000177](#)

¹⁵ [CJS0074041](#) para 48; [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, para 7.1; [CJS0074041](#) paras 48-70

¹⁶ [CJS0074041](#) para 55

¹⁷ [INQ000111_018](#) para 41

¹⁸ [David Webb 3 March 2022 121/20-122/4](#); [INN000013_011](#) para 34

¹⁹ For example, [Steven Dix 9 March 2022 6/2-18](#); [Ioannis Paschali 24 February 2022 21/9-20](#); [Nathan Ring 25 February 2022 55/13-22](#); [Stephen Loughton 1 March 2022 102/22-103/4](#); [Charles Francis 3 March 2022 8/5-8](#); [Julian Williams 16 March 2022 60/3-9](#); [Daniel Haughton 16 March 2022 149/14-152/18](#); [Stewart Povey-Meier 17 March 2017 4/3-5/12](#)

Evidence of when and why force was used

13. The G4S contract to manage Brook House replicated the requirement in the Detention Services Operating Standards Manual for IRCs that force should only be used in certain situations, as set out above.²⁰

14. Whenever a member of staff finds it necessary to use force, they are required to record the circumstances that led up to the use of force, the type of force that was used, and why it was used.²¹

15. Based on the Inquiry's review of Use of Force reports completed by G4S officers, there were 109 use of force incidents recorded as occurring during the relevant period, when there were on average around 450 people detained at Brook House.²² The number of use of force incidents recorded at Brook House varied from month to month – from 30 in April 2017 to 11 in August 2017.²³ The majority were recorded as unplanned incidents (ie when force was reported to have been spontaneous or responsive to an unforeseen situation). Examples included the prevention of self-harm or assault, or for the personal safety of officers.²⁴ However, G4S also recorded that “*by far*” the most common reason provided by officers for force being used was to “*maintain good order and discipline*”.²⁵

Concerning themes

16. At the end of 2016, HM Inspectorate of Prisons (HMIP) recommended that “*all use of force should be necessary, proportionate and competently applied*”.²⁶ The inspectors concluded that “*there was a mixed practice*” at Brook House in November 2016, as Dr Hindpal Singh Bhui (Inspection Team Leader at HMIP) confirmed in his oral evidence to the Inquiry.²⁷ Such a basic recommendation on such a fundamental issue ought not to be necessary. However, unfortunately the evidence provided to the Inquiry demonstrates that these issues, and many more, were prevalent during the relevant period, a few months after HMIP made this recommendation.

²⁰ [HOM000916_126](#); see [INQ000050_76](#) para 1

²¹ [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, para 8.2

²² Average population calculated using the occupancy on the last date of each month reported in IMB/G4S combined reports April–August 2017: [IMB000021](#), [IMB000050](#), [IMB000011](#), [IMB000047](#), [IMB000019](#)

²³ [CJS000905_006](#); [CJS000619_009](#)

²⁴ [INQ000111_011-012](#) paras 19-20. See [Jonathan Collier 30 March 2022 91/7-10](#); [INQ000111_012](#) para 24

²⁵ [CJS000905_006](#); [CJS000908_010](#); [CJS000914_008](#); [CJS000910_010](#); [CJS000619_10](#)

²⁶ [CJS000761_026](#) para 1.58

²⁷ [Dr Hindpal Singh Bhui 24 March 2022 133/15-19](#); [CJS000761_026](#) para 1.53

17. A number of concerning themes arise from the evidence. These include the nature and purpose of the use of force, those against whom force was used, the monitoring and oversight of its use, and the rules currently in place for using force in IRCs.

Force used in order to provoke and punish

18. The most serious use of force incident took place on 25 April 2017 against D1527, and was the centrepiece for the *Panorama* programme.

18.1 During this incident, force was used on D1527 despite the fact that he was vulnerable due to suffering from mental ill health, and despite his obviously distressed state.

18.2 I consider that DCO Ioannis (Yan) Paschali deliberately, and with an intention to provoke and punish D1527 for what Mr Paschali considered poor behaviour, placed his hands around D1527's neck while threatening to harm him, uttering in D1527's ear, "*You fucking piece of shit, because I'm going to put you to fucking sleep.*"²⁸ Mr Collier's view was that this language was "*provoking, disrespectful and unprofessional*".²⁹ Rule 41 of the Detention Centre Rules 2001 forbids an officer from acting in a way that deliberately provokes a detained person.

18.3 Concerningly, none of the officers filled out any use of force paperwork. As discussed below, there was a widespread issue with officers not completing Use of Force reports, even when they participated in use of force incidents. DCO Charles Francis and DCO Clayton Fraser, who were involved in the incident, accepted that they had not completed Use of Force reports but said that this was not because Mr Paschali, or anyone else, instructed them not to.³⁰ However, Mr Tulley, who was also involved in the incident, told the Inquiry that he interpreted Mr Paschali's comment "*no use of force, as it stands*" as an instruction not to fill out a Use of Force report.³¹ In addition, staff who were involved in or witnessed the incident did not make any serious attempt to intervene, nor did they report Mr Paschali's actions after the incident occurred. As noted in Chapter C.4 in Volume I, I consider this to be the most extreme and disturbing incident involving a detained person at Brook House about which the Inquiry heard evidence.

²⁸ [Day 2 AM 24 November 2021 00:53:55-01:23:53 \(KENCOV1007 - V2017042500021\)](#)

²⁹ [INQ000111_018](#) para 51

³⁰ [Charles Francis 3 March 2022 71/12-76/8](#); [Clayton Fraser 28 February 2022 85/7-92/15](#)

³¹ [Day 2 AM 24 November 2021 00:53:55-01:23:53 \(KENCOV1007 - V2017042500021\)](#); [Callum Tulley 9 March 2022 106/14-107/13](#); [TRN0000002_014](#)

Use of an unauthorised technique and staff incompetence

19. In a number of use of force incidents, staff struggled with “*basic techniques*”.³² Mr Collier noted that often there was poor understanding and execution of techniques within the training syllabus, notwithstanding that mistakes may be made when transferring skills from the classroom to the operational environment.³³

20. On several occasions, staff used an unauthorised technique that had been removed from the Use of Force Training Manual because it had been found to be dangerous – namely, the handcuffing of detained people with their hands secured behind their back when seated.

21. This practice was removed from the Use of Force Training Manual in 2015, following the death of Mr Jimmy Mubenga on 12 October 2010, after being restrained by G4S officers.³⁴ In his evidence to the Inquiry, Mr Collier explained that, by forcing the torso forwards, there is a risk of restricting oxygen to the detained person and thereby causing serious injury or death (this is sometimes referred to as ‘positional asphyxia’, whereby a person’s ability to breathe is impeded because of the way they are being restrained).³⁵ Before Mr Mubenga’s death, an instruction had been issued by G4S staff to all DCOs directing that they were not to leave a detained person handcuffed to the rear for this reason.³⁶ From January 2016, the fact that this technique had been removed from the Use of Force Training Manual would have been included in the instructor revalidation course and the initial training and yearly refresher training for DCOs. Therefore, from at least 2016 officers ought to have known of this change.³⁷ Despite this, G4S officers continued to use this technique at Brook House during or close to the relevant period, including against D1234 on 28 March 2017, D1914 on 27 May 2017, D149 on 31 May 2017 and D2054 on 28 June 2017.³⁸ No reason has been given as to why this dangerous technique continued to be used by G4S officers. It is also concerning that, even when the Professional Standards Unit (PSU) investigated complaints about incidents

³² [INQ000111_159](#) para 667

³³ [INQ000111_013](#) para 29; [INQ000111_146](#) para 637

³⁴ [Jonathan Collier 30 March 2022 51/24-52/25](#); [NOM000001_080-081](#) 166; [INQ000111_044, 075, 158](#) paras 166, 300 and 662

³⁵ [Jonathan Collier 30 March 2022 51/24-25, 52/1-25, 53/1-12](#); [Inquest into the Death of Jimmy Kelenda Mubenga Report by the Assistant Deputy Coroner, Karon Monaghan QC Under the Coroner’s Rules 1984, Rule 43](#) p25 para 68

³⁶ [Inquest into the Death of Jimmy Kelenda Mubenga Report by the Assistant Deputy Coroner, Karon Monaghan QC Under the Coroner’s Rules 1984, Rule 43](#) p25 para 68

³⁷ [Jonathan Collier 30 March 2022 52/18-25, 53/1-12](#)

³⁸ [HOM002496](#); [CJS005574](#); [INQ000111_027](#) paras 86, 88; [INQ000111_042](#) para 151; [INQ000111_075](#) para 300; [CJS0073730 \[Disk 23 S1940003\]](#); [Disk 50 UOF 134.17 cam 3](#); [CJS0074062 \[Disk 53 S2120003\]](#); [CJS0073736 \[Disk 27 28 June 2017 2221BWVC DCM Aldis\]](#)

where the technique was used, it did not identify the dangers that were associated with it.³⁹

22. Additionally, at times, staff used authorised techniques that became dangerous due to their incompetent application. Mr Collier reported:

“the lack of knowledge [of officers] does not help in providing a safe environment and as evidenced can be potentially injurious during difficult restraints”.⁴⁰

23. The use of force against D149 on 31 May 2017 included staff employing a variety of techniques wrongly and incompetently, which could have caused injury.

23.1 D149 was kept in the ‘prone position’ (lying flat on his stomach) longer than necessary.⁴¹ The prone position should only be used if necessary, and time spent in the position must be minimised as there is a risk of positional asphyxia.⁴² Indeed, Mr Collier warned: *“Prolonged restraint in the prone position has been identified by medical experts as a contributing factor in restraint related deaths.”*⁴³ Similar to using handcuffs on a detained person who is seated, this is a medical risk, given its potential for serious harm or death. The review process did not identify this as an issue, and lessons were not learned. In my view, Mr Stephen Webb’s review of this particular incident (as C&R coordinator) was perfunctory and wholly inadequate. Mr Webb ought to have identified training needs and lessons learned. Without additional training, a similar situation at a later date could have resulted in serious injury or, as had already occurred in the case of Mr Mubenga, a fatality.⁴⁴

23.2 Staff appeared unsure how to exit safely with D149 from the cell where the restraint took place, and positioned themselves incorrectly. Because of this, officers tried to compensate by forcibly pulling on the detained person’s legs, which also meant his feet were twisted, causing pain. Officers appeared to be *“lost and lacking in knowledge”* about how to carry out the techniques.⁴⁵

23.3 Although it was reasonable for DCO David Webb to use a pain-inducing technique (PIT) to bend D149’s hand towards his wrist (known as a

³⁹ [Helen Wilkinson 24 March 2022 59/9-24](#); [HOM002750_009](#) para 6.2.15; [HOM002750_026](#) para 6.16.10, [HOM002750_029](#) para 7.2.6; [HOM002750_036](#) para 8.1; [CJS005991_022-024](#) paras 7.5-7.5.12

⁴⁰ [INQ000111_146](#) para 637

⁴¹ [INQ000111_027](#) para 86

⁴² [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, paras 3.1 and 3.10, Annex D p34

⁴³ [INQ000111_024](#) para 69

⁴⁴ [INQ000111_024](#) para 69; [INQ000111_027](#) para 88

⁴⁵ [INQ000111_023](#) para 66

‘wrist flexion’), it was not applied in accordance with the guidance in the Use of Force Training Manual.⁴⁶ No warning was given beforehand explaining that Mr Webb would apply the PIT, and the relevant instruction was not repeated before applying it.⁴⁷

23.4 After the incident, Mr Tulley asked Mr Webb: “*Did you manage to get any digs in?*”, and he replied:

*“I fucking hurt him bruv, big time. I put him in a restraint hold and they heard him in the office downstairs screaming. Put my weight behind him. Nothing personal but if you’re going to be a fucking dick it’s going to hurt isn’t it.”*⁴⁸

It is possible that, in making these comments, Mr Webb was saying that he had used the PIT, and force more generally, deliberately to inflict pain above and beyond what is permitted in the Use of Force Training Manual. I cannot be sure whether he was simply posturing about this incident, or whether in fact he was betraying his true actions and intentions. Either way, Mr Webb’s attitude and comments were completely inappropriate.

(A detailed summary of the Inquiry’s factual findings regarding this incident can be found in Chapter C.7 in Volume I.)

24. A refresher course for new joiners after six months in the role, as Mr Collier suggested, may be helpful.⁴⁹ However, a lack of refresher training for new joiners cannot account for all incidents in which staff employed techniques wrongly, since all were supervised by a more senior DCM.⁵⁰ Given the number of troubling incidents, it may be that a poor standard of training contributed to the low level of staff competency when employing particular techniques.

25. On several occasions, staff at Brook House used an unauthorised technique to handcuff detained people with their hands secured behind their back when seated, which poses a risk of causing positional asphyxia. Officers ought to have known that this was unauthorised by at least 2016, but it was used against D1234 on 28 March 2017, D1914 on 27 May 2017 and D2054 on 28 June 2017 (as discussed in Chapters C.2, C.6 and C.13 in Volume I, respectively). No reason has been given as to why this dangerous technique continued to be used by G4S officers. Therefore, I am recommending that the Home Office ensure that staff at all IRCs are aware that the application of handcuffs behind the back while a person is seated is not permitted.

⁴⁶ [NOM000001_022-023, 185-198](#)

⁴⁷ [INQ000111_026](#) para 89; [NOM000001_022-023, 185-198](#)

⁴⁸ [TRN0000088_020](#)

⁴⁹ [INQ000111_146](#)

⁵⁰ See in particular where an unauthorised technique was used in Chapters C.2, C.6 and C.13 in Volume I

Recommendation 14: Handcuffing behind backs while seated

The Home Office and contractors operating immigration removal centres must ensure that all staff are aware that the technique of handcuffing detained people with their hands behind their back while seated is not permitted, given its association with positional asphyxia.

Use of force not as a last resort

26. There was considerable evidence that, during many incidents, officers were too quick to employ force. Indeed, force was used on these occasions as a first resort rather than a last resort. During the relevant period, de-escalation techniques were either not used at all or were not used for long enough. It appears that, even at DCM level, there was a lack of understanding of how to de-escalate a situation and explore all other reasonable options before using force.⁵¹ Two incidents exemplify this.

27. The first incident is the use of force on D1978 on 23 May 2017, after D1978 apparently refused to move to the Care and Separation Unit (CSU).

27.1 Video footage shows DCM Steven Dix going to the doorway of D1978's cell and saying to D1978 that he had "*one last chance to come out and walk. Yes or no?*".⁵² However, the footage does not show D1978 being offered a chance to walk prior to this. When Mr Dix received no reply, he turned his back towards the door. At this point, other officers rushed in wearing full PPE, including shields. Mr Dix said "*no, no, no*" to the officers, indicating that he knew it was too soon for the officers to go in. D1978 was led out while saying to the officers, "*why are you doing this?*" Force was not used as a last resort on this occasion, and was unnecessary and disproportionate in the circumstances, as D1978 was being compliant.

27.2 Mr Dix should have been more assertive when telling staff what to do. He also ought to have given D1978 more time and opportunity to walk out of the door compliantly. As Mr Collier noted, Mr Dix "*mismanaged*" the situation by allowing staff to enter and restrain D1978.⁵³ Mr Dix agreed that he had controlled the situation poorly, but said that he had been trying to stop the officers going into the cell because the detained person was complying.⁵⁴

⁵¹ [INQ000177_016](#) para 82

⁵² [Disk 48 20170523210142_e1606N_0013.mov](#)

⁵³ [INQ000111_097](#) para 398

⁵⁴ [Steven Dix 9 March 2022, 70/7-71/14, 74/8-12](#)

- 28.** Another troubling feature about Mr Dix's behaviour in this incident is that, in both his incident statement and the debrief following the incident, he gave a very different version of events from what can be seen in the footage.
- 28.1** In the incident statement, he justified force by stating that it was necessary because D1978 was not complying.⁵⁵ In the debrief, he said that D1978 started to "*encroach*" towards him and he had "*no option*" but to deploy the team.⁵⁶ In his oral evidence to the Inquiry, Mr Dix claimed what he had said on the debrief was a "*mistake*" and that it had "*slipped [his] mind*" that he had told officers not to go in.⁵⁷ When asked how that was possible, he blamed a lack of training on how to be a supervisor and said that it would not have happened had there been a proper review of the situation.⁵⁸
- 28.2** His explanation is not credible. It is unclear how additional training might have helped him tell the truth about what had happened. The fact that D1978 was complying is unlikely to have slipped his mind when providing the debrief, given that the incident had only just happened – it was a crucial feature of the incident. It is also unclear how a "*proper review*" of the incident could explain why he gave a different version of events in the debrief. A review of the officers' witness statements and footage would have come after the debrief, and therefore this would not have changed Mr Dix's behaviour in the debrief, which would have already happened.
- 28.3** This incident brings into question Mr Dix's honesty and integrity. As mentioned above, the video footage clearly does not show D1978 "*encroaching*" officers as Mr Dix claimed in the debrief. It shows Mr Dix trying to stop officers who were rushing into the cell because force was not necessary. It is clear to me that Mr Dix lied in the incident statement and debrief to cover up the fact that force was not used as a last resort and was disproportionate. This calls into question whether other witness statements and debriefs written or led by Mr Dix may also be unreliable. It is particularly troubling that such a senior member of staff, both then as a DCM and now as Assistant Director of Brook House, should lie about such a significant event. It provides little confidence that the issues this Inquiry has investigated have since been addressed.
- 28.4** Had there been a proper procedure for reviewing incidents, a reviewer would most likely have quickly concluded that the account given in the incident statement and debrief was not aligned with the actual events.⁵⁹

⁵⁵ [CJS0074374_003](#)

⁵⁶ [Disk 48 V20170523210142_E1606N_0013](#)

⁵⁷ [Steven Dix 9 March 2022 71/18-74/7](#)

⁵⁸ [Steven Dix 9 March 2022 73/5-74/7](#)

⁵⁹ [Jonathan Collier 30 March 2022 89/20-24](#)

However, a comprehensive review did not occur and so this lie was not exposed.

29. Another concerning example of where force was not used as a last resort was during an incident involving D687 on 13 May 2017 (also discussed in Chapter C.5 in Volume I).

- 29.1** D687 was due to be transferred from Brook House to another IRC. Staff from Tascor, an escort contractor, were ready and waiting to transfer him. Covert footage shows D687 being found in an accessible toilet sitting on the edge of the toilet holding a ligature around his neck.⁶⁰ The ligature was attached to the wall behind him approximately a foot above his head. He told G4S staff that he no longer wanted to live, expressed frustration at the length of time he had been detained, and said he did not want to be moved. This conversation lasted around 11 minutes.
- 29.2** At this point, Mr Daniel Haughton, Support Services Manager acting as Duty Director, leant towards D687 and offered to light his cigarette as a ploy to move closer to him and initiate a restraint. Force was then initiated and D687 was handcuffed.
- 29.3** It is difficult to see from the footage what exactly happened during the restraint. In his statement, D687 said that after Mr Haughton removed the ligature, all the other officers then *"instantly charged"* at him.⁶¹
- 29.4** After approximately 90 seconds, D687 said, with some urgency, *"Get off my fucking arm, bruv. I'm on the cuffs."* For approximately 40 seconds he told DCM Shane Farrell to stop resting on his arm and that he was going to break it. D687 said in his statement that he did not understand why the officers were still on top of him when he was calm and was already handcuffed.⁶² D687 wrote that it appeared to him that the officers were *"prolonging the incident, during which I was in pain and struggling to breathe"*.⁶³ D687 added that it was at this point that he recalled what he described as: *"Someone putting what felt like all their body weight through my arm, which is behind my back."*⁶⁴ He added:

*"The pain was really intense and completely unnecessary. As I say, I had already been restrained and was in handcuffs. I think it was done just to cause me pain."*⁶⁵

⁶⁰ [Day 2 PM 24 November 2021 14:37-32:06 KENCOV1016 - V2017051300011](#)

⁶¹ [DPG000021_073-074](#) para 210

⁶² [DPG000021_074](#) para 211

⁶³ [DPG000021_074](#) para 211

⁶⁴ [DPG000021_074](#) para 211

⁶⁵ [DPG000021_074](#) para 211

- 29.5** After being held face down on the floor, D687 was then brought to his feet and led to Reception.
- 29.6** In his statement, D687 stated that the officers made efforts to talk with him but that he felt: *“None of them got it.”*⁶⁶ He described some of the officers as calm but recalled DCM Christopher Donnelly commenting that if D687 dropped his weight onto the ligature: *“Then we’ll wait for a minute until you pass out and then we’ll cut you down.”* This comment can be heard on the footage. D687 said in his statement that this remark *“added to my feeling of worthlessness”*.⁶⁷
- 30.** Having reviewed this incident, Mr Collier found that force was not used as a last resort, since Mr Haughton was:

*“intent on resolving the situation by any means possible, evidenced by him taking a colleague’s fish knife and using a diversionary tactic to cut the noose. Staff appeared surprised by his actions which lead me to assume there was no warning of his intentions. Negotiation and persuasion should have continued, especially as the incident was contained and not effecting [sic] the regime ... I do not believe that the restraint was necessary in the first place as engagement was taking place and staff could react if the threat to D687 escalated.”*⁶⁸

Mr Collier concluded:

*“In order for force to be lawful it has to be when there is an imminent risk of harm and that all other options have been exhausted. The engagement should have continued with an aim for D687 to remove the ligature and be escorted peacefully. It is accepted that escort staff were waiting but negotiation and persuasion must always be the prime resolution option.”*⁶⁹

31. I agree. Staff, and in particular Mr Haughton, having begun a conversation with D687, should have continued with efforts to de-escalate the situation. In his oral evidence to the Inquiry, Mr Haughton said he had intended to act in the *“best interests of everyone there to sort of bring that to a quick and safe resolution”*.⁷⁰ He accepted that, because of the way the ligature was secured to the wall, the risk of self-strangulation was low if D687 had released his weight onto it.⁷¹ It is clear from the covert footage of the incident that D687 was not posing a threat to the safety of the officers who were talking to him. It is also clear from their positions in the room that they

⁶⁶ [DPG000021_073](#) para 209

⁶⁷ [DPG000021_073](#) para 209

⁶⁸ [INQ000111_60-61](#) paras 238-239

⁶⁹ [INQ000111_055-057](#) para 220

⁷⁰ [Daniel Haughton 16 March 2022 110/25-111/3](#)

⁷¹ [Daniel Haughton 16 March 2022 111/18-112/3](#)

were not anticipating that force was needed. Mr Haughton accepted that, in failing to communicate his intentions to his colleagues, he placed them in a situation where they had to react spontaneously. He maintained that it had never been his intention to use force against D687 but merely to remove the ligature.⁷² Force, in these circumstances, was not used as a last resort, and may well have made D687 feel humiliated and frightened.

32. Evidence that the same officers were repeatedly being chosen to conduct planned use of force incidents is also troubling.⁷³ This was a contributory factor to some elements of the toxic culture that is discussed in Chapter D.9. Staff who carried out repeated uses of force because they were the ‘go-to’ officers were at risk of becoming traumatised and desensitised. This reinforced the ‘us and them’ culture, in which officers felt alienated from the detained people who were in their care. Force may have been more readily used as a consequence. Having the same officers involved in use of force incidents also reinforced cliques among staff, since they did not feel that all officers were doing their “*fair share*” of use of force incidents.⁷⁴ The Inquiry was encouraged to learn from the 2022 HMIP inspection report that officers who repeatedly use force now have a formal review.⁷⁵

33. It is clear that force was sometimes used at Brook House against detained people as the first, rather than last, resort. Alternatives to force, such as de-escalation techniques and negotiation skills, should be prioritised and emphasised in training. Force should only be used when these alternatives have been exhausted. It is a coercive tool which, even if used correctly, carries a risk of injury. The Inquiry is therefore recommending that these principles are confirmed through the issue of further instructions.

Lack of de-escalation: inappropriate use of Personal Protective Equipment

34. PPE is described in the Use of Force PSO as:

- “● *Short shield / mini shield (may be carried by the number 1*
- *Helmets*
- *Shin / knee guards*
- *Forearm guards*

⁷² [Daniel Haughton 16 March 2022 110/2-11](#)

⁷³ For example, [John Connolly 2 March 2022 165/14-167/7, 205/22-207/3](#); [Derek Murphy 2 March 2022 6/20-10/11](#); [IPA000001_002](#) para 11

⁷⁴ For example, [Ioannis Paschali 24 February 2022 31/5-12](#); [Daniel Small 28 February 2022 160/4-11](#)

⁷⁵ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre, 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022, p12, para 1.13

- *Gloves*
- *Flame retardant overalls (if required)*".⁷⁶

Figure 33: Examples of officers wearing PPE



35. The guidance on the use of PPE in the Use of Force PSO states:

*"It is recommended that all staff are provided with, and wear protective equipment in planned C&R incidents."*⁷⁷

36. C&R is the practice of the techniques described in the Use of Force Training Manual.⁷⁸ Basic C&R techniques are used by a team of three officers (with the option of having another person involved to control the legs) in order

⁷⁶ Prison Service Order 1600: Use of Force (INQ000185), HM Prison Service, August 2005, p39

⁷⁷ Prison Service Order 1600: Use of Force (INQ000185), HM Prison Service, August 2005, p39

⁷⁸ NOM000001

to manage a violent or refractory prisoner.⁷⁹ The Use of Force Training Manual provides that “*there may be occasions*” when PPE “*must*” be used, such as where the person is behaving aggressively, is known to be aggressive or has, or is likely to have, weapons.⁸⁰ The Use of Force PSO provides that:

*“The Supervising Officer will decide whether to remove some items of protective equipment (eg. helmet, shield) before escorting a prisoner through an establishment. Normal practice would be to remove shields and helmets.”*⁸¹

37. However, during planned incidents at Brook House during the relevant period, full PPE was routinely worn – even where the detained person offered little threat of violence to officers but simply was not complying with an order. Mr Collier provided examples of at least five incidents where, in his view, PPE could have been removed during the incident to de-escalate the situation.⁸²

38. It is difficult to communicate effectively while wearing helmets and visors, and it can give a frightening impression to the detained person subject to force and to the rest of the detained population.⁸³ Wearing balaclavas during use of force incidents is not appropriate for “*local planned interventions*” as they are intended only to be used by specially trained HM Prison Service staff responding to serious incidents of concerted indiscipline (such as a riot).⁸⁴ Despite this, DCO Derek Murphy wore a balaclava in an incident involving D1234 on 28 March 2017 (see Chapter C.2 in Volume I). In my opinion, this was entirely inappropriate and suggests a disregard for the impact that it would have on a detained person. Each incident should be judged individually and PPE should be worn only when necessary. The removal by staff of PPE – particularly helmets, shields and gloves – is also a tool for de-escalation following the initial intervention in a use of force incident.⁸⁵

39. Mr Collier also expressed concern that there was a “*cultural process of automatically resorting to PPE*” among Brook House staff.⁸⁶ The Inquiry heard evidence from DCM Stephen Loughton and DCM Nathan Ring that they believed PPE should always be worn for planned use of force incidents, and that only

⁷⁹ [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, p10 paras 4.22-4.23

⁸⁰ [NOM000001_201](#) para 8.1

⁸¹ [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, Annex F

⁸² [INQ000111_145-146](#) para 636 (use of force incidents involving D1914 on 27 May 2017 [134/17], D1234 on 28 March 2017 [81/17], D2054 on 28 June 2017 [162/17, 86/17 and 108/17])

⁸³ [Jonathan Collier 30 March 2022 78/19-79/20; DL0000143_012](#) para 44

⁸⁴ [Jonathan Collier 30 March 2022 79/21-80/18; Callum Tulley 1 December 2021 23/7-24/1 and 42/1-16; INQ000111_042](#) para 153; [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, p13 para 4.58

⁸⁵ [INQ000111_029](#) para 101

⁸⁶ [INQ000111_156](#) para 658 (incidents 164/17 and 165/17)

“full” PPE was ever worn – as Mr Ring put it, “no half measures”.⁸⁷ This understanding is misconceived.⁸⁸ Once any risk of violence had been reduced, PPE should have been removed. Mr Collier suggested that, as an absolute minimum, the helmet and gloves should be removed when moving through Brook House.⁸⁹

40. In the footage reviewed by the Inquiry, PPE was never removed during an incident in order to de-escalate a situation.⁹⁰ In my view, the wearing of full PPE appeared to have the opposite effect on detained people – escalating the tension when this was unnecessary. There should always have been a dynamic assessment of risk to consider whether full PPE was in fact necessary, so that full PPE was not resorted to when partial or no PPE could be worn.

41. Mr Collier made a recommendation that scenario-based training should include training on planned use of force incidents and where it is not appropriate to wear PPE, or where PPE can be removed as a de-escalation technique.⁹¹ Mr Steven Hwer (current Director of Brook House and Tinsley House immigration removal centre, known together as Gatwick IRCs) told the Inquiry that there is a “blanket policy” in place so that full PPE is still used for every incident for all planned uses of force.⁹² While Mr Hwer explained that he considered this was necessary in order to protect staff, I am disappointed that he did not address the significance of PPE from a detained person’s perspective.

42. The use of PPE (particularly helmet, gloves and shield) by IRC staff during use of force incidents can be unnecessarily intimidating for detained people and can hamper communication and efforts to de-escalate a situation. The removal of PPE during an incident can be effective in de-escalating the incident.

Use of force against naked detained people

43. Force was used inappropriately against naked detained people. In his oral evidence, Mr Collier commented that there were “unusually high” instances of this – possibly due to the timing of removals (eg early morning when a detained person was more likely to be in a state of undress).⁹³ It is important that there are guidelines in place to protect the dignity of detained people in these circumstances. It is clear that a strategy did not exist, which

⁸⁷ [Stephen Loughton 1 March 2022 109/19-110/20](#); [Nathan Ring 25 February 2022 107/8-15](#)

⁸⁸ [Jonathan Collier 30 March 2022 75/20-76/15](#)

⁸⁹ [INQ000111_152-153](#) para 650

⁹⁰ [Jonathan Collier 30 March 2022 79/21-80/24](#)

⁹¹ [INQ000111_152](#) recommendation 6, para 650

⁹² [Steven Hwer 1 April 2022 144/20-146/9](#)

⁹³ [Jonathan Collier 30 March 2022 61/22-62/8](#)

resulted in what may otherwise have been unproblematic use of force incidents becoming humiliating for the detained person.

44. Mr Collier told the Inquiry that he considered Brook House should have identified that using force against detained people who were naked was a frequent issue. He said that local measures should have been developed to preserve the dignity of detained people being restrained.⁹⁴ There is no specific policy or guidance regarding what to do with detained people who are naked when using force.⁹⁵ I agree that this is something that G4S should have identified and taken steps to address.

45. The purpose of use of force reviews should include identifying issues of concern relating to individual incidents, but they should also provide an insight into any recurring challenges that need to be addressed. As discussed below, the oversight of use of force was wholly inadequate during the relevant period and so the problematic nature of using force on naked detained people was not highlighted and addressed.

46. Three use of force incidents (which are considered in greater detail in Chapters C.3, C.13 and C.2, respectively, in Volume I) involving naked or near-naked detained people during the relevant period demonstrate this.

46.1 The first is when force was used on 11 April 2017 against D2416, who was naked or near-naked throughout the incident. Body worn camera footage shows staff only engaging verbally with D2416 for 26 seconds before force was used.⁹⁶ Staff had moved D2416 to the bottom of the stairs, where staff from Tascor were waiting to escort him to the airport. D2416 was left naked or near-naked in the presence of several staff for almost nine minutes while they tried to find a sheet to cover him, or a pack of clothing for him to put on.⁹⁷ This was unacceptable and, in my opinion, likely to be humiliating.

46.2 The second incident involved D2054 being restrained during a prolonged use of force incident on 28 June 2017.⁹⁸ During the incident, D2054 only had a towel wrapped around his waist. D2054 had experienced mental health problems and was awaiting an urgent mental health assessment.⁹⁹ Earlier that morning, he had self-harmed and had been moved to E Wing where he was put on constant observation.¹⁰⁰ In my view, the fact that D2054 was suffering from mental ill health was likely to have increased the detrimental impact on him.

⁹⁴ [Jonathan Collier 30 March 2022 71/4-10](#)

⁹⁵ [Steven Dix 9 March 2022 30/8-13](#)

⁹⁶ [Day 41 AM 30 March 2022 \(CJS0074115 UOF 88.17 BWC\)](#)

⁹⁷ [Day 41 AM 30 March 2022 \(CJS0074115 UOF 88.17 BWC\)](#), 8:50-17:35 of the footage

⁹⁸ [INQ000111_076](#) para 302

⁹⁹ [HOM002389_014](#)

¹⁰⁰ [CJS005991_009](#) para 6.2.3

46.3 The third example is the alarming footage of the lengthy use of force incident on 28 March 2017 concerning D1234.¹⁰¹ I found that the force used against D1234 while he was naked and surrounded by a large number of staff was likely to have caused him humiliation.

Inappropriate application of a Prison Service Order

47. Many of the above issues demonstrate that the application of the Use of Force PSO to govern the use of force inside IRCs is inappropriate. IRCs have a different purpose to prisons and a different type of population, and so different types of issues arise.

48. The justifications for force provided by the Use of Force PSO demonstrate why, in particular, its application is unsuitable. There are specified justifications for the use of force in IRCs in the Detention Services Operating Standards Manual, as set out above. For example, force can be justified in IRCs in order to remove a person to another country. This is not covered in the Use of Force PSO.

49. As stated above, G4S staff recorded “*maintain[ing] good order and discipline*” as a justification for force in the vast majority of incidents.¹⁰² However, this is not listed as a justification for force in Rule 41 or any other Detention Centre Rule, nor is it mentioned in the Detention Services Operating Standards Manual.¹⁰³ Maintaining “*good order and discipline*” is a reason why a person can be removed from association where it is necessary for the security or safety of other detained people (Rule 40) or confined temporarily in special accommodation if the person is being disruptive or violent (Rule 42).

50. The Use of Force PSO refers to “*good order of the establishment*” (but not to “*good order and discipline*”). The Use of Force PSO states:

“It is important to take into account the type of harm that the member of staff is trying to prevent – this will help to determine whether force is necessary in the particular circumstances they are faced with. ‘Harm’ may cover all of the following risks:

- *Risk to life*
- *Risk to limb*
- *Risk to property*
- *Risk to the good order of the establishment.*

¹⁰¹ [CJS0073730 \[Disk 23 S1940003\]](#); [CJS0073731 \[Disk 23 S1940004\]](#); [CJS0073732 \[Disk 24 28 March 2017\]](#); [CJS0073729 \[Disk 23 S1940002\]](#)

¹⁰² [CJS000905_006](#); [CJS000908_010](#); [CJS000914_008](#); [CJS000910_010](#); [CJS000619_010](#)

¹⁰³ [HOM002395_075](#)

*It is clearly easier to justify force as 'necessary' if there is a risk to life or limb."*¹⁰⁴

51. In reality, the “*good order and discipline*” justification used by detention staff at Brook House meant force was used to justify the removal of detained people, or in order to move them to a different part of the centre (usually to the CSU or E Wing).

52. In my view, there is a danger that “*good order and discipline*”, which was relied on by officers so heavily when justifying force at Brook House, became a catch-all and did not properly reflect why force was used. Furthermore, reviews of use of force incidents become more difficult when the justification is so general.

53. Reliance by IRC staff on a variety of sources for rules and guidance on use of force (including the Use of Force PSO, the Detention Centre Rules 2001 and the Detention Services Operating Standards Manual) has created unnecessary complexity and thus confusion among IRC staff. The application of a PSO to the use of force inside IRCs is inappropriate. In my view, permissible justifications for force should be clear. They should be set out in one provision. That provision should be specifically addressed to the use of force in immigration detention, rather than drawing on practices from other secure settings. The provision should be consulted upon with stakeholders, including representatives of detained people. The Inquiry therefore recommends that there should be new mandatory guidance about the use of force in detention settings.

A new framework for the use of force for immigration detention

54. Given the breadth of significant issues identified by the Inquiry, I am recommending the introduction of a DSO that sets out comprehensive and mandatory guidance about the appropriate use of force in IRCs. In addition to the issues set out above, it should set out the circumstances in which force can be used against vulnerable detained people experiencing mental ill health. It should also set out the framework for monitoring and oversight (about which I make further specific recommendations below).

¹⁰⁴ Prison Service Order 1600: Use of Force (INQ000185), HM Prison Service, August 2005, p5

Recommendation 15: A new detention services order about the use of force

The Home Office must introduce, as a matter of urgency, a new and comprehensive detention services order to address use of force in immigration removal centres.

The detention services order must include the following issues:

- the permissible justifications for the use of force within immigration removal centres, based on the key principle that force must not be used unnecessarily and must be used only as a last resort;
- the use of Personal Protective Equipment (PPE), including that it must be subject to a dynamic risk assessment before and during any use of force incident;
- the protection of dignity when force is used on a naked or near-naked detained person;
- the circumstances in which force can be used against a detained person with mental ill health; and
- monitoring, oversight and reporting of use of force by contractors and by the Home Office.

The Home Office must ensure that training about the application of the new detention services order and use of force techniques takes place on a regular (at least annual) basis for all detention staff as well as healthcare staff. Attendance must be mandatory for all staff working in immigration removal centres and those responsible for managing them. The training must be subject to an assessment.

In anticipation of a new detention services order on the use of force in immigration detention, the Home Office must issue an immediate instruction to its contractors managing immigration removal centres that force must be used only as a last resort, using approved techniques.

Use of force against unwell detained people

55. Force was used inappropriately against detained people who were physically and/or mentally unwell. It was often unnecessary in the circumstances since the threat to officers was low and there was little or no resistance from the detained person. The type and duration of the force used in many cases was disproportionate in light of the detained person's health condition. Prior consideration of whether and how much force ought to be used on vulnerable detained people in any particular circumstance was not given. Additionally, as discussed in Chapters C.4 and C.6 in Volume I and in Chapter D.8, Healthcare staff failed to recognise their role in safeguarding the health and welfare of detained people – rather, they facilitated the use of force. Some examples are set out below, although it is likely that there have been many more in practice.

56. Physically vulnerable detained people were the subject of force. For example, following refusal of food and fluids by D2159 and the raising of serious concerns by Healthcare staff about his condition, a decision was taken to move him to E Wing for *"his own welfare and health and safety of others"*.¹⁰⁵

56.1 Handheld camera footage of the use of force showed Mr Dix looking through the cell window and then instructing officers to go immediately into the cell.¹⁰⁶ When the door opened, D2159 was lying on the bed. Three officers and Mr Dix then entered the cell wearing full PPE, including helmets and shields. DCO Neil Timms led the way, placing a shield on D2159's chest. After officers physically restrained him, D2159 was handcuffed. He appeared very weak and entirely passive throughout the incident.

56.2 Prior to the use of force incident, Ms Christine Williams (Clinical Lead at Brook House) recorded in D2159's medical records *"restraints may be used"*.¹⁰⁷ This reflected an inappropriate and concerning practice by Healthcare staff of pre-sanctioning use of force. Their focus ought to have been on safeguarding. This issue is covered in more detail in Chapter D.8.

56.3 It is alarming to see how quickly officers resorted to the use of force in this incident, especially when the detained person appeared to be weak and unresponsive, rather than deliberately uncooperative. Mr Collier told the Inquiry that, given what was already known about the state of health of the detained person, Mr Dix ought initially to have gone into

¹⁰⁵ [CJS005529_027](#)

¹⁰⁶ [Day 41 PM 30 March 2022 00:34:02-00:40:32 \(S1970002 \[CJS0074113\]\)](#)

¹⁰⁷ [CJS007001_001](#)

the cell with a member of the Healthcare team to check on D2159's health before force was used.¹⁰⁸ It is clear from the footage that, although the shield was placed on D2159 for only a short time, force should not have been used at all, as D2159 posed little or no threat.¹⁰⁹ He could not have been described as non-compliant. The use of handcuffs was also inappropriate, as was the use of any other C&R techniques, given (as Mr Collier put it) *"there is no clear risk presented and D2159 appears weak and unable to walk"*.¹¹⁰ The use of force was entirely disproportionate in this instance. I agree with Mr Collier that *"a full assessment before the intervention would have identified the level of risk and the response should have been proportionate to that risk"*.¹¹¹

57. Similarly, force was used disproportionately on 27 May 2017 against D1914, who had a heart condition and mental health problems. D1914 had refused to move to E Wing in order to facilitate his removal, which was due to take place the following day.¹¹² I agree with Mr Collier that D1914 did not offer a level of threat to staff that justified force being used, and more time ought to have been given to persuade D1914 to comply with the instruction to move.¹¹³ The role of Healthcare staff in this incident was also concerning. Dr Husein Oozeerally (the lead GP at Brook House during the relevant period and at the time of the Inquiry's public hearings) inappropriately pre-sanctioned use of force and failed to identify and raise clinical concerns when necessary.¹¹⁴ D1914 stated that he found this incident to be *"One of the most disturbing and distressing events during my time in Brook House"*, and that he was *"worried he might have a heart attack"* during the incident.¹¹⁵ This incident provides yet another example of disregard shown by staff for the physical vulnerabilities of detained people.

58. The use of force against detained people with mental ill health was also common. It was often used as a response to, and a form of management of, symptoms of mental ill health, which were wrongly treated as non-compliance and disruptive behaviour.¹¹⁶ There was a routine and quick resort to force in response to incidents of self-harm.¹¹⁷ It was also used to manage the behaviour of those with mental ill health and in order to move detained people to E Wing or the CSU (whether under Rule 40 of the Detention Centre Rules

¹⁰⁸ [Jonathan Collier 30 March 2022 116/19-117/12](#)

¹⁰⁹ [INQ000177_005](#) para 10

¹¹⁰ [Jonathan Collier 30 March 2022 117/4-121/20; INQ000177_005](#) para 10

¹¹¹ [INQ000111_036](#) para 133

¹¹² [SER000437_006](#) para 22

¹¹³ [INQ000111_034](#) para 124

¹¹⁴ [INQ000111_034](#) para 124

¹¹⁵ [DL0000229_037](#) para 130; [DL0000229_041](#) para 145

¹¹⁶ See, for example, Mr Dix's attitude towards D1527 on the safety netting on 4 May 2017: [Steven Dix 9 March 2022 56/21-25, 57/1-18](#)

¹¹⁷ [Dr Rachel Bingham 14 March 50/5-51/5; Theresa Schleicher 14 March 90/1-12](#)

2001 or informally to segregate them).¹¹⁸ One stark example of this was when a PIT was used on D1527 by DCM Michael Yates on 4 May 2017 when officers were trying to move D1527 out of D Wing in order to segregate him. The technique was not justified, especially as D1527 was severely mentally unwell, was securely in handcuffs, and there were at least four officers present.¹¹⁹ The use of a PIT was not reasonable or proportionate in the circumstances. I have made further findings in relation to this incident in Chapter C.4 in Volume I.

59. The Use of Force Training Manual provides brief and general guidance on the importance of considering the consequences of the use of force on a person in the context of Article 3 of the European Convention on Human Rights. It refers to the “*physical or mental effects*” of ill treatment and the importance of taking into consideration, among other factors, “*the state of health*” of a detained person.¹²⁰ However, no relevant examples are given and there is no reference in the Use of Force Training Manual to the fact that the severity or impact of the use of force is likely to be much more significant where a person suffers from ill health. Mr Collier suggested that this lack of consideration was due to the fact that it was a “*specific area*”.¹²¹ He also suggested that staff perhaps could not relate to a detained person who experienced mental health problems, or who had suffered torture or abuse.¹²² He also confirmed that the test criteria used medically to evaluate the appropriateness and safety of the C&R techniques deployed within the IRC estate did not include consideration of mental illness or vulnerabilities, such as histories of torture or trauma, and that this was still the case now.¹²³ In my view, staff ought to be provided with proper and specific training on how, when and whether to use force on detained people with mental ill health. The training should pay particular attention to evaluating dynamically and individually the likely effect of the use of force on a person’s mental health.

60. Dr Rachel Bingham, clinical advisor to Medical Justice (a charity that provides medico-legal reports and advice to detained people), told the Inquiry that use of force can lead to a serious worsening of symptoms of mental ill health and deter detained people from engaging with clinical care.¹²⁴ The use of physical restraint is likely to be traumatising in itself for detained people with pre-existing clinical vulnerabilities, and risks re-traumatising those with a past history of torture or trauma.¹²⁵ Moreover, the use of certain restraints and PITs is of particular concern with respect to detained people experiencing

¹¹⁸ [Theresa Schleicher 14 March 89/7-25, 97/25-98/22](#)

¹¹⁹ [Jonathan Collier 30 March 2022 133/3-137/12](#)

¹²⁰ [NOM000001_029](#)

¹²¹ [Jonathan Collier 30 March 2022 140/3-141/2](#)

¹²² [Jonathan Collier 30 March 2022 140/3-141/2](#)

¹²³ [Jonathan Collier 30 March 2022 141/3-23](#)

¹²⁴ [BHM000033_050](#) para 133

¹²⁵ [BHM000030_038](#) paras 77-78

mental illness, including those who have experienced trauma, given its triggering nature.¹²⁶

61. Dr Brodie Paterson provided evidence on behalf of Medical Justice that the current “*prison-based model*” of C&R deployed at Brook House is not equivalent to current practice and care within clinical settings, where force is only used “*in extremis*”.¹²⁷ I accept that the use of force model used in IRCs needs to be adapted in order to take into account the vulnerabilities of the detained population.¹²⁸ However, it is not clear whether adopting a C&R model used in clinical settings would be appropriate in the context of immigration detention, where other considerations apply.

62. Mr Collier suggested that consideration should be given to a bespoke package for staff working in IRCs to cover behaviour management and to be therapeutic-based, focusing on preventative strategies as opposed to reactive strategies when a situation has escalated.¹²⁹ Mr Collier also suggested that individual personal officers (ie DCOs assigned to each detained person to be an individual point of contact) could document how to engage with a detained person, understanding triggers for behaviour, and then employ tried and tested de-escalation methods.¹³⁰

63. Force was often used as an inappropriate response to detained people in the depths of mental health crises, including self-harm. In my view, a person’s mental health should be taken into consideration when deciding whether and when to use force and, in particular, if and when to apply certain techniques, such as PITs. This can only be done if officers understand the different considerations that ought to apply. This requires specific mental health training in relation to use of force, and may mean that the current model for the use of force needs to be adapted. There must be a stronger focus on prevention and de-escalation, both in general and particularly when force is used on detained people with mental ill health.¹³¹ Although mental health first aid training is provided as part of the ITC, Serco does not provide specialist training regarding the particular considerations that ought to apply when using force on detained people with mental ill health.¹³²

64. Therefore, I am recommending, in advance of the introduction of a new DSO, that there should be a thorough review of the use of force against detained people with mental ill health in an IRC context. That review should

¹²⁶ [BHM000045_011](#) para 47

¹²⁷ [BHM000045](#) paras 1-9, 40-43

¹²⁸ [BHM000045_010-011](#) paras 44-47

¹²⁹ [INQ000111_148](#)

¹³⁰ [INQ000158_057](#) para 24.7

¹³¹ [Jonathan Collier 30 March 2022 141/22-23](#)

¹³² [SER000256_004](#)

draw on clinical expertise and input from those who specialise in mental health issues in immigration detention.¹³³

Recommendation 16: Urgent review of use of force on detained people with mental ill health

The Home Office must urgently commission an independent review (with the power to make recommendations) of use of force on detained people with mental ill health within immigration removal centres.

The review must consider:

- how, when and whether to use force on detained people with mental ill health (including the application of pain-inducing techniques);
- the likely effect of the use of force on a detained person's mental health;
- the use of individual risk assessments for detained people, which could be conducted by personal officers and healthcare professionals; and
- the increased use and prioritisation of de-escalation techniques for those who have mental ill health.

The review must take place in consultation with relevant stakeholders, including detained people's representative groups and mental ill health experts.

The recommendations of the review must be incorporated in the new detention services order regarding the use of force (see Recommendation 15), in respect of which additional, regular (at least annual) training should then be provided.

Inadequate monitoring and oversight of uses of force

65. The monitoring and oversight of the use of force at Brook House was inadequate and led to dangerous situations for detained people and staff. Use of force, at times, caused significant harm to detained people, as outlined in my findings concerning specific incidents in Part C in Volume I. There were serious failings in the way in which use of force incidents were managed and reviewed.

¹³³ Jonathan Collier 30 March 2022 154/11-20

Lack of presence of senior management

66. Senior managers, above DCM level, were not sufficiently visible and available on wings. The lack of managers to supervise and witness how staff were behaving was particularly acute during use of force incidents. Mr Collier described DCMs being “*almost left to their own devices*”, without input or guidance from duty managers.¹³⁴ The Use of Force PSO requires that a duty manager (the most senior manager on shift) should, where possible, attend use of force incidents or respond to a general alarm for staff assistance.¹³⁵ In my view, their absence allowed (and in some cases may have encouraged) DCOs and DCMs to act with impunity.

67. The Inquiry heard evidence about staff telling others that they had been violent towards detained people, such as when Mr David Webb told Mr Tulley that he had deliberately hurt D149.¹³⁶ There was also evidence that Mr Murphy bragged about kneeling a detained person in the face during a restraint.¹³⁷ Boasting about hurting detained people on purpose fostered a “*culture of silence*” where officers did not complain about other officers’ wrongdoing.¹³⁸

Failure to activate body worn cameras or failure to film

68. Prison Service Instruction 04/2017: Body Worn Video Cameras was in place from March 2017. It stated:

*“In situations where it is difficult to commence recording prior to force being applied, such as when users face spontaneous and/or unexpected violence for example, the user should activate the BWVC [body worn video camera] as soon as it is practicable to do so. In such circumstances users should explain why earlier recording was impracticable on the BWVC device and within their written statement.”*¹³⁹

Where a use of force incident was planned, “*the member of staff planning this type of physical intervention must prioritise the use of their handheld video cameras where available and not rely solely on BWVCs*”.¹⁴⁰

¹³⁴ Jonathan Collier 30 March 2022 155/23-156/16

¹³⁵ INQ000111 159-160 para 668

¹³⁶ TRN0000088_020

¹³⁷ CPS000024_004-005

¹³⁸ Callum Tulley 30 November 2021 23/11-24/15; INQ000052_042 paras 167-168

¹³⁹ NOM000002_023 paras 5.1-5.2

¹⁴⁰ NOM000002_023 paras 5.7-5.8

69. The G4S Guiding Principles for Use of Body Worn Camera Systems (dated May 2012) stated:

“Detainee Custody Managers will wear BWCS [body worn camera systems] for the duration of their shift. The camera should be switched on when footage might support ‘professional observation’ or would corroborate what would be written in a Use of Force Report, Incident report or witness statement. The decision to record or not to record any incident remains with the user. The user should be mindful that failing to record incidents that are of evidential value may require explanation in court.”

They also noted:

*“it is evidentially important to record as much of an incident as possible ... recording should begin at the earliest opportunity from the start of an incident”.*¹⁴¹

70. Mr Gordon Brockington, Managing Director of Justice and Government Chief Commercial Officer at G4S, relied on a Standard Operating Procedure on Body Worn Video Cameras which was effective only from December 2017 to support his evidence that body worn cameras were only “introduced post-Panorama”.¹⁴² However, this is not correct. A substantial amount of body worn camera footage taken by DCMs during the relevant period was disclosed by G4S to the Inquiry, and therefore body worn cameras must have been utilised to some extent during that time.¹⁴³ Indeed, in much of the footage received by the Inquiry, DCMs can be seen wearing body worn cameras. In addition, the Standard Operating Procedure refers to an “expanded roll-out of the use of Body Worn Video Cameras” and not simply their introduction.¹⁴⁴ Furthermore, as set out above, G4S’s own Guiding Principles demonstrate that it was mandatory for body worn cameras to be worn by DCMs during the relevant period.

71. Despite the policies in place during the relevant period, the Inquiry found that there was no body worn or handheld camera footage for a large number of use of force incidents during the relevant period.¹⁴⁵ For DCMs who were wearing body worn cameras, failing to switch them on was of particular concern.¹⁴⁶ For example, Mr Stephen Webb explained that he did not turn on his body worn camera during an incident involving D642 on 3 August 2017 because he was not “in the habit” of doing so.¹⁴⁷ In addition, Mr Dix did not

¹⁴¹ PSI 04/2017; NOM000002_023 paras 5.1-5.2; CJS0074355_001

¹⁴² CJS0074041_036 para 178; see CJS0073866

¹⁴³ For example, UOF 129.17 BWC

¹⁴⁴ CJS0073866_001

¹⁴⁵ INQ000111_160 para 669

¹⁴⁶ Jonathan Collier 30 March 2022 157/19-158/2

¹⁴⁷ Stephen Webb 8 March 2022 161/8-21

turn on his body worn camera during a use of force incident on 4 May 2017 in which a PIT was used on D1527.

72. Another example which highlights the importance of video footage is the use of force incident involving D52 on 22 May 2017. Mr Collier revised his initial view concerning the appropriateness of force being used during this incident once body worn camera footage was made available to the Inquiry, just before the second phase of its hearings. This footage showed that D52 had in fact offered minimal threat to officers, and more effort ought to have been made to negotiate before force was used – the period of pre-force discussion lasted 6 minutes 30 seconds.¹⁴⁸ On reviewing previously missing footage in relation to this and three other incidents, Mr Collier expressed the view that the force used was unnecessary.¹⁴⁹ Without this footage, the Inquiry would not have known about the serious issues that have arisen from these incidents, and an opportunity to learn from them would have been lost – as happened repeatedly during the relevant period at Brook House.

73. Another troubling aspect of the incident concerning D52 is that DCM David Aldis appears to have deliberately obscured body worn footage of this use of force incident. As soon as the restraint started (at time stamp 07:05), the camera was obscured by fingers which appear to come towards it and the lens was covered so that the viewer cannot see what is happening. A few seconds later, the camera appears to slip down into a white pocket, which was probably Mr Aldis's given his location both before and after the camera is obscured. Screaming can be heard from 07:10 to 07:50 on the time stamp, during which time the camera was obscured. It is likely, although it cannot be seen, that this screaming came from D52. The picture is only restored and visible at 08:48, at which point D52 was being restrained on the floor.

74. In a witness statement to the Inquiry, Mr Aldis provided an implausible account as to why he did not record the entire incident. He said that he could not recall the incident but suggested that the head of the camera may have twisted when he handed the camera to a colleague, possibly DCM Dean Brackenridge.¹⁵⁰ He said he did this because Mr Brackenridge "*was less likely to be involved in the incident ... [which would] enable [him] to video the incident much clearer than me*".¹⁵¹ However, the footage shows that the camera seems to capture the incident from the same viewpoint in the cell both immediately before the camera is obscured and immediately afterwards. It does not appear to have been handed to another officer before the camera is obscured. Mr Aldis's account is also inconsistent with what Mr Brackenridge stated in his

¹⁴⁸ [UOF 129.17 BWC](#)

¹⁴⁹ [INQ000177_006-008](#) paras 20-30

¹⁵⁰ [INQ000197_001](#) para 1b

¹⁵¹ [INQ000197_001](#) para 1c

Use of Force report,¹⁵² which was that Mr Aldis instructed him to go into the cell and assist the officers to take control of D52 who was “*lashing out*”.¹⁵³ Mr Brackenridge also gave an account of his “*hands on*” involvement in the use of force incident. This is supported by the footage, which demonstrates that Mr Brackenridge could not have been holding the camera at 07:10 while the camera is obscured since he was involved in the restraint. It seems that Mr Aldis is correct to say that the camera was passed to others at some point during the filming: first to Ms Karen Churcher (Registered Mental Health Nurse) at 08:50 and then to Mr Brackenridge at 10:15. This is long after the use of force incident occurred and after the camera was uncovered at 08:48.

75. It appears to me that Mr Aldis covered the camera deliberately. In my view, it is unlikely that the camera was accidentally dislodged. I take into consideration:

- the timing of the hand being placed in front of the camera;
- the position of the camera throughout filming;
- the inconsistencies between Mr Aldis’s account, Mr Brackenridge’s Use of Force report and the footage which shows when the camera was passed to him;
- Mr Brackenridge’s involvement in the use of force incident itself; and
- that Mr Aldis did not physically participate in the restraint and therefore did not have a reason to pass the camera to another officer immediately before force was used.

Generally, body worn camera users “*should record entire encounters from beginning to end without the recording being interrupted*”, unless the nature of the incident makes it unnecessary to record it entirely – for example, if it is of a sensitive nature.¹⁵⁴ However, this was not the case here. I find it deeply concerning that a member of staff behaved in such a way, which resulted in valuable footage of the main part of the use of force incident being unviewable.

76. However, I am encouraged that the policy applicable to IRCs on body worn footage appears to have been strengthened after the relevant period. The Standard Operating Procedure on Body Worn Video Cameras (effective from December 2017) states that body worn cameras “*are made available to all designated operational front line staff e.g. Residential Units, Dep Rep, Visits, Activities, Healthcare, Education and searching Security Officers*” and not just to DCMs as was previously the case.¹⁵⁵

¹⁵² [CJS005620_030-032](#)

¹⁵³ [CJS005620_031](#)

¹⁵⁴ [CJS0074355_003](#)

¹⁵⁵ [CJS0073866](#)

77. Detention Services Order 04/2017: Surveillance Camera Systems (introduced in February 2018, the Surveillance Camera DSO) states that body worn cameras should be used:

- “● When spontaneous use of force is required against a detainee(s)*
- On a planned relocation where the use of force is assessed as a possibility – see also paragraph 23*
- If the wearer believes the interaction presents, or is likely to present, a risk to the safety of the wearer, other members of staff, detainee or other persons present*
- If the wearer considers the use of BWC [body worn camera] to be a necessary and proportionate means of recording any other interaction or event*
- When available, consideration should be given by officers to activating a BWC at a detainee’s request.”¹⁵⁶*

Where body worn cameras should routinely have been used but were not used, records of the reasons why should have been kept.¹⁵⁷ The Surveillance Camera DSO also states:

“Centre suppliers must have in place effective procedures to manage BWC assets. These procedures should accurately record who a device is assigned to, the location of the device and its operational status.”

“When involved in any incident which would normally cause BWC to be activated (as set out in the local policy) the user should commence recording at the earliest opportunity. The member of staff recording the incident should state out loud the reason for turning on the BWC. This ensures that there is a formal record of the decision to use the BWC and also notifies detainees and staff in the area that they are being recorded by both video and audio surveillance (if applicable). Staff dressed in personal protective equipment (PPE) should also identify themselves to camera, ensuring that their protective helmets (with numbers) are visible to camera before carrying out any actions. This will ensure that they are identifiable when incidents are reviewed.”

“When surveillance cameras are used to record an incident involving the use of force. The use of force report must contain a log or reference number of the footage.”¹⁵⁸

¹⁵⁶ Detention Services Order 04/2017: Surveillance Camera Systems, Home Office, February 2018, para 20

¹⁵⁷ Detention Services Order 04/2017: Surveillance Camera Systems, Home Office, February 2018, para 21

¹⁵⁸ Detention Services Order 04/2017: Surveillance Camera Systems, Home Office, February 2018, paras 17, 18, 24

78. The Inquiry also heard evidence that Serco’s current policy is that body worn cameras “*must be activated without exception*” where a member of staff is responding to an incident or finds it necessary to use force of any kind.¹⁵⁹ The Inquiry is encouraged to learn from HMIP’s 2022 inspection report that body worn cameras are now “*well used*”.¹⁶⁰ The importance of body worn camera footage is clear. Without it, this Inquiry would not have known about the serious issues that have arisen from these incidents, and an opportunity to learn from them would have been lost – as happened repeatedly during the relevant period at Brook House.

Inaccurate, undetailed and missing reports

79. The reports that officers submitted about incidents were sometimes inaccurate as to the justification for the use of force. In the use of force against D2416 on 11 April 2017 (discussed above), two officers stated that D2416 was refusing to comply before the head restraint was applied and they started to move down the stairs, and that this justified force being used.¹⁶¹ However, the footage shows that, at the time the DCM insisted that a head support (where the ‘number 1’ officer supports the detained person’s head) be applied when moving down the stairs, D2416 was in fact compliant and offering no threat.¹⁶²

80. Similarly, in the use of force against D2559 on 28 April 2017, Mr Paschali stated that D2559 was banging on the cell door. Mr Paschali had struggled to open the door, and he pushed the door open as he was worried something had happened to D2559.¹⁶³ This appeared to be a justification for entering the cell and then using force as, he said, D2559 became aggressive. However, the footage does not show Mr Paschali having any difficulty opening the door.¹⁶⁴ This is all the more concerning because Mr Paschali entered the cell without first checking how D2559 was behaving or summoning others if necessary.¹⁶⁵ This is another example of inaccurate report writing.

81. Reports from officers were also often lacking in detail. I agree with Mr Collier that the overall standard of post-incident witness statements written by officers was poor in “*most*” cases, due to lack of detail about the events prior to, during and after the use of force was applied.¹⁶⁶ Mr Collier told the Inquiry that this was a “*huge issue*”.¹⁶⁷ Some officers, including Mr Paschali,

¹⁵⁹ [SER000170_002](#) para 2.0

¹⁶⁰ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre, 30 May–16 June 2022](#) (HMIP000702), HM Chief Inspector of Prisons, September 2022, p12, para 1.13

¹⁶¹ DCO Neil Timms ([CJS005630_014](#)) and DCO Ben Wright ([CJS005630_019](#))

¹⁶² [INQ000177_009](#) para 35

¹⁶³ [CJS005532_008](#)

¹⁶⁴ [280417 - BH 204-17, UOF 110-17, DVT 166-17.mp4](#) at 1:30-1:46

¹⁶⁵ [INQ000177_016](#) para 84

¹⁶⁶ [INQ000111_152](#) para 651

¹⁶⁷ [Jonathan Collier 30 March 2022 105/4-6](#)

claimed that they did not have enough time to complete Use of Force reports.¹⁶⁸

82. Some DCOs thought that it was only officers who had physically put their hands on the detained person during the use of force incident who should complete a report.¹⁶⁹ When asked about why he did not complete Use of Force reports for four incidents that he supervised, Mr Dix told the Inquiry that it was a *“misconception at the time, not just by myself, by many other managers there”*.¹⁷⁰ The policy in place at the time stated that all those *“involved”* in the use of force must complete a report.¹⁷¹ This included every officer who used force in any way (every member of a C&R team), including the supervising officer.¹⁷² The term *“involved”* seems to have been applied too narrowly by officers. Clearly, it is important that an accurate account of a use of force incident can be obtained. In my view, either the Use of Force PSO ought to be changed to state *“all those who witness or participate in the use of force must fill out a report”*, or additional training which further defines *“involvement”* in a use of force incident ought to be provided.

83. The accurate and detailed writing of Use of Force reports by all officers who witness or participate in use of force incidents is crucial for the proper review and monitoring of the use of force. Sufficient time must be allowed to write these reports. Additionally, though this should be obvious from training and guidance, it is imperative that when only one officer is involved in an incident and uses force against a detained person, they complete a Use of Force report. Failure to do so means that there is no record available of any incident occurring and thus no scrutiny, as was demonstrated by, for example, the incident involving DCO Sean Sayers and D313 discussed in Chapter C.12 in Volume I.

Poor quality of debrief

84. The Inquiry was not provided with many videos of debriefs conducted by officers after use of force incidents. It is unclear whether this is because the debriefs did not occur or because they were not filmed. The quality of the debriefs that were filmed was very poor. They were cursory and demonstrated a complete lack of reflection. Their purpose – to act as a review of use of force

¹⁶⁸ [Ioannis Paschali 24 February 2022 47/23-25](#); [Clayton Fraser 28 February 2022 86/10-19](#); [Derek Murphy 2 March 2022 120/18-121/9](#); [Sean Sayers 10 March 2022 168/24-169/20](#)

¹⁶⁹ For example, [Ryan Bromley 7 March 2022 102/5-10](#), [Shayne Munroe 4 March 2022 8/17-19](#) and [Stephen Webb 8 March 2022 151/16-24](#)

¹⁷⁰ [Steven Dix 9 March 2022 47/1-16](#)

¹⁷¹ According to [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, paras 4.33 and 8.10; see also [Amendments to Use of Force Policy \(PSI 30/2015\)](#), National Offender Management Service Agency Board, November 2015 (which amends [Prison Service Order 1600](#)), paras 2.36 and 8.10. “Involved” is defined as “any role in a C&R team, any use of a baton, protective strategy etc” (para 2.36)

¹⁷² [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, para 8.4

incidents – was hindered by their brevity and the absence of any discussion about whether anything could or should have been managed differently.

85. An example of an inadequate debrief following a use of force is that carried out following the use of force on D390 on 6 June 2017. In this instance, force was not used as a last resort as D390 was fully compliant, and the force used, particularly the use of a shield, was not necessary or proportionate.¹⁷³ DCM Stewart Povey-Meier conducted a very quick debrief, which simply involved asking the officers if they had any injuries and the officers confirming that they did not.¹⁷⁴ The debrief did not address whether there were any wider issues or staff concerns, or provide any feedback to staff from Mr Povey-Meier on their performance. A proper debrief might have prevented force being resorted to so quickly in subsequent incidents.

86. Mr Collier stated that, in all the debriefs he had seen during the Inquiry, none of the staff involved had identified recommendations, suggestions for improvement or additional training needs.¹⁷⁵ They should have done so. He said that, even in the 43 incidents that he reviewed, there were “*many*” training needs that ought to have been identified.¹⁷⁶ Staff should be properly trained in how to conduct debriefs so that lessons can be learned from them.¹⁷⁷

Lack of proper review and governance

87. None of the issues relating to how force was used were highlighted by any review process.

88. The review process consisted of Mr Stephen Webb sitting alone (as C&R coordinator), on his days off, reviewing Use of Force documents completed by officers involved in the incidents and filling in a one-page, mainly tick-box, Use of Force review meeting form.¹⁷⁸ This review process was cursory and of poor quality, and there were long delays between the incident occurring and the review. There was also a conflict of interest on occasions when Mr Webb reviewed an incident he had taken part in.

89. There should also have been two more layers of governance to ensure effective oversight.

89.1 At ‘scrutiny’ meetings or Use of Force Committee meetings, the C&R coordinator and the C&R trainers were supposed to review all reports staff filed after their involvement in a use of force incident.

¹⁷³ [INQ000111_065](#) paras 260-264

¹⁷⁴ [INQ000177_005](#) paras 14-17

¹⁷⁵ [Jonathan Collier 30 March 2022 176/14-20](#)

¹⁷⁶ [Jonathan Collier 30 March 2022 176/21-177/1](#)

¹⁷⁷ See Mr Collier’s suggestion at [INQ000177_006](#) para 16 and [INQ000177_017](#) para 87

¹⁷⁸ [Stephen Webb 8 March 2022 176/19-23](#)

89.2 At weekly use of force meetings, the C&R coordinator and senior managers should have considered any concerns about the use of force identified in the reviews conducted by Mr Webb to decide on any further action, including disciplinary proceedings. They also ought to have considered any wider strategic issues in relation to use of force.¹⁷⁹

However, these meetings appeared largely to have been cancelled due to a lack of another C&R coordinator and C&R trainers to view the footage.¹⁸⁰ As discussed in Chapter D.11, it is unlikely that the scrutiny meetings happened at all during the relevant period.

90. Furthermore, each month, the agenda of the security meeting indicated that G4S reviewed, among other things, the number, type and reason why force was used against detained people.¹⁸¹ However, upon review of the minutes of the security meetings, the Inquiry found that use of force was rarely discussed and issues with use of force were not identified.¹⁸²

91. Mr Webb described the title ‘Use of Force review meeting form’ as misleading since there was no meeting to discuss the particular incidents. He alone reviewed the footage.¹⁸³ He did not characterise this as a “*tick-box exercise*” as Mr Collier had done, in the colloquial sense, but said it involved going through the form, ticking boxes, and reviewing the officers’ witness statements and the footage.¹⁸⁴ He added that he had so much to do on the wings that he had to come in on his days off in order to conduct the reviews.¹⁸⁵ He did not accept that he may not have given as much attention to the reviews as he ought to have done.¹⁸⁶

92. In my view, there were several problems with the reviews. These had an impact on their effectiveness and impartiality.

93. None of the reviews were carried out in a timely manner. They were all conducted more than two months after the use of force incident.¹⁸⁷ For example, the use of force against D191 on 27 April 2017 was not reviewed by Mr Webb until 17 July 2017, almost three months later.¹⁸⁸ Mr Webb did not know why the delay occurred, but told the Inquiry that senior management

¹⁷⁹ [CJS0073709_207](#) para 12.69; see also [INQ000111_148-149](#)

¹⁸⁰ [CJS0073709_207](#) para 12.70

¹⁸¹ G4S security meeting data, April–August 2017: [CJS000905](#), [CJS000908](#), [CJS000914](#), [CJS000910](#), [CJS000615](#)

¹⁸² [CJS000915_003](#) (April concerning March data, which is before the relevant period); [CJS000917_001](#) (May); [CJS000911](#) (June); [CJS000913](#) (August); [CJS000918](#) (September)

¹⁸³ [Stephen Webb 8 March 2022 175/14-176/23](#)

¹⁸⁴ [Stephen Webb 8 March 2022 177/6-8](#)

¹⁸⁵ [Stephen Webb 8 March 2022 176/19-23](#)

¹⁸⁶ [Stephen Webb 8 March 2022 175/25-179/9](#)

¹⁸⁷ [CJS0074041_38](#) para 189

¹⁸⁸ [CJS000902_003](#)

*“panicked and dumped it on my desk and said ‘sort that’”.*¹⁸⁹ The delay in reviewing use of force incidents gives rise to two principal concerns. The first is that staff members’ recollections were likely to have faded over the time it took to review these incidents. The second is that if reviews were not timely, with an intervening lengthy period between the incident and the review, inappropriate behaviour might be repeated in the interim. The delay is of particular concern where unauthorised techniques risking death or injury were used and then not highlighted on review.¹⁹⁰

94. Having made enquiries about a large number of missing review meeting forms, the Inquiry was told by G4S that use of force incidents were not reviewed at all after September 2017 (ie for those incidents occurring from June 2017). Staff members who would have conducted the reviews had been suspended or sacked, and were not subsequently replaced.¹⁹¹ This means that for over half of the relevant period, use of force incidents were not being reviewed at all.¹⁹² This is unacceptable. In my judgement, it created a potentially dangerous situation over a prolonged period.

95. I am also concerned about the quality of the review process. Mr Collier told the Inquiry that he had significant concerns about staff competence in around 25 per cent of the incidents that he reviewed.¹⁹³ The Inquiry was provided with all the review forms that Mr Webb conducted over a two-day period between 17 and 18 July 2017.¹⁹⁴ Not a single review form from this period suggested that any further investigation was required, that any lessons should be learned, or that further training was indicated. It seems highly unlikely that, in all the 30 incidents reviewed, none was worthy of comment by the reviewer.¹⁹⁵

96. In my view, the review process was undoubtedly a ‘tick box’ exercise that did not amount to an effective monitoring system. Mr Webb did not approach it with the necessary rigour and he did not assess adequately whether lessons ought to be learned or recommendations made.

97. Furthermore, Mr Webb was not provided with enough time or support to conduct these reviews. Senior managers at G4S should have ensured that Mr Webb had sufficient time and resources to undertake a proper review of each use of force incident.

¹⁸⁹ [Stephen Webb 8 March 2022 182/12-183/2](#)

¹⁹⁰ See, for example, incidents involving D1234 on 28 March 2017 ([HOM002496](#)); D2054 on 28 June 2017 ([CJS005574](#)); and D149 on 31 May 2017 ([INQ000111_027](#) para 86)

¹⁹¹ [Counsel to the Inquiry’s Opening Statement, 23 November 2021 61/7-15](#)

¹⁹² The Inquiry compared Mr Webb’s ‘Use of Force review meeting forms’ for 30 incidents ([CJS000902](#)) and the 109 individual Use of Force forms completed by G4S officers

¹⁹³ [Jonathan Collier 30 March 2022 30/2-31/19](#)

¹⁹⁴ [CJS000902](#)

¹⁹⁵ [Jonathan Collier 30 March 2022 179/9-18](#)

98. The Inquiry also found that Mr Webb conducted several reviews of use of force incidents in which he had personally been involved. One such incident was the use of force against D191 on 27 April 2017, in which there were several failings.¹⁹⁶

98.1 Mr Webb and DCO Slim Bessaoud used force against D191 after he struck D356 on the head with a remote control. They then escorted him to the CSU.¹⁹⁷

98.2 CCTV footage of this incident shows that only Mr Webb and Mr Bessaoud escorted D191 down a set of stairs.¹⁹⁸ However, the Use of Force Training Manual in effect from December 2015 states that a four-person team is required as the starting point for navigating a staircase with a person under restraint.¹⁹⁹ D191 was therefore restrained and moved to E Wing by an insufficient number of staff. This put both D191 and the officers at risk of injury. Mr Collier, with whom I agree, said:

“by not summoning assistance the staff are left with insufficient numbers to properly carry out the approved method for moving. This put D191 and staff at a risk of falling and should not have taken place until such time as additional staff were in attendance.”²⁰⁰

98.3 The CCTV footage also shows that Mr Webb maintained hold of D191’s arm in a wrist flexion position (a pain-inducing technique) throughout the use of force, rather than using handcuffs. I agree with Mr Collier that this was unnecessary, and did not promote de-escalation.²⁰¹

98.4 D191 complained to the PSU that Mr Webb held his left hand aggressively, bent his fingers and pulled his arm with increased force. He said that he screamed in pain and asked the officer to stop but he did not. He said that Mr Webb told him that the officers would hurt him more if he did not stop shouting.²⁰² Mr Webb told the Inquiry that he had not inflicted pain on D191’s wrist, and that he could not recall telling D191 that if he did not stop screaming he would feel more pain.²⁰³ Mr Bessaoud told the PSU that he did not recall Mr Webb saying this, but accepted that it was possible that D191 was told that if he did not comply, he would feel more pressure through his wrist.²⁰⁴ In my view, Mr Webb probably did inflict pain on D191’s wrist and he did not follow

¹⁹⁶ [CJS005549_009](#); [INQ000111_047](#) para 179

¹⁹⁷ [CJS005549_009](#)

¹⁹⁸ [Day 26 PM 8 March 2022; 00:56:25-00:59:34 \(Disk 3 UOF 109.17 \[CJS0074071\]\)](#)

¹⁹⁹ [NOM000001_228](#)

²⁰⁰ [INQ000111_048](#) para 190

²⁰¹ [INQ000111_047-048](#)

²⁰² [CJS002741_008-009](#)

²⁰³ [Stephen Webb 8 March 2022 173/8-175/13](#)

²⁰⁴ [CJS002741_013](#) para 6.5.10

the correct protocol in doing so. As stated by Mr Collier in his second report to the Inquiry:

“There is a correct protocol for using a PIT where the member of staff gives a clear indication of what is expected, a chance for the information to be processed by the detainee, and a final order. The terminology should not be aggressive and should be delivered calmly but assertive [sic].”²⁰⁵

99. That notwithstanding, when Mr Webb reviewed this incident, he identified no issues or learning points whatsoever.²⁰⁶ In oral evidence, Mr Webb eventually conceded that he should not have been “*marking [his] own homework*”.²⁰⁷ There was clear potential for a conflict of interest that he ought to have recognised at the time, and which managers should have identified if there had been a proper system of monitoring. Mr Webb told the Inquiry that he had to work on his rest days in order to carry out the use of force reviews that senior managers had asked him to complete.²⁰⁸ The implication is that senior managers were not concerned that Mr Webb conducted the reviews alone or that he reviewed incidents in which he had been personally involved.

100. The ineffectiveness of Mr Webb’s reviews should have been identified by other layers of governance – that is to say, the weekly use of force meetings and security meetings. However, the weekly use of force meetings between the C&R coordinator and senior managers “*were usually cancelled*”.²⁰⁹ Two use of force meetings took place in late 2017 or early 2018, but these were “*largely concerned with administrative matters*”.²¹⁰ The Inquiry was not provided with any evidence of those meetings. At the security meetings, use of force was rarely discussed and, when it was, none of the issues detailed in this Report were identified.²¹¹ The concerns about use of force the evidence gives rise to were compounded by the failures in the review and monitoring process. The quality of internal monitoring and governance by G4S during the relevant period at Brook House was extremely poor.

101. The Home Office’s role in the oversight of use of force was inadequate. The National Audit Office noted that the Home Office measured the timeliness of the Use of Force reports (or ‘forms’ as G4S described them) that G4S was required to produce each time its staff used force against detained people, and reviewed a sample of incidents each week, including video footage and reports

²⁰⁵ [INQ000158_038](#) para 15

²⁰⁶ [CJS000902_003](#); [INQ000111_047](#) para 179

²⁰⁷ [Stephen Webb 8 March 2022 179/18-181/16](#)

²⁰⁸ [Stephen Webb 8 March 2022 176/9-25](#)

²⁰⁹ [CJS0073709_207](#) para 12.70

²¹⁰ [CJS0073709_207](#) para 12.71

²¹¹ [CJS000915_009_003](#) (April concerning March data, which is before the relevant period); [CJS000917_001](#) (May); [CJS000911](#) (June); [CJS000913](#) (August); [CJS000918](#) (September)

on incidents.²¹² However, inappropriate use of force incidents were not themselves contractual performance measures.²¹³ The Inquiry received evidence that most of the uses of force by staff against detained people shown in the *Panorama* programme were already known to G4S and the Home Office:

“Of the 84 incidents, the majority had not been previously reported under the contractual performance and incident reporting, but the Home Office agreed G4S did not have a responsibility to report most of them. The Home Office and G4S agreed penalties for eight incidents, four of which should have been reported under the contract.”²¹⁴

102. The contract between the Home Office and Serco now contains a provision imposing a financial penalty in the event of failures relating to use of force techniques, and the recording, reporting and scrutiny of use of force incidents.²¹⁵ The Inquiry was informed of a number of changes under Serco’s management of Brook House.

102.1 Mr Hewer, who became Director of Gatwick IRCs when Serco took over the contract on 21 May 2020, told the Inquiry that he set up a Use of Force Committee.²¹⁶ The Committee is chaired and attended by senior management, the Use of Force Coordinator and other key stakeholders (the Home Office and the Independent Monitoring Board at Brook House (Brook House IMB)).²¹⁷ He confirmed that representatives of detained people were not currently included but said he would consider this.²¹⁸ The Committee meets monthly. It reviews trends and agrees actions to reduce use of force, and does so by reviewing one use of force from the previous month.²¹⁹ In my view, meeting once a month is not enough. Mr Hewer told the Inquiry there was insufficient time to meet more often.²²⁰ I find this unimpressive.

102.2 According to Mr Hewer, there is now managerial oversight of use of force debriefs.²²¹

102.3 Mr Hewer also stated that every use of force was reviewed within 24 hours by the Assistant Director Security and the Use of Force

²¹² [DL0000175_021](#) paras 2.8-2.9

²¹³ [DL0000175_021](#) paras 2.8-2.9

²¹⁴ [DL0000175_021](#) para 2.9

²¹⁵ [SER000226_0215](#) KPI 10

²¹⁶ [Steven Hewer 1 April 2022 2/14-16, 135/17-25](#)

²¹⁷ [SER000451_014](#) para 61

²¹⁸ [Steven Hewer 1 April 2022 136/3-23](#)

²¹⁹ [Standard Operating Procedure 27 April 2020, pp22-23; SER000054_016](#)

²²⁰ [Steven Hewer 1 April 2022 137/11-18](#)

²²¹ [SER000451_015](#) para 65

Coordinator.²²² Home Office representatives and Brook House IMB members are also invited to attend.²²³

103. The Inquiry has not reviewed footage of recent use of force events and therefore I cannot reach specific conclusions about the appropriateness of use of force methods deployed in Brook House today (nor would this fall within the Inquiry’s Terms of Reference). However, while I welcome the increased oversight and monitoring of the use of force, I consider that more can be done by the Home Office and Serco to ensure that force is used only as a last resort and in a way that is as safe and transparent as possible. This is particularly important in relation to the use of force in response to incidents of self-harm and to manage the behaviour of those with mental health issues.²²⁴ The 2020 Brook House IMB report noted that 37 per cent of the use of force incidents at Brook House during 2020 were in response to incidents of self-harm (which had also increased).²²⁵ This remains of considerable concern.²²⁶

104. Use of force incidents must be comprehensively reviewed to ensure that force has been used appropriately and to identify any necessary improvements to practice or training. This is of critical importance as a general principle, but there is also an important practical purpose, given the range of issues identified above by the Inquiry with key aspects of uses of force in the relevant period. The oversight of use of force was wholly inadequate during the relevant period and so the problematic nature of some incidents was not highlighted and addressed. Reviews of individual incidents were perfunctory and, as a result, some poor practice was not identified and challenged. I am therefore recommending urgent action to address how uses of force are reviewed, in advance of the introduction of a new DSO.

²²² [SER000170_022](#); [SER000451_014](#) para 61

²²³ [SER000170_022](#); [SER000451_014-015](#) paras 61-65

²²⁴ [Dr Rachel Bingham 14 March 50/5-51/5](#); [Theresa Schleicher 14 March 2022 90/1-90/12, 97/25-98/22](#)

²²⁵ [IMB000202_016](#) para 4.5

²²⁶ [Theresa Schleicher 14 March 2022 89/7-90/12](#); [BHM000031_58](#) paras 173-174

Recommendation 17: Urgent improvement of use of force reviews

The Home Office must ensure, as a matter of urgency, that training is delivered on how to conduct an effective use of force incident debrief, ensuring that issues of detained person and staff welfare, as well as training needs, are covered. The training must be mandatory for all immigration removal centre contractor employees who conduct such reviews and those who manage them.

The Home Office must also require that use of force incidents be reviewed, at a minimum, at the following levels:

- Within 36 hours of each use of force incident, the Use of Force Coordinator must conduct a thorough incident review, ensuring that all documentation and footage are collated and preserved, and with a view to taking emergency action in instances of unlawful or inappropriate force. On a weekly basis, all use of force incidents must be reviewed (including all necessary paperwork and available video footage) at a formal meeting by the Use of Force Coordinator and a suitable manager in order to review each incident and to identify any issues or further action required.
- On a monthly basis, immigration removal centre contractor senior management must arrange meetings with other stakeholders (including detained people and representatives of non-governmental organisations) to review use of force trends.
- Periodically, the Home Office (or its Professional Standards Unit if the Home Office considers it more appropriate) must review use of force at Brook House and across the immigration detention estate, to identify trends and to direct the implementation of any changes and improvements that are required.

This review process must be reflected in the new detention services order regarding the use of force – see Recommendation 15 – in respect of which additional, regular (at least annual) training must then be provided.

Chapter D.8:

Healthcare

Introduction

- 1.** Detained people are entitled to the same range and quality of healthcare services as the general public receives in the community – this is known as ‘equivalence of care’. This requirement is set out in the Detention Services Operating Standards Manual for Immigration Service Removal Centres.¹ To reflect this, since 2013 NHS England has been responsible for commissioning healthcare in immigration removal centres (IRCs) in England.
- 2.** This chapter considers a range of issues in relation to healthcare. These include the approach of healthcare staff to detained people, the role of healthcare staff in the use of force by detention staff, incidents of food and fluid refusal, the assessment of the mental capacity of detained individuals and the handling of complaints. (Matters relating to initial health screening are considered separately in Chapter D.5.)
- 3.** The Inquiry is aware that this is a complex and technical area, and that there are challenges in the provision of healthcare services in immigration detention, given the nature of the environment and the vulnerabilities of the detained population. However, it is also important to recognise that inadequacies in the provision of healthcare to detained people (particularly those who are vulnerable) risk deterioration in their health as well as misinterpretation of their conduct, and may potentially expose them to incidents of abuse.

Provision of healthcare

- 4.** The healthcare service was and is an NHS-commissioned service on behalf of the Home Office, provided entirely separately from the contract to manage Brook House.
- 5.** G4S Health Services (UK) Ltd (G4S Health Services) held the contract for the provision of healthcare services in Brook House from September 2014 until 31 August 2021, including during the relevant period (1 April 2017 to

¹ Detention Services Operating Standards Manual for Immigration Service Removal Centres, January 2005, p34

31 August 2017).² Practice Plus Group (PPG) took over this contract in September 2021.³

6. The provision of GP services was subcontracted to Doctor PA Ltd during the relevant period and still is currently.⁴ Dr Husein Oozeerally, lead GP at Brook House during the relevant period and at the time of the Inquiry's public hearings, and Dr Saeed Chaudhary were and remain the co-directors of Doctor PA Ltd, and they provided most GP services at Brook House.

7. There were a number of other key personnel during the relevant period.

7.1 Ms Maxine York, Regional Clinical Governance Manager at G4S Health Services, was responsible for the line management and clinical supervision of the Head of Healthcare at Brook House.⁵ She was not based at Brook House but had daily contact with the Head of Healthcare and face-to-face meetings when necessary.

7.2 The Head of Healthcare in Brook House from 2016 (and continuing under PPG) was Ms Sandra Calver, an experienced Registered General Nurse (RGN) who had worked in IRCs since November 2004. Her responsibilities included:

- financial budgetary control;
- the daily running of the Healthcare department;
- the line management of the Practice Managers (who were responsible for overseeing the administrative functions of the Healthcare department) and Clinical Leads (who managed and supervised the senior nurses) at both Brook House and Tinsley House; and
- the clinical supervision of the Clinical Leads.

She was also Safeguarding Lead, responsible for giving guidance on safeguarding vulnerable adults and reviewing referrals.⁶

7.3 Ms Christine Williams was the Clinical Lead at Brook House. Senior nurses under her management in turn managed nurses and healthcare assistants, some of whom were 'bank' and agency staff (ie temporary staff provided by third-party organisations when needed).⁷ There were a total of nine RGNs (plus four bank RGNs), five Registered Mental

² [CJS0074040_002](#) paras 6-11. The contract was initially held by G4S Medical and Forensic Services (UK) Ltd, which changed its name to G4S Health Services (UK) Ltd in October 2016

³ [PPG000182](#)

⁴ [CJS0073870](#); [PPG000040](#). The Inquiry was told that PPG intends to move towards an employed GP model ([PPG000169_009](#) paras 43-44)

⁵ [DWF000009_007](#) paras 33-34

⁶ [DWF000009_006](#) para 27; [DWF000009_007](#) para 33; [Sandra Calver 1 March 2022 142/13-143/10](#)

⁷ [DWF000009_006-007](#) paras 27-29

Health Nurses (RMNs) and seven healthcare assistants (plus five bank healthcare assistants).⁸

7.4 There were also a pharmacy technician, a learning disability nurse and two practice administrators.⁹

8. There was no in-patient healthcare unit in Brook House but there were nurses on duty, available to respond to any medical emergencies 24 hours a day, seven days a week. Otherwise, the services provided were intended to be the equivalent of primary and community care available in the community.

8.1 The nurse triage clinic was a walk-in service that was open between 09:30 and 11:30, and between 14:30 and 15:30. If someone needed to see a nurse at any other time, they could ask the officers on their wing to call Healthcare and alert the nurses. The nurses would then attend the wing to treat them, or the detained person could be brought to the Healthcare department by officers.¹⁰

8.2 The GP service was appointment-based. If a detained person needed to see a GP more urgently than by booking a routine appointment in advance, they would first need to see a nurse for assessment and referral. They could see the nurse in the triage clinic without needing an appointment and then the nurse would book an urgent GP appointment. GPs worked on weekdays and (for more limited hours) on weekends.¹¹

8.3 RMNs were available at Brook House during the day. In order for a detained person to see an RMN, they first needed to be assessed by an RGN, admissions staff or a GP, who could then make a referral. Specific forms were used to refer detained people to the mental health team, which were reviewed and actioned every day. If a detained person needed to see a psychiatrist, they would first have to be assessed and referred by an RMN. A psychiatrist visited Brook House to see patients once a week for an afternoon clinic.¹² In 2017, there were no psychologists employed at Brook House, but the RMNs held some group psychological therapy sessions and one-to-one sessions with detained people.

8.4 The pharmacy opened for 45 minutes three times each day to dispense medication.¹³

8.5 Opticians and dentists visited Brook House periodically to hold pre-booked clinics.

⁸ [DWF000009_006](#) para 27

⁹ [DWF000009_006](#) para 27

¹⁰ [DWF000001_008](#) para 87; [DWF000001_009](#) para 89; [DWF000020_017](#) paras 92-94

¹¹ [DWF000020_017](#) para 92

¹² [DWF000020_017-018](#) paras 92-97

¹³ [DWF000020_016](#) para 87

- 8.6** There was also a substance misuse team (provided by Forward Trust, an external charity) who held one-to-one sessions with detained people to address issues with drug or alcohol misuse.¹⁴

Challenges facing delivery of healthcare services

- 9.** The management of healthcare and delivery of clinical care in Brook House presented a number of challenges for both staff and detained people.

Staffing levels

- 10.** During the relevant period, there were long-standing difficulties in the recruitment and retention of staff members.

- 10.1** In the Healthcare department, many of the staff were agency staff. Ms Calver stated that the department had *“never been fully staffed with permanent staff since 2012”*. Despite several recruitment drives, there were vacant permanent positions and *“19.5% of shifts were covered by agency staff”* between April and August 2017.¹⁵

- 10.2** Ms Havva Daines, an RGN who had worked at Brook House since 2010, said that staffing levels were insufficient *“to provide adequate healthcare to the detainees”*.¹⁶ She stated:

*“We did our best but some days, I don’t think it was enough ... A lot of the time, there would only be one RMN on shift ... This was not enough to treat all of the detainees who were suffering from mental health issues.”*¹⁷

However, Ms Calver did not consider lack of resources to be an issue. She told the Inquiry: *“we had a fully staffed team even if partially covered by agency staff”*.¹⁸

- 10.3** The Inquiry received some evidence of delays and frustration related to Healthcare staff attending to incidents.¹⁹ For example, as discussed in Chapter D.5, detained people were sometimes not seen within the required two-hour time frame on admission to Brook House and their

¹⁴ [DWF000020_015](#) para 80

¹⁵ [DWF000009_008](#) paras 42-44; [DWF000020_010](#) para 54

¹⁶ [DWF000001_005](#) para 46; [DWF000001_009](#) para 97

¹⁷ [DWF000001_005](#) para 46; [DWF000001_005](#) para 51; [DWF000001_009](#) para 97. See also [DWF000014_010](#) para 35

¹⁸ [DWF000009_008](#) paras 42-44. See also [DWF000020_010](#) para 54; [DWF000003_006](#) para 34; [DWF000003_006](#) para 40; [INQ000052_058](#) para 221

¹⁹ [INQ000052_060](#) para 230

admission was therefore unduly delayed.²⁰ Additionally, where an incident needed a medical emergency response, two members of Healthcare staff were required to respond, which had an impact upon the availability of staff to undertake initial reception health screening or triage clinics.²¹ This would have been likely to leave detained people waiting in Reception, which may have caused frustration and disruption.

Prevalence of mental ill health in the detained population

11. The prevalence of mental ill health, the presence of high risks of self-harm and suicide, a stressful environment, a significant number of victims of torture and other past trauma, and vulnerability to the loss of mental capacity are all factors that present challenges to the assessment of the medical needs of detained people and their care and medical treatment. From the evidence the Inquiry heard and received, it is clear that this was very much the case during the relevant period in Brook House, and is likely to still be the case.²²

12. Conditions such as depression, anxiety, post-traumatic stress disorder (PTSD), psychosis and substance abuse are more common in IRCs than in the community. Research suggests that a high proportion of detained people display clinically significant levels of depression, PTSD and anxiety, as well as intense fear, sleep disturbances, profound hopelessness, self-harm and suicidality.²³ There is also a heightened risk of self-harm and suicide among those in immigration detention, and self-harm is a risk factor for both mental ill health and suicide. Self-harm may be a symptom of complex PTSD, personality disorder or other mental ill health.²⁴

13. Stressors associated with detention, including the sudden nature of being detained, uncertainty and anxiety about the future, separation from social support and other coping mechanisms, and the highly stressful environment of detention, may exacerbate mental ill health. Detention can also be very disruptive to pre-detention medical care.²⁵

14. In addition, many detained people report a history of torture or serious ill treatment. Specific experiences of detention, such as the banging of cell doors and jangling of keys, may trigger powerful and traumatising memories of past experiences of ill treatment. These effects not only often exacerbate

²⁰ [DWF000010_013](#) para 55; [D1851 3 December 2021 64/12-65/7, 104/18-106/19](#)

²¹ [DWF000001_002](#) para 8; [DWF000001_009](#) para 94; [DWF000003_014](#) paras 97-99

²² [BHM000033_010](#) paras 35-36; [BHM000030_008-009](#) para 17; [BHM000030_039-040](#) paras 81-83

²³ [BHM000033_010](#) para 35; [BHM000033_017-018](#) para 58; [INQ000060_083-085](#) paras 4.1-4.16; [BHM000030_008-009](#) para 17; [BHM000030_011](#) paras 20-21

²⁴ [BHM000033_022](#) para 65

²⁵ [BHM000033_010](#) para 35; [INQ000060_307](#); [INQ000060_321-322](#)

pre-existing mental ill health but also may specifically elicit trauma-related symptoms such as nightmares and flashbacks.²⁶

15. As discussed further below, detained people with mental ill health may be more vulnerable to losing mental capacity to make decisions about their medical care and treatment.

Lack of therapeutic interventions

16. The absence of access to a full range of psychiatric interventions available to victims of torture, those who had experienced trauma, PTSD sufferers and others experiencing mental ill health was a further challenge facing Healthcare staff in Brook House during the relevant period.

17. There was a lack of trauma-related psychological therapies and cognitive behavioural therapy during the relevant period.

17.1 Ms Calver agreed with Professor Cornelius Katona, Emeritus Professor of Psychiatry at the University of Kent and Medical and Research Director at the Helen Bamber Foundation (a human rights charity that assists victims of torture and trafficking), that detention was not an appropriate therapeutic setting to promote recovery from mental ill health, due to the nature of the environment and the lack of specialist mental health treatment resources.²⁷

17.2 Ms Karen Churcher (an RMN during the relevant period) told the Inquiry that, although there were group talking therapy sessions at Brook House, they did not explore trauma. In her view, Brook House was not an appropriate environment in which to give trauma therapy. There were emotional support groups but they did not provide treatment for PTSD. Some detained people, such as D643, did not like these groups and found that they exacerbated their PTSD symptoms.²⁸

17.3 Ms Williams said that she was not confident her staff could identify symptoms of trauma and PTSD, and that neither she nor her staff had received any training on PTSD or torture awareness.²⁹

18. Despite the clear need for them among detained people, which should have been obvious to G4S Health Services and the Home Office, appropriate interventions and resources were not available during the relevant period. In my view, they should have been. This contributed to an environment that rendered those vulnerable detained people yet more vulnerable. In such

²⁶ [BHM000033_010](#) para 36; [BHM000033_013-016](#) paras 46-53; [INQ000060_091-092](#); [INQ000060_316](#); [INQ000060_320-321](#); [INQ000060_324](#); [BHM000030_008-009](#) para 17

²⁷ [BHM000030_009](#) para 18; [Sandra Calver 1 March 2022 189/10-190/10, 190/23-191/23](#)

²⁸ [Karen Churcher 10 March 2022 40/19-41/3, 59/23-61/13](#); [DL0000228_009](#) paras 39-40

²⁹ [Christine Williams 10 March 2022 103/11-21](#)

circumstances, the operation of the systems to safeguard the welfare of those who may be subject to harm in detention (see Chapter D.5) was crucial.

19. Similar concerns remained at the time of the Inquiry’s hearings. The 2021 Independent Monitoring Board (IMB) report stated:

“However, irrespective of Serco’s efforts, Brook House is not a safe or appropriate environment for the few men who have arrived in 2021 with severe mental health issues or have significantly deteriorated while in detention. The Board is concerned that the Home Office Detention Gatekeeper is not adequately preventing the detention of men whose mental health needs make such detention inappropriate or inadvisable (section 4.4).”³⁰

20. PPG told the Inquiry that it had made various improvements to the provision of healthcare services since it took over the contract for Brook House in September 2021. These included increasing levels of Healthcare staff and the provision of mental healthcare through, for example, low and medium-intensity trauma-based psychological interventions led by a psychologist and assistant psychologists.³¹ As Dr Sarah Bromley (National Medical Director for Health and Justice at PPG) explained, the psychologist would support psychological interventions, initiate psychological therapy programmes and introduce training for Healthcare staff in trauma-informed practice.³² In addition, PPG stated that:

- Training sessions on self-harm and suicidal thought were provided as part of the Healthcare staff induction programme.
- Multi-Professional Complex Case Clinics were introduced which fed in to weekly ‘vulnerable persons’ meetings to ensure that the full clinical picture was taken into account when considering a detained person’s ongoing fitness for detention.³³
- All detained people placed on constant supervision underwent a mental health assessment to ensure that mental health needs were identified and (wherever possible) met.³⁴
- Trauma-informed training was provided for the mental health team and bespoke mental health assessment training for secure environments,

³⁰ *Annual Report of the Independent Monitoring Board at Gatwick IRC: For Reporting Year 1 January–31 December 2021*, IMB, June 2022, p9 section 4.4. See also [SER000038](#) regarding Serco. The Home Office Detention Gatekeeper is a Home Office official who makes decisions about whether to detain an individual

³¹ [PPG000172_004](#). See also [PPG000169_003](#) paras 13-14

³² [PPG000172_004](#) para 15

³³ [PPG000172_020](#) para 116

³⁴ [PPG000204_005](#) para 19

although its intention is for all Healthcare staff at Brook House to be given trauma-informed training.³⁵

21. I remain concerned that the improvements made by PPG, while welcome, focus upon the management of mental ill health in detention and do not address significant concerns about the lack of priority given to the safeguards for vulnerable people in detention and the deficiencies that remain in that system (discussed further in Chapter D.5).

22. The 2022 HM Inspectorate of Prisons (HMIP) inspection report recorded the following as a priority concern:

“The centre did not meet the needs of the high number of detainees with mental health problems. The centre held many people with low level mental health needs who could not access psychological interventions as all the psychology posts were vacant. Several detainees with poor mental health had been located in the separation unit, which was not a suitable place for them.”³⁶

The Care Quality Commission issued a ‘requirement to improve’ notice following the 2022 HMIP inspection concerning insufficiencies in staffing levels, particularly in relation to mental health staff and the absence of psychology provision.³⁷

Drugs

23. As discussed in Chapter D.4, during the relevant period there was a significant problem in Brook House with a new psychoactive substance known as ‘spice’.³⁸

24. Healthcare staff were required to respond to a number of medical emergency calls in relation to detained people who were intoxicated with spice.³⁹ This sometimes had the effect of diverting resources away from the provision of medical care – for example, the nurses’ triage clinic would be closed.⁴⁰

25. For the most part, the responses to calls for emergency assistance and the care given on those occasions by Healthcare staff were appropriate.⁴¹ However, on occasion, Healthcare staff made inappropriate, mocking and derogatory comments about, and in the presence of, intoxicated detained

³⁵ PPG000172_004 paras 15-16

³⁶ HMIP000702_048 para 3

³⁷ HMIP000702_035 para 3.25; HMIP000702_061-062 Appendix III

³⁸ DWF000001_002 para 8; DWF000003_14 paras 97-99; Anton Bole 8 December 2021 128/15-131/4; HOM0331981_011 para 41; Darren Tomsett 7 March 2022 37/10-14

³⁹ DWF000001_002 para 8; DWF000003_014 paras 97-99

⁴⁰ DWF000001_005 para 51

⁴¹ TRN0000083_006; TRN0000083_009; TRN0000083_011

people.⁴² The Head of Healthcare accepted that some comments by a nurse had been inappropriate and dehumanising. For example, one nurse who was caring for and conducting observations on a detained person who had been unconscious due to intoxication with spice made comments such as:

“Let’s open your eyes. Oh, like saucers. That’s what we like. You’ve had a good old time, haven’t you? Was that fun? You enjoyed a good time. I think you enjoyed your stash.”⁴³

26. There were also occasions where Healthcare staff did not challenge or report inappropriate, derogatory and dehumanising language used by detention custody staff about and towards detained people.⁴⁴ On 14 June 2017, Detention Custody Manager (DCM) Nathan Ring was heard to say, for example, *“Does your face taste nice? Because you appear to be chewing it off”* to a detained person who was intoxicated with spice in the presence of a nurse.⁴⁵

27. In regulated and trained professionals – whose primary duties are to put the interests of their patients first, to make their patients’ care and safety their main concern and to make sure that their dignity is preserved – this behaviour and lack of action is particularly shocking.⁴⁶ It is indicative of the ingrained nature of a toxic culture in Brook House during the relevant period, to which the Inquiry returns later in this Report. It also reflects some of the issues with the adequacy of care provided during the relevant period, as set out below.

The culture within the Healthcare department

28. In a report on immigration detention published in 2016, Mr Stephen Shaw (former Prisons and Probation Ombudsman) noted *“a culture of disbelief”* that pervaded healthcare and immigration casework.⁴⁷ He pointed to:

- a lack of trust among detained people in the GPs operating within IRCs to provide independent advice to the Home Office in reports made under Rule 35 of the Detention Centre Rules 2001 (discussed in Chapter D.5);
- the readiness of caseworkers to reject medical opinion on fitness for detention;⁴⁸

⁴² [Sandra Calver 1 March 2022 146/9-147/13; INQ000075_154 para 6.1.1.7](#)

⁴³ [Sandra Calver 1 March 2022 146/17-20](#)

⁴⁴ [Sandra Calver 1 March 2022 145/2-146/8; TRN0000092_039-040](#)

⁴⁵ [Sandra Calver 1 March 2022 145/24-146/8](#)

⁴⁶ *Good Medical Practice*, General Medical Council, updated 29 April 2014, paras 1, 2, 4; *The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates*, Nursing and Midwifery Council, updated 10 October 2018, para 1

⁴⁷ [INQ000060_167-168 para 7.53](#)

⁴⁸ [INQ000060_028 para 1.78; INQ000060_186 para 10.7; INQ000060_187 para 10.9](#)

- inadequate mental health provision for detained people; and
- inadequacies in the Assessment Care in Detention and Teamwork (ACDT) process (a process for managing those at risk of self-harm and suicide in detention, through constant supervision, discussed in Chapter D.5).

29. The Inquiry heard evidence from formerly detained people which indicated that doctors and nurses were, on occasions, dismissive of detained people and exhibited a lack of care or empathy during the relevant period.

29.1 D643 believed that Healthcare staff were frustrated with him for being mentally unwell and when he asked for help. They were not *“sympathetic”* to his suffering with PTSD and he *“was treated as an inconvenience”*.⁴⁹ When he asked one of the GPs for a Rule 35 assessment, it was refused; he was spoken to *“very harshly”* and interrupted when he tried to explain his PTSD symptoms.⁵⁰

29.2 D1473 stated that he *“felt that healthcare at Brook House was really on the side of the detention centre rather than being focussed on looking after vulnerable detainees”*.⁵¹ He said:

*“Healthcare at Brook House never sent a Rule 35 report to the Home Office about my situation, despite knowing that I was a victim of torture and was suffering from serious mental health problems.”*⁵²

29.3 D687 told the Inquiry that, when he disclosed a past history of trauma and suicidal intentions to a nurse for the first time on 7 March 2017, *“The nurse didn’t take it very seriously.”*⁵³ He stated:

*“I wasn’t given any medication, just referred to an ‘art and craft class’ and a ‘victim awareness group’. I did not receive a Rule 35 appointment, or any other appointment to see a doctor. I continued to struggle with my mental health throughout the rest of my detention at Brook House.”*⁵⁴

29.4 D2077 committed an act of serious self-harm in Brook House by sewing his lips together. In his witness statement to the Inquiry, he said:

⁴⁹ [DL0000228_010](#) para 44

⁵⁰ [DL0000228_011](#) para 47; [INQ000060_085](#) para 4.12. See also [DL0000222](#); [DL0000226_036-037](#) paras 143-151; [DPG000021_046](#) para 137; [DPG000021_053](#) para 146; [BHM000039_009-010](#) para 48

⁵¹ [BHM000039_009-010](#) para 48; [HOM029928_020-021](#)

⁵² [BHM000039_009-010](#) para 48; [HOM029928_020-021](#)

⁵³ [DPG000021_046](#) para 137; [DPG000021_053](#) para 146

⁵⁴ [DPG000021_046](#) para 137; [DPG000021_053](#) para 146

“I did not have any confidence in the healthcare system at Brook House. I felt that the doctors and nurses were part of the system and they had the same lack of care and disrespect for the detainees as the guards. I do not feel as if they truly wanted to help and were mainly concerned with trying to help the Home Office try to remove us.”⁵⁵

30. In my view, this dismissive attitude of some Healthcare staff and their failure to fulfil their obligations under Rule 35, as well as failing to provide adequate healthcare, exposed vulnerable detained people to a risk of suffering harm in detention. In some cases, detained people’s mental health deteriorated as a result.⁵⁶

Food and fluid refusal

31. Guidance regarding dealing with an adult refusing food and/or fluid was set out in Detention Services Order 03/2017: Care and Management of Detained Individuals Refusing Food and/or Fluid (the Food and Fluid DSO). As a result, where a detained person refused food and/or fluids for over 24 hours, they were required to be offered a routine medical appointment to ensure that the refusal was not caused by undiagnosed mental ill health or any physical illness, they understood the consequences and risks of their actions, and they were offered appropriate care. An ACDT document was to be opened after 24 hours of fluid refusal and after 48 hours of food refusal.⁵⁷

32. The Inquiry received records in relation to approximately 60 detained people refusing food and fluid during the relevant period for varying periods of time. Shift handover notes indicated that, at any one time, between one and eight detained people were being monitored for food and fluid refusal.

33. Ms Calver explained that, on days one and two, the checks carried out by Healthcare staff on a detained person refusing food and fluid involved a full set of physical observations, including blood sugars, blood pressure and weight. If necessary, a referral would be made to a GP, although this referral generally focused solely on physical abnormalities in observations.⁵⁸

34. There may be many different reasons why a detained person refuses food and fluid. Dr James Hard, the Inquiry’s medical expert, told the Inquiry that it can be a sign of distress, that there can be psychological causes and

⁵⁵ [DL0000226_036](#) paras 144-145

⁵⁶ [Dr James Hard 28 March 2022 49/6-21, 85/23-86/20, 100/25-105/12; INQ000112_025-027; INQ000112_029-030; Dr Rachel Bingham 14 March 2022 22/8-23/14; CJS000887_036](#)

⁵⁷ [Detention Services Order 03/2017: Care and Management of Detained Individuals Refusing Food and/or Fluid \(CJS000724\)](#), Home Office, October 2017 (updated most recently [September 2022](#)), paras 17 and 18

⁵⁸ [Sandra Calver 1 March 2022 240/20-241/9](#)

that, depending upon the cause identified, different responses may be required.⁵⁹

35. Ms Calver confirmed that detained people would be asked the reasons why they were refusing food and fluids, but an examination of their mental state would not be carried out unless there was continued refusal.⁶⁰ This was, however, a cursory enquiry. She also said that consideration was not always given to food and fluid refusal as a form of self-harm, or to it being a manifestation of mental ill health.⁶¹ This demonstrated a tendency not to investigate adequately or explore any clinical or underlying reasons for food and fluid refusal in any depth.⁶²

36. It was apparent from the evidence that the issue of food and fluid refusal was not afforded the attention it merited. Instead, it was sometimes dismissed as manipulative behaviour by detained people, some form of protest or attention-seeking behaviour.

36.1 Dr Oozeerally said that, when he asked detained people why they were refusing food or fluids, he often received a response along the lines of *"I'm frustrated with the Home Office. I'm frustrated with my solicitor."*⁶³ He also suggested that the most common reason for food refusal was protest.⁶⁴ He said that, in his experience at that time, there were a lot of people refusing food and fluid together: *"it was groups and co-ordinated"*.⁶⁵

36.2 This assumption is also demonstrated by Mr Ring's attitude towards a detained person who had not eaten. Mr Ring called him a *"penis"* and Detention Custody Officer (DCO) Callum Tulley was effectively instructed to *"cross him off"* the list that recorded which detained people had eaten their meal.⁶⁶ Mr Ring's explanation was that he knew the detained person was eating food from the shop.⁶⁷ Whether or not this was correct, in circumstances where there was no reliable method to monitor each individual, it was inappropriate to bypass the system to identify and monitor detained people who were refusing food in this manner.

36.3 Ms Calver commented that *"a lot of them were refusing [food and fluid] literally to prevent their flights"*, ie their removal from the UK.⁶⁸

⁵⁹ [Dr James Hard 28 March 2022 167/21-168/3](#)

⁶⁰ [Sandra Calver 1 March 2022 241/10-19](#)

⁶¹ [Sandra Calver 1 March 2022 241/20-22 and 242/4-22](#)

⁶² [Dr Rachel Bingham 14 March 2022 18/23-19/25](#); [Dr James Hard 28 March 2022 167/5-20](#)

⁶³ [Dr Husein Oozeerally 11 March 2022 158/9-19](#)

⁶⁴ [DRO000001_011](#) para 99

⁶⁵ [Dr Husein Oozeerally 11 March 2022 157/25-158/11](#)

⁶⁶ [TRN0000079_007](#)

⁶⁷ [Nathan Ring 25 February 2022 112/7-14](#)

⁶⁸ [Sandra Calver 1 March 2022 241/24-242/3](#)

37. I consider these examples to be further clear evidence of a culture among GPs and Healthcare staff at Brook House of characterising behaviour as wilfully disobedient and obstructive, instead of countenancing the idea that behaviour may be a manifestation of mental anguish or ill health. These are themes that were an inherent feature of the experience of detained people in Brook House. For example, DCO Daniel Small gave evidence that he construed self-harm as not being about mental health but about avoiding deportation.⁶⁹ Dr Rachel Bingham, clinical advisor to Medical Justice (a charity that provides medico-legal reports and advice to detained people), described this as “*mental health symptoms ... reinterpreted as behavioural symptoms*”.⁷⁰

38. In cases of food and fluid refusal, there was inadequate consideration of the detained person’s mental capacity. The Inquiry heard evidence that assessments were not routinely carried out to ensure that they had the capacity to make the decision to refuse food and fluid.⁷¹ Instead, the ACDT process was used in response. An ACDT document could be opened by any member of staff who had a concern, for example, that a detained person had told someone that they wanted to die, or as a result of an incident of self-harm. The individual would then be reviewed and observed depending upon the level of risk. However, the ACDT process is not a clinical response and does not include therapeutic interventions or the provision of treatment for the underlying causes of the risk.⁷²

39. Food and fluid refusal was not generally considered by Healthcare staff at Brook House to be a genuine form of self-harm, or considered in conjunction with any deterioration in mental health. Generally, it was felt to be a form of protest about detained people’s immigration cases. While this may sometimes have been the case, this could not always be reliably concluded without carrying out mental state, mental health or mental capacity assessments, and without more detailed exploration of the reasons for food and fluid refusal. The Inquiry received evidence of a number of examples of this.

39.1 Dr Bingham told the Inquiry that the Home Office’s statutory guidance Adults at Risk in Immigration Detention (Adults at Risk policy) should have been considered in relation to D13’s case in particular.⁷³ D13 intermittently stopped eating for various periods throughout his detention at Brook House. There was a delay in identifying several episodes of food refusal and triggering the food and fluid refusal monitoring process, with physical observations belatedly imposed only several days after D13 had stopped eating. D13 was a patient of the mental health team throughout and subject to an ACDT for an

⁶⁹ [Daniel Small 28 February 2022 117/8-18](#)

⁷⁰ [Dr Rachel Bingham 14 March 2022 20/3-22](#)

⁷¹ [Dr Rachel Bingham 14 March 2022 20/20-21/8](#)

⁷² [Dr Rachel Bingham 14 March 2022 21/9-22/7](#)

⁷³ [Dr Rachel Bingham 14 March 2022 20/1-21/8](#)

overlapping period on account of his suicidal ideation. There was no substantive assessment of the motivation for his food refusal or the potential interplay with an exacerbating effect on his mental vulnerabilities and risk to himself, and no consideration of producing a report under Rule 35(1) or Rule 35(2).⁷⁴

39.2 D1527 refused food, fluids or both for a prolonged period in Brook House – a total of 34 days within a 40-day period: on 19 April, for 6 days between 22 and 27 April, for 10 days between 30 April and 9 May, and for 17 days between 11 May and 27 May. He was accepted by the Home Office to be an ‘adult at risk’ who suffered from underlying mental health and self-harm issues, and was unwell and deteriorating.⁷⁵ The underlying reasons were not investigated and there was no apparent consideration of the Adults at Risk policy or Rule 35.⁷⁶ No capacity assessment was carried out, although this should have occurred routinely.⁷⁷ Instead, D1527 was managed solely through the ACDT process, which does not provide any therapeutic interventions. It is hard to escape the conclusion that this too was a feature of the mischaracterisation of this behaviour as deliberately manipulative.

40. Such cases, where there was prolonged refusal of food and/or fluids combined with a history of mental ill health and/or self-harm, should have prompted consideration of the safeguards designed to protect vulnerable individuals provided under Rule 35 or the Adults at Risk policy as a matter of routine. This in turn would have triggered consideration of whether that person should continue to be detained.⁷⁸ Instead, Rules 35(1) and (2) were not always or usually considered in cases of food and fluid refusal, even where this should have prompted concerns about a detained person’s mental health deterioration or risk of self-harm or suicide.

⁷⁴ [Dr Rachel Bingham 14 March 2022 22/8-23/14](#)

⁷⁵ [HOM000644](#)

⁷⁶ [INQ000075_053](#) para 5.78; [INQ000075_80-81](#) para 5.147

⁷⁷ [Dr Rachel Bingham 14 March 2022 20/20-21/8](#)

⁷⁸ [Dr James Hard 28 March 2022 167/5-168/20](#); [Dr Rachel Bingham 14 March 2022 20/1-19](#); [INQ000112_050](#)

41. Dr Hard was critical of how the Rule 35 procedures worked in practice. They did not always ensure that the Home Office was notified of a change in the detained person’s circumstances (as demonstrated by refusing food and fluid) in order for their detention to be reviewed and for there to be consideration of their release.⁷⁹ For example, records from 13 April 2017 demonstrated a deterioration in D1527’s mental health following the completion of a Rule 35(3) report – used where a detained person may have been a victim of torture – and the subsequent response from the Home Office stating that detention was being maintained.⁸⁰ This case highlights that there was no appropriate and dynamic approach to the use of the Rule 35 system.⁸¹ As Dr Hard noted, D1527’s prolonged food and fluid refusal, after the completion of the Rule 35(3) report and the Home Office decision to maintain his detention, should have prompted consideration of the Adults at Risk policy and a Rule 35(1) report, even if that “*needed to have been on a repeated basis*”.⁸² He should also have undergone a mental capacity assessment.

42. As a result of failures to connect food and fluid refusal with consideration of whether the detained person was an adult at risk and with the Rule 35 process, vulnerable detained people were allowed to remain at risk of deterioration and exposed to a risk of harm in detention. In addition, the Home Office was not informed and so did not have the opportunity to review their detention and consider their release, as should have occurred. I am therefore recommending that the Food and Fluid DSO be updated urgently.

⁷⁹ [Dr James Hard 28 March 2022 168/21-170/7](#)

⁸⁰ [CJS001002_034-051](#); [CJS001123](#); [HOM000644](#)

⁸¹ [Dr James Hard 28 March 2022 168/14-170/7](#); [INQ000112_073](#) para 4.7.5

⁸² [Dr James Hard 28 March 2022 168/21-25](#)

Recommendation 18: Urgent guidance in relation to food and fluid refusal

The Home Office must, as a matter of urgency, update Detention Services Order 03/2017: Care and Management of Detained Individuals Refusing Food and/or Fluid, to ensure that it deals with:

- food and fluid refusal being clearly and directly linked to consideration of the Rule 35 process and whether a detained person is defined as an 'adult at risk';
- the consideration by the healthcare provider at each immigration removal centre, upon an incidence of food and fluid refusal occurring, of assessments of mental capacity, of mental state, and under Rule 35, and the conduct of these where indicated, as well as ensuring compliance with the Adults at Risk in Immigration Detention policy and making sure that decisions made in relation to these are recorded;
- the notification to the Home Office of the numbers of detained people refusing food and fluids, and the reasons for such refusal, on a monthly basis (in the same way that incidents of self-harm are notified); and
- the monitoring by the Home Office of the compliance by healthcare providers with Detention Services Order 03/2017 and the numbers of detained people refusing food and fluids, and the reasons for such refusal, in order to identify any patterns of concern and take appropriate action.

The Home Office must ensure that mandatory training about the application of the updated detention services order takes place on a regular (at least annual) basis for all detention staff and healthcare staff, as well as those responsible for managing them. Attendance must be mandatory for all staff working in immigration removal centres and those responsible for managing them. The training must be subject to an assessment.

In anticipation of the update to Detention Services Order 03/2017, the Home Office must issue an immediate instruction to communicate this clarification to those operating immigration detention centres.

The role of healthcare staff in relation to use of force

43. Use of force is a serious intervention, with potential to cause harm to vulnerable detained people, and is open to a risk of abuse. While broader issues regarding the use of force are considered in detail in Chapter D.7, this chapter focuses on the role of healthcare staff in relation to such incidents. Prison Service Order 1600: Use of Force states that a member of healthcare staff “*must, whenever reasonably practicable, attend every incident where staff are deployed to restrain violent or disturbed prisoners*”.⁸³

44. Contrary to the established principle that the use of force in a custodial environment should be a response of last resort, the Inquiry heard that restraint was used inappropriately at Brook House as a risk management tool and for convenience.⁸⁴ Dr Hard described use of force as the “*go to option*”.⁸⁵ This extended to responses to incidents of self-harm, managing behaviour (including of those with mental ill health) and moving or segregating detained people.⁸⁶

Safeguarding role

45. Healthcare staff have an important safeguarding role in the context of the use of force on a detained person.⁸⁷ The first important safeguarding role is the need to raise concerns about any use of force and contraindications (clinical reasons not to use force on a particular detained person), both in advance of a planned use of force and during any use of force (whether planned or unplanned).⁸⁸

46. D1914 was subject to a planned use of force to move him to E Wing on 27 May 2017, in advance of a planned flight to remove him from the country. (The use of force for the sole reason of moving D1914 in preparation for removal was inappropriate in itself.⁸⁹ This is considered separately in Chapter C.6 in Volume I.)

⁸³ [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, paras 6.7-6.8

⁸⁴ [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, paras 4.24-4.26; [Detention Centre Rules 2001](#), Rule 41; [INQ000111_013](#) para 28; [Dr James Hard 28 March 2022 87/2-8](#)

⁸⁵ [Dr James Hard 28 March 2022 137/11-138/9](#)

⁸⁶ [Dr Rachel Bingham 14 March 2022 50/5-51/5](#); [Theresa Schleicher 14 March 2022 89/7-25, 90/1-12, 97/25-98/22](#); [Theresa Schleicher 14 March 2022 89/7-25](#); [Dr James Hard 28 March 2022 163/19-164/16](#)

⁸⁷ [Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, paras 6.3-6.8; [BHM000033_49](#) para 130; [Joanne Buss 14 March 2022 118/17-23](#)

⁸⁸ [Dr James Hard 28 March 2022 89/5-9](#)

⁸⁹ [Dr James Hard 28 March 2022 90/16-24](#)

- 46.1** In addition to a history of self-harm, D1914 had a serious heart condition that was documented in his medical records.⁹⁰ He had undergone two coronary artery bypass surgeries prior to his detention.⁹¹ While at Brook House, he experienced cardiac symptoms including chest pain and palpitations. He had been taken to hospital by ambulance, including on 17 May 2017 due to abnormal blood results.⁹² He was awaiting a cardiac catheter procedure due to an abnormal heart rhythm.
- 46.2** This was ample information to demonstrate contraindications to a planned use of force on D1914, although Dr Oozeerally was adamant that there were no such contraindications.⁹³ As Dr Hard and Dr Bingham confirmed, Dr Oozeerally, when asked to write a 'fit to fly and fit for detention' letter, should have explicitly raised D1914's complex medical history (particularly his cardiac condition) as contraindications in advance of the planned use of force. Instead he wrote: *"I am happy for reasonable force to be used (C and R) in order to facilitate the removal."*⁹⁴ He did not raise any concerns or contraindications. I consider that Dr Oozeerally failed in his safeguarding role in this regard.
- 46.3** As shown by handheld camera footage viewed by the Inquiry, the use of force lasted for just over 18 minutes.⁹⁵ The footage began with officers standing outside D1914's cell in full Personal Protective Equipment (PPE). They entered the cell and D1914 was checked by a nurse. Within 14 seconds, D1914 was told he was moving to E Wing (to which he replied he did not want to go and refused twice) and DCM Steven Dix authorised the use of force.
- 46.4** D1914 was moved from the bed and sank to the floor. Multiple officers told him repeatedly to stand up, which he partially did with assistance from the officers, but then sank back to the floor. Mr Dix told him that if he did not stand up and walk, he would be placed into handcuffs and lifted. D1914 asked why he was being restrained and stated that he had had three heart attacks. D1914 cried out and could be heard breathing deeply. Mr Dix again instructed D1914 to stand, to which he replied, *"It's not possible to."* Officers helped him to stand and move to the bed. D1914 was handcuffed with his hands behind his back. He walked without resistance, with officers holding his arms. D1914 told the officers that he was *"not feeling good"* and Mr Dix responded, *"Healthcare are here so the quicker we get going, the quicker we can*

⁹⁰ [Dr Rachel Bingham 14 March 2022 44/3-45/19; CJS000990_001](#)

⁹¹ [CJS000990_003](#)

⁹² [CJS000990_013-014](#)

⁹³ [Dr Husein Oozeerally 11 March 2022 136/9-138/15](#)

⁹⁴ [Dr James Hard 28 March 2022 90/6-92/18, 93/25-95/25; Dr Rachel Bingham 14 March 2022 44/3-45/10, 48/5-48/16](#)

⁹⁵ [Day 8 AM 2 December 2021 03:11:15-03:17:53 \(Disk 50 UOF 134.17 cam 3\)](#)

release you.” D1914 walked along the wing, his arms still being held. When he arrived at a cell on E Wing, D1914 was told by Mr Dix that a full search would be carried out. D1914 was compliant and the cuffs were removed.

Figure 34: Use of force involving D1914



47. In my view, it was not in D1914’s best interests to be subject to a use of force in these circumstances. Indeed, it was positively harmful to D1914 and put him at further risk.

48. In his evidence to the Inquiry, Dr Oozeerally was intransigent in his view that he was acting in the interests of his patient, although he accepted that it would never be in the best interests of a patient to have force used against them (except in the very limited circumstances of an immediately life-threatening situation in order to save their life).⁹⁶ Self-evidently, a use of force to move someone from one area to another in preparation for removal from the country does not qualify as an immediately life-threatening situation. Dr Oozeerally did not acknowledge the potential harm his attitude towards detained people’s safety and welfare could cause, and the risk at which he had placed D1914.⁹⁷

49. There is a tension between the healthcare professional’s obligation to act in the best interests of the patient and their involvement in a use of force incident in circumstances other than those that pose an immediate threat to life. This does not form part of the standard role of a healthcare professional in the general context of the doctor/patient or nurse/patient relationship in the community, and is peculiar to custodial settings. All healthcare staff should be vigilant in acting on concerns about their patients.

⁹⁶ [Dr Husein Oozeerally 11 March 2022 134/21-135/11](#)

⁹⁷ [Dr Husein Oozeerally 11 March 2022 136/9-138/15](#)

50. The second important safeguarding role of healthcare staff during the course of a use of force incident is to monitor the safety and wellbeing of a detained person.⁹⁸ Medical staff have the power, and indeed the duty, in certain circumstances to intervene or declare a medical emergency, and to issue an instruction to immediately stop restraint or other use of force.⁹⁹ The Inquiry heard evidence that some Healthcare staff had intervened in the past in such a way during a use of force.¹⁰⁰

51. This monitoring role encompasses intervention to raise concerns prior to and during the course of the use of force. During the relevant period, there did not seem to be an understanding or recognition among Healthcare staff of this aspect of the role, or that they should be intervening prior to the moment a use of force became an emergency situation.¹⁰¹

51.1 D812 was the subject of a use of force in response to a suicide attempt in which he had placed a bag over his head. Force was used to remove the bag. However, the use of force continued after the life-threatening situation had ended and the bag had been removed. There was, nevertheless, no intervention by Healthcare staff when there should have been.¹⁰²

51.2 As discussed in Chapter C.13 in Volume I, force was used against D2054 to move him to Reception for his removal flight on 28 June 2017. During the use of force, D2054 was naked or near-naked and handcuffs were inappropriately applied to D2054 behind his back while seated. This could potentially have created serious medical risks caused by being bent forwards for prolonged periods of time, including compression of the chest, interference with normal breathing and possibly death.¹⁰³ Ms Williams was present throughout the use of force and restraint upon D2054 but did not raise any concerns. She should have challenged the actions of the other staff, in particular in handcuffing him inappropriately behind his back while seated. She should have reported the incident immediately afterwards. If she could not observe the incident adequately, she should have moved so as to be able to monitor his safety. She could also have raised a concern with the officers that she could not adequately monitor his safety or intervened immediately to stop the restraint.

⁹⁸ [Dr James Hard 28 March 2022 88/25-89/4 and 89/10-14; Prison Service Order 1600: Use of Force \(INQ000185\)](#), HM Prison Service, August 2005, paras 6.7-6.8

⁹⁹ [Sandra Calver 1 March 2022 251/2-14; Joanne Buss 14 March 2022 142/14-20](#)

¹⁰⁰ [Christine Williams 10 March 2022 86/13-22; Joanne Buss 14 March 2022 138/10-14](#)

¹⁰¹ [Christine Williams 10 March 2022 109/21-110/22, 111/6-116/4](#)

¹⁰² [Dr Rachel Bingham 14 March 2022 50/20-52/10](#)

¹⁰³ [INQ000111_075](#) para 300

- 52.** Force was also used against D2159 in order to move him to E Wing on 5 April 2017.
- 52.1** Medical records noted that he was unwell and had been refusing food and fluids for approximately 11 days.¹⁰⁴ He was being managed through an open ACDT document. No referral for a Rule 35 report was considered by any member of the Healthcare department in relation to D2159’s food and fluid refusal, despite the deterioration in his physical health.
- 52.2** A nurse became concerned about him and his general welfare, and asked if a psychiatrist ought to assess him.¹⁰⁵ Ms Williams saw D2159 a few hours later that same day, and felt that it was in his interests to move him to E Wing so that he could be observed closely. The medical records note that he was not engaging with anyone, it was difficult to assess him, he appeared to have lost weight and he had not showered. Ms Williams recorded that “*restraints may be used*”, by which she had meant, as she explained in evidence, “*holding his hand*”.¹⁰⁶ No contraindications or concerns were raised prior to the planned use of force, in particular in relation to the effect of D2159’s food and fluid refusal or his physical state generally. They should have been. In this instance, Ms Williams failed to fulfil her safeguarding role.
- 52.3** In fact, considerably more force was used.¹⁰⁷ A planned use of force occurred (as opposed to a spontaneous or unplanned use of force). This was recorded as being required to prevent self-harm.¹⁰⁸ Nothing further was recorded about the nature of the self-harm or the risk of self-harm. It was unclear if this referred to the fact of his refusing food and fluids. Ms Williams told the Inquiry that no ‘in person’ risk assessment was carried out prior to the planned use of force in this case, nor did these routinely occur prior to a use of force.¹⁰⁹
- 52.4** D2159 was put in an inverted wrist hold and an arm hold/lock, and was then handcuffed for five minutes. A four-man Control and Restraint team was used, in full PPE, including the use of a shield.¹¹⁰ At one point, D2159 appeared to be resisting because he dropped to his knees, but this could also have been because he was too weak to stand as a result of his food and fluid refusal.¹¹¹ As noted by Mr Jonathan Collier, the Inquiry’s use of force expert, the use of such force on someone who was

¹⁰⁴ [CJS006999](#)

¹⁰⁵ [CJS007001](#)

¹⁰⁶ [CJS007001](#); [Christine Williams 10 March 2022 107/11-22](#)

¹⁰⁷ [Christine Williams 10 March 2022 108/12-109/5](#)

¹⁰⁸ [CJS005529_002-003](#)

¹⁰⁹ [Christine Williams 10 March 2022 105/2-22](#)

¹¹⁰ [CJS005529_003](#)

¹¹¹ [Christine Williams 10 March 2022 109/9-13](#)

physically weak was unnecessary and disproportionate to the risk.¹¹² There was no intervention by Healthcare staff, despite D2159's obviously weakened physical state, which was an abject failure in their monitoring role during the use of force. Ms Williams accepted in evidence that force should not have been used on D2159 to move him to E Wing, and that she should have intervened to raise contraindications prior to the use of force and the use of handcuffs. She also agreed that she should have raised concerns about his physical state at the time.¹¹³ This contributed to an unnecessary and disproportionate use of force on a vulnerable detained person.

- 52.5** The next entry in the medical records – made by Raymond Little (RGN) – stated that D2159 was moved from D Wing to E Wing, and that no force was required, as he was “*fairly weak*”.¹¹⁴ This was clearly inaccurate. The disconnect between the medical record and the Use of Force documentation is of serious concern.
- 52.6** More generally, there appeared to be a lack of engagement in the process on the part of Healthcare staff. Instead, the custodial management of the detained person was prioritised and Healthcare staff showed a deference to detention staff and security issues, as opposed to a focus upon patient welfare. The safeguards, which should have operated to protect D2159, failed.
- 53.** On 25 April 2017, D1527 was the subject of an unplanned use of force as a result of his attempting to strangle himself with his own hands.
- 53.1** Four officers dressed in full PPE forcibly restrained D1527 on the floor of his cell in order to prevent him harming himself. There was a physical struggle that lasted some time, during which D1527 was distressed. DCO Ioannis (Yan) Paschali took up a position kneeling at D1527's head facing his feet with his knees either side of D1527's head. In the course of Mr Paschali's restraint, he placed his hands on D1527's neck in what has sometimes been described as a 'chokehold'. D1527 was heard to make a choking noise and to say, several times, “*my neck*”. Mr Paschali told D1527, “*I'm going to put you to fucking sleep.*” Mr Tulley was heard to say, “*Yan, easy.*” Ms Joanne Buss (RGN) was present in the cell throughout the restraint. Eventually, D1527 was forcibly put into the recovery position and subsequently the officers left the cell and the restraint ended.
- 53.2** Ms Buss was referred to the Nursing and Midwifery Council (NMC), the regulatory body for the nursing professions, by G4S Health Services as a result of this incident. Disciplinary proceedings were brought against

¹¹² [INQ000111_035 para 128](#); [INQ000111_036 para 130](#); [INQ000111_036 para 133](#)

¹¹³ [Christine Williams 10 March 2022 109/21-110/22](#)

¹¹⁴ [CJS007001](#)

her; she admitted all charges, and was removed from the register in February 2021, although she had already retired from nursing.¹¹⁵

53.3 By the time she gave evidence to the Inquiry, her position had changed from that in the NMC proceedings. Ms Buss did not accept that she had:

- seen Mr Paschali applying a ‘chokehold’, where his hands were on D1527’s neck;
- heard any choking noise;¹¹⁶
- heard Mr Paschali say: *“I’m going to put you to fucking sleep”*;¹¹⁷
- heard D1527 say *“my neck”* any of the five times he said those words;¹¹⁸ or
- heard Mr Tulley’s intervention with Mr Paschali.¹¹⁹

53.4 Ms Buss told the Inquiry that she had no memory of the incident, stating that if she had seen or heard the above, she would have reported it or stopped it.¹²⁰ This assertion was made and maintained despite the incident being captured on covert footage filmed by Mr Tulley.¹²¹ This footage clearly showed the actions and comments detailed above, with Ms Buss directly next to D1527 and Mr Paschali at the time, as she can be identified from footage walking around Mr Paschali because her shoes are visible, as she accepted in her evidence.¹²²

53.5 Ms Buss told the Inquiry that she *“couldn’t see hardly anything”*.¹²³ Based upon both the video and documentary evidence, I have concluded that Ms Buss was in a position to see or hear the incident as set out above, and I consider it probable that she did witness this inappropriate conduct without challenging or reporting it.¹²⁴ She had a duty to do both.¹²⁵ She did not raise any concerns throughout the entirety of the use of force and restraint upon D1527. She should have challenged the actions of the other staff at the time in the strongest possible terms, and reported the incident immediately to relevant managers.

¹¹⁵ [INN000025_031-035 paras 50-53](#)

¹¹⁶ [Joanne Buss 14 March 2022 132/16-133/15](#)

¹¹⁷ [Joanne Buss 14 March 2022 136/10-25](#)

¹¹⁸ [Joanne Buss 14 March 2022 139/14-140/25](#)

¹¹⁹ [Joanne Buss 14 March 2022 137/1-11](#)

¹²⁰ [Joanne Buss 14 March 2022 133/23-135/10](#)

¹²¹ [Day 2 AM 24 November 2021 00:34:29-00:53:24 \(KENCOV1007 - V2017042500020\) and 00:53:55-01:23:53 \(KENCOV1007 - V201704200021\)](#)

¹²² [Joanne Buss 14 March 2022 137/12-138/9](#)

¹²³ [Joanne Buss 14 March 2022 135/17-136/7](#)

¹²⁴ [Joanne Buss 14 March 2022 123/15-124/21, 126/17-128/3, 131/10-132/5](#)

¹²⁵ [Dr James Hard 28 March 2022 121/6-123/6](#)

- 53.6** Even if I had been persuaded that Ms Buss was not in a position to see or hear what was happening, I would have concluded that she should have moved so as to be able to monitor his safety, raised a concern with the officers that she could not adequately monitor his safety, or acted immediately to stop the restraint. Ms Buss did not do any of those things. She did not intervene at any stage of the use of force or restraint on D1527, despite being aware of the length of time the restraint had continued and of four officers struggling with him on the ground, and despite hearing the noises he was making. She should have taken action immediately, decisively and as a matter of urgency. At the very least, Ms Buss should have raised a concern with the officers, stating that there was no immediate risk to his life and therefore use of force was no longer necessary. The safeguards designed to protect D1527, keep him safe and ensure his welfare were the subject of an egregious failure. The inaction of Ms Buss allowed D1527 to be exposed to appalling treatment by detention staff and a terrifying ordeal.
- 53.7** Despite this, having reviewed the video footage, Ms Buss denied any inappropriate behaviour on her part, except that she accepted referring to D1527 as an “arse”. She apologised for this, although she said that the door to his cell was shut and there was no possibility that he could have heard it.¹²⁶
- 53.8** D1527 was forcibly put into the recovery position and the restraint continued. Ms Buss accepted that he was very distressed at this stage and she considered him to be unwell. Nevertheless, she raised no concerns then or afterwards.¹²⁷ I agree with Dr Hard that she should have stopped the restraint and shown “*some level of concern for the welfare of the detained person who is lying on the floor in a very distressed state*”.¹²⁸ Dr Hard said, “*But I don’t see anything other than what appears to be disdain.*”¹²⁹ I consider this demonstrated a total disregard for D1527’s welfare during an intense and prolonged use of force against him.
- 54.** Following the incident, Ms Buss had a conversation with Mr Tulley. As a result, she understood that neither he nor any other DCO involved was going to complete the requisite Use of Force report. Although she was aware that this was mandatory, she did not raise any concern with Mr Tulley or anyone else. Ms Buss had no convincing explanation as to why she did not do so.¹³⁰ As a

¹²⁶ [Joanne Buss 14 March 2022 110/9-112/7](#)

¹²⁷ [Joanne Buss 14 March 2022 145/20-147/16](#)

¹²⁸ [Dr James Hard 28 March 2022 128/14-130/8](#)

¹²⁹ [Dr James Hard 28 March 2022 128/14-130/8](#)

¹³⁰ [Joanne Buss 14 March 2022 148/13-150/22, 151/22-153/9](#)

healthcare professional, she, and any member of staff, had a duty to challenge this inappropriate behaviour and report it to management.¹³¹

55. Ms Buss did complete other documentation.

55.1 Within the ‘ongoing observations’ section of the ACDT document, she recorded:

“Seen in room 7. Constant watch. D1527 had tied a T-shirt around his neck. Angry, upset. Had mobile phone battery in his mouth. Attempted to self-strangulate in toilet. Visual obs due to demeanour. Resp 16.”¹³²

There is no mention of a use of force or restraint. There is no record of D1527’s presentation or demeanour, other than that he was “angry” and “upset”. This description does not begin to accurately record the events or capture the severity of D1527’s distress, or consider that it was likely to be a result of underlying mental ill health.¹³³ I agree with Dr Hard that the entry does “not remotely” accurately convey D1527’s presentation and the restraint on him and that the ACDT record was “not adequate at all”.¹³⁴ Its effect was positively misleading.

55.2 Ms Buss’s entry in D1527’s medical record noted:

“Examination: placed on rule 40 constant supervision as he refused to return to E wing. Called to E wing at [approximately] 19:00. Constant watch. Had placed a ligature around his neck. Removed by staff. Staff trying to engage with him. RMN Dalia tried to engage with him with minimal effect. Put mobile phone battery in his mouth which he later removed battery removed from his room. Went to toilet and attempted to self-strangulate. Angry and not engaging with staff. Hands removed from his neck by staff. Salivating ++. Unable to take any observations. Visual obs resps 16. Slight redness noted on his neck. 20:00 got up and walked around room. Taken a small drink. Restless. Constant watch continues. Not engaging with staff. Plan: pls review later this evening.”¹³⁵

Again, there is no mention of a use of force or restraint on D1527, other than to say that a ligature and his hands had been “removed” from his neck by staff. I agree with Dr Hard that there should have been.¹³⁶ There is no record of D1527’s clinical presentation, as might be expected to

¹³¹ *Raising Concerns: Guidance for Nurses, Midwives and Nursing Associates*, Nursing and Midwifery Council, updated January 2019. The Inquiry understands that the same guidance was in place in 2017

¹³² [CJS001085_017](#)

¹³³ [Joanne Buss 14 March 2022 133/23-135/10](#)

¹³⁴ [Dr James Hard 28 March 2022 131/8-132/25](#)

¹³⁵ [CJS001002_038](#)

¹³⁶ [Dr James Hard 28 March 2022 133/1-134/5](#)

ensure appropriate future treatment, other than that he was “angry and not engaging with staff”.¹³⁷ As Dr Hard noted, it does “not even remotely” convey the totality of the nature of the incident and “it feels somewhat blaming of the detained person for the incident”.¹³⁸ The language used in this record again minimised the severity of the incident and the nature, degree and duration of the use of force on D1527.¹³⁹

56. Ms Mariola Makucka (RGN) completed the Healthcare staff member’s section of a ‘Report of Injury to Detainee’ form (F213) on behalf of Ms Buss.¹⁴⁰ It records:

“Seen on E Wing room by RGN Jo. Detainee had placed a ligature around his neck, removed by staff. After this he went to toilet and attempt [sic] to self-strangulate. Hands removed from his neck. Slightly [sic] redness noted on his neck.”¹⁴¹

This language again completely obscured the true nature of what happened to D1527 in this incident.

57. Ms Buss maintained to the Inquiry that she completed her documentation appropriately. She did not expressly accept that the notes minimised the seriousness of the incident and the nature of the force used against D1527, although she did accept that her notes could have been “fuller” and “better”.¹⁴² I consider that the medical records – which should have been clear and accurate in order to support safe and effective care – were entirely inadequate. This was a significant failure on her part to fulfil her duties as a nurse towards her patient.¹⁴³

58. The only evidence of any Healthcare monitoring of D1527’s condition and welfare following this serious incident was a visit by Dr Oozeerally on E Wing for a review under Rule 40 on 26 April 2017. There was no further record in the medical notes by any member of Healthcare staff on that night or the following day. In the circumstances, in my view, D1527 should have been reviewed by Healthcare staff overnight prior to Dr Oozeerally seeing D1527 and thereafter. Dr Oozeerally’s note in the medical record, timed at 10:36 on 26 April 2017, reads:

¹³⁷ [Dr Rachel Bingham 14 March 2022 17/18-18/22](#)

¹³⁸ [Dr James Hard 28 March 2022 134/6-19](#)

¹³⁹ [Dr James Hard 28 March 2022 134/6-135/5](#)

¹⁴⁰ The F213 form is routinely annexed to the Use of Force – DCF 02 form and section 3 is used to record healthcare staff’s observations from a clinical perspective on the use of force incident and any injuries to the detained person. The detention custody sections (sections 1 and 2) of the F213 form were blank because they were not filled in by any of the detention custody staff involved in the use of force, as they should have been. The reader is able to understand that force was used upon D1527 from this documentation because it forms part of the Use of Force documentation as a whole

¹⁴¹ [CJS005534_010-011](#)

¹⁴² [Joanne Buss 14 March 2022 153/1-155/5, 156/9-157/25](#)

¹⁴³ [Dr James Hard 28 March 2022 131/8-136/24; Dr Rachel Bingham 14 March 2022 15/4-18/2](#)

“History: seen in E wing. He says he feels well today and no medical problems. I believe he presented with challenging behaviour overnight but settled and later became co-operative.”¹⁴⁴

This note is so brief as to be of little assistance in ascertaining the nature of his review of D1527. There is no evidence of any physical or mental state examination of D1527, which, in the circumstances, was required.

Dr Oozeerally’s note is indicative of an extremely cursory review, which in effect was likely to have consisted merely of asking D1527 how he was. This was wholly inadequate and is indicative of the system designed to safeguard vulnerable detained people failing once again.¹⁴⁵

59. Dr Hard suggested that better training and a more robust approach towards use of force are needed so that healthcare staff fully understand and fulfil both their safeguarding and monitoring roles.¹⁴⁶ In his 2016 report, Mr Shaw noted that nursing staff in IRCs attended all planned use of force incidents but had no formal training for their role and responsibilities in relation to the use of force.¹⁴⁷ Ms Calver stated that she was responsible for *“looking after all the nursing staff and leading the nursing team, so being in charge of all the nursing roles, giving them supervision”*.¹⁴⁸ She also told the Inquiry that *“at the time”* it did not concern her that force was being used on vulnerable detained people, although it was of concern to her when she gave evidence.¹⁴⁹ In my view, given her important role at Brook House, Ms Calver should have made sure that she and her staff understood their safeguarding and monitoring roles in relation to the use of force and that they were fulfilling those roles in practice wherever force was used against vulnerable detained people. They could have done this by raising concerns or contraindications to the use of force with detention custody staff where necessary.

60. Dr Bromley told the Inquiry that PPG’s healthcare staff are not trained in use of force but can attend the refresher training given to detention staff to observe and see what the response from healthcare staff should be.¹⁵⁰ The Inquiry understands that more bespoke training is planned.¹⁵¹ Dr Bromley also stated that monthly use of force meetings – at which all use of force incidents in the previous month are reviewed and footage of one or two cases is examined – are attended by a member of healthcare management and a clinical staff member. At the time of the Inquiry’s public hearings, it remained unclear whether these meetings adequately enabled healthcare staff to fully

¹⁴⁴ [CJS001002_039](#)

¹⁴⁵ For examples of the GP reviews, see: [KENCOV1034 - V2017061100005](#)

¹⁴⁶ [Dr James Hard 28 March 2022 140/7-141/1](#)

¹⁴⁷ [INQ000060; Sandra Calver 1 March 2022 249/20-251/5](#)

¹⁴⁸ [Sandra Calver 1 March 2022 142/1-5](#)

¹⁴⁹ [Sandra Calver 1 March 2022 247/22-248/25](#)

¹⁵⁰ [PPG000172_004](#) para 20

¹⁵¹ [PPG000204_007](#) paras 29-30

understand the nature and extent of their safeguarding role in relation to the use of force on vulnerable detained people, and the importance of this role in protecting vulnerable detained people from harm.

61. In all the circumstances, it is unclear whether sufficient action has been taken to address the deficiencies relating to the role of healthcare staff in use of force incidents. I remain concerned that a risk of the inappropriate use of force on vulnerable detained people may well persist. I am therefore recommending that guidance and mandatory training be introduced for healthcare staff in immigration removal centres in order to ensure that they fulfil their role in relation to use of force, both prior to and during an incident.

Recommendation 19: Guidance and training for healthcare staff on the use of force

The Home Office must ensure that guidance is issued to healthcare staff in immigration removal centres clarifying their role in use of force incidents. It must liaise as necessary with NHS England and any relevant medical regulators.

The Home Office must ensure that mandatory training is introduced for healthcare staff, and those responsible for managing them, on their roles and responsibilities in relation to planned and unplanned use of force (liaising with NHS England and any other relevant parties). The training must be subject to an assessment.

‘Fit to fly and fit for detention’ letters and healthcare sanction of use of force

62. The Inquiry heard evidence of a practice by the Home Office of asking Brook House GPs to write letters regarding the fitness to fly and fitness for detention of individuals.¹⁵² Detention Services Order 01/2016: The Protection, Use and Sharing of Medical Information Relating to People Detained Under Immigration Powers set out the relevant process.¹⁵³ Dr Hard – and Dr Bingham – expressed reservations and concerns about the way in which GPs responded to such requests, with reference to D1914 in particular.¹⁵⁴

63. There appeared to be no adequate physical or mental examination carried out immediately prior to the writing of such a letter by a GP.¹⁵⁵ There

¹⁵² [DL0000218](#); [CJS001048 027](#); [CJS003768](#); [CJS003264](#); [CJS003608](#)

¹⁵³ [Detention Services Order 01/2016: The Protection, Use and Sharing of Medical Information Relating to People Detained Under Immigration Powers](#), Home Office, April 2016 (reissued May 2016)

¹⁵⁴ [Dr James Hard 28 March 2022 87/9-88/16](#); [Dr Rachel Bingham 14 March 2022 46/2-22](#)

¹⁵⁵ [Dr Husein Oozeerally 11 March 2022 97/5-99/25](#)

was evidence that GPs would review a detained person’s medical records prior to writing such a letter.¹⁵⁶ In my view, this process alone was unlikely to be sufficient in every case, and an examination might well have been necessary.¹⁵⁷

64. On review of a detained person’s medical records, GPs would have been aware of relevant history such as physical or mental health conditions and past experience of trauma (such as torture). The Inquiry received evidence that, on occasion, limited details about an individual’s medical history were referred to in ‘fit to fly and fit for detention’ letters. However, significant concerns or contraindications were not routinely raised in relation to a use of force or whether they were fit to fly and fit for detention. On other occasions, no such details were referred to at all when assessing whether a detained person was fit to fly and fit for detention.¹⁵⁸ In my view, this demonstrates that, generally, insufficient regard was had to the relevant medical history of detained people in the writing of such letters.

65. On occasion, this practice extended to pre-emptive positive approval for a planned use of force on a detained person by the GP.

65.1 For example, Dr Oozeerally wrote to the Home Office on 27 May 2017, at its request, regarding D1914. His letter stated:

*“The above detainee is fit to fly and fit for detention. He will need a medical escort due to the nature of his medical condition. I am happy for reasonable force to be used (C and R) in order to facilitate the removal.”*¹⁵⁹

As is plain from the face of the letter, Dr Oozeerally approved or sanctioned the use of force against D1914 for the sole purpose of removing him from the country.

65.2 In oral evidence, Dr Oozeerally attempted to justify his sanction of the use of force against D1914 as being “*unfortunate*” wording.¹⁶⁰ He did not accept that it was necessary to raise D1914’s heart condition as a concern or contraindication, or indeed any other concerns or contraindications, in relation to a planned use of force on D1914.¹⁶¹ This lack of insight by Dr Oozeerally, even by the time he gave his evidence to the Inquiry, was itself of serious concern.

¹⁵⁶ [Dr Husein Oozeerally 11 March 2022 97/18-98/4](#)

¹⁵⁷ Civil Aviation Authority (CAA) or British Medical Association (BMA) guidance on certification of fitness to fly was unlikely to have been sufficient to safeguard vulnerable detained people in these particular circumstances, given the context of the risk that a detained person may be forcibly removed from the country (see the CAA’s [Guidance for Health Professionals](#) and the BMA’s [Guidance on Medico-Legal Aspects of Providing Certificates](#))

¹⁵⁸ [CJS002771](#)

¹⁵⁹ [CJS001160](#)

¹⁶⁰ [Dr Husein Oozeerally 11 March 2022 132/11-20, 135/12-20](#)

¹⁶¹ [Dr Husein Oozeerally 11 March 2022 136/9-138/15](#)

- 65.3** The DCOs involved in the planned use of force on D1914 relied upon the sanction of the use of force by Dr Oozeerally, referred to by them as the “*disclaimer*”, effectively to abdicate any responsibility for D1914’s health and welfare during the use of force on him.¹⁶²
- 65.4** The failures in the safeguards that should have operated to protect D1914 led to him being put in harm’s way.¹⁶³ Those systemic failures in the safeguards are linked with the treatment of detained people – for example, by exposing them to inappropriate and excessive use of force.¹⁶⁴
- 66.** This sanctioning of force is completely inappropriate and of serious concern.¹⁶⁵ The decision to use force is a custodial one. It is important for GPs and healthcare staff not to involve themselves in custodial management decisions, but to maintain their independence in order to fulfil their important safeguarding role of raising concerns about, and contraindications to, the use of force on a detained person where concerns or contraindications are present.¹⁶⁶
- 67.** GPs at Brook House did not appear to have an adequate understanding of the implications of this practice for the confidentiality of a patient’s medical information and the requirement to obtain a patient’s consent for disclosure of such information to the Home Office for this particular purpose.¹⁶⁷
- 68.** In my view, when writing letters about a detained person being fit to fly and fit for detention, GPs must be cognisant of the inherent potential for a conflict of interest and an inconsistency with the primary duty of the doctor to their patient in these circumstances. It is critical that appropriate clinical assessment of the individual is undertaken prior to writing any letter, and that medical concerns or contraindications are set out clearly in the letter in a way that is compatible with the provision of or refusal to provide patient consent to share medical information with the Home Office for such a purpose. I am therefore recommending that updated guidance and training be provided to doctors working within the immigration detention estate about their duties and responsibilities in this context.

¹⁶² [Dr James Hard 28 March 2022 96/23-98/22](#)

¹⁶³ [Dr James Hard 28 March 2022 97/18-98/23](#)

¹⁶⁴ [Dr James Hard 28 March 2022 98/23-100/13](#)

¹⁶⁵ [Dr James Hard 28 March 2022 89/15-24](#); [Dr Rachel Bingham 14 March 2022 46/23-48/17](#); [Sandra Calver 1 March 2022 247/11-21](#)

¹⁶⁶ *Locked Up, Locked Out: Health and Human Rights in Immigration Detention*, British Medical Association, 2017, p5 (‘Dual loyalties in immigration detention’)

¹⁶⁷ [Dr Rachel Bingham 14 March 2022 47/10-48/4](#). See *Locked Up, Locked Out: Health and Human Rights in Immigration Detention*, British Medical Association, 2017, p6 (‘Capacity and consent’)

Recommendation 20: Updating guidance regarding ‘fit to fly and fit for detention’ letters

The Home Office must review and update Detention Services Order 01/2016: The Protection, Use and Sharing of Medical Information Relating to People Detained Under Immigration Powers, to ensure that guidance given to GPs working in the immigration detention estate in relation to their duties and responsibilities in writing ‘fit to fly and fit for detention’ letters is clear. It must liaise with NHS England and any relevant medical regulators as necessary.

The Home Office must ensure that training about the updated guidance takes place on a regular (at least annual) basis for GPs working in the immigration detention estate and those responsible for managing them. The training must be subject to an assessment.

The Home Office must monitor compliance with this updated guidance at least annually.

Mental capacity

69. A person lacks capacity if their mind is impaired or disturbed in some way that means they are unable to make a decision at that time. This may be because they are unable to understand the information relevant to the decision, remember the information or use it to make the decision.¹⁶⁸

70. Detained people with mental ill health may be more vulnerable to losing capacity to make decisions about their medical care and treatment. Medical Justice told the Inquiry that evidence from its clinical casework experience raised serious concerns that pre-existing mental disorders and those arising in detention may result in detained people losing decision-making capacity with regard to healthcare (and legal) matters.¹⁶⁹ Medical Justice holds long-standing concerns that the processes in place to address this are not sufficiently robust.¹⁷⁰

71. The assessment of mental capacity in an immigration setting is often challenging. There may be language barriers and the movement of people between IRCs can make it difficult to build a therapeutic rapport sufficient to elicit the detail necessary for an assessment. Capacity in people with mental ill

¹⁶⁸ See Mental Capacity Act 2005, section 3

¹⁶⁹ BHM000033_030 para 81. This was corroborated by the 2016 Shaw report (INQ000060_190) and Decision-Making Capacity of Detainees in Immigration Removal Centres (IRCs), Royal College of Psychiatrists, Position statement PS03/17, November 2017; see also the first statement of Professor Katona (BHM000030_021-022).

¹⁷⁰ BHM000033_030 para 81

health can also fluctuate, as capacity is time and decision-specific, so a person can only have capacity or lack capacity to make a specific decision at a specific time.¹⁷¹

72. D1275 was an Iranian national detained for immigration purposes who had experienced previous mental ill health.

72.1 Having already been detained for 843 days since December 2015, he was detained in Brook House for 422 days between May 2017 and June 2018. At times, his behaviour was bizarre and aggressive, and he was noted for giving incoherent answers to questions.¹⁷² Despite this, his severe mental ill health was not identified or managed, and he received no mental health treatment.

72.2 Between May 2017 and January 2018, D1275 missed 13 appointments for a mental health assessment at Brook House. Healthcare staff repeatedly discharged him from the mental health team caseload because of his non-attendance.

72.3 The underlying reasons for D1275's non-attendance do not appear to have been explored by Healthcare staff. The Inquiry has not seen any evidence that his non-attendance was followed up at all by Healthcare staff. As Dr Hard noted, this was a serious concern. There should have been a more proactive investigation into the reasons for D1275 missing so many appointments.¹⁷³ There is no evidence that D1275's mental capacity to make decisions about his attendance at medical appointments or his medical treatment was considered or assessed by Healthcare staff. Ms Calver accepted that D1275's non-attendance should have been followed up, the reasons for it explored and a mental capacity assessment undertaken, and that he should not have been discharged from the caseload.¹⁷⁴

72.4 D1275's mental health continued to deteriorate. On 20 June 2017, a Security Information Report (SIR) completed by detention staff noted "*mental health issues, erratic and strange behaviour*".¹⁷⁵ It is not clear what action was taken by detention custody staff as a result of this entry, although it is noted that "*RMN requested to add him back on their list*".¹⁷⁶ It does not appear that Healthcare staff saw him as a result. In my view, if there was no mental health assessment of D1275, one should have been carried out as a result of this referral.

¹⁷¹ [BHM000033_031](#) para 83

¹⁷² [CJS001120](#); [CJS001121_068](#)

¹⁷³ [Dr James Hard 28 March 2022 153/9-23](#)

¹⁷⁴ [Sandra Calver 1 March 2022 181/2-184/4](#)

¹⁷⁵ [CJS004642_005](#)

¹⁷⁶ [CJS004642_005](#)

72.5 On 22 June 2017, another SIR recorded a concern that D1275 may not understand some of his decisions, and that he may be being used as a “guinea pig” for spice.¹⁷⁷ The record of a meeting on the same day for an Anti-Bullying Support Plan recorded that D1275’s answers did not make sense and that DCO Marina Mansi did not believe he had grasped what she was saying. It noted that D2553 (another detained person) had tried to sort out D1275’s appointments with solicitors and doctors because “it appears [D1275] doesn’t have the mental capacity to know when his appointments are and to attend them”.¹⁷⁸ It also stated that he was “possibly not fit for detention” and added: “DCM Yates to investigate.”¹⁷⁹ Ms Calver told the Inquiry that, given its content, she would have expected this SIR to have been brought to the attention of Healthcare staff by the security team. It was of concern to her that it did not appear to have been.¹⁸⁰

72.6 After his release from detention in June 2018, D1275 was diagnosed with schizo-affective disorder and assessed as having no capacity to make decisions about medical appointments. In July 2018, D1275 was hospitalised under the Mental Health Act 1983, and treated in hospital for several months until December 2018 – an indication of just how unwell he had become.¹⁸¹

73. This demonstrates serious omissions in the system of safeguards to protect detained people who may have either a disability arising from mental impairment or a mental health condition, which failed D1275.¹⁸² This exposed him to the risk of further harm in detention. His detention was not reviewed by the Home Office in respect of the above concerns, and his release was not considered. The Inquiry heard no evidence of a system in existence or guidance available to staff for the routine transfer of relevant information about mental health concerns from residential wings to Healthcare staff. Ms Calver told the Inquiry that an SIR “goes directly to security. If they feel there was a need for healthcare to be informed, then they send us that part of the security information form.”¹⁸³ It is of serious concern that this does not appear to have occurred in D1275’s case, which suggests the possibility that records such as SIRs did not routinely lead to clinical investigation into a detained person’s vulnerabilities and mental capacity.

74. The Inquiry heard evidence that in circumstances where detained people did not attend appointments with the mental health team, they “generally did

¹⁷⁷ [CJS005347](#)

¹⁷⁸ [CJS001127_003](#)

¹⁷⁹ [CJS001127_004](#)

¹⁸⁰ [Sandra Calver 1 March 2022 182/5-19](#)

¹⁸¹ [BHM000042_026-031](#)

¹⁸² [Sandra Calver 1 March 2022 181/2-182/22](#)

¹⁸³ [Sandra Calver 1 March 2022 182/7-10](#)

*go to the wings to check why people hadn't attended".*¹⁸⁴ D687 disclosed thoughts of self-harm in the days preceding an incident on 13 May 2017. He missed three scheduled appointments with the mental health team between 5 May 2017 and 13 May 2017, and there were no apparent attempts to follow these up with D687, despite him being subject to an ACDT document at the time.¹⁸⁵ The Inquiry heard no evidence of any training or guidance provided to staff at the time on their duties and responsibilities in this regard, or of any adequate system in place to ensure that there was proper follow-up of multiple missed appointments in every case in order to safeguard vulnerable detained people.

75. There was – during the relevant period and at the time of the Inquiry's hearings – a lack of independent advocacy provision by the Home Office within Brook House to support those who cannot make or understand decisions by stating their views and wishes or securing their rights.¹⁸⁶ This leaves those such as D1275 – who were not followed up by Healthcare staff but who might lack mental capacity – vulnerable and unable to make decisions in relation to their immigration cases and medical care. I agree with Dr Hard that the consequences of falling through the gap left by a lack of independent advocacy provision was harmful to D1275, as during his time in detention he continued to deteriorate. He lacked capacity to deal with both his attendance at medical appointments and his immigration case.¹⁸⁷

76. Detention Services Order 04/2020: Mental Vulnerability and Immigration Detention: Non-Clinical Guidance aims to provide IRC staff with the guidance necessary to ensure that appropriate support is offered to those who lack decision-making capacity, those with disabilities arising from mental impairment and those who have a mental health condition.¹⁸⁸ The Inquiry heard evidence, however, that it does not adequately address concerns about the efficacy of the safeguards for those who lack mental capacity, as it does not contain any provision for independent advocacy.¹⁸⁹ The Home Office should address this.

77. Proper communication between detention custody staff and healthcare staff concerning detained people's vulnerabilities is vital. There remain gaps in the safeguards for vulnerable people concerning missed healthcare appointments and in relation to assessments of mental capacity, mental health and mental state in such circumstances. I am therefore recommending an

¹⁸⁴ [Sandra Calver 1 March 2022 181/2-23](#)

¹⁸⁵ [CJS001139_010-012; CJS000993](#)

¹⁸⁶ [Theresa Schleicher 14 March 2022 84/14-86/1](#)

¹⁸⁷ [Dr James Hard 28 March 2022 157/19-24](#)

¹⁸⁸ [Detention Services Order 04/2020: Mental Vulnerability and Immigration Detention: Non-Clinical Guidance](#), Home Office, July 2020

¹⁸⁹ [Theresa Schleicher 14 March 2022 84/14-86/1](#)

update to the guidance to ensure effective communication of medical information between staff in IRCs.

Recommendation 21: Ensuring effective communication of medical information

The Home Office must review and update Detention Services Order 04/2020: Mental Vulnerability and Immigration Detention: Non-Clinical Guidance to set out comprehensive guidance for detention and healthcare staff where there are concerns that a detained person is suffering mental ill health or lacks mental capacity. This must include an appropriate system for:

- the routine handover or sharing of relevant information between detention custody staff and healthcare staff (for example, in Security Information Reports and Anti-Bullying Support Plans);
- the identification and follow-up of missed medical appointments;
- the assessment of mental capacity where indicated; and
- mental health assessment where indicated.

The Home Office must ensure that training about the updated guidance takes place on a regular (at least annual) basis for detention and healthcare staff, as well as those responsible for managing them. The training must be subject to an assessment.

Healthcare complaints

78. Complaints concerning healthcare provision and the conduct of healthcare staff, including GPs, were investigated under NHS complaints procedures in a separate process from that for detention custody staff.¹⁹⁰ Detention Services Order 03/2015: Handling of Complaints (the Complaints DSO) provided the process for the investigation and response to complaints including healthcare complaints.¹⁹¹

79. Healthcare complaints could be made in writing on a complaint form.¹⁹² The Inquiry received evidence of the complaints made during the relevant period. None of the complaints recorded appear to relate to verbal or informal complaints and the Inquiry did not receive any evidence to suggest that such

¹⁹⁰ Detention Services Order 03/2015: Handling of Complaints (CJS000727), Home Office, February 2017 (updated April 2023), para 9

¹⁹¹ Detention Services Order 03/2015: Handling of Complaints (CJS000727), Home Office, February 2017 (updated April 2023), paras 9-21

¹⁹² DWF000020_020 para 110

complaints were investigated by the Healthcare department.¹⁹³ In my view, they should have been.

79.1 Only two complaints were made directly to NHS England, or were referred by G4S Health Services.¹⁹⁴ As Ms Williams explained, only “*serious complaints*” were referred to NHS England.¹⁹⁵ Ms Williams was left to use her own judgement as to what amounted to a serious complaint.

79.2 Others were investigated by G4S Health Services. Written complaints would “*be passed for assessment to the on site healthcare manager for the NHS commissioned service*” by Home Office staff emptying the complaints box, although the Home Office would record the date and the name of the complainant.¹⁹⁶

80. During the relevant period, 53 written complaints relating to healthcare were received by the Healthcare department. It is likely that barriers to the making of complaints, discussed in relation to detention staff in Chapter D.10, also existed in relation to healthcare complaints. These included, for example, language and communication issues, a lack of understanding among detained people of their rights and a view that nothing would change or no one would listen.

81. As Clinical Lead at Brook House, Ms Williams investigated and determined the outcome of 51 of the 53 healthcare complaints. She told the Inquiry that she was not given any training for this role or any particular written guidance to follow, but was shown by her manager what to do.¹⁹⁷ Ms Williams explained that her investigations involved looking at any relevant documents and speaking to the member of staff concerned.¹⁹⁸ She did not speak to the detained person who had made the complaint.¹⁹⁹ This cursory investigation was also reflected in the responses to complaints. For the most part, the written responses provided to complainants – produced by reference to a template – were lacking in any detail. Responses did not engage with the underlying substance of the complaint on anything other than a superficial level. Most were without any analysis or conclusion as to whether medical care had been inadequate or the complaint was substantiated. Routinely, responses merely offered an apology that the detained person was unhappy with the

¹⁹³ [CJS001413](#)

¹⁹⁴ [NHS000053](#) rows 39 and 40

¹⁹⁵ [Christine Williams 10 March 2022 89/6-11](#)

¹⁹⁶ [Detention Services Order 03/2015: Handling of Complaints \(CJS000727\)](#), Home Office, February 2017 (updated [April 2023](#))

¹⁹⁷ [Christine Williams 10 March 2022 88/9-20](#)

¹⁹⁸ [Christine Williams 10 March 2022 88/13-89/5](#)

¹⁹⁹ [Christine Williams 10 March 2022 91/3-10](#)

medical treatment and advised them to attend the Healthcare department if required.²⁰⁰

82. Most complaints (35 of 53 complaints, or 66 per cent) concerned medication: either a failure to obtain medication or delays in obtaining it, or the inadequacy of the medication prescribed.²⁰¹ This has been a consistent theme within healthcare complaints over a period of time. For example, in his 2016 report, Mr Shaw noted that a high proportion of the written complaints he reviewed were about medication.²⁰²

83. Of the remaining 18 complaints during the relevant period, 7 related to Rule 35 reports or the attitude of doctors or other healthcare staff being rude or dismissive.²⁰³ In my view, this is also an area in which it is apparent that the conflict of interest arising between GPs' obligations towards the Home Office on the one hand and their role within the system of safeguards and duties to vulnerable detained people on the other is likely to have been problematic.

84. Dr Bromley stated that there were 13 healthcare complaints in total in the five-month period between September 2021 and January 2022. The subject matter varied and there was no discernible pattern to the complaints.²⁰⁴ All complaints were internally investigated by a clinician within Brook House.²⁰⁵ Themes arising from a review of complaints were shared at PPG local quality assurance (QA) meetings and shared with the wider healthcare team locally as well as via PPG regional QA meetings. Learning from complaints is shared via learning bulletins cascaded to all staff. Dr Bromley also said that significant concerns arising from a complaint would be escalated by the regional governance manager and a Clinical Case Review that would utilise a multidisciplinary team to review the care provided. If failures were identified from this process, an Internal Learning Review would be commissioned and the incident reported to NHS England as a significant incident.²⁰⁶

85. The Complaints DSO provides for complaints which have been formally investigated by the local IRC healthcare provider to be reported to the Home Office via a quarterly Healthcare Partnership Board meeting.²⁰⁷ It also allows the healthcare provider to send a table recording the previous quarter's complaints to the Detention and Escorting Services Complaints team at the

²⁰⁰ [CJS001610](#); [CJS001389](#); [CJS001396](#); [CJS001417](#)

²⁰¹ [Christine Williams 10 March 2022 90/6-19](#); [DWF000020_21](#); [CJS001413](#)

²⁰² [INQ000060_167](#)

²⁰³ [CJS001413](#); [CJS001389](#); [CJS001396](#); [DL0000273_14-15 paras 36-37](#); [DL0000228_063 para 212](#)

²⁰⁴ [PPG000172_014 para 74](#)

²⁰⁵ [PPG000172_011 para 58](#); [PPG000172_012 para 65](#)

²⁰⁶ [PPG000172_013 paras 68-69](#)

²⁰⁷ [Detention Services Order 03/2015: Handling of Complaints \(CJS000727\)](#), Home Office, February 2017 (updated [April 2023](#)), para 18

Home Office.²⁰⁸ The Inquiry is not aware of whether this is currently occurring or what, if any, action is generally taken by the Home Office as a result of such reporting.

86. For detained people using healthcare services, complaints matter. They deserve an explanation when things go wrong and should be informed that steps have been taken to make it less likely to happen to anyone else. A robust and effective complaints procedure in healthcare is also important to promote accountability and help the healthcare provider and healthcare staff learn, as well as to improve the quality of care they provide. I am therefore recommending improvements to the handling and audit of healthcare complaints.

Recommendation 22: Improving the handling and audit of healthcare complaints

The Home Office must review and update Detention Services Order 03/2015: Handling of Complaints to ensure that appropriate guidance is given to healthcare providers on the investigation and handling of complaints specific to the provision of healthcare in an immigration detention setting.

The Home Office must ensure that training about the updated guidance takes place on a regular (at least annual) basis for staff dealing with healthcare complaints, as well as those responsible for managing them. The training must be subject to an assessment.

Healthcare providers in immigration removal centres must ensure that all healthcare complaints are robustly investigated in accordance with the updated guidance. The methodology and outcomes must be clearly communicated, including to the detained person. They must also ensure that appropriate, regular (at least annual) training and guidance is provided to those holding responsibility for the investigation of healthcare complaints.

²⁰⁸ Detention Services Order 03/2015: Handling of Complaints (CJS000727), Home Office, February 2017 (updated April 2023), para 27

Chapter D.9:

Staffing and culture

Introduction

1. Rule 45 of the Detention Centre Rules 2001 sets out general duties for officers in immigration removal centres (IRCs), which include that:

“At all times the treatment of detained persons shall be such as to encourage their self-respect, a sense of personal responsibility and tolerance towards others.”¹

2. During the relevant period (1 April 2017 to 31 August 2017), G4S and the Home Office did not provide a sufficiently caring, secure or decent environment for detained people or staff at Brook House. As Professor Mary Bosworth (the Inquiry’s cultural expert) observed, there were:

“significant questions about the relationship between care, trust, and security in Brook House and about the extent to which staff in Brook House treated detained people with dignity or decency”.²

3. The culture at Brook House, particularly among staff, set the tone for interactions with, and the treatment of, detained people. This chapter assesses evidence of a toxic culture during the relevant period, including the ‘prisonisation’ of Brook House and the dehumanisation of detained people, which reflected a number of staffing and cultural issues.

Staffing issues

4. The Inquiry identified a number of issues relating to staffing, both by G4S and the Home Office, including inadequate staffing levels, problems with recruitment and retention, insufficient training and development, and ineffective management.

Inadequate staffing

5. The Inquiry heard that those working at Brook House were aware of concerns around staffing, even when the centre was fully staffed. Many witnesses described insufficient staffing levels during the relevant period. Staff reported that two Detention Custody Officers (DCOs) per residential wing was

¹ [Detention Centre Rules 2001](#), Rule 45(6)

² [INQ000064_007](#) para 2.6; see also para 3.15 regarding the lack of respect for other staff

insufficient.³ At times there might in fact have been only one DCO per wing.⁴ Detention Custody Manager (DCM) Shane Farrell recalled that overtime was available most days and “*everyone knew*” about the staffing issues.⁵

6. Witnesses also told the Inquiry that Brook House was dangerous due to understaffing.⁶ Staff felt unable to provide necessary and basic services.⁷ For example, at times, courtyards could not be opened and activities could not be provided.⁸ When wings were understaffed, the Inquiry heard that Activities officers would cover any shortfalls.⁹

7. It was suggested by some that understaffing was a conscious decision by G4S.

7.1 Ms Sarah Newland, Head of Tinsley House IRC during the relevant period, said her view (as previously recorded in the 2018 Verita report) was that understaffing at Brook House was an intentional choice made “*in order to attain the profit*”, and involved a manipulation of true staffing figures to reduce the level of financial penalties.¹⁰

7.2 Mr Daniel Haughton, G4S Support Services Manager during the relevant period and now Assistant Director of Safeguarding, recalled a conscious decision by Mr Ben Saunders (Centre Director for Brook House and Tinsley House (Gatwick IRCs) during the relevant period) “*to run staffing levels below the typical headcount*” in preparation for the upcoming contract renewal.¹¹ The renewed contract that came into force in May 2018 provided for fewer staff, although the number of staff increased in the wake of the *Panorama* programme. Mr Haughton believed that, during the relevant period, there was a decision not to recruit to the target number so that Brook House was maintaining a lower level of staff consistent with the new contract. He noted that this decision was “*financially beneficial*”¹² but created unnecessary pressure on staff and compounded general difficulties.¹³ As a result, an Initial Training Course

³ [Callum Tulley 29 November 2021 107/8-12](#); [Ioannis Paschali 24 February 2022 32/24-25](#); [Daniel Haughton 16 March 2022 99/2-18](#)

⁴ [INQ000052 para 71](#); [Dominic Aitken 8 December 2021 64/4-22](#); [Ioannis Paschali 24 February 2022 32/21-25](#)

⁵ [Shane Farrell 8 March 2022 83/9-22](#); [Stephen Webb 8 March 2022 146/19-147/8](#)

⁶ [Ryan Bromley 7 March 2022 88/14-15, 89/2-7](#); [Ian Castle 15 March 2022 9/17-22](#); [Stephen Loughton 1 March 2022 75/24-76/3](#)

⁷ [Sean Sayers 10 March 2022 121/18-122/17](#)

⁸ [Julian Williams 16 March 2022 48/19-49/15](#); [Stephen Webb 8 March 2022 140/9-11](#); [HOM0332049 para 42](#)

⁹ [INQ000064 paras 4.10-4.11](#); [Julian Williams 16 March 2022 48/19-23, 49/11-15](#); [Daniel Lake 1 March 2022 16/5-14](#)

¹⁰ [VER000223 20](#); [Sarah Newland 21 March 2022 190/4-191/2](#)

¹¹ [SER000453 para 84](#)

¹² [SER000453 para 84](#)

¹³ [SER000453 para 85](#); [Daniel Haughton 16 March 2022 93/7-23](#)

(ITC) planned for an intake of 30 to 50 new recruits, involving weeks of planning, would either not go ahead or be run with very few trainees.¹⁴

7.3 Mr Saunders told the Inquiry that he had never instructed anyone not to recruit up to the contractual headcount.¹⁵ He accepted that staff were moved from Tinsley House to Brook House but said that this was primarily for operational reasons, and that avoiding financial penalties was not the primary benefit.¹⁶

7.4 Mr Peter Neden, G4S Regional President UK and Ireland during the relevant period, disagreed that Brook House was consciously understaffed but accepted that Brook House was “*particularly struggling*” to reach intended staffing levels.¹⁷ He suggested that understaffing would not be a “*sensible model*”, as it would lead to higher staff turnover and increased overtime payments.¹⁸

8. Mr Saunders stated that the staffing position was discussed regularly with the Home Office.¹⁹ Mr Neden told the Inquiry that G4S and the Home Office were “*content*” with the staffing levels.²⁰ He suggested that the Home Office was content that G4S had covered shifts adequately despite attrition rates, although he did not recall being made aware of the times when G4S failed to meet the contractual levels.²¹ Mr Haughton did not recall staffing levels being raised as a performance issue in his meetings with the Home Office.²² He suggested that it would have been for the Home Office to amend the contract if they had wanted more staff, although he agreed that G4S could have asked for an amendment too.²³

9. Mr Ian Castle, Home Office Detention and Escorting Services (DES) Area Manager for Gatwick IRCs during the relevant period, described the G4S staffing levels as inadequate at that time from a Home Office perspective. However, he said:

¹⁴ [Daniel Haughton 16 March 2022 97/2-15](#)

¹⁵ [Ben Saunders 22 March 2022 176/14-24, 180/3-6](#)

¹⁶ [Ben Saunders 22 March 2022 181/18-183/5](#)

¹⁷ [Peter Neden 22 March 2022 34/2-5](#)

¹⁸ [Peter Neden 22 March 2022 33/18-34/1](#)

¹⁹ [Ben Saunders 22 March 2022 176/14-24, 180/3-6](#)

²⁰ [Peter Neden 22 March 2022 34/2-5; INQ000119 para 95](#)

²¹ [Peter Neden 22 March 2022 38/19-39/6](#)

²² [Daniel Haughton 16 March 2022 95/15-23](#)

²³ [Daniel Haughton 16 March 2022 91/16-92/10](#)

“I did not raise any concerns ... as I did not think that increasing staff levels was an available option due to contractual and budget constraints. I also believed that they were already aware of the issues and I assumed that they were part of the discussions around staffing levels.”²⁴

10. The evidence reviewed by the Inquiry suggested a lack of appreciation by G4S and the Home Office of the need (both contractual and practical) for adequate staffing, and a failure to address concerns that were raised about staffing levels. There was no evidence of a proper evaluation, by G4S or the Home Office, of whether the level of staffing met the needs of Brook House, or of the benefit of a dynamic approach to staffing levels to meet the needs of a changeable population. Mr Jeremy Petherick, Managing Director of G4S Custodial and Detention Services during the relevant period, acknowledged in hindsight the benefits of a more flexible approach to staffing levels.²⁵

11. The basis upon which appropriate staffing levels were determined was unclear (although, as discussed in Chapter D.2, there were concerns at the initial procurement stage over the staffing levels proposed by most bidders, including both Global Solutions Ltd and G4S). It is therefore difficult to say whether contractually prescribed levels were adequate. In any event, it is clear that the actual staffing levels achieved by G4S were insufficient for much of the relevant period, as those working at Brook House (from both G4S and the Home Office) were aware.²⁶ There appears to have been no attempt by G4S to exceed contractually prescribed minimum levels (although this would have reduced the profit margin) or to renegotiate the contract to provide for more staff, or by the Home Office to require increased staff to ensure the order and safety of Brook House. Despite this, the renewed contract agreed in 2018 between G4S and the Home Office was intended to provide even lower staffing levels.²⁷ It was only following the *Panorama* programme that this changed, when G4S’s action plan included increasing staff numbers.²⁸

12. The Serco contract allows for significantly higher minimum staff numbers at Brook House than during the relevant period.²⁹ Ms Mary Molyneux (who was Chair of the Independent Monitoring Board at Brook House (Brook House IMB) after the relevant period and is a current member of the Gatwick IRCs IMB), described the increased staffing levels as *“the biggest improvement and the biggest change”* compared with the relevant period. However, she

²⁴ [HOM0332049](#) para 41

²⁵ [Jeremy Petherick 21 March 2022 147/22-148/18](#)

²⁶ [HOM0332049](#) para 41; [SER000453](#) para 85; [Daniel Haughton 16 March 2022 93/7-23](#)

²⁷ [SER000453_021](#) para 84

²⁸ [DL0000175_030](#) para 3.10; [DL0000175_031](#)

²⁹ For example, there are 10 Detention Operations Managers (DOMs) and 75 DCOs on weekdays (daytime), 9 DOMs and 76 DCOs on weekends (daytime) and 2 DOMs and 18 DCOs overnight (see [SER000451_008](#) paras 27-28). DOMs were previously known as Detention Custody Managers (DCMs)

noted that Serco was “beginning to have retention issues again as the airport reopens” and added that, at the time of giving her evidence, Brook House was running at half capacity due to Covid-19 measures:

“Numbers are going to go up. Serco, even if they are fully staffed, have a lot of highly inexperienced staff under those conditions. So that is a concern; they acknowledge it.”³⁰

13. Insufficient staffing levels had a detrimental – and sometimes significant – impact on safety, as well as resulting in detained people being unable to access services and activities to which they were entitled. This led to frustration towards staff. My view is that staff, in turn, saw detained people and their needs as problems rather than the reason why the staff were there.³¹ The impact of understaffing was recognised by some witnesses.³² Adequate staffing levels are critical to ensure that there is an ordered and safe environment for detained people, staff and others in immigration removal centres. I am therefore recommending that the Home Office and those managing IRCs undertake regular and ongoing assessments of staffing levels.

Recommendation 23: Ongoing assessment of staffing levels

The Home Office and contractors operating immigration removal centres must ensure that there is ongoing assessment of staffing levels (at least on a quarterly basis), so that the level of staff present within each centre is appropriate for the size and needs of the detained population.

The Home Office must also ensure that the detained population does not increase at any immigration centre unless staffing is at an adequate level.

Inadequate recruitment and retention of staff

14. Recruitment was an ongoing issue at Brook House prior to and during the relevant period.

15. Minutes from G4S’s Senior Management Team (SMT) meetings in 2016 demonstrated concerns about vacancies and pressure to recruit new staff due to the number of staff leaving.³³ In that year, 81 staff left. Mr Lee Hanford, Interim Director of Gatwick IRCs in 2016 and again in 2017–18 following the *Panorama* programme, reported that around six to eight DCOs resigned each

³⁰ [Mary Molyneux 25 March 2022 168/3-14](#)

³¹ [Stephen Webb 8 March 2022 139/23-140/14](#); [BDP000002_003 para 8](#); [BDP0000003_011-12 paras 34-35](#)

³² [Ryan Bromley 7 March 2022 88/14-15, 89/2-7](#); [Ian Castle 15 March 2022 9/17-22](#); [Stephen Loughton 1 March 2022 75/24-76/3](#); [Sean Sayers 10 March 2022 121/18-122/17](#)

³³ [CJS0073709_097-098 para 8.6](#)

month.³⁴ In 2017, a total of 75 staff members left, including those who left or were dismissed following the *Panorama* programme.³⁵

16. Various efforts were made to recruit new staff, such as local press advertisements, publication on the G4S Global Career Centre website and recruitment days.³⁶ Despite this, Mr Saunders described multiple challenges in relation to staff recruitment, including that positions with better rates of pay were available at Gatwick Airport.³⁷ The requirement for staff to be cleared by the Home Office also reduced the potential cohort of staff.³⁸ The Inquiry heard that the “*pipeline for recruits*” was variable.³⁹ The Inquiry also heard that, while staff numbers would increase following a recruitment drive, numbers would drop quite quickly. DCO Owen Syred (who was also Welfare Officer during the relevant period), told the Inquiry, “*there was never a period when there was prolonged stability*”.⁴⁰ New staff were primarily trained and assessed off site. Mr Houghton recalled it being difficult to evaluate whether an individual would be successful in a role due to “*the unique nature of the environment*” at Brook House.⁴¹ It is of fundamental importance that people are appropriately recruited and subject not only to adequate initial training (considered below) but also to continuing development.

17. Retention was also an issue. DCM Steven Dix recalled new staff starting frequently but said that “*there was an issue with retaining staff*”, particularly on the wings. He suggested that allowing new recruits onto wings before the ITC could give a more realistic impression of the job and “*weed out*” those who were unlikely to continue.⁴² A number of witnesses told the Inquiry that the DCO recruitment and training process did not give a realistic picture of what the job was like or prepare them fully for the role.⁴³ They recalled that other DCOs had reported feeling unprepared and, in some cases, left during or soon after the ITC due to feeling ill equipped for the reality of the work.⁴⁴ DCO Luke Instone-Brewer recalled that, when applying for the job, he believed it was at

³⁴ [VER000266](#) para 66

³⁵ [CJS0073709_098](#) para 8.8

³⁶ [KEN000001](#) para 90; [CJS0074041](#) para 32

³⁷ [KEN000001](#) para 84; [KEN000001](#) para 87. During the relevant period, DCOs were paid between £22,000 and £24,000 per year

³⁸ [KEN000001](#) para 85

³⁹ [SER000453](#) para 137

⁴⁰ [INN000007](#) para 137

⁴¹ [SER000453](#) para 136

⁴² [SER000436](#) para 47

⁴³ For example, [Daniel Small 28 February 2022 107/21-108/18](#); [Daniel Lake 1 March 2022 2/10-3/15](#); [Charles Francis 3 March 2022 17/2-3, 18/9-19](#); [Darren Tomsett 7 March 2022 2/16-3/19](#); [Shayne Munroe 4 March 2022 3/17-4/16](#)

⁴⁴ [Charles Francis 3 March 2022 17/2-19/3](#); [Daniel Houghton 16 March 2022 154/21-24](#); [Shayne Munroe 4 March 2022 4/11-16](#)

Gatwick Airport “*stamping passports and the like*”.⁴⁵ DCO Charles Francis believed that, after the ITC, when DCOs shadowed a colleague within Brook House, “*reality hits ... it’s then you think ‘is this for me? Do I need this?’*”.⁴⁶

18. In the DCO role, G4S provided limited incentives for long service.⁴⁷ Mr Syred noted a “*lack of recognition and reward for experience*”, which he associated with high turnover, a failure to recruit people interested in a long-term career, and the stresses of the role. He estimated that, when he returned to Brook House in 2014 after a year away, approximately three-quarters of the staff were new.⁴⁸ It is likely that high turnover affected the morale of those who remained.⁴⁹

19. There were also no financial rewards provided by G4S for taking on additional DCO responsibilities, such as becoming an Assessment Care in Detention and Teamwork (ACDT) assessor.⁵⁰ Despite his important Welfare Officer role and his 10 years of service, Mr Syred was earning the same as a new DCO with no experience. His only option for career progression was to become a DCM, which he did not wish to do.⁵¹ Related to retention was the working pattern of the detention staff. Some current and former members of staff told the Inquiry (and had previously told Verita) that the long shifts and shift patterns could be stressful and exhausting, and could negatively affect their mental health and their personal and family lives.⁵² The combination of this with the insufficient staffing levels clearly does not excuse ill treatment of detained people, but it is likely that stress, fatigue and the feeling of being overworked and understaffed exacerbated the poor staff culture.

20. Some painted a more positive picture of working life in Brook House and explained that morale levels were variable (by time, between staff or between areas of Brook House).⁵³ However, the Inquiry repeatedly heard staff members describe poor morale during the relevant period. It was described as dropping into an “*abyss*”,⁵⁴ while “*sickness was through the roof. People didn’t want to*

⁴⁵ [MAR000001_2](#) para 6

⁴⁶ [Charles Francis 3 March 2022 18/23-19/3](#)

⁴⁷ [KEN000001_019-020](#) paras 100-103

⁴⁸ [INN000007_005](#) para 17

⁴⁹ [SER000434_008](#) para 30

⁵⁰ [Owen Syred 7 December 2021 89/9-20](#)

⁵¹ [Closing Statement on behalf of Owen Syred](#), Brook House Inquiry, 2 May 2022, paras 85-86

⁵² [Aaron Stokes 9 March 2022 169/8-12](#); [VER000238_009](#) para 121; [Ioannis Paschali 24 February 2022 15/7-13](#); [VER000238_009](#) para 121; [MIL000003_004](#) para 20; [Stephen Webb 8 March 2022 139/23-140/14](#)

⁵³ [Christopher Donnelly 23 March 2022 65/23-66/13](#); [Darren Tomsett 7 March 2022 13/24-14/13](#); [INN000013_003](#) para 10

⁵⁴ [MAR000001_003](#) para 23

turn up for work.”⁵⁵ This low morale was specifically attributed by many to low staffing levels and a high turnover.⁵⁶ DCO Daniel Lake told the Inquiry:

*“You come in and see the rota straight away and realise how many people are in the building and straight away you’re on the back burner, you think, ‘Oh, it’s going to be a long day’. Yeah, that’s why morale was mostly down, was staffing reasons.”*⁵⁷

Mr Callum Tulley, a DCO until July 2017, said that the majority of staff were *“trying to do their best in a bleak, poorly staffed, highly charged and toxic environment”*.⁵⁸

21. There were obvious pressures on an understaffed and insufficiently capable workforce at Brook House during the relevant period, working in an inherently challenging environment. A number of DCOs and DCMs were inherently unsuitable for those roles. Along with the need to recruit appropriate employees to maintain a quality workforce and encourage a positive culture, I consider that high levels of turnover contributed to a negative staff culture. The impact of low staffing levels also increased stress and pressure on those remaining. In my view, these issues made the environment difficult for most staff and exacerbated unacceptable behaviour by some.

22. Changes have been made since the relevant period. The DCO role has been reduced to a 40 hour per week position, from 46 hours during the relevant period. This change came into force in July 2018 as part of G4S’s action plan⁵⁹ and was retained for the Serco contract. Following a pay review finalised on 1 April 2022, the salary for the DCO role was increased to £27,441, *“above any other IRC salary”*.⁶⁰ Turnover was *“about ten leavers a month”*, and the Inquiry was told those vacancies were being filled with active recruitment.⁶¹ Nonetheless, Mr Haughton told the Inquiry that, while Serco had *“improved conditions for staff”*, competition with better paid and less pressured roles would always remain.⁶²

Inadequate development of staff

23. The content of staff training was set by G4S, although its plan was approved by the Home Office.⁶³ All DCOs employed at Brook House during the

⁵⁵ [Ioannis Paschali 24 February 2022 31/19-32/17](#)

⁵⁶ [Daniel Small 28 February 2022 113/22-114/22; SER000434_008](#) para 30

⁵⁷ [Daniel Lake 1 March 2022 12/1-7](#)

⁵⁸ [INQ000052_017](#) para 73

⁵⁹ [DL0000175_031; SER000451_006](#) para 20

⁶⁰ [Steven Hewer 1 April 2022 41/24-25](#). The Detention Operations Manager salary was £32,585.88 on 1 March 2022 ([SER000451_010](#) para 40)

⁶¹ [Steven Hewer 1 April 2022 42/11-18](#)

⁶² [Daniel Haughton 16 March 2022 154/13-155/7](#)

⁶³ [DL0000175_0007](#) para 14

relevant period were required to complete the ITC before being certified by the Home Office and allowed to engage in DCO duties.⁶⁴ This included training in Control and Restraint (C&R, discussed in Chapter D.7), personal protection, first aid, ACDT, health and safety, and safeguarding and security, and lasted six weeks with a further two-week period for shadowing an existing member of staff.⁶⁵ In addition, staff received some ongoing training such as annual refresher courses on security and safer custody.⁶⁶

24. Some staff spoke positively about their experiences on the ITC.⁶⁷ However, the 2018 Verita report “*had cause to question the quality and content*” of some of the training offered on the ITC and in refresher courses, and found that not all of those delivering training were appropriately qualified.⁶⁸ G4S disputed this, despite a review in 2018 identifying certain gaps and inconsistencies in its training.⁶⁹ Professor Bosworth considered that DCO training was inadequate and had too much emphasis on security.⁷⁰ For example, C&R and first aid were the only elements of the ITC that prospective staff explicitly needed to pass in order to have contact with detained people.⁷¹

25. There were also a number of areas in which there was insufficient or no training.

25.1 Mental health: A number of witnesses told the Inquiry that there was a lack of mental health training during or prior to the relevant period, although the ITC contained an introduction to mental health and first aid training.⁷² One consequence of this was that detained people with mental health conditions were sometimes dismissed as simply behaving badly.⁷³ Adequate training is necessary for staff working at Brook House

⁶⁴ [CJS0074041_012](#) para 48

⁶⁵ [CJS0074041_012-016](#) paras 48-70. A breakdown of the training involved is set out by Professor Bosworth in her first report to the Inquiry: [INQ000064_030](#) para 5.6; [CJS006085](#)

⁶⁶ [CJS0074041_016](#) para 70

⁶⁷ [INQ000114_004](#) para 18; [Owen Syred 7 December 2021 6/24](#)

⁶⁸ [CJS0073709_013](#) para 1.38

⁶⁹ [CJS0074041_015](#) paras 62-65; [CJS0074041_015-016](#) paras 66-67

⁷⁰ [Professor Mary Bosworth 29 March 2022 23/16-23](#)

⁷¹ [John Connolly 2 March 2022 156/19-157/8](#)

⁷² For example, [Owen Syred 7 December 2021 46/2-23](#); [Daniel Small 28 February 2022 109/6-110/15](#); [Charles Francis 3 March 2022 6/5-8](#); [David Webb 3 March 2022 105/14-106/6](#); [Shayne Munroe 4 March 2022 7/23-25](#); [Darren Tomsett 7 March 2022 22/15-25](#); [Stephen Loughton 1 March 2022 102/11-103/13](#); [Shane Farrell 8 March 2022 79/13-81/1](#); [Steven Dix 9 March 2022 6/2-5](#); [Ioannis Paschali 24 February 2022 29/9-16](#). See also [INQ000064_030](#) para 5.6

⁷³ [Owen Syred 7 December 2021 46/2-23](#). DCO Stewart Povey-Meier also accepted this was a possible consequence of the lack of training ([Stewart Povey-Meier 17 March 2022 5/8-12](#))

to understand and respond to detained people with mental health conditions, as has been identified in various reports.⁷⁴

- 25.2 Working with vulnerable detained people:** Some staff felt that there was a particular failure to provide those who worked on E Wing (where detained people with particular vulnerabilities were held) with sufficient training to deal with various issues arising among detained people, including drug misuse and other types of vulnerability.⁷⁵ Professor Bosworth considered that, although the Home Office's statutory *Guidance on Adults at Risk in Immigration Detention* (Adults at Risk policy), which is discussed further in Chapter D.5, was in place during the relevant period, it was likely that it was not widely understood and there was little evidence of staff being trained on it.⁷⁶
- 25.3 Use of force:** A number of staff felt that the training they received on use of force was good.⁷⁷ However, there appears to have been no training on particular factors that need to be taken into account when using force against, for example, people with mental ill health.⁷⁸ The adequacy of use of force training is considered in more detail in Chapter D.7.
- 25.4 DCM training:** While DCOs tended to be recruited externally, the majority of DCMs were – and still are – recruited from the DCO level. The Inquiry heard from various witnesses that when DCOs were promoted to DCM level, they did not receive adequate training for their increased responsibilities. At most, they would shadow a DCM for a short time.⁷⁹ Mr Jonathan Collier, the Inquiry's use of force expert, described this as "*wholly inadequate*".⁸⁰ This risks poor culture and practices being passed on and is illustrative of the lack of professionalisation of these roles. Professor Bosworth suggested that the Home Office run DCO training, working with contractors and other stakeholders, including HM Inspectorate of Prisons (HMIP), the IMB and representatives from detained people, and emphasised the need to revisit the DCO role with

⁷⁴ The Brook House IMB had recommended in its 2017 and 2018 annual reports that staff working with vulnerable detained people receive appropriate 'Advanced mental health training' ([VER000138_005](#); [IMB000156_005](#)). See also the Medical Justice report in 2013 on Mental Health in Immigration Detention ([BHM000041_013-014](#) paras 36-37) and DCO Charles Francis ([HOW000001_006](#) para 9; [HOW000001_024](#) para 25a)

⁷⁵ [Owen Syred 7 December 2021 59/25-60/19](#); [VER000219_002](#)

⁷⁶ [INQ000123_004-005](#) paras 2.5-2.11

⁷⁷ [David Webb 3 March 2022 121/23-24](#); Shayne Munroe ([INN000013_011](#) paras 33-34)

⁷⁸ See, for example, [Steven Dix 9 March 2022 76/1-4](#)

⁷⁹ [Nathan Ring 25 February 2022 5/9-6/23](#); [Darren Tomsett 7 March 2022 4/1-9](#); [Steven Dix 9 March 2022 4/4-20](#)

⁸⁰ [Jonathan Collier 30 March 2022 57/25-59/4](#)

an emphasis on care over security.⁸¹ These suggestions should be considered by the Home Office and private providers when designing staff training.

Better training on these matters would have helped staff to implement requirements more appropriately.

26. Professor Bosworth reviewed some of the staff training materials currently in place under Serco's management of Brook House. She noted that, while there was training in matters such as human rights and interpersonal skills, the course was skewed heavily towards security and risk, as it had been during the relevant period.⁸² The human rights training was significantly out of date and was a missed opportunity to link, for example, the explanation of Articles 3 and 6 of the European Convention on Human Rights to the rights of those detained in an IRC. The speaker notes suggested some confusion about the scope and purpose of Article 3. Insufficient weight was placed on the rights of detained people, while there was too much focus on the dangers of working in an IRC and on the use of force.⁸³

27. The consequence of inadequate training and development during the relevant period was that staff were left unprepared and unable to do their jobs properly, particularly in relation to vulnerable detained people. Staff do not, for example, need to be mental health experts, but they should have an understanding of how mental health conditions might affect behaviour and how they should respond.

28. In my opinion, being a DCO is a job that demands a complex combination of skills, including resilience, compassion, strength and authority. The role is, if anything, even more challenging and complicated than that of a prison officer, given the language barriers and the difficulty in forming relationships with people detained for an uncertain and relatively short-term duration. I am therefore recommending that the training provided to detention staff be improved – it should be at least equivalent in depth and breadth to that received by prison officers.

⁸¹ [INQ000123_017](#) paras 3.15-3.19. Mr Syred also suggested that a National Vocational Qualification in a custodial discipline would improve career progression, retention and staff morale ([INN000007_059](#) para 221)

⁸² [INQ000123_012](#) para 2.69

⁸³ [SER000351](#)

Recommendation 24: Mandatory training for immigration removal centre staff

The Home Office, in conjunction with contractors, must ensure that all relevant immigration removal centre staff receive mandatory introductory and annual training on:

- mental health;
- race and diversity;
- a trauma-informed approach;
- their own resilience;
- drug awareness; and
- the purpose of immigration removal centres.

This training must include the perspectives of, or be conducted in consultation with, detained people.

The Home Office must also ensure, in conjunction with contractors, that new joiners must start on probation on completion of introductory training and be adequately supervised for a period of time as necessary to establish their competence to work independently.

Ineffective management by G4S Senior Management Team

29. In an institution like Brook House, the SMT is responsible for setting, monitoring and maintaining a healthy culture. If senior managers are absent or ineffective, there is a risk of deterioration in culture and standards. This was the case under the management by G4S of Brook House during the relevant period.

30. Many staff who gave evidence to the Inquiry felt that the SMT was “not visible”, “barely visible”, “rarely seen or heard” around Brook House, insufficiently accessible and “notoriously unavailable”.⁸⁴ Some DCOs and DCMs stated that they received “no back-up from senior management”,⁸⁵ who were perceived to inhabit an “ivory tower”,⁸⁶ removed from daily life in Brook House. Mr Saunders agreed that he could have been more visible, but said that a key

⁸⁴ [INN000007_006 para 21](#); [Daniel Lake 1 March 2022 8/24-9/15](#); [Callum Tulley 30 November 2021 158/2](#); [INN000013_005 para 15](#); [SER000459_009 para 43](#); [MAR000002_006 para 47](#)

⁸⁵ [Derek Murphy 2 March 2022 4/9-10](#)

⁸⁶ [Derek Murphy 2 March 2022 5/5-8](#); [INQ000087_003](#)

element of his role was “*reporting upwards*”.⁸⁷ Mr Stephen Skitt (Deputy Director of Brook House during the relevant period) saw himself as having been “*relatively visible*”,⁸⁸ while Mr Julian Williams (Residential Manager) considered himself to be more present on the wings than other managers.⁸⁹ DCO Edmund Fiddy described “*a nice atmosphere at the top of the building*” where the Home Office and SMT were based, which was quiet and “*didn’t feel like a prison*”.⁹⁰

31. The Inquiry also heard evidence of dysfunctional relationships within the SMT. Mr Saunders said he felt “*isolated*” in his role and was distrustful of some SMT members.⁹¹ Mr Haughton suggested that Mr Saunders was “*shouted down*” by SMT members when Mr Haughton raised compliance issues, although Mr Saunders denied this.⁹²

32. As Professor Bosworth also noted, the G4S contract created a significant pay gap between the SMT and DCOs. The steep hierarchy was compounded by shift patterns that meant that there were long periods with limited SMT (and indeed DCM) presence.⁹³

33. The lack of presence and visibility of SMT members, and their hierarchical separation from those ‘on the ground’, likely contributed to a feeling that the DCOs and DCMs were largely left to manage on their own ‘against’ the detained people, with their actions neither under sufficient scrutiny from, nor of particular concern to, senior managers. This lack of engagement, compounded by unprofessional conduct such as in-fighting, reduced the likelihood of detention staff seeking SMT advice or sharing concerns. It also reduced the ability of SMT members to recognise and to act proactively upon behavioural and cultural issues. I am therefore recommending that contractors managing IRCs ensure that senior managers are more accessible to other staff.

Recommendation 25: Improving the visibility of senior managers within centres

Contractors operating immigration removal centres must ensure that senior managers are regularly present and visible within the immigration removal centre and are accessible to more junior detention staff.

⁸⁷ [Ben Saunders 22 March 2022 85/2-14, 87/17-88/1](#)

⁸⁸ [Stephen Skitt 17 March 2022 93/24-94/12](#)

⁸⁹ [Julian Williams 16 March 2022 29/7-20](#)

⁹⁰ [Edmund Fiddy 7 March 2022 157/16-20](#)

⁹¹ [Ben Saunders 22 March 2022 108/4-25](#)

⁹² [Ben Saunders 22 March 2022 108/4-25](#)

⁹³ [INQ000123_021 para 4.22; INQ000064_031 para 6.3](#)

Home Office staff at Brook House

34. During the relevant period, the Home Office was represented on site at Brook House by a single team, comprising one Immigration Manager/Contract Monitor, two Deputy Immigration Managers/Contract Monitors, and seven or eight Contract Managers.⁹⁴

35. Home Office staff based at Brook House sat in an office on the third floor above the visits area.⁹⁵ Mr Lake recalled having *“no working relationship with the Home Office. They would enter the building via the main reception and take the lift to the top floor.”*⁹⁶ The office was not accessible to detained people, and those wishing to speak with a Home Office representative would book a meeting, to be held in the visits area.⁹⁷

36. The lack of interaction with detained people during the relevant period is also indicative of a general ‘hands-off’ culture. A number of detained people felt that contact with Home Office staff was limited. D1851 said:

*“they tend to call you when they have got bad news for you ... it’s not actually speaking, it’s more of handing you documents, reminding you ... ‘Don’t forget, we will be picking you up one day.’”*⁹⁸

Detention staff, particularly DCOs, also described Home Office staff as physically distant from detained people and *“very rarely”* seen.⁹⁹ Mr Saunders noted that Mr Paul Gasson (Home Office Contract Monitor at Brook House during the relevant period) *“wouldn’t go out ... wouldn’t talk to the detainees”*.¹⁰⁰ Mr Gasson stated that he did in fact spend time walking around Brook House, but the examples he gave the Inquiry involved more superficial issues such as bins being emptied and a formulaic concern with monitoring Reception waiting times.¹⁰¹

37. This reflected the primary focus of the Home Office’s efforts at Brook House on ‘engagement’ work. This included serving paperwork on behalf of caseworkers, meeting various targets related to induction and ensuring that detained people could speak to the Home Office within a set time frame. Complaints boxes were emptied by a team that also undertook ad hoc inspections of Brook House, led by Mr Gasson.¹⁰² The Home Office staff were

⁹⁴ [HOM0332004](#) para 5

⁹⁵ [Michelle Smith 23 March 2022 102/7-10](#)

⁹⁶ [BDP000002_008](#) para 23

⁹⁷ [HOM0332141](#) para 10

⁹⁸ [D1851 3 December 2021 76/14-22](#)

⁹⁹ [INQ000052_028](#) para 119; see also [INN000013_020](#) para 61

¹⁰⁰ [VER000226_040](#) para 570

¹⁰¹ [Paul Gasson 15 March 2022 152/4-155/2](#)

¹⁰² [Michelle Smith 23 March 2022 115/24-116/5](#)

“essentially act[ing] as the middle person”, passing information and paperwork (including removal directions) between detained people and caseworkers.¹⁰³

38. Home Office staff at Brook House were not caseworkers or decision-makers, and therefore were of limited assistance to detained people.¹⁰⁴ D687 expressed the frustration this caused:

*“you never see your caseworker and the person giving you your report can’t answer any of your questions”.*¹⁰⁵

The Inquiry heard D687’s account of an interaction with a Home Office employee, Ms Vanessa Smith, who was visiting him prior to his planned removal. Ms Smith had recorded on D687’s General Case Information Database notes that D687 said he would only return to Somalia *“in a body bag”* and could not *“take it anymore”*.¹⁰⁶ He had also started to write a suicide note. In response, she warned G4S staff but did not open an ACDT document.¹⁰⁷ D687 recalled her telling him things like *“I’m just a messenger ... you’ll need to lump it and deal with it ... I’m not your caseworker, so can’t help you.”*¹⁰⁸ Ms Smith told the Inquiry she would have explained that she was *“between”* the detained person and their caseworker, but did not use the words D687 described, and did not feel she was dismissive.¹⁰⁹ She said she did not personally open an ACDT document in response to the suicidal comments because *“He didn’t say he was going to do it immediately”* (adding that she *“assumed”* she would now open one in a similar situation).¹¹⁰

39. Alongside the detachment between decision-makers and Home Office staff on the ground, there was a lack of concern by some for the welfare of those detained at Brook House. In 2018, Mr Saunders said that, while some individuals in the Home Office cared very much, *“the Home Office didn’t really care about the people we looked after ... the Home Office entity corporately was mostly concerned about the removal process and the functionality of it”*.¹¹¹ Mr Hanford similarly noted that, when he started in 2016, there were *“elements of criticism aimed at G4S ... from the Home Office, about showing too much empathy, supporting detainees in their appeals and the likes”*.¹¹²

¹⁰³ [HOM0332141_011](#) para 40; [Paul Gasson 15 March 2022 221/6-13](#)

¹⁰⁴ [IMB000203_013](#) para 40

¹⁰⁵ [DPG000021_062-063](#) para 172; see also [HOM0332141](#) para 40; [Jamie Macpherson 8 December 2021 206/3-16](#)

¹⁰⁶ [HOM032193_001](#)

¹⁰⁷ [HOM032193_001](#)

¹⁰⁸ [DPG000021_062-063](#) para 172

¹⁰⁹ [Vanessa Smith 15 March 2022 247/4-16](#)

¹¹⁰ [Vanessa Smith 15 March 2022 249/8-250/23](#)

¹¹¹ [VER000226_020](#) para 249; see also [INN000007_023](#) para 98

¹¹² [VER000266_022](#) para 288

40. The lack of Home Office staff at Brook House gave the impression of detachment and a lack of concern felt by both centre staff and detained people. Had the Home Office staff been more present and actively involved, there might have also been opportunities to identify and challenge poor culture and behaviour, and to better assess the welfare of detained people. I am therefore recommending that the Home Office take action to improve the visibility of its staff within Brook House.

Recommendation 26: Improving the visibility of Home Office staff

The Home Office must ensure that its staff are regularly present and visible within each immigration removal centre.

Cultural issues

41. Racist language and actions, and a culture of bullying, bravado and ‘macho’ attitudes, underpinned a number of the events discussed in this Report. I also consider in more detail below the abusive and derogatory language used towards and about so many of the detained people. I observed explicit racism and tolerance of racism by others, along with a desire by some staff to ‘fit in’ and to appear ‘tough’ or masculine by adopting the aggressive culture of some existing staff. These aspects of staff behaviour cannot be separated from cultural issues. Prisonisation, dehumanisation, the ‘us and them’ attitude exhibited by many and the fundamental failure to understand the power imbalance all fed into and also fed off attitudes of racism and toxic bravado.

The prisonisation of Brook House

42. Brook House was built to the specification of a Category B prison.¹¹³ It was not just the building that was prison-like; the regime, the way staff saw their roles and the treatment of detained people all demonstrated ‘prisonisation’ (which refers to a non-prison setting being treated, in effect, as a prison, with detained people treated as criminal and dangerous). Professor Bosworth described a prisonised setting as one in which “*those who are detained are labelled and treated as risky and dangerous*”, and in which detention officers come to feel that they are “*working in an institution that was effectively a prison with people who were, therefore, criminal and dangerous*”.¹¹⁴

¹¹³ HMIP000311_0033 para 2.8; CJS000761_015 para S13

¹¹⁴ INQ000064_016 para 3.16; Professor Mary Bosworth 29 March 2022 13/23-14/2

43. DCO Shayne Munroe told the Inquiry that some staff “*thought they were working in a prison*”.¹¹⁵ This manifested in the way they spoke to detained people. I find the use of prison-focused language entirely unsurprising, as I have no doubt that Brook House felt like a prison to many, particularly to the majority of detained people. Ms Munroe was aware that DCOs did not have the same powers as prison officers, and that they must instead “*learn to talk to people, because that’s the most we can do*”.¹¹⁶ I consider that a greater focus on the importance of communication skills would help DCOs to de-escalate some situations that, with more ‘prison-minded’ staff, may have resulted in conflict, use of force or removal from association.

44. The 2016 HMIP inspection report noted that “*elements of procedural security remained disproportionate to the risks of the population*”.¹¹⁷

45. The Inquiry noted similar issues. For example, DCO Darren Tomsett described a challenging role “*controlling the door*” and preventing detained people from moving from one wing to another. He did not know why they were not allowed to circulate freely around the building – he simply understood that he was “*trying to maintain that control and security*” and enforcing the rules.¹¹⁸

46. A number of detention staff had previously worked in prisons or in private security.¹¹⁹ Many continued to perceive their role in this way. Mr Skitt, who had worked in prisons for 28 years, was recorded in the 2018 Verita report as saying that he “*missed working in a prison*”.¹²⁰ It concluded that he gave an impression of feeling more comfortable “*with the more disciplined and hierarchical working environment, practices and behaviours of the prison service and the military*”.¹²¹

47. The focus on criminality and security from the ITC onwards encouraged staff to adopt, in many cases and often without question, a prison-like mentality.¹²² This is at odds with the purpose of an IRC.

48. The starting point, as required by the Detention Centre Rules 2001, should have been the promotion of as much “*freedom of movement*” around

¹¹⁵ [INN000013_013](#) para 41

¹¹⁶ [Shayne Munroe 4 March 2022 24/3-16](#)

¹¹⁷ [CJS000761_024](#) para 1.41

¹¹⁸ [Darren Tomsett 7 March 2022 10/15-11/25](#)

¹¹⁹ See, for example, [Daniel Small 28 February 2022 107/15-17](#); [SER000434_002](#) para 4; [SER000455_001](#) para 3; [IPA000001_001](#) para 2

¹²⁰ [CJS0073709_069](#) para 7.13

¹²¹ [CJS0073709_069](#) para 7.13. Ms Michelle Brown, a member of the SMT, also recalled Mr Skitt continuously using prison terminology ([INQ000164_006](#) para 7). DCO Ryan Bromley referred to working “*in the security industry*” when describing an assault by a detained person; see also [Ryan Bromley 7 March 2022 132/8-9](#) and Mr Philip Dove (Director of G4S Health Services), who referred to Mr Skitt as “*director of the prison*” ([Philip Dove 31 March 2022 149/21](#))

¹²² For example, the training materials and timetable summarised at [INQ000064_016](#) paras 5.5-5.6

Brook House as possible.¹²³ Instead, many staff appeared to adopt a restrictive and prison-like approach. Mr Philip Riley, Director of DES within the Home Office, commented that *“the regime there, and the culture, is anything but prison-like”* and that *“residents have free movement”*.¹²⁴ This does not reflect the reality of detention in Brook House. The 2016 HMIP inspection report noted that *“detainees felt they were held in prison conditions”*.¹²⁵ During the relevant period, as today, people at Brook House were detained within a secure building and a high-walled perimeter. They were often locked in their cells, including overnight every night. This is not ‘free movement’. Based on the totality of the evidence that the Inquiry heard, the reality of day-to-day life for those detained at Brook House was that it was prison-like.

49. The new contract with Serco now provides for an extended ‘core day’, meaning detained people may access activities off their wings until 21:00 and must be in their cells by 22:00, where they are locked in until 07:00. There are still two half-hour periods per day of lock-in for roll count.¹²⁶ This amounts to an additional two hours of time out of the cell compared with the relevant period. Such efforts to increase free movement around Brook House, to provide diverting and beneficial activities and to soften the appearance (as previously recommended by the Brook House IMB, HMIP and Verita) must continue.¹²⁷ This may help to prevent the building inevitably continuing to look (and perhaps feel) like a prison.

‘Us and them’ culture and dehumanisation

50. Closely related to prisonisation was the existence of an ‘us and them’ mentality among staff towards detained people, which manifested at times in desensitisation to detained people’s needs, and ultimately in their dehumanisation by staff. The institutional emphasis on security and danger within Brook House created, for many, a volatile environment, far from the *“safe and secure”* setting required by the Detention Centre Rules 2001.¹²⁸

51. ITC materials repeatedly emphasised the risks of escape, physical assault and radicalisation.¹²⁹ This set the tone for staff at Brook House. Officers were, as Professor Bosworth put it, *“taught to think of the detained population as potential threats”*.¹³⁰ As a result, situations that could and should have been

¹²³ [Detention Centre Rules 2001](#), Rule 3

¹²⁴ [Philip Riley 4 April 2022 60/12-25](#)

¹²⁵ [CJS000761_018](#) para S36

¹²⁶ [SER000026_009-010](#)

¹²⁷ [HMIP000613_020](#) para S36; [HMIP000613_028](#) para 1.59; [HMIP000613_045](#) para 3.16; [IMB000156_005](#); *Independent Investigation into Concerns about Brook House Immigration Removal Centre*, Verita, October 2018, paras R17 and R23

¹²⁸ [Detention Centre Rules 2001](#), Rule 3

¹²⁹ [INQ000064_030](#) para 5.6; [INQ000064_015-016](#) paras 3.12-3.13; [CJS006350](#)

¹³⁰ [INQ000064_015](#) para 3.12

de-escalated instead led to the use of force and, at times, removal from association.

52. The Inquiry heard evidence from staff members who described a fear of being attacked with boiling water. In a clip the Inquiry saw, alleged concern about a boiling kettle was used to justify force to remove D390 from his cell (see Chapter C.8 in Volume I). Separately, DCM Stephen Webb said:

*“you could always tell the room of a foreign national offender ... there would be a kettle half full of water ... with an open bag of sugar, because if you do anything wrong, that sugar is going in the kettle and that kettle is going all over you ... that’s known as ‘prison napalm’”.*¹³¹

Mr Webb went on to say that sugared boiling water (the sugar causing more severe scalding) had not in fact ever been used as a weapon at Brook House.¹³² Later in his evidence it became apparent that Mr Webb had inaccurately recorded, on a Use of Force form, that hot water had been thrown over an officer, when in fact D642 had thrown the contents of a bottle of cold water.¹³³ Mr Webb said he believed the water was hot at the time, *“because that’s the worst-case scenario”*.¹³⁴ Mr Tulley told the Inquiry that, while he had heard staff talk of the use of hot or sugared water as a weapon from time to time, he knew of no examples of it happening, and considered it *“came from a place of fear”*.¹³⁵

53. This mentality gave rise to a more pervasive culture of ‘us and them’, exacerbated by a largely absent SMT, which led to more junior staff relying on one another ‘against’ the detained population. DCO Babatunde Fagbo described DCOs being *“on the frontline”* and disregarded by managers while having to deal with *“the extreme pressure of the centre harbouring hardcore criminals”*.¹³⁶ This was not lost on detained people. D643 suggested that the *“way you get treated is that the officers would talk about us as ‘they’”*.¹³⁷ When Mr Stephen Loughton (a DCM during the relevant period, now Assistant Director) was asked about Mr Tulley’s undercover reporting with the BBC, he said that it was a *“challenging”* job where staff received daily threats and abuse from detained people:

¹³¹ [Stephen Webb 8 March 2022 148/10-20](#)

¹³² [Stephen Webb 8 March 2022 148/6-149/2](#)

¹³³ [Stephen Webb 8 March 2022 156/21-160/21; CJS005587](#)

¹³⁴ [Stephen Webb 8 March 2022 158/25](#)

¹³⁵ [Callum Tulley 9 March 2022 157/13-18](#)

¹³⁶ [BFA000002_007](#)

¹³⁷ [D643 22 February 2022 90/4-9](#)

*“so I think people felt let down by Callum because he was part of a team. It was a close-knit team, the staff, in those days. Everyone looked out for everyone. I think that’s why people felt let down by Callum.”*¹³⁸

54. Mr Syred told the Inquiry of “gangs” or “cliques” of staff who saw detained people as “different humans”. By contrast, he enjoyed getting to know detained people and described asking himself, “if that was my son in detention in another country, how would I feel?”.¹³⁹ He took admirable steps to communicate with residents, such as greeting people “in approximately 20 different languages”.¹⁴⁰ Ms Munroe described asking detained people to teach her some basic words in their native language.¹⁴¹ These examples of friendly rapport-building stand in stark contrast to many interactions between staff and detained people.

55. Other detention staff should have been encouraged to think and behave as Mr Syred did. Instead, Mr Syred’s empathy for those under his care, and his reporting of racist behaviour by others, led to him being mocked and ostracised by some staff, and he was insufficiently supported by senior management.¹⁴² His locker and a photograph of his face were defaced with “grass” and “nigger lover”.¹⁴³ He told the Inquiry: “you could tell the culture of ‘Well you’ve just grassed on an officer who was really good at C&R. He was one of the lads’.”¹⁴⁴ I accept his account, which reflects the ‘us and them’ attitudes described above. This culture played a part in enabling poor treatment of detained people, who were seen as ‘other’, while simultaneously making it less likely that staff would challenge or report each other. It led to those who spoke out, like Mr Syred and Mr Tulley, being seen as ‘grasses’ and traitors.

56. Professor Bosworth highlighted three examples from the covert footage that she considered “*instructive in thinking about staff culture*”.¹⁴⁵ The first was a clip of an incident on 25 April 2017 when a ligature was removed from D1527’s neck. He was spoken to aggressively and loudly by staff, and his distressing comments – including saying “*I will die here*” – were met with silence.¹⁴⁶ The second featured a man on suicide watch, screaming from his E Wing cell, asking why he was still detained. He too was met with silence from staff.¹⁴⁷ In the final example, DCO Aaron Stokes – in a conversation with staff

¹³⁸ [Stephen Loughton 1 March 2022 136/7-138/5](#); see also [INQ000001](#)

¹³⁹ [Owen Syred 7 December 2021 97/1-15](#)

¹⁴⁰ [INN000007_015](#) para 66

¹⁴¹ [INN000013_013](#) para 39

¹⁴² [Owen Syred 7 December 2021 107/6-11, 110/6-20, 116/21-117/5, 122/2-7](#)

¹⁴³ [Owen Syred 7 December 2021 117/16-17](#)

¹⁴⁴ [Owen Syred 7 December 2021 117/25-118/2](#)

¹⁴⁵ [INQ000064_009](#) para 2.15

¹⁴⁶ [INQ000064_009](#) para 2.15

¹⁴⁷ [INQ000064_009](#) para 2.16

about a man who had threatened suicide – said “*he’s a bell end. Can’t keep up with him. I’ll hang myself, I’ll hang myself. I don’t really care ... just do it.*”¹⁴⁸ Many other examples could have been chosen, all illustrating a culture in which staff had become desensitised to the distress of those under their care.

57. The Inquiry also saw footage of occasions where staff, talking about a detained person, used the phrase “*if he dies, he dies*”.¹⁴⁹ DCO Derek Murphy said during an investigation by G4S that this was a quotation from a film, although he apologised to the Inquiry for saying it.¹⁵⁰ Mr Lake, who also used the phrase, claimed that he did not remember saying it but said it was “*the culture at Brook House*”.¹⁵¹ Mr Loughton was asked about others using the expression while discussing the planned use of force on D1914 on 27 May 2017 (see Chapter C.6 in Volume I). He did not accept that it was used in relation to D1914, when it clearly was, and said “*it was talked about in the wing office at E wing*” and “*it was a bit of a joke*”.¹⁵² I reject the attempts to justify these words. Their use was not only callous and unacceptable but betrays the extent of desensitisation to detained people’s health issues and vulnerabilities, and the dehumanisation of detained people by some staff. During his involvement with the Inquiry, D1914 watched footage of staff talking in this way about him regarding his heart condition and planned removal. Unsurprisingly, he found it disturbing and deeply upsetting. He felt he was seen as “*sub-human – as a dog*”.¹⁵³

58. Alongside the dehumanisation of detained people caused by the ‘us and them’ culture, many staff lacked healthy coping mechanisms for the undoubtedly genuinely difficult, stressful and at times traumatic situations in which they found themselves, particularly when dealing with detained people with complex problems. When asked about the conversation above, Mr Stokes told the Inquiry he had “*cracked as a human being*” at that point and was “*overwhelmed with stress and trauma*”.¹⁵⁴ He said that traumatising events he had witnessed in Brook House had left him “*numb*”.¹⁵⁵ In fact, on 5 May 2017, Mr Stokes requested a transfer to Tinsley House.¹⁵⁶ He said he spoke to both Mr Skitt and Mr Saunders about being unable to “*handle the stresses*” of work at Brook House. He claimed that, despite referral to Healthcare, “*nothing really*

¹⁴⁸ [TRN0000094_054](#) lines 1845-1846

¹⁴⁹ Shown on transcript as DCO David Webb ([TRN0000087_016](#) – although he denied being the person who said this, and noted that there were a number of people in the room: [David Webb 3 March 2022 129/4-5](#)), Daniel Lake ([TRN0000087_019](#)) on 27 May 2017 and Derek Murphy ([TRN0000092_040](#)) on 14 June 2017

¹⁵⁰ [CJS005928; Derek Murphy 2 March 2022 86/14-16](#)

¹⁵¹ [Daniel Lake 1 March 2022 42/13-22](#)

¹⁵² [Stephen Loughton 1 March 2022 114/2-116/17](#)

¹⁵³ [DL0000229_039](#) para 138

¹⁵⁴ [Aaron Stokes 9 March 2022 201/12-14, 202/19-22](#)

¹⁵⁵ [Aaron Stokes 9 March 2022 199/1-10](#)

¹⁵⁶ [INQ000130_002](#) para 4

changed", and he was not offered any support or a transfer.¹⁵⁷ DCM Nathan Ring told the Inquiry:

*"seeing the things we saw and had to deal with it, if you couldn't desensitise to a certain extent, it would probably have an effect on your mental health".*¹⁵⁸

59. Becoming desensitised to the suffering of detained people was not an acceptable response to these pressures. However, institutional as well as individual failures allowed this culture to take root. Self-harm was not unusual at Brook House in the relevant period. There were 248 open ACDT documents, and that statistic only covers the self-harm incidents that were formally recorded.¹⁵⁹ It is therefore concerning that more attention was not paid to its impact on both detained people and staff. It was unacceptable that staff were not equipped in how to respond to self-harm in a way that supported detained people but also acknowledged the impact on their own wellbeing.

The power imbalance

60. In a detention setting there is an inevitable power imbalance between the detained population and the staff. There was a lack of appreciation of this by many members of staff at Brook House.

61. D643 described staff as engaging in arbitrary punishments, abuses of power and petty intimidation, such as denying him toilet roll or questioning why he needed it.¹⁶⁰ D1851 gave a similar account.¹⁶¹ D643 also felt that placing letters (which may contain removal directions) under cell doors overnight was *"very intimidating and very frightening"*, as it felt like waking up to *"an ambush"*.¹⁶²

62. Mr Tomsett was filmed by Mr Tulley having a verbal altercation with a detained person, during which Mr Tomsett told the detained person he was *"whining like a fucking girl"* and told him to *"man up"*, saying that he would not listen to his *"fucking bollocks"*.¹⁶³ In his statement to the Inquiry, Mr Tomsett gave the following context:

¹⁵⁷ [Aaron Stokes 9 March 2022 171/11-174/1](#)

¹⁵⁸ [Nathan Ring 25 February 2022 101/20-23](#)

¹⁵⁹ [Sandra Calver 1 March 2022 224/15-22](#). Figures originally derived from the following IMB reports: [IMB000021](#); [IMB000050](#); [IMB000011](#); [IMB000047](#); [IMB000019](#)

¹⁶⁰ [DL0000228_040-41](#) para 145; [D643 22 February 2022 45/3-6](#)

¹⁶¹ [D1851 3 December 2021 75/10-76/1](#)

¹⁶² [D643 22 February 2022 45/3-46/19](#)

¹⁶³ [TRN0000080_002-003](#)

*“The detainee involved had demanded new boxers, even though he had been given a full set of clothing, because his clothing was in the laundry. This request was properly refused by the officers, and the detainee became abusive and very rude.”*¹⁶⁴

Mr Tomsett said that he regretted the language used, but it was only during his oral evidence that he appeared to understand that it would be humiliating for an adult man to have to request clean underwear, and that there was an imbalance of power between him and the person making that request.¹⁶⁵ This was one of multiple occasions on which Mr Tomsett appears to have behaved aggressively towards detained people who had made requests for basic items. Other instances included detained people asking for a curtain (used to divide the toilet from the sleeping area).¹⁶⁶

63. Mr Tulley told the Inquiry about incidents that he alleged he saw prior to the relevant period.

63.1 An event in around 2015, in which a detained person was naked and five or six members of staff (at least two being DCMs) were standing around him, laughing at him and making comments about his penis. Mr Tulley recalled that the detained person was *“completely humiliated”*.¹⁶⁷

63.2 Prior to a restraint, DCM Graham Purnell shouting *“bend them up”* and *“twist his wrist”*, and calling a detained person a *“fucking idiot”*.¹⁶⁸ In oral evidence, Mr Tulley said that Mr Purnell described detained people to him in disparaging terms on numerous occasions, often referring to them as *“cunts”*.¹⁶⁹ He also recalled one occasion in March 2016 when Mr Purnell mocked a detained person who was sitting naked on his bed, shivering and covered in faeces, sarcastically asked the detained person, *“Do you need some toilet roll?”*, and laughed at him with DCM David Roffey, after which they turned off the power in the cell. Mr Tulley described this as *“sickening”* and an *“act of cruelty”*, and said that the detained person remained in the same state a couple of hours later.¹⁷⁰ In a statement to the Inquiry, Mr Purnell denied both allegations.¹⁷¹

¹⁶⁴ [INN000024_041](#) para 143

¹⁶⁵ [INN000024_043](#) para 146; [Darren Tomsett 7 March 2022 27/17-29/25](#)

¹⁶⁶ [TRN0000080_002](#); [TRN0000080_016-017](#); [INN0000024_042-043](#) paras 145-146; [CJS001443_004-005](#); [HOM002190](#) row 11

¹⁶⁷ [Callum Tulley 29 November 2021 70/19-77/19](#); [INQ000052_011-015](#) paras 44-62

¹⁶⁸ [CPS000024_004-005](#) (this was recorded at the time by Mr Tulley as Graham ‘Panel’, but is understood to be Mr Purnell)

¹⁶⁹ [Callum Tulley 29 November 2021 91/24-92/1](#)

¹⁷⁰ [Callum Tulley 1 December 2021 50/22-57/20](#); [INQ000052_049-050](#) para 194

¹⁷¹ [BDP00008_003](#) paras 8-10

64. DCO Sean Sayers was asked about a recorded conversation with a detained person.¹⁷² The detained person said, *“If they want to start on me, I don’t give a fuck, I’ll start”*, to which Mr Sayers replied, *“If you want to start on him, I’ll back you up.”* Mr Sayers said he was not encouraging a fight; rather, he and the detained person *“bounced off each other”*, and it was *“all one big joke ... banter”*.¹⁷³ While he accepted this was not appropriate, he added:

“that was my way of connecting with him ... do what they want to do to keep the peace as best you can, otherwise it was just going to be a problem for you constantly”.¹⁷⁴

Mr Sayers seemed unable to accept that he was in a position of power over this detained person and others, and that, while such conversations may have made his life easier, they were completely inappropriate in that setting.¹⁷⁵ If this was indeed commonplace, I am extremely concerned that more senior staff did not appreciate the issue and take action.

65. It is entirely credible that matters about which staff may not have thought deeply (such as the delivery of letters) or conduct that they may have seen as ‘banter’ (such as delaying access to basic necessities such as toilet roll) felt both intimidating and humiliating to detained people, who were in an inherently more vulnerable position. The lack of understanding of the power dynamic sometimes manifested in directly abusive behaviour but also fostered a more insidious culture of belittling and ‘othering’ detained people. This was compounded by a failure by management to recognise and address the issue.

Bravado and machismo

66. Professor Bosworth described a *“masculine, authoritarian response”* by staff to their roles, contributed to by the prisonised environment.¹⁷⁶ Covert filming by Mr Tulley revealed:

- staff telling one another, as well as detained people, to *“man up”*;¹⁷⁷
- a detained person being told to stop acting like a *“girl”*;¹⁷⁸ and
- detained people being accused of *“being a baby”*, told, *“just fucking grow up, man. You’re a man”*, and asked, *“what are you, a man or a mouse?”*.¹⁷⁹

¹⁷² [TRN0000081_012](#)

¹⁷³ [Sean Sayers 10 March 2022 147/1-16](#)

¹⁷⁴ [Sean Sayers 10 March 2022 148/8-20](#)

¹⁷⁵ [Sean Sayers 10 March 2022 173/23-174/15](#)

¹⁷⁶ [Professor Mary Bosworth 29 March 2022 63/6-14](#)

¹⁷⁷ [TRN0000080_002-003](#); [Derek Murphy 2 March 2022 8/12](#)

¹⁷⁸ [TRN0000080_002-003](#)

¹⁷⁹ [TRN0000002_009](#); [Ioannis Paschali 24 February 2022 44/13-17](#); [TRN0000002_009](#) (DCO Charles Francis to D1527)

67. This culture appears to have pervaded higher levels of seniority. Officers who were struggling were told to *“just get on with it”* or similar.¹⁸⁰ Mr Fiddy described feeling undermined and belittled by Mr Williams within *“quite a ‘man up’ culture”*,¹⁸¹ and Mr Instone-Brewer, after being injured by a detained person, recalled being told to *“man up”* by Mr Skitt, although he was not sure how common this was.¹⁸² Mr Syred described how, when seeing new staff starting, he would wonder, *“Which way are you going to go?”*. He noted that some staff – to counterbalance fear on starting the role – would soon be heard speaking negatively about immigrants and asylum seekers generally. He considered they had decided to *“join that gang to cover up their insecurities”*.¹⁸³

68. Violence and violent language were extreme manifestations of the toxic culture and bravado. I made a number of findings in Part C in Volume I where the evidence suggests that staff were describing actual assaults on detained people. The Inquiry also heard many examples of staff speaking about violence.

68.1 DCO Ioannis (Yan) Paschali discussed *“breaking bones”*, DCO John Connolly described his role in a *“fucking brutal”* riot at Brook House in 2009 as *“happy days”*, and Mr Derek Murphy described threatening to *“smash the fucking shit”* out of a detained person.¹⁸⁴

68.2 Asked about his suggestion – captured on covert footage – that Mr Tulley should give D1914 *“a right hook”*, Mr Lake told the Inquiry he was trying to fit in: *“you get sucked into whatever the culture is”*.¹⁸⁵

68.3 Mr Tulley also told the Inquiry that DCO Jason Murphy had boasted that he had:

“used the riot shield to ‘smash’ the detainee to the back of the cell, before again using the shield to ‘floor him’, and then using it again to push his face into the detainee’s faeces and urine”.¹⁸⁶

68.4 In March 2017, Mr Derek Murphy had *“recently”* bragged that he had kned a detained person in the face during a restraint, and had ‘choke slammed’ a detained person who had attacked DCO Daniel Small.¹⁸⁷ When asked about the latter incident in oral evidence, Mr Murphy said

¹⁸⁰ [Edmund Fiddy 7 March 2022 156/10-19](#); [Daniel Small 28 February 2022 111/19-22](#); [Derek Murphy 2 March 2022 7/17-19](#)

¹⁸¹ [Edmund Fiddy 7 March 2022 154/16-23](#)

¹⁸² [Luke Instone-Brewer 8 March 2022 35/8-36/19](#)

¹⁸³ [Owen Syred 7 December 2021 97/24-98/14](#)

¹⁸⁴ [TRN0000077_045](#); [TRN0000085_024](#); [TRN0000024_003](#)

¹⁸⁵ [Daniel Lake 1 March 2022 45/22-46/1](#)

¹⁸⁶ [INQ0000052_046-047](#) para 184

¹⁸⁷ [CPS000024_005](#)

that he did not recognise it and would not have used a chokehold.¹⁸⁸ In oral evidence, Mr Small accepted that this is what he had told Mr Tulley, but said he had embellished it for dramatic effect and that, in fact, it was the detained person who had put Mr Small in a chokehold, following which Mr Murphy “took [the detained person] to the ground”. Mr Small said that Mr Murphy “may have” used a chokehold but he could not recall, and that a manager was present.¹⁸⁹

69. While I consider that prisonisation played a large part in this, the “performance of masculinity” was also likely a reaction to the traditionally “feminised” roles detention staff in fact played, such as stripping beds, ensuring everyone had eaten, and providing clothing and toiletries. As Professor Bosworth put it:

*“it’s much more exciting to think of yourself as being there in security, potentially dealing with somebody who might be dangerous and a threat, than ... tell yourself that your job is to clean up after them and basically do women’s work”.*¹⁹⁰

70. Rather than being alert to and eradicating any concerning signs of a macho-aggressive culture, the evidence shows that some managers fed into it. It is likely that the lack of effort to address it was in part due to wanting to retain those staff members who, like Mr Paschali, were seen as able to ‘handle things’. I can readily see that Mr Paschali would, inappropriately, have been an influential presence among a group of more junior, inexperienced or impressionable staff, as well as being a frequent choice for use of force incidents. As discussed in Chapter D.7, the repeated use of the same individuals for use of force roles contributed to an aggressive culture, desensitising staff and reinforcing unhealthy cliques.

Racism

71. The Inquiry saw evidence of racist beliefs and words becoming part of the culture and being seen by some as a way to ‘fit in’. Although it was relatively rare for directly racist language to be used by staff towards detained people, it is likely that racially charged language towards detained people (such as “go back to your own country”, given the number of allegations about this kind of comment) was more prevalent and that racist comments among staff were common.¹⁹¹

72. Ms Anna Pincus, current Director of Gatwick Detainees Welfare Group (GDWG), told the Inquiry that people formerly detained at Brook House

¹⁸⁸ [Derek Murphy 2 March 2022 23/19-26/4](#)

¹⁸⁹ [Daniel Small 28 February 2022 152/12-158/3; BDP000003_015 para 44](#)

¹⁹⁰ [Professor Mary Bosworth 29 March 2022 64/19-65/1](#)

¹⁹¹ See, for example, [DPG000040_014-015 paras 62-64](#); [DPG000021_026 para 83](#); [DPG000021_027 para 87](#); [HOM002190_001 row 3](#); [DPG000002_024 para 63](#); [GDW000010_004-005](#)

reported having witnessed racist and other verbal abuse directed at them or others, including being called names such as “*monkey*” and “*blacky*”.¹⁹²

73. A particularly egregious instance of racist and derogatory language occurred on 17 May 2017.

73.1 Mr Connolly, a use of force instructor, was filmed covertly by Mr Tulley waiting in a stairwell with a group of other officers. The officers had been assembled in the event that they were needed to use force to remove D275 from the safety netting, where he was protesting. Mr Connolly told the officers that they should say, “*listen here nigger. Listen to me. Do what you are told, nigger.*”¹⁹³

73.2 Mr Connolly said, gesturing to the staircase, “*That’s our justification. We fucking throw him in that corner.*” He was also heard to say: “*Fuck him up in the corner*” and “*Throw him down the fucking stairs. Go for it.*”¹⁹⁴ At one point, Mr Small gestured up to a camera and said to Mr Connolly, “*There’s a camera there, boss*”, to which Mr Connolly appeared to reply, “*I’ll scrub the cunt, no fucking problem.*” Mr Connolly also talked about allowing D275 to bleed in the event that he cut himself with the razor blade, and said that he would whisper “*dying*” in his ear.¹⁹⁵

74. Following the *Panorama* programme, G4S carried out a disciplinary investigation into Mr Connolly’s comments. He denied that he used the word ‘nigger’ and suggested that the footage had been edited in a way that gave a falsely negative impression of his behaviour. The investigation found that he did indeed make the comments, and Mr Connolly’s employment was terminated.¹⁹⁶

75. The audio quality of the covertly recorded footage is variable. However, I found that all of the comments I have referred to could be heard clearly. The comments were also corroborated by the account given by Mr Tulley, both in his BBC video diary and in his later evidence to the police and to the Inquiry.¹⁹⁷

76. Ultimately, in his evidence to the Inquiry, Mr Connolly accepted that he did speak the words attributed to him, but maintained that “*scrub the cunt*” was incorrectly transcribed and was actually “*grab the cunt*”.¹⁹⁸ However, the footage shows that Mr Connolly made the remark only after Mr Small had

¹⁹² [Anna Pincus 9 December 2021 79/8-80/13; DPG000002_025 para 64; GDW000010_004-005](#)

¹⁹³ [Day 20 PM 28 February 2022 01:39:12-01:40:09 \(KENCOV1019 - V2017051700016\); TRN0000085_044-047](#)

¹⁹⁴ [Day 20 PM 28 February 2022 01:39:12-01:40:09 \(KENCOV1019 - V2017051700016\); TRN0000085_044-047](#)

¹⁹⁵ [KENCOV1019 - V2017051700018](#)

¹⁹⁶ [HOM001428](#)

¹⁹⁷ [TRN0000053_031; SXP000120_007-008; INQ000052_044-045 paras 174-177; Callum Tulley 2 December 2021 46/15-19, 47/25-57/12](#)

¹⁹⁸ [SER000442_014 para 24](#)

gestured up to a camera and commented about it. Given Mr Small's gesture, I find that it is more likely that Mr Connolly used the word "*scrub*" in reference to deleting closed-circuit television (CCTV) evidence of an assault rather than using the word "*grab*". That Mr Connolly told the Inquiry it was not possible to delete CCTV footage is not relevant to the question of whether or not he said the word.¹⁹⁹

77. During G4S's disciplinary investigation into Mr Small's conduct, Mr Small claimed that he had forgotten to report what Mr Connolly had said in the stairwell.²⁰⁰ However, in his evidence to the Inquiry, Mr Small said that he did not report what he had heard because he feared being labelled a "*grass*".²⁰¹ I find Mr Small's explanation to the Inquiry more credible than his assertion to the G4S investigators. I heard evidence from a variety of witnesses about the consequences of reporting misconduct during the relevant period.²⁰² I believe that staff who witnessed inappropriate behaviour by their colleagues did not routinely speak out.

78. In her oral evidence to the Inquiry, Professor Bosworth discussed the incident on 17 May 2017. In her opinion, Mr Connolly had "*an extremely violent way of thinking about his job and the man in question*".²⁰³ Professor Bosworth noted that, as Brook House's use of force instructor, Mr Connolly was in a position of authority with the ability to communicate racist and violent views to other officers. She also noted that Mr Connolly appeared to feel able to communicate these views without fear of repercussions.²⁰⁴

79. When asked about these comments, Mr Paschali told the Inquiry that he considered Mr Connolly's comments should not be taken at face value, suggesting that it was "*Just shit talk. That's all I can put it down to, just nonsense, crap, which it shouldn't have been said, but in that environment, at that time, it was like that.*"²⁰⁵ Other officers, both former and current, told the Inquiry that they were surprised by Mr Connolly's comments in the footage and that they had not heard him use racist language.²⁰⁶

80. Mr Connolly clearly used racist language and suggested that violence be used towards D275 on 17 May 2017. In line with Professor Bosworth's analysis, I find it of particular concern that these two elements came together in a situation where the power imbalance between staff and a detained person was

¹⁹⁹ [John Connolly 2 March 2022 193/1-194/12](#)

²⁰⁰ [CJS006639_005](#)

²⁰¹ [BDP000003_015-016 para 45](#); [Daniel Small 28 February 2022 159/24-160/2](#)

²⁰² [Owen Syred 7 December 2021 116/18-123/6](#); [Callum Tulley 30 November 2021 3/13-9/19, 157/14-168/6](#); [Callum Tulley 1 December 2021 1/1-2/24](#); [DL0000141_105-106 paras 302-305](#); [Reverend Nathan Ward 7 December 2021 187/23-191/19](#)

²⁰³ [Professor Mary Bosworth 29 March 2022 102/21-22](#)

²⁰⁴ [Professor Mary Bosworth 29 March 2022 103/21-104/4](#)

²⁰⁵ [Ioannis Paschali 24 February 2022 26/21-24](#)

²⁰⁶ [Derek Murphy 2 March 2022 11/3-19](#); [Christopher Donnelly 23 February 2022 89/22-90/22](#)

so pronounced. I believe that the language used by Mr Connolly on 17 May 2017 is indicative of the aggressive and unprofessional attitudes that flourished among some officers. Violent language was normalised, and detained people who were to be restrained were spoken about in a way that dehumanised them. There is no evidence of any violence or abuse towards D275 during or as a result of this incident. There is also no evidence to suggest that D275 was in the vicinity or was aware of what Mr Connolly had said. Although this incident did not meet the threshold for inclusion within Part C in Volume I of this Report, it remains among the most concerning instances of a detained person being referred to with such overtly violent, racist and abusive language.

81. Several former or current staff members, either in oral evidence to the Inquiry or in written evidence, said that they did not witness any racism or racist language.²⁰⁷ While it is possible that some staff did not witness such behaviour, I think it is likely that many did and that it did not register with them at the time or has since been forgotten, or that witnesses were being untruthful in this regard.²⁰⁸

82. Mr Tulley's view was that directly racist language such as the 'N word' was not commonplace, although anti-immigration rhetoric and language with racist undertones was.²⁰⁹ He said that racism was "*certainly there*".²¹⁰

83. Mr Small said that racist comments along the lines of "*too many Blacks*" were used by everyone within Brook House and on a regular basis, estimating that it happened every week or so.²¹¹

84. There were allegations of racism against Mr Tomsett from at least five detained people over a number of years, which he denied.²¹² Two detained people alleged that Mr Tomsett told them to go back to 'their country'.²¹³ He denied this, saying that he might have suggested they consider returning to their home country, which may have been "*misconstrued*".²¹⁴ Mr Tomsett said

²⁰⁷ [Daniel Lake 1 March 2022 48/6-15](#); [Charles Francis 3 March 2022 15/18-25](#); [Nathan Ring 25 February 2022 35/18-37/21](#); [Ioannis Paschali 24 February 2022 60/2-63/2](#); [Christopher Donnelly 23 February 2022 68/10-16, 82/11-17](#). Additionally, 34 out of 35 former staff members who provided responses to questionnaires submitted by the Inquiry said that they had not experienced any racist attitudes or behaviours

²⁰⁸ For example, Mr Lake said in his statement that he could not remember any instances of racism by any member of staff ([BDP000002_007-008](#) para 22) but he was present when Mr Small used extremely racist language ([TRN0000079_010](#); see [Daniel Lake 1 March 2022 48/6-15](#))

²⁰⁹ [Callum Tulley 2 December 2021 46/20-23, 57/11-12](#)

²¹⁰ [Callum Tulley 2 December 2021 56/25-57/1](#)

²¹¹ [Daniel Small 28 February 2022 137/10-18](#)

²¹² D180, D4277, D381, D668 and D4049: [CJS001443_001-005](#); [INN000024_051-052](#) para 171; [HOM002190_001](#) row 5; [D668 6 December 2021 88/24-92/16](#); [HOM002547](#); [INN000024_056-057](#) paras 183-186; [TRN0000080_002](#); [Darren Tomsett 7 March 2022 44/19-20, 49/5-50/17, 62/24-63/23](#)

²¹³ [DPG000040_034](#) para 64; [INN000024_050](#) para 169; [HOM002190](#) row 3

²¹⁴ [Darren Tomsett 7 March 2022 44/3-45/1](#)

that 'racist' was a "loose term that was thrown around" in Brook House.²¹⁵ He was recorded commenting that detained people wanted to come to the UK because of the "amazing benefits system" and "when they come over here, and they want this and they want that ... how about we ... sort out our own kids first".²¹⁶

85. D1473 said that he heard another unknown officer, who was formerly in the military, telling a Black African detained person, "I used to kill people like you for fun."²¹⁷ D790 and D180 recalled that officers were often very rude, aggressive and racist to detained people, saying things like "Fuck off back to your own country."²¹⁸ D1713 described being told by a member of staff, "I would never lock up my dog but I would lock you up", which he believed had "racial undertones".²¹⁹ D643 told the Inquiry that he and other detained people were subjected to overt racist abuse, including repeated use of the word "nigger" and staff saying "why don't these blacks go back to their country" and "all the blacks are the same".²²⁰ He recalled that Mr Purnell, DCO Joe Marshall and Mr Instone-Brewer had made racist comments, and that Mr Purnell was the officer who had called him a "nigger" in October 2016.²²¹ Mr Purnell denied ever having used such language.²²²

86. There were several occasions on which Mr Small was recorded making comments that, in my view, reflected deeply held racist attitudes that made him completely unsuitable for employment at Brook House.

86.1 On 29 April 2017, Mr Small described to Mr Tulley an occasion on which he had "lost [his] rag" with "an Indian bloke", who he said had been swearing at him in a different language.²²³ He said, "I was like, you're in fucking England, speak English." Mr Small accepted in his evidence to the Inquiry that he realised at the time that this language was unacceptable.²²⁴

86.2 He was covertly recorded, in June 2017, saying that he did not like London because it was "Minority white people", that White people would

²¹⁵ [INN000024_056-057](#) para 183. This suggestion was supported by a member of Healthcare staff at Brook House (see [HOM002748_032](#) para 7.4.8)

²¹⁶ [TRN0000083_015-016](#)

²¹⁷ [BHM000039_008](#) para 41

²¹⁸ [DPG000022_008-011](#) paras 29-40; [DPG000040_014-015](#) paras 62-64

²¹⁹ [BHM000018_005](#) para 22; [BHM000018_009](#) para 34

²²⁰ [DL0000228_039](#) para 14; [D643 22 February 2022 40/4-5](#); [DL0000228_039](#) para 142; [DL0000228_039](#) para 142

²²¹ [D643 22 February 2022 40/23-41/4](#); [DL0000228_019-020](#) paras 74-76; [DL0000228_039](#) para 142

²²² [BDP00008_002](#) para 5

²²³ [TRN0000021_007](#)

²²⁴ [Daniel Small 28 February 2022 134/5-21](#)

be the minority in the UK by 2050 and that he would not visit Cleveland, USA, because there were *“too many Blacks”*.²²⁵

86.3 On the day of the Grenfell Tower fire, Mr Small was covertly recorded as saying that it was *“12 foreigners”* who had been reported dead at that point, and Mr Tulley recorded in his video diary that evening that Mr Small had also said words to the effect of *“oh well, that’s ... a few less foreigners in England”*.²²⁶ Mr Small told the Inquiry that he could not recall making the comment about *“a few less foreigners”* but, given his other comments and Mr Tulley’s near contemporaneous video diary recounting it, I think it is likely that he did make this comment. When asked about these comments in evidence, Mr Small said they did not reflect his actual views, that he was ashamed of the comments and that he had never made any racist remarks until he became a DCO and witnessed the casual use of racist language around him.²²⁷ However, I consider it likely that they reflected his actual views, although those views may have developed while he was working at Brook House.

87. It was not disputed that Mr Small went on to say, *“This job has made me racist.”*²²⁸ In his video diary that evening, Mr Tulley commented that Mr Small *“wasn’t racist when he started working at Brook House. He spoke to detainees and treated detainees with respect.”* While he believed Mr Small would never physically abuse a detained person, he said at the time of filming that *“he looks at them as if they’re vermin”*.²²⁹ Mr Small told the Inquiry:

*“It changes a person working in that environment, it makes you angry working there ... think of it as a sheep in the herd ... just following suit what everyone else did.”*²³⁰

88. There is also evidence suggesting that detained people from particular nationalities were grouped together and/or stereotyped. Professor Bosworth described this as the *“predominant form that racism takes”* in IRCs and thought that it was *“an inevitable part”* of them.²³¹ She noted that, generally, staff appeared to label young Black men as potential security threats but not older Asian men.²³² This stereotyping was a further way in which detained people were ‘othered’ within Brook House. For example:

²²⁵ [TRN0000079_010](#)

²²⁶ [TRN0000092_021](#); [TRN0000092_022](#); [TRN0000101_010](#); [TRN0000068_006-007](#)

²²⁷ [Daniel Small 28 February 2022 146/5-147/17](#)

²²⁸ [TRN00000092_050](#)

²²⁹ [TRN0000068_009-010](#)

²³⁰ [Daniel Small 28 February 2022 147/19-23, 149/22-24](#)

²³¹ [Professor Mary Bosworth 29 March 2022 35/7-36/19](#)

²³² [INQ000064_040](#) para 8.7

- Mr Skitt stated that Albanians had “no respect”, that Nigerian and Ghanaian people were litigious, that Chinese people liked sharing cells and that Congolese people and young Somalians were quite challenging.²³³
- Mr Connolly was recorded saying, “Black fellas. They think they are ‘it’.”²³⁴
- D643 stated that officers were more ready to use physical force against Jamaicans.²³⁵
- Mr Syred said that some staff would stereotype detained people – for example, regarding all Somalians as pirates.²³⁶
- D2033 described staff assuming that all Afghan detained people were connected to the Taliban.²³⁷
- When interviewed for the 2018 Verita report, Dr Dominic Aitken (then a PhD student who spent a month at Brook House over June and July 2017) described that staff had a belief that Jamaican men were very chivalrous, which would lead to female officers carrying out their removals, and that Muslim men were very disrespectful, which would lead to male officers carrying out their removals.²³⁸

89. Some Core Participants have argued that the Inquiry should conclude that there was institutional racism at Brook House during the relevant period.²³⁹ As noted in those submissions, the definition of institutional racism used by Sir William Macpherson in the Stephen Lawrence Inquiry was:

“The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.”²⁴⁰

The context of this Inquiry – the treatment of foreign nationals while in immigration detention – makes it inevitable that issues of racism will arise. As set out above, I have found considerable evidence of racist beliefs and abuse by staff at Brook House. However, the Terms of Reference do not instruct me to investigate the issue of institutional racism, and to do so would

²³³ [VER000248_016](#); [VER000248_022-023](#)

²³⁴ [TRN0000085_035](#)

²³⁵ [D643_22_February_2022_41/22-25](#)

²³⁶ [INN000007_028](#) para 115

²³⁷ [D2033_10_December_2021_127/1-10](#)

²³⁸ [VER000257_007-008](#)

²³⁹ For example, [Core Participant Group Closing Statement](#), Brook House Inquiry, 3 May 2022, paras 214-231

²⁴⁰ [Core Participant Group Closing Statement](#), Brook House Inquiry, 3 May 2022, para 215; [Report of the Stephen Lawrence Inquiry](#), Sir William Macpherson of Cluny, Cm 4262-1, February 1999, para 6.34

have required a much broader investigation that would have strayed from the Inquiry’s core focus. As a result, I do not have sufficient evidence from which to reach a conclusion on whether institutional racism was present at Brook House. However, I have found that Brook House appears to have been a breeding ground for racist views in the relevant period and was perceived as an acceptable environment in which to express them.

Abusive and derogatory language

90. The Inquiry heard numerous examples of abusive and derogatory language – as well as childish behaviour – by G4S staff towards and about detained people. These ranged from demeaning comments about detained people in conversations between staff to direct verbal abuse towards detained people.

91. It was commonplace for staff to talk about detained people in an abusive and derogatory manner. Various members of staff, including Mr Paschali, Mr Small, Mr Lake and Mr Francis, acknowledged that verbal abuse and swearing towards detained people were widespread.²⁴¹ It was described as “prolific”, “commonplace” and “the norm”.²⁴² This was noted by Professor Bosworth, who commented that, in Mr Tulley’s covert footage, “All of the officers swore all of the time.”²⁴³ She described this as “completely unacceptable”.²⁴⁴ One DCO who had previously worked in a prison was recorded saying, “It’s unprofessional here ... you get staff that call detainees dickheads to their faces and stuff like that.”²⁴⁵

92. Some of the most pernicious examples of staff talking about detained people in this way included staff talking about past violence, verbal abuse and threats to detained people, or describing future intentions to use violence.

92.1 In relation to an incident involving D1527 on 25 April 2017 (discussed in Chapter C.4 in Volume I of this Report), Mr Stokes was recorded on 4 May 2017 saying to Mr Tulley about D1527, “Did you not have the urge to just punch him in his face as he’s gone up and ‘bang’.”²⁴⁶ In oral evidence, Mr Stokes apologised for any upset or insensitivity arising from what he had said, and explained that he was “letting off steam” among colleagues.²⁴⁷ On 9 May 2017, Mr Derek Murphy and Mr Paschali had a conversation about D87 in the presence of Mr Tulley. Mr Paschali said:

²⁴¹ Daniel Lake 1 March 2022 28/9-29/8; Charles Francis 3 March 2022 9/11-11/8

²⁴² Daniel Small 28 February 2022 125/10-126/23; BDP000003 006-007 para 18; Ioannis Paschali 24 February 2022 60/19-63/2

²⁴³ Professor Mary Bosworth 29 March 2022 84/4-5

²⁴⁴ INQ000064_037 para 7.17

²⁴⁵ INQ000064_037 para 7.21

²⁴⁶ TRN0000096_002

²⁴⁷ Aaron Stokes 9 March 2022 191/23-193/15

*"I'd love to get in the ring with him. Put the gloves on and see what he's fucking made of. I would love to ... He's just got some shoulders and a bit of height. Fucking crack him straight in the ribs."*²⁴⁸

Mr Murphy replied, *"Straight in the solar."* They both went on to discuss incidents of violence they had been involved in outside Brook House. Mr Murphy claimed in oral evidence that they were exchanging *"tall stories"* made up for Mr Tulley's benefit.²⁴⁹

92.2 On 31 May 2017, Mr Paschali was discussing with Mr Tulley the possibility of a detained person returning to Brook House, saying, *"If he comes up to you just fucking floor him. Don't restrain him give him the hardest kick you fucking can."*²⁵⁰

92.3 On 20 June 2017, DCM Nathan Harris spoke with Mr Derek Murphy, Mr Sayers and Mr Tulley about what should happen with people who were deported, saying, *"I reckon they should do what they do on Con Air masking tape, bag 'em, job done ... Just tape over the mouth, bag over the head."* He added:

*"We should just go back to putting them to sleep mate really ... Get the gas, chuck it in there, they're all knocked out ... needle in, he wakes up in fucking wherever."*²⁵¹

Neither Mr Sayers nor Mr Murphy reported any of these comments at the time. In oral evidence to the Inquiry, Mr Sayers said he did not recall this conversation but accepted that it was the sort of thing he should have reported.²⁵²

92.4 On 13 August 2017, Mr Derek Murphy described to a fellow officer how he had gone into the cell of a detained person (understood to be D149), who he described as a *"fucking arsehole"*, and said:

*"Oy, get the fuck out of bed. Clean this shit up. You ain't going nowhere until you clean this up, you little prick ... If you don't clean it up within the hour, I'm going to come and smash the fucking shit out of you and you ain't doing no flying."*²⁵³

He also described throwing a quilt at D149, saying *"Get the fuck out"* and *"Put it in a fucking bag before you go."*²⁵⁴ When investigated by G4S, Mr Murphy did not contest the allegations about this comment,

²⁴⁸ [TRN0000077_040-041](#)

²⁴⁹ [Derek Murphy 2 March 2022 37/2-39/19](#)

²⁵⁰ [TRN0000101_026](#)

²⁵¹ [TRN0000084_010](#)

²⁵² [Sean Sayers 10 March 2022 179/1-5](#)

²⁵³ [TRN0000024_003](#)

²⁵⁴ [TRN0000024_003](#)

but said he had a good relationship with D149 and therefore D149 would have known he did not mean it.²⁵⁵ In oral evidence, Mr Murphy said he could not recall this incident but accepted that the language was inappropriate and sounded *“like a threat”*.²⁵⁶

92.5 On 19 June 2017, Mr Tomsett described D693 as a *“horrible bastard”*.²⁵⁷ On the same day, he recounted to Mr Tulley that he had said to D693:

*“You throw the first one, and I’ll fucking put you out of your misery. If you throw the first one, I’ll fucking put you out of this office. So, it’s up to you mate. Stinking attitude.”*²⁵⁸

Although he said in his statement that he would never threaten a detained person, and in oral evidence he stated, *“I was just standing up for myself”*, he accepted that it went beyond that.²⁵⁹ I consider this to have been an example of threatening behaviour.

93. There were also multiple occasions on which staff were recorded by Mr Tulley being directly abusive towards detained people. While these are likely to have been only a small proportion of the occasions on which abusive language was used during the relevant period, they reflect a pattern of demeaning and threatening conduct from staff directed at detained people.

94. Troubling examples of abuse towards detained people include the following.

94.1 There were multiple examples of abusive language used by Mr Derek Murphy towards detained people. On 14 June 2017, Mr Murphy said to a detained person: *“You look like a fucking mong. Get in your room.”* He then said: *“He looks like a right cunt doesn’t he?”*.²⁶⁰ In his evidence to the Inquiry, Mr Murphy accepted that the language was inappropriate and unprofessional.²⁶¹ On the same day, he was filmed telling D149 to *“stop fucking about”* and said:

*“Listen, I don’t want to come back in this room again. You will be in trouble, all right? ... You understand? You don’t want to be in trouble with me. Trust me.”*²⁶²

94.2 On 19 June 2017, Mr Sayers was recorded calling D720 a *“cunt”* and a *“fucking dick”*, threatening him with a *“fucking warning”* and saying to

²⁵⁵ [Derek Murphy 2 March 2022 55/22-24; HOM005830_005](#)

²⁵⁶ [Derek Murphy 2 March 2022 27/9-29/14](#)

²⁵⁷ [TRN0000083_002](#)

²⁵⁸ [TRN0000083_002](#)

²⁵⁹ [Darren Tomsett 7 March 2022 37/15-39/19; INN000024_47-48](#) paras 159-162

²⁶⁰ [TRN0000092_028](#)

²⁶¹ [Derek Murphy 2 March 2022 58/12-19](#)

²⁶² [TRN0000092_026](#)

him *"I am going to skull fuck you like the little bitch you are."*²⁶³

This was said in front of other detained people and members of staff. Nobody reported the incident at the time. In his evidence to the Inquiry, Mr Sayers accepted that this was an aggressive use of language and sounded like a threat, but maintained that it was not an aggressive situation and was not in fact a threat. He described D720 laughing and asserted that he had a rapport with him.²⁶⁴

- 94.3** On 2 June 2017, Mr Fiddy was recorded describing a detained person as an *"absolute poofter"*.²⁶⁵ Although he said he had no recollection of the incident, he accepted subsequently that it was *"terrible language and behaviour, and I'm sorry"*.²⁶⁶
- 94.4** As discussed in Chapter C.9 in Volume I, I found that Mr Tomsett probably told D1538 that he needed to change his clothes as he *"looked gay"*, and this led to him being mocked by other detained people for days after the comment.²⁶⁷ This incident was not recorded by Mr Tulley and Mr Tomsett denied the allegations.²⁶⁸
- 95.** Inappropriate behaviour by staff also included, on some occasions, a callous disregard for the lives of detained people.
- 95.1** On 20 April 2017, Mr Tulley noted that Mr Paschali had said words to the effect of *"I don't care if he lives or die[s]"* about a detained person for whom he was performing constant supervision duties, that he bragged about having once broken someone's arm in three places during a restraint and that he said of a detained person that he would like to *"fucking do him"*.²⁶⁹
- 95.2** During the same incident described above, Mr Stokes was recorded on 4 May 2017 saying that the best way to deal with someone like D1527 was *"Turn away and hopefully he's swinging, probably."*²⁷⁰
- 95.3** In discussions about a planned use of force against D1914 on 28 May 2017, several staff members made derogatory comments about him. After discussion of D1914's medical history, including the fact that he was scheduled to undergo heart bypass surgery, Mr Lake speculated that D1914 may fake having a heart attack and said, laughing, *"If he*

²⁶³ [TRN0000083_038-039; Day 28 PM 10 March 2022 01:32:55-01:35:06 \(KENCOV1037 - V2017061900011\)](#)

²⁶⁴ [Sean Sayers 10 March 2022 172/1-175/25](#)

²⁶⁵ [TRN0000031_005; KENCOV1029 - V201706020013, clip 1 00:25-00:45](#)

²⁶⁶ [Edmund Fiddy 7 March 2022 181/11-183/11](#)

²⁶⁷ [DL0000231_029](#) para 104

²⁶⁸ [Darren Tomsett 7 March 2022 57/19-60/13; INN000024_054-056](#) paras 177-181

²⁶⁹ [CPS000025_013-014](#)

²⁷⁰ [TRN0000096_002](#)

dies, he dies."²⁷¹ When Mr Tulley said that he was nervous about the use of force, Mr Paschali responded: "*Oh relax man, you will be fine.*" Mr Webb added: "*If he dies, he dies ... It's nothing on us.*"²⁷² Mr Webb also referred to D1914 as a "*cunt*".²⁷³

96. Despite all of the above, only two members of staff – Mr Fagbo and Ms Munroe – were dismissed for directing abusive language at a detained person that was not shown on the *Panorama* programme.²⁷⁴ Both incidents involved D119.

96.1 It was alleged that, on 21 April 2017, Mr Fagbo called D119 a "*dickhead*" or a "*fucking dickhead*" and used other derogatory language towards him, such as saying, "*I get to go home and you are stuck here.*"²⁷⁵ Both D119 and D720²⁷⁶ complained about this incident and, during a disciplinary investigation, at least two members of staff said that Mr Fagbo had called D119 a "*fucking dickhead*", was being aggressive and was antagonising D119.²⁷⁷ Mr Fagbo accepted at the time,²⁷⁸ and in oral evidence to the Inquiry,²⁷⁹ that he had called D119 a "*dickhead*" in response to what D119 was saying to him.

96.2 D119 also alleged that, on 22 April 2017, the day after the incident with Mr Fagbo, he had been subjected to abusive comments from Ms Munroe.²⁸⁰ Ms Munroe denied much of what she was alleged to have said²⁸¹ and told the Inquiry of highly offensive remarks made to her by D119.²⁸² In oral evidence, she accepted saying something along the lines

²⁷¹ [KENCOV1025 - V2017052700012](#)

²⁷² [KENCOV1025 - V2017052700011](#); [CJS001160](#)

²⁷³ [KENCOV1025 - V201705270019](#)

²⁷⁴ [INN000013_028](#) paras 85-86

²⁷⁵ [CJS001594](#); [CJS005888_002](#); [CJS005880](#); [CJS005874](#)

²⁷⁶ D720 subsequently withdrew his complaint, but this was still considered as part of the disciplinary investigation (see [CJS001594_013](#))

²⁷⁷ See, for example, DCO Henry Hutton-Mawdsley ([CJS005894_002](#)) and DCO Vicky Moore ([CJS005889_001-002](#)). There was also evidence to suggest that D119 had used abusive and racist language towards Mr Fagbo (see [CJS005280](#); [TRN0000099_002](#); [Luke Instone-Brewer 8 March 2022 65/23-67/10](#))

²⁷⁸ [CJS005907_006](#); [CJS0073303](#); [CJS0072930](#)

²⁷⁹ [Babatunde Fagbo 4 March 2022 93/4-94/4](#); [BFA000001_004](#) para 13; [BFA000001_007](#) para 26

²⁸⁰ [CJS005880_002](#). This was also supported by at least one staff member (see [CJS005894](#)). There was no reference to Ms Munroe in D119's initial complaint (see [INN000013_027](#) paras 82-83; [CJS001594_001-002](#)) but he made the allegations during his interview following the complaint made against Mr Fagbo

²⁸¹ [CJS005880](#); [INN000013_025-026](#) para 78; [INN000013_030-031](#) para 93; [Shayne Munroe 4 March 2022 49/9-50/8](#)

²⁸² She said that D119 had said she was a "*shit mum*" and that her child would die after she swore on her child's life that she had not been speaking about D119 ([INN000013_025-26](#) para 78). She also said that he had made abusive remarks to her a few days before the incident (see [Shayne Munroe 4 March 2022 46/3-6](#))

of “fuck you”, “fuck off” or “shut the fuck up” in response.²⁸³ There was an investigation, and a letter of dismissal from Mr Skitt concluded that both Ms Munroe and D119 were using inappropriate and offensive language and were shouting and screaming at each other.²⁸⁴

97. In both incidents, the staff members accepted using inappropriate language towards D119 after having received racist and other verbal abuse from him.²⁸⁵ Although other former members of staff told the Inquiry about receiving verbal abuse from detained people, ethnic minority staff also faced racist abuse and were thus particularly affected.²⁸⁶ Nevertheless, there remained a power imbalance between those staff members and detained people. Staff members should not have responded by using abusive language towards detained people.

98. There were concerns raised by both Mr Fagbo and Ms Munroe in relation to both investigations.

98.1 There were four or five months between suspension and disciplinary hearings (without any identifiable reasons for this) despite initial investigation interviews happening soon after the incidents. More broadly, delays are likely to have had a negative impact both on staffing levels and on staff morale, as well as being suggestive of an organisation that was unable to run proper investigations.²⁸⁷

98.2 Both Mr Fagbo and Ms Munroe thought that their dismissals were related to the *Panorama* programme.²⁸⁸ Mr Fagbo was informed of his dismissal on 16 August 2017, before G4S learned of the *Panorama* programme on 24 August.²⁸⁹ Ms Munroe’s dismissal occurred soon after the broadcast, and therefore it may well have played some role in the decision to dismiss her, although the outcome is consistent with that reached for Mr Fagbo.

98.3 Both officers are Black and felt that their race had some impact on the decision to dismiss them. Mr Fagbo gave an example of a White female officer who swore at a detained person but was not disciplined.²⁹⁰

²⁸³ [Shayne Munroe 4 March 2022 48/20-23](#)

²⁸⁴ [CJS005896](#)

²⁸⁵ See, for example, [CJS005884_002](#); [CJS005881_002](#); [INN000013_024-025](#) paras 76-78; [CJS005880_003](#)

²⁸⁶ For example, see [Ioannis Paschali 24 February 2022 60/25-61/1](#); [Christopher Donnelly 23 February 2022 56/1-3, 62/13-17](#); [SER000459_13-14](#) paras 67-73; [Luke Instone-Brewer 8 March 2022 38/14-39/1](#); [MAR000002_014](#) para 119r. See also the evidence of Ms Munroe and Mr Fagbo below

²⁸⁷ [Shayne Munroe 4 March 2022 54/9-16](#). Even longer delays were identified in the 2018 Verita report (see [CJS0073709_072-073](#) paras 7.25-7.26)

²⁸⁸ [Babatunde Fagbo 4 March 2022 100/16-21, 101/9-102/23](#); [Shayne Munroe 4 March 2022 55/5-17](#); [INN000013_029](#) para 88

²⁸⁹ [BBC000031](#)

²⁹⁰ [Babatunde Fagbo 4 March 2022 100/4-101/8](#)

Ms Munroe suggested that covert racism played a part, noting that there were “*a lot of accusations of officers using bad language*”.²⁹¹ She gave DCO Bonnie Spark, who was still working at Brook House, as an example of this – although I note that the recorded instance of Ms Spark using bad language was directed at a fellow officer (Ms Munroe) rather than at a detained person.²⁹² Mr Skitt denied that race had any role in the dismissals and said that both officers were treated in line with what was presented to him at the disciplinary hearings.²⁹³ While I do not think there is sufficient evidence to make a finding on this issue, I am conscious that two of the few Black members of staff were the only two staff members dismissed for verbal abuse during the relevant period, separate to that shown on the *Panorama* programme.

99. Multiple witnesses to the Inquiry and several other former staff members said that they did not witness any direct verbal abuse of detained people.²⁹⁴ Given the examples set out above, I do not find it credible that so many staff members genuinely did not witness verbal abuse.²⁹⁵ Those who said that they did not hear direct verbal abuse largely accepted that abusive language about detained people was used by staff members among themselves.²⁹⁶ In any event, I am confident that the examples of which the Inquiry is aware were not the full extent of the use of such language during the relevant period. There would have been countless other conversations between staff during which it is likely such language was used.

100. The suggestion by some that this was just about swearing is, at best, a mischaracterisation of the evidence received by the Inquiry. I also reject attempts to justify the language used on the basis that Brook House was not a normal workplace and that swearing was common and inoffensive.²⁹⁷ First, this was not restricted to swearing but, as set out above, included shocking language towards and about detained people. Second, in a setting in which staff have a duty to care for vulnerable detained people and where there is an imbalance of power, the language used is even more important in contributing to a relationship of trust between them. It does not mean that a more lenient

²⁹¹ [INN000013_016](#) para 50

²⁹² [Shayne Munroe 4 March 2022 55/18-56/5](#)

²⁹³ [Stephen Skitt 17 March 2022 151/8-15](#)

²⁹⁴ For example, [Christopher Donnelly 23 February 2022 68/10-16, 82/11-17](#); [MAR000002_009](#) para 77; [David Webb 3 March 2022 116/17-18](#); [Daniel Haughton 16 March 2022 31/2-4](#); [MIL000002_025](#) para 101; [SER000447_015](#) para 65. All of the 35 former staff members who provided questionnaire responses to the Inquiry said they had no concerns about the verbal or physical abuse of detained people by staff

²⁹⁵ See, for example, [Christopher Donnelly 23 February 2022 169/15-174/20](#); [CJS001415](#)

²⁹⁶ For example, [Edmund Fiddy 7 March 2022 185/1-188/1](#); [David Webb 3 March 2022 112/13-16, 116/17-18](#); [Daniel Haughton 16 March 2022 148/22-149/2](#); [John Connolly 2 March 2022 171/18-21](#)

²⁹⁷ For example, by Mr Ring (see [INQ000199_011](#))

approach to abusive and derogatory language is needed; in fact, it means the opposite.

101. There is no such thing as “*consensual banter*” in such a setting.²⁹⁸ Swearing or offensive language among the detained population or by them towards staff does not excuse or permit the same by staff. Similarly, as noted above, there was evidence of verbal abuse and threats made by detained people towards staff.²⁹⁹ However, this does not justify staff verbally abusing detained people.

102. The nature of discussions about detained people or interactions with them was indicative of the way in which some staff thought about detained people. It is likely to have affected the way staff treated detained people. This was not only unprofessional but deeply troubling. It was harmful, unacceptable and has no place in an IRC, in which staff should be conducting themselves professionally. As Professor Bosworth noted, the language used towards and around detained people was “*corrosive*”, contributed to an “*us and them*” mentality and “*played quite a large role in the physical manifestation*” of abuse.³⁰⁰

103. The reasons for the prevalence and nature of abusive and derogatory language are varied, and it is likely that different motivations applied to different members of staff at different times. I have considered potential explanations that may be relevant to any actions taken to address these behaviours.

103.1 Reaction to stressful conditions: The evidence of some members of staff showed that, when faced with detained people in distress, they responded with mockery or anger. Mr Instone-Brewer thought that verbal abuse of detained people was caused or contributed to by staff morale being so low and staff being tired and under considerable pressure.³⁰¹ Mr Tulley noted that Mr Tomsett’s workload was very heavy, and that when he was stressed he would take it out on detained people, “*probably as a way of venting off his anger and his stress*”.³⁰² Professor Bosworth expressed a similar view in her report, noting: “*The coarse language evident in the footage could be evidence of high levels of frustration among the staff.*”³⁰³ One response by some staff to the challenges of their job is to create an “*emotional barrier*” between them

²⁹⁸ [Professor Mary Bosworth 29 March 2022 84/6-19, 85/8-12](#)

²⁹⁹ See also, for example, [CJS005280_002](#), which records Mr Fagbo allegedly being called a “*snake*” and a “*coconut*”, and [TRN0000093_0026](#), in which D313 describes a staff member as a “*cunt*” and says he’s “*going to get his fucking head smashed up*”

³⁰⁰ [Professor Mary Bosworth 29 March 2022 92/24-93/5](#)

³⁰¹ [Luke Instone-Brewer 8 March 2022 15/4-22](#)

³⁰² [TRN0000063_002-004](#)

³⁰³ [INQ000064_037](#) para 7.21

and detained people, which can lead to them not appreciating the difficulties that detained people are facing.³⁰⁴

103.2 A culture of dehumanisation of detained people: Some staff appeared to view detained people as being less human, making those staff more likely to use abusive language.³⁰⁵ Dr Brodie Paterson (on behalf of Medical Justice) and Professor Bosworth agreed that such dehumanisation is more likely to happen where the subjects are already part of a marginalised group, such as asylum seekers and foreign nationals facing removal.³⁰⁶

103.3 An attempt to fit in: One reason given by DCO Calvin Sanders and Mr Small for making derogatory comments was that they were trying to fit in with their colleagues.³⁰⁷ I agree with Professor Bosworth that Mr Sanders *“said and did lots of terrible things and to say he was just trying to fit in is a little bit denying his responsibility for that”*.³⁰⁸ Mr Small said: *“everyone made such comments. It’s not something I’m proud of. I think it’s horrific. I am ashamed and embarrassed to be honest with you.”*³⁰⁹

103.4 Effects of the environment at Brook House: It is clear that some members of staff felt that it was the effect of working at Brook House that had caused them to use derogatory language. Mr Small was recorded during the relevant period as saying, *“This job has made me racist, man.”*³¹⁰ In evidence to the Inquiry, he also explained that he had started to *“mould to”* the environment around him.³¹¹ While this clearly does not relieve Mr Small or other officers of responsibility for their actions, certain ways of talking to and about detained people in a derogatory and often racist manner were *“clearly encouraged”* by a group of officers, which made other staff more inured to the impact of that conduct.³¹² This accords with the evidence of Mr Francis, who said that he was led into using derogatory language by more dominant staff members.³¹³

³⁰⁴ [Professor Mary Bosworth 29 March 2022 42/18-43/6](#)

³⁰⁵ [Professor Mary Bosworth 29 March 2022 54/15-23](#)

³⁰⁶ [BHM000045_024 para 106; Professor Mary Bosworth 29 March 2022 54/06-115-23](#)

³⁰⁷ [Kalvin Sanders 4 March 2022 124/20-126/14; BDP000003_006-007 para 18](#)

³⁰⁸ [Professor Mary Bosworth 29 March 2022 87/24-88/22](#)

³⁰⁹ [Daniel Small 28 February 2022 130/9-14](#)

³¹⁰ [Daniel Small 28 February 2022 145/3-151/23; TRN000092_050](#)

³¹¹ [Daniel Small 28 February 2022 142/5-12](#). This reflected almost exactly the same language used by another detention officer in a book chapter published by Professor Bosworth: *“Working in This Place Turns You Racist”*: Staff, Race, and Power in Detention’, in *Race, Criminal Justice, and Migration Control*, Mary Bosworth et al. (eds), 2018, pp214-228. See also [Daniel Small 28 February 2022 142/1-15; BDP000003_0008 para 23](#)

³¹² [Professor Mary Bosworth 29 March 2022 91/6-92/4](#)

³¹³ [Charles Francis 3 March 2022 4/13-5/13, 6/9-12](#)

103.5 Lack of concern about being reported: Ultimately, staff were not deterred from using abusive and derogatory language, in part because there was no robust approach to challenging it, but also because there was a low prospect of it ever being reported. Professor Bosworth considered that such language being so widespread suggested that nobody was worried that they would be reported for its usage.³¹⁴

104. Mr Petherick said that, if he had heard any inappropriate language, he would have addressed it immediately and followed it up via disciplinary action.³¹⁵ That may be true, but it is of limited relevance, given the infrequency with which he walked around the corridors of Brook House and the likelihood that staff would have been more careful about what they said in front of him. There is some evidence that G4S took disciplinary action when abusive language was reported (such as in the cases of Ms Munroe and Mr Fagbo), but on many other occasions this does not appear to have been the case (such as with the allegations against Mr Tomsett).³¹⁶

Grievances

105. The extent to which staff raised grievances about one another appears to have been a significant aspect of the culture at Brook House. These grievances are important because of their content and what they show about the staff culture at Brook House and the failure of management to heed warning signs.

106. In the years prior to the relevant period, there was a widespread culture of senior managers at Brook House raising grievances against one another rather than resolving issues through discussion.³¹⁷ The majority of grievances related to complaints about the treatment of staff by other members of staff, and concerns about decision-making.³¹⁸ For example:

- In September 2014, Mr Duncan Partridge (Deputy Director) raised a grievance against Mr Saunders for bullying Mr Partridge and others.³¹⁹
- Mr Wayne Debnam (Head of Safety and Security) raised a grievance against Mr Partridge and Mr Saunders for bullying.³²⁰

³¹⁴ [INQ000064_037](#) para 7.21

³¹⁵ [Jeremy Petherick 21 March 2022 37/12-25](#)

³¹⁶ [CJS0074153_031](#) para 89; [CJS0074153_115](#) para 323; [CJS0074153_118](#) paras 329 and 330

³¹⁷ [KEN000001_009](#) para 43; [KEN000001_011](#) para 54; [VER000216_014](#) para 176; [SER000455_011](#) para 38; [Stephen Skitt 17 March 2022 77/21-82/2](#); [Professor Mary Bosworth 29 March 2022 158/17-23](#)

³¹⁸ [CJS0073666_003-006](#); [INQ000164_009-010](#) para 13

³¹⁹ [CJS0073663_006](#) para 6.3

³²⁰ [CJS0073663_005](#) para 6.1

- Ms Stacie Dean (Head of Tinsley House) raised her first grievance in 2014 about Mr Saunders, workload and policy issues, and a subsequent grievance about various other issues.³²¹

107. The consequences of this were “*difficult dynamics*”, a “*hostile and awkward*” environment between members of the SMT at that time and a poor management culture.³²² This impact was sufficiently serious for there to be an “*amnesty from grievance*” at one point, and for Mr Petherick to become personally involved.³²³ Mr Hanford said that he had not seen “*so many grievances from colleague to colleague and manager to manager together*” in 31 years in the custodial environment.³²⁴ This reinforces a picture of an unhealthy working environment and a G4S management team that did not recognise the grievance culture as a symptom of a wider problem with staff culture and that was distracted from the core business of detaining people safely and decently.

108. There were also a number of grievances about matters similar to those subsequently shown on the *Panorama* programme, demonstrating that these issues were present and known to senior management prior to the relevant period. For example, Ms Dean raised a grievance in writing to Mr Neden around November 2016 and in a subsequent meeting with Mr Petherick in January 2017.³²⁵ The grievance raised concerns about a failure to investigate the bullying of detained people by staff, staff bullying, the close relationship between members of the SMT and DCMs about whom complaints had been made, a toxic staff culture, a focus on profit by G4S and under-reporting of incidents. A follow-up email from Ms Dean also alleged that staff were known to have been supplying drugs to detained people.³²⁶ All of these issues remained a concern during the relevant period. There was no evidence of any investigation or outcome regarding most of the issues raised in Ms Dean’s grievance.³²⁷ The only outcome recorded was as follows:

“There were no under-reporting concerns discovered regarding incident reports or any intention to avoid financial penalties. There were no under-reporting concerns identified regarding internal reporting, which follows the C&DS [Custodial and Detention Services] model.”³²⁸

³²¹ [CJS0073632_001](#)

³²² [INQ000164_008](#) para 10; [CJS0073709_066](#) para 7.3; [CJS0073663_007](#)

³²³ [CJS000463_001](#); [Stephen Skitt 17 March 2022 83/7-84/15](#); [Jeremy Petherick 21 March 2022 136/9-137/17](#); [CJS0073663_006](#) para 6.4; [VER000103](#)

³²⁴ [Lee Hanford 15 March 2022 71/14-20](#)

³²⁵ [CJS0073632](#) (this was mistakenly addressed to ‘Mr Needham’ but Mr Neden accepted in evidence that he knew it was for him: [Peter Neden 22 March 2022 18/3-10](#)); [CJS0073633](#)

³²⁶ [CJS0073679_002](#)

³²⁷ Mr Petherick said that he had asked Mr Hanford to investigate the concerns, but Mr Hanford said that this did not happen, and it is not included in the note of the meeting between the two of them: [CJS0073680](#); [CJS0073681](#); [CJS0073663_008](#)

³²⁸ [CJS0073631_001](#)

109. During the relevant period, there were continued investigations of some grievances raised prior to the relevant period about bullying.³²⁹ There were, however, very few new grievances raised by staff, suggesting that the earlier grievance culture may have been largely resolved.³³⁰ The reasons for this are unclear. One exception is a grievance raised by DCO Kye Clarke alleging that, while he was on suspension in relation to a use of force incident with a detained person, people said that he would be sacked.³³¹ Mr Clarke resigned on the day of his disciplinary hearing and before any grievance investigation could be carried out.³³² Mr Clarke also said in his statement to the Inquiry that he raised a grievance around April 2017 about bullying by two DCOs.³³³ However, there is no record of this grievance.³³⁴

110. Overall, there appears to have been a dysfunctional SMT that likely paved the way for a toxic culture among staff during the relevant period. G4S managers at Brook House during the relevant period did not always take appropriate action when concerns were raised about the conduct of staff members, as is considered further in Chapter D.10.

Current staff culture

111. In 2019, in the wake of the *Panorama* programme, the Home Affairs Committee called on the Home Office urgently to monitor more closely the policies, procedures and practices of contractors to expose inappropriate behaviour, and to ensure that Home Office staff also received training on promoting a healthy staff culture.³³⁵

112. When Serco took over the contract to run Brook House, a large number of former G4S staff were transferred to continue, in effect, their existing roles under Serco. The Inquiry was told about a number of efforts that Serco has made to improve culture.

112.1 The current Serco contract for the management of Brook House contains provisions relating to “*healthy staff culture*”, including a key

³²⁹ By DCO David Waldock (CJS0073243; CJS0073274) and the interrelated grievances raised by Ms Munroe, Assistant Custody Officer Nicola Kaminski and DCM David Killick (CJS0073334; CJS0072840; CJS0073047; CJS0073051)

³³⁰ CJS000473 ‘Grievance Log’

³³¹ CJS0073368. See INN000012_017-018 paras 69-74; CJS005927_015; CJS005618_009-010

³³² CJS000473 ‘Grievance Log’

³³³ INN000012_013 para 52; INN000012_018-019 para 76

³³⁴ CJS000473 ‘Grievance Log’

³³⁵ *Immigration Detention – Fourteenth Report of Session 2017–19*, House of Commons Home Affairs Committee, 21 March 2019, para 61 (‘Conclusion and recommendations’). This supported an earlier recommendation by Mr Stephen Shaw; see *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons*, Stephen Shaw, July 2018, Recommendation 42

performance indicator (KPI) on the issue.³³⁶ However, there was a ‘relief period’ on all KPIs, including this one, between May and August 2020, such that no penalties would be applied for failure to comply.³³⁷ From July 2021 and continuing in April 2022 when Mr Steven Hewer (the current Director of Gatwick IRCs under Serco) gave evidence, a “*derogation*” had also been agreed with the Home Office in respect of multiple KPIs including that related to staff culture.³³⁸ Mr Hewer called this a “*temporary arrangement*” that had “*gone on a bit longer than anticipated, from a Home Office perspective*”.³³⁹

112.2 All SMT members and Detention Operations Managers (DOMs) completed ‘Culture Development’ programmes.³⁴⁰ Mr Hewer described a “*Positive Detention Culture programme*”, which he said:

*“assesses the culture and conduct within the IRC against specific criteria ... to create healthy behaviours amongst staff by encouraging positive role modelling and effective leadership”.*³⁴¹

112.3 Serco’s current recruitment advertisements for DCO positions also place significant emphasis on the role being one of “*supporting*” people and helping to ensure that “*residents are treated with decency and respect from the moment they arrive*”.³⁴² The emphasis on attracting those with skills in relationship-building, and the need for emotional intelligence, patience and “*a genuine commitment to helping people*”, is appropriate and sets the correct tone at an early stage in recruitment.³⁴³

112.4 The Inquiry heard that there is now a framework for investigating staff who are involved in three instances of misconduct or alleged misconduct in a three-month period. This ‘three in three’ approach was said to allow Serco to “*monitor and record patterns of behaviour, identify trends and more importantly, ensure early intervention is applied, where needed, to maintain a healthy staff culture*”.³⁴⁴ While it is no doubt difficult to measure ‘culture’ in a quantifiable manner, the threshold of three concerning incidents in three months may be unnecessarily high and may risk overlooking infrequent behaviour or acts falling short of ‘misconduct’ that are nevertheless concerning.

³³⁶ [SER000451_007](#) para 4

³³⁷ [SER000451_007](#) para 23

³³⁸ [Steven Hewer 1 April 2022 35/1-38/2](#); [SER000451_007](#) para 23

³³⁹ [Steven Hewer 1 April 2022 36/23, 37/22-24](#)

³⁴⁰ [Closing Statement on behalf of Serco, Brook House Inquiry](#), paras 29-30

³⁴¹ [SER000451_002](#) para 4; [SER000451_011](#) para 44; [SER000023](#)

³⁴² [INQ000245](#)

³⁴³ [INQ000245](#)

³⁴⁴ [SER000041](#)

112.5 A ‘House Rules’ document provided to detained people on arrival appropriately emphasises that they should expect *“to be treated with dignity and respect”*, and provides information about the Brook House IMB, GDWG and other external organisations, as well as how to complain, whether internally or to the Safer Community team.³⁴⁵

113. An HMIP report on an unannounced inspection of Brook House between 30 May and 16 June 2022 noted that *“promising”* work commissioned by Serco to understand staff culture was in *“its early stages of implementation”*, and recorded that *“a large number”* of staff were *“inexperienced and operational leaders did not provide them with enough support in the unit”*.³⁴⁶

114. While I have seen evidence that steps have been taken by Serco in terms of protocols, training, and provision of a whistleblowing service, the derogation from the culture-focused KPI, high threshold for the ‘three in three’ programme and outdated materials (discussed above) are troubling. Serco has recognised that further reflection may be required and has stated that, once the Inquiry’s recommendations are published, it *“intends to address the issues contained within the[m] ... whilst reflecting on the evidence”*.³⁴⁷ I am concerned that insufficient progress has been made to address culture within Brook House.

115. More fundamentally, however, evidence heard during the Inquiry undermined Serco’s assurances that a culture is developing where unethical behaviour is not tolerated and that there is *“complete transparency”* in self-reporting failures.³⁴⁸ Evidence from the following staff, in particular, caused concern.

115.1 Mr Stephen Loughton is now Assistant Director, having been a DCM during the relevant period. He was involved in an incident with D1527 discussed in Chapter C.4 in Volume I.³⁴⁹ Despite his belief that D1527 was able to self-harm because DCO Clayton Fraser had failed to perform proper observations, Mr Loughton did not report his colleague or, as far as he could recall, take any action, as Mr Fraser *“didn’t often work at Brook House”*.³⁵⁰ Mr Loughton did not accept, even with the benefit of hindsight, that there had been a ‘laddish’ culture or a culture of non-reporting.³⁵¹ When asked about describing D1527, immediately after his attempted self-ligature, as *“sulking”*, and challenged about calling him a *“cock”* and about offensive comments made by Mr Ring, Mr Loughton

³⁴⁵ [SER000026](#)

³⁴⁶ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022

³⁴⁷ [Closing Statement on behalf of Serco, Brook House Inquiry, para 15](#)

³⁴⁸ [SER000465_006](#) para 20

³⁴⁹ [SER000447_001-002](#) para 1

³⁵⁰ [Stephen Loughton 1 March 2022 98/3-99/1](#)

³⁵¹ [Stephen Loughton 1 March 2022 84/7-11](#)

suggested that the Inquiry was “*focusing on language ... reading into it too much*”.³⁵² I found his comment provided a damning insight into the continued lack of awareness of culture at Brook House.³⁵³ His attempts to excuse other staff for using the phrase “*if he dies, he dies*” prior to a planned use of force on a detained person with a heart condition were completely unconvincing.³⁵⁴ He was asked for a view on D1527’s treatment by Mr Paschali, and replied, “*I wasn’t there, so I can’t comment on that.*”³⁵⁵ Finally, his answers to questions about Mr Tulley (and his social media comments about the *Panorama* programme)³⁵⁶ indicated that he felt “*let down*” by Mr Tulley and was in denial about what Mr Tulley had exposed, and gave the sense that he believed that the staff shown on the programme were the real victims.³⁵⁷

115.2 Mr Steven Dix was a DCM during the relevant period and is currently Assistant Director.³⁵⁸ He was involved in a concerning use of force incident involving D1978, also discussed in Chapter D.7. This showed mismanagement by Mr Dix resulting in force being used on a detained person who was attempting to comply. In a debrief following this event, Mr Dix lied about the rationale for using force, inaccurately stating that force was used because D1978 was “*encroaching*” on the team.³⁵⁹ When giving evidence to the Inquiry, Mr Dix admitted a “*discrepancy*”, but added, “*I’m not saying I haven’t told the truth*”,³⁶⁰ despite it being clear from the footage that he had lied. Rather than admitting to and apologising for fabricating his account, he gave various unconvincing explanations, blaming confusion, the moving of D1978 that followed, a lack of review of his own actions and a lack of “*prior knowledge of what that footage showed*”.³⁶¹

115.3 Mr Christopher Donnelly was a DCM during the relevant period, and remains in post as a DOM.³⁶² He was involved in an incident on 4 July 2017 in which, having found D865 on the floor of his cell, he failed to check for a ligature, which was therefore not removed until Mr Tulley entered and pointed it out. Mr Tulley believed that Mr Donnelly had done this intentionally and was “*intent on allowing the detainee to suffer*”.³⁶³

³⁵² [Stephen Loughton 1 March 2022 96/10-25](#)

³⁵³ [Stephen Loughton 1 March 2022 96/10-25](#)

³⁵⁴ [Stephen Loughton 1 March 2022 116/6-17](#)

³⁵⁵ [Stephen Loughton 1 March 2022 138/10-23](#)

³⁵⁶ [INQ000001](#)

³⁵⁷ [Stephen Loughton 1 March 2022 137/2-138/5](#)

³⁵⁸ [SER000436_001](#) para 1; [Steven Dix 9 March 2022 2/16-17](#)

³⁵⁹ [Jonathan Collier 30 March 2022 89/6-13](#); [CJS0074374_003](#)

³⁶⁰ [Steven Dix 9 March 2022 73/7-15](#)

³⁶¹ [Steven Dix 9 March 2022 71/20-74/7](#)

³⁶² [SER000444_001](#) para 2

³⁶³ [Callum Tulley 2 December 2021 26/8-10](#)

In his written statement (as well as in the course of an internal G4S investigation),³⁶⁴ Mr Donnelly said he could not recall any detail and accepted that he “*missed*” the ligature but had relied on a DCO present to have seen it. It was not until his oral evidence in February 2022, following detailed questioning, that Mr Donnelly accepted that he intentionally omitted facts from documents completed on the day,³⁶⁵ including that there was a delay in removing the ligature and that Mr Tulley had to point it out to him, “*probably because I didn’t want to make myself look bad*”.³⁶⁶ Mr Donnelly also described the reaction to the *Panorama* programme in his written statement in terms that suggest that he and others were more concerned about Mr Tulley’s ‘betrayal’ and their own sense of injustice than by the shocking abuses shown:

*“Devastatingly negative. Outraged. People felt betrayed, cheated and lied to. Overwhelmingly, every staff member said it was an outrageous travesty, unfair, biased and deceitful. They did not recognise it as the place where they worked.”*³⁶⁷

In his evidence to the Inquiry, Mr Donnelly appeared to maintain a similar view, saying that he and other staff had been outraged at “*how unfair they thought it was*”.³⁶⁸

115.4 Mr Stewart Povey-Meier was a DCM during the relevant period and remains in the equivalent role.³⁶⁹ He led a team involved in a use of force on D390 on 6 June 2017. As discussed in Chapter C.8 in Volume I, Mr Povey-Meier’s debrief was inadequate, and the use of force was not employed as a last resort.³⁷⁰ When asked about this event, Mr Povey-Meier maintained that there was still “*a risk*” in allowing D390 a chance to comply, despite his team being safely behind a door.³⁷¹ In Use of Force documents following the event, Mr Sayers recorded that D390 refused an instruction prior to the use of force, but the footage showed that there was no such instruction and no time given to comply.³⁷² Mr Povey-Meier still refused to accept that this record was untrue, simply stating, “*DCO Sean Sayers wrote his report based on what he believed he’d done*”.³⁷³ His failure to re-evaluate his actions, or acknowledge that his colleague was wrong, suggests a lack of

³⁶⁴ [CJS005952_003-004](#)

³⁶⁵ [CJS004312](#)

³⁶⁶ [Christopher Donnelly 23 February 2022 125/11-127/3; CJS004312; CJS005952_003-004](#)

³⁶⁷ [SER000444_016](#) para 85

³⁶⁸ [Christopher Donnelly 23 February 2022 83/10-15](#)

³⁶⁹ [SER000456_001](#) para 1

³⁷⁰ See [INQ000111_062-065](#)

³⁷¹ [Stewart Povey-Meier 17 March 2022 15/18-16/17](#)

³⁷² [CJS0074063 UOF 137.17 \(2\).MOV UOF 137.17 BWC.MOV](#)

³⁷³ [Stewart Povey-Meier 17 March 2022 16/25-17/3](#)

willingness to learn and an ongoing effort to ‘close ranks’ rather than challenge errors or wrongdoing.

115.5 Mr Ryan Bromley was and remains a DCO.³⁷⁴ When asked about his actions during the relevant period, Mr Bromley gave the impression that he valued ‘protecting’ colleagues more than providing an honest reflection on what happened. In relation to the same event involving D390, he recorded that *“D390 continued to ignore instructions from DCO Sayers”* once staff had entered the cell, after which, *“For the safety of the team, DCO Sayers advanced, placing the shield into his chest.”*³⁷⁵ Footage shown to him during his oral evidence demonstrated that Mr Sayers gave no such instructions, that D390 was not given any time at that point to comply and that, rather than *“placing”* a shield, Mr Sayers forcefully pinned D390 to his bed. Mr Bromley, however, stood by his description. Although he had (inaccurately) recorded at the time that de-escalation had continued after staff entered the cell, he appeared to suggest in his oral evidence that there was in fact no need to attempt further de-escalation: *“if a detainee is boiling the kettle, threatening officers with it, then ... talking to them ... they are past that”*.³⁷⁶ While officers had discussed whether a kettle was boiling in the cell, the Inquiry saw no evidence that D390 intended to use it as a weapon, or that he was threatening anyone in any way.³⁷⁷ As Mr Collier noted, D390 went on to walk very compliantly to the discharge area.³⁷⁸

116. Mr Hewer was asked about a number of the accounts summarised above. He disagreed that employees had ‘closed ranks’. He recognised that Mr Loughton’s evidence suggested that he (Mr Loughton) had not appropriately reflected on the events in which he was involved.³⁷⁹ Although he accepted that fabricating the rationale for a use of force was very serious and said he expected *“honest, truthful evidence”*, inexplicably Mr Hewer had not already taken the matter up with Mr Dix, despite being provided with relevant information some time before.³⁸⁰ Mr Hewer told the Inquiry he hoped that *“culturally-wise and from my leadership, that the team is open, honest and fully transparent now”*, but accepted that evidence considered by the Inquiry suggested this was not so.³⁸¹

³⁷⁴ [SER000434_002](#) para 4; [SER000434_003](#) para 9

³⁷⁵ [CJS005624_021](#)

³⁷⁶ [Ryan Bromley 7 March 2022 113/10-119/1](#)

³⁷⁷ This is from footage, part of which was played in closed session ([CJS0074063 UOF 137.17\(2\)](#))

³⁷⁸ [INQ000111_065](#) para 257

³⁷⁹ [Steven Hewer 1 April 2022 73/5, 81/11, 83/4-5](#)

³⁸⁰ [Steven Hewer 1 April 2022 76/16-77/20](#). Mr Hewer was provided with the transcript of Mr Dix’s evidence and with Mr Collier’s report

³⁸¹ [Steven Hewer 1 April 2022 78/5-10](#)

117. These are only some examples of evidence that caused me concern regarding current practice under Serco’s management of Brook House. I am particularly troubled that some staff involved in problematic events during the relevant period are now in senior roles, with responsibility for setting the culture, despite showing little or no real reflection on their actions.

Mr Haughton was a rare example of a remaining member of staff who gave evidence and accepted a number of his errors during the relevant period.³⁸²

118. The defensiveness and self-preservation of a number of current Brook House staff, some very senior, suggest a failure to learn from the relevant period. This is very concerning, given that self-reporting requires a significant level of trust in the ethical behaviour of staff, and assurance that wrongdoing by some would be reported by others.

119. Cultural change must start at the top, as recognised by Ms Newland:

“Culture is ... driven from senior leaders, and ... the work that we’re doing on positive detention culture at Gatwick has started with the SMT and is now being driven through ... the first-line managers and the officers.”³⁸³

As Mr Hewer also rightly said, a culture does not change overnight.³⁸⁴

The evidence I have seen shows that there is still a long way to go. I was disappointed that Mr Hewer had to have excerpts from the transcripts of evidence from other staff read to him before he recognised that the cultural change he described in his statement did not reflect reality.³⁸⁵

120. The spotlight of a public inquiry should not be required to effect this change. The *Panorama* programme and evidence subsequently seen or heard by the Inquiry were so significant as to require more urgent action. While it is appropriate for further reflection to take place in light of the Inquiry’s Report and recommendations, Serco should have already investigated and resolved the continuing cultural issues, and the Home Office should have ensured that this was done.³⁸⁶

121. Matters such as staffing and recruitment, support from managers and the culture of a workplace are the primary responsibility of the contractor. While the Home Office does not have direct control over policies and procedures, it should ensure that these issues are addressed when contracting with private firms, through robust and suitable systems and policies. I am therefore recommending that action be taken to improve the culture among staff.

³⁸² [Daniel Haughton 16 March 2022 73/20-155/12](#)

³⁸³ [Sarah Newland 21 March 2022 170/21-25](#)

³⁸⁴ [SER000451_011](#) para 44

³⁸⁵ [Steven Hewer 1 April 2022 78/8-10](#)

³⁸⁶ [SER000465_004](#) para 15

Recommendation 27: Developing a healthy culture among staff

Contractors operating immigration removal centres must develop and implement an action plan to ensure a safe and healthy staff culture in immigration removal centres. The action plan must address:

- the identification of and response to any sign of desensitisation among staff;
- training staff on coping mechanisms and secondary trauma awareness; and
- maintaining an appropriate balance between care and safety or security.

The Home Office must regularly monitor each contractor's compliance with its action plan.

Chapter D.10:

Complaints and whistleblowing

Introduction

1. Complaints and whistleblowing processes should have been an important safeguard against poor treatment or abuse of detained people. Detained people and staff should have been able to raise concerns and have those issues resolved satisfactorily, with thorough investigations into alleged wrongdoing and action taken against any staff responsible for misconduct. In addition, steps should have been taken to improve policies and practices found to be problematic.

2. In reality, many detained people felt unable to complain about poor treatment. When they did, there were a number of failures in the responses from G4S, the Home Office and the Home Office's Professional Standards Unit (PSU). Similarly, most staff were either unwilling or unable to raise concerns about the treatment of detained people. The whistleblowing processes in place during the relevant period (1 April 2017 to 31 August 2017) were insufficient and ineffective, and responses to concerns raised were inadequate.

Complaints by detained people

3. Rule 38 of the Detention Centre Rules 2001 provides for detained people to make requests or complaints to the manager, the visiting committee (ie the Independent Monitoring Board or IMB) or the Secretary of State and requires those requests or complaints to be responded to in accordance with procedures approved by the Secretary of State.¹ This is expanded upon in Detention Services Order 03/2015: Handling of Complaints (the Complaints DSO), which includes mandatory instructions and guidance regarding the handling of complaints, as well as in G4S's Requests and Complaints policy (the G4S policy).²

¹ Detention Centre Rules 2001, Rule 38. Healthcare complaints were usually handled separately and are discussed in Chapter D.8 (HOM0331998_005 para 18; see also CJS000727_007-009 paras 9-21)

² Detention Services Order 03/2015: Handling of Complaints (CJS000727), Home Office, February 2017 (updated April 2023); Requests and Complaints policy (CJS000700), G4S Gatwick IRCs, September 2008

4. Within Brook House, detained people or others on their behalf could raise a complaint in writing or verbally.³ Forms were transferred electronically to a Home Office team known as the Detention Services Customer Service Unit, which was responsible for categorising and allocating them for investigation.⁴ Staff in receipt of verbal complaints were to encourage detained people to put the complaint in writing.⁵

Table 6: Allocation of complaints as required by Detention Services Order 03/2015: Handling of Complaints

Type of complaint	Investigated by	Time limit
Immigration removal centre (IRC) service delivery	IRC supplier (at Brook House, G4S Care and Justice Services (UK) Ltd)	Within 20 working days of allocation of the complaint
Minor misconduct	IRC supplier (at Brook House, G4S Care and Justice Services (UK) Ltd)	Within 20 working days of allocation of the complaint
Serious misconduct	PSU	Within 12 weeks of receipt within the Home Office (this includes the investigation)
Healthcare complaint (England)	Healthcare provider (at Brook House, G4S Health Services (UK) Ltd)	NHS England processes and timescales apply

Source: Extract from *Detention Services Order 03/2015: Handling of Complaints (CJS000727)*, Home Office, February 2017 (updated April 2023). See examples of various categories of complaint at [CJS000727_033-034](#)

³ A complaints form (DCF9) or any other written complaint was to be deposited in boxes at Brook House, marked 'Immigration and Enforcement Complaints' ([HOM002748_046](#)). Example form: [CJS001616_003-005](#)

⁴ [CJS000727_004](#) para 1; [HOM0331998_004](#)

⁵ [CJS000727_010](#) para 27

Barriers to reporting

- 5.** In a 2017 survey carried out by staff within Brook House, 42 per cent of detained people said that they did not know what to do if they were a victim or witness of violence.⁶ In the 2019 HM Inspectorate of Prisons (HMIP) report, 58 per cent of those surveyed said they did not know how to complain.⁷
- 6.** This was supported by other evidence received by the Inquiry.
- 6.1** In its February 2018 report on D1527's complaints, the PSU noted that many detained people discussed their complaint with an officer before submitting a formal complaint. The report stated, "*It is not known why detainees do not formally complain and this may require further investigation with the detainees themselves.*"⁸ Ms Julie Galvin (the investigating officer in this case) recommended that the Home Office Detention and Escorting Services (DES) consider discussing this with detained people.⁹ The Home Office recorded that this had been completed, but it is unclear whether any such discussion took place or, if it did, what the results were.¹⁰
- 6.2** The "*reticence by detainees to using the formal complaint procedure*" was also identified by the PSU in its February 2018 report into D668's complaints. The report made two recommendations: first, that the Home Office use its direct contact with detained people to either address any concerns or organise an awareness-raising campaign; and second, that the 'Immigration and Enforcement Complaints' label on the complaints box be changed to make clear it is for complaints about Brook House and not immigration matters.¹¹
- 6.3** Ms Anna Pincus, current Director of Gatwick Detainees Welfare Group (GDWG), told the Inquiry that when detained people mentioned poor treatment, they would usually say that they did not want a complaint to be made. If there was a safeguarding concern, GDWG would inform the Safer Community team (the team of G4S staff within Brook House who were responsible for management of self-harm, Assessment Care in Detention and Teamwork and anti-bullying), ideally with the detained person's consent.¹²

⁶ [CJS0074154_005](#) Q11

⁷ [HMIP000674_083](#)

⁸ [CJS001107_041](#) para 9.11

⁹ [CJS001107_041](#) para 9.14

¹⁰ [HOM0332029](#) row 90

¹¹ [HOM002748_046](#); [HOM0332047_010](#) paras 34-35. It is unclear what, if any, changes were made by the Home Office in response (see [HOM0332029](#) row 83)

¹² [DPG000002_031-032](#) para 83 (see also [CJS000625](#))

7. Some detained people did not understand their rights or what safeguards should be in place, or did not have confidence in making a complaint or reporting poor treatment by staff. D1713 said he did not know to whom he should report an incident of abusive and dehumanising language, or how to make a complaint. His cell mate suggested that there was no safe space in which to report a member of staff.¹³ D2158, D801 and D790 also indicated that they did not know how the complaints system worked.¹⁴ Although complaints forms were available in multiple languages, detained people may have found it more difficult to know how to complain.¹⁵

8. Additionally, many people suffered from health problems or disabilities that may have reduced their ability to follow the complaints process. For example, D313 said he was not aware of how to complain, and that he had a serious learning disability that would have prevented him from reading any materials explaining the process.¹⁶ Some might have felt more confident making a complaint through a legal representative, but many detained people did not have access to a lawyer, and legal advice surgeries were said to be insufficient.¹⁷

9. A good understanding of how the complaints process works can encourage detained people to use it. Once he was told (by a fellow detained person) that complaints made using the complaints form would go straight to the Home Office, D1747 followed this process.¹⁸ Under its contract with the Home Office and its own complaints policy, G4S was required to explain to detained people how to make a complaint, as well as to acknowledge, investigate and respond within a set time period to complaints allocated to it.¹⁹ Although some steps were taken by G4S to make detained people aware of the complaints process, it is clear that, for many detained people at Brook House, any explanations that were given were insufficient.²⁰

10. The Inquiry received evidence about why detained people felt unable to complain about poor treatment, either at the time or at all.

10.1 Fear of repercussions from staff: In HMIP's 2019 report, 35 per cent of those surveyed said that they had been too afraid to make a

¹³ [BHM000018_009](#) para 34; [BHM000018_012](#) para 40

¹⁴ [BHM000029_010](#) para 38; [BHM000034_022](#) para 60; [DPG000022_012](#) para 44; [BHM000039_008](#) para 43

¹⁵ [HOM0331998_005](#) (see also [BHM000031_077](#); [DL0000226_039](#) para 158)

¹⁶ [DL0000233_018](#) paras 83-84

¹⁷ [DPG000002_033-034](#) para 88

¹⁸ [HOM002521](#); [HOM002520](#)

¹⁹ [CJS000421](#); [HOM000798_124-126](#); [CJS000700](#); [CJS000292](#); [HOM0331998_005-006](#) para 16; [CJS000727_010-011](#). They were also required to encourage a detained person to make their complaint in writing, and to make arrangements to help people who might find it difficult to submit a complaint in the correct way (for example, because of language or literacy difficulties)

²⁰ See, for example, [DL0000151_004](#) para 21; [CJS000994_011](#)

complaint about their treatment in Brook House.²¹ This issue had already been identified in a 2014 report by Medical Justice (a charity that provides medico-legal reports and advice to detained people).²² Both D313 and D1713 said that they were scared that officers might target them if they complained.²³ D2158 said he was scared of something being done to him if he complained.²⁴ Although she could not recall the detail of the conversations, Ms Pincus told the Inquiry that, about once a month, a detained person would tell her that detention staff had explicitly told them either not to make a complaint or to withdraw a complaint.²⁵

10.2 Fear of repercussions for their immigration case: Immigration removal centres (IRCs) differ from prisons in that the Home Office, rather than a third party, makes decisions about whether or not to remove an individual and determines the fact and length of detention.²⁶ The complaints form explicitly stated: *“The submission of a complaint will not affect consideration of your immigration status.”*²⁷ The Complaints DSO also made clear that detained people *“must not be penalised for making a complaint”* and that complaints would not interfere with a detained person’s immigration case.²⁸ However, it is unlikely that this was sufficient to dispel fears that it would do just that. Dr Hindpal Singh Bhui, Inspection Team Leader at HMIP, told the Inquiry that it was also his major concern that detained people might not make complaints for this reason.²⁹ Ms Pincus noted separately that *“detained people had strong concerns that making a complaint could jeopardise their immigration case”*.³⁰ This barrier may have been compounded by the PSU being part of the Home Office and by the labelling of the complaints box as ‘Immigration and Enforcement Complaints’.³¹ D668 told the PSU that his friend had made a complaint about *“being beaten up at the airport ... The last thing he heard from them (Home Office),*

²¹ [HMIP000674_091](#)

²² [BHM000041_042-043](#) para 117 (see also [INQ000057_015](#) para 43)

²³ [DL0000233](#) para 85; [BHM000018_012](#) para 40

²⁴ [BHM000029_010](#) para 38

²⁵ Anna Pincus 9 December 2021 61/6-63/20; [DPG000002_033](#) para 87

²⁶ [HMIP000671_009](#). By contrast, in prisons, the Ministry of Justice is responsible for detention and complaints but a judge decides on fact and length of sentence

²⁷ See, for example, [CJS001616_003](#)

²⁸ [CJS000727_006](#) para 6

²⁹ Dr Hindpal Singh Bhui 24 March 2022 146/5-15

³⁰ [DPG000002_033](#) para 87

³¹ [HOM002748_046](#). This labelling is mandated by the [Detention Services Order 03/2015: Handling of Complaints \(CJS000727\)](#), Home Office, February 2017 (updated April 2023), para 25

they came to pick him up at 16:00 hrs and take him back to his country.”³²

10.3 Lack of confidence: Most critically, there was also a view among detained people that nothing would change as a result of a complaint or that nobody would listen. Some 10 per cent of detained people who responded to an internal Brook House survey in 2017 said that the reason they had not complained was that centre staff did not care. A further 22 per cent said that staff could not or would not do anything.³³ This was echoed by some detained people:

- D1713 said that he did not think anyone would listen or anything would change if he did report incidents.³⁴
- D668 told the PSU that he had filed a complaint once and received no feedback, so he stopped doing it.³⁵
- D1851 said that he thought it was a waste of time to complain in writing, as staff had not listened when he kept complaining verbally.³⁶

10.4 Ms Pincus confirmed that most people to whom GDWG spoke viewed complaining as pointless and had no confidence that their complaint would be dealt with fairly.³⁷

11. At least one member of staff was unaware of the barriers faced by detained people and relied on the lack of immediate complaints about their conduct to support their position that they had not behaved inappropriately.³⁸

12. It is evident that many detained people did not complain, or at least did not do so at the time, including those who featured in the *Panorama* programme. There are numerous reasons why some detained people felt unable to complain about their treatment at the time or at all, and there was a lack of understanding by at least one member of staff of the barriers to complaining. It was the Home Office’s and G4S’s responsibility to create an environment and relationships that enabled disclosure of any concerns, in order to provide opportunities for both parties to learn about what was happening. The 2022 HMIP inspection report noted that although most detained people they spoke to were confident about making complaints, a substantial number did not know how to make complaints or were not

³² [HOM002748_012](#)

³³ [CJS0074154_011](#)

³⁴ [BHM000018_012](#) para 40

³⁵ [HOM002748_012](#)

³⁶ [D1851_3 December 2021_76/7-11](#)

³⁷ [DPG000002_033](#) para 87

³⁸ See, for example, [Sean Sayers 10 March 2022_164/11-165/22](#)

confident enough to complain.³⁹ Further action is required to ensure that processes for detained people to make complaints and for handling those complaints are improved. I am therefore recommending that both the Home Office and contractors take further action, as previously suggested by the PSU in February 2018.

Recommendation 28: Action to address barriers to making complaints

The Home Office and its contractors operating immigration removal centres must take steps to identify and address the barriers to making complaints that are faced by detained people, including a fear of repercussions. This must include training for staff on their role in enabling detained people to overcome these barriers.

Complaints to Gatwick Detainees Welfare Group

13. In addition to making complaints to G4S staff or the Home Office, detained people could also raise concerns about their treatment with staff or visitors from GDWG. As one of the few non-governmental organisations with a presence on the ground at Brook House, and the only one concerned with detained people's general welfare, GDWG was particularly important to the experience of detained people at Brook House. Several detained people described the group in positive terms⁴⁰ and emphasised the significance of its role at Brook House.⁴¹

14. GDWG provided anonymised summaries of occasions when it was told about concerns. For example, five detained people told GDWG that they had been physically abused by staff during the relevant period, a further three made allegations against escort staff in Brook House, and others made allegations outside the relevant period.⁴² If a complaint was raised by a detained person or by a GDWG visitor on their behalf, the GDWG Director decided whether to pass it on to G4S.⁴³ Mr James Wilson (Director of GDWG during the relevant period) said that, beyond a threshold of immediate risk, the decision whether to report a concern was fact-specific.⁴⁴ Ms Pincus noted that one difficulty with taking action was that, after they reported something,

³⁹ *Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 (HMIP000702)*, HM Chief Inspector of Prisons, September 2022, p66

⁴⁰ *D668 22 February 2022 68/14*; *DPG000023_010* para 37; *DPG000040_010* para 43

⁴¹ *Anton Bole 8 December 2021 160/1-10*; *Anton Bole 8 December 2021 160/1-10*; *SER000455_022* para 60; *SER000453_057* para 253

⁴² *GDW000010*; *DPG000002_023* para 58

⁴³ *Anna Pincus 9 December 2021 57/3-58/14*

⁴⁴ *James Wilson 10 December 2021 71/19-25*

a detained person might be moved around the immigration detention estate, making it more difficult for GDWG to follow up.⁴⁵ She also said that there were “*very, very many people complaining about very, very many things*”, and that GDWG would have overwhelmed G4S and the Home Office if it had raised matters with them on every occasion.⁴⁶

15. More generally, GDWG told the Inquiry that, although it knew that some detained people had complaints about their treatment and were not treated well, it only realised the gravity of the situation upon watching the *Panorama* programme.⁴⁷ Mr Wilson said that GDWG staff and visitors could not see things themselves because they were not allowed onto the wings.⁴⁸ Ms Pincus felt that they did not appreciate the situation from talking to detained people because poor treatment was just “*another ... manifestation of an injustice that they felt, but it was one of many, and they were bringing them all to us*”.⁴⁹ Mr Jamie Macpherson, a GDWG visitor, said he was aware of inadequate healthcare and use of segregation as a punishment, but not of the sort of abuse shown by the *Panorama* programme.⁵⁰

Issues identified regarding the role of G4S in the complaints process

16. Complaints about minor misconduct (such as staff being rude or unhelpful) and service delivery (such as access to IT services or issues about the physical environment) were allocated to G4S.

Problems arising from the handling of complaints by G4S

17. Most of the complaints submitted during or about the relevant period about service delivery or minor staff misconduct, which G4S was responsible for investigating, were found to be unsubstantiated. This included complaints about facilities, staff behaviour, bullying, access to property, the smell of the cells and staff rudeness during visits.⁵¹ Complaints about alleged racism and aggressive behaviour by Detention Custody Officer (DCO) Darren Tomsett, discussed in Chapter D.9, were found to be unsubstantiated.⁵² Three

⁴⁵ [Anna Pincus 9 December 2021 69/10-70/13](#)

⁴⁶ [Anna Pincus 9 December 2021 78/10-20](#)

⁴⁷ [DPG000002_027-031](#) paras 70-82; [DPG000003_004](#) para 14

⁴⁸ [James Wilson 10 December 2021 68/17-24](#)

⁴⁹ [Anna Pincus 9 December 2021 92/14-16](#)

⁵⁰ [Jamie Macpherson 8 December 2022 222/23](#)

⁵¹ See, for example, [HOM002781](#); [HOM002695](#); [HOM002783](#); [HOM002697](#); [HOM005233](#); [HOM005232](#); [HOM005247](#); [HOM005246](#)

⁵² For example, [HOM002784](#); [HOM002714](#); [HOM002767](#); [HOM002190](#)

complaints that were upheld against staff were related to allegations of the verbal abuse of D119.⁵³

18. Several complaints investigations were carried out by Detention Custody Managers (DCMs) or acting DCMs who themselves were or had been subject to multiple complaints about their conduct towards detained people (such as Mr Tomsett, who was made acting DCM in August 2017) or who I have found to have verbally or physically abused detained people (such as DCM Nathan Ring).⁵⁴ This may be unavoidable when complaints investigations are undertaken internally, but it is problematic.

19. The majority of complaints were found to be unsubstantiated, which may suggest a tendency for an accused member of staff to be believed over a detained person.⁵⁵ This is an inherent risk when staff members investigate their own colleagues.

20. There was, more generally, an incentive for G4S to find complaints to be unsubstantiated. In any system in which an organisation is investigating complaints made against its own staff, there is the potential for managers not to find such complaints to be substantiated because it would reflect badly on them. This can happen non-deliberately and is the inevitable consequence of permitting G4S to investigate complaints itself. There was also a specific incentive for G4S managers to find complaints to be unsubstantiated: penalty points were incurred under the contract for substantiated complaints.⁵⁶

21. Although it is appropriate for certain types of complaints to be investigated by contractors who run IRCs, the issues highlighted above must be taken into account to ensure a proper process. This includes guarding against managers feeling incentivised to find complaints to be unsubstantiated, ensuring that investigations are carried out by senior managers who are not themselves the subject of multiple complaints, and avoiding any tendency for accused members of staff to be believed over detained people.

Monitoring

22. The Complaints DSO required G4S to appoint a manager with responsibility for ensuring that effective systems and processes were in place to manage and investigate complaints relating to service provision or the behaviour of G4S staff.⁵⁷ In turn, the G4S policy required a monthly complaints

⁵³ [HOM002709](#); [CJS005888](#); [HOM002789](#); [HOM002701](#)

⁵⁴ [INN000024_001](#) para 2; Mr Tomsett said that he dealt with complaints with an open mind, but had no formal training in investigations ([Darren Tomsett 7 March 2022 66/25-67/12, 68/1-11, 78/2-8](#)). See Chapters C.11 and C.4 in Volume I regarding Mr Ring's conduct in relation to D1275 and D1527 respectively

⁵⁵ See, for example, [HOM002769](#); [HOM002767](#)

⁵⁶ [HOM000921_003](#)

⁵⁷ [Detention Services Order 03/2015: Handling of Complaints \(CJS000727\)](#), Home Office, February 2017, para 35 (updated [April 2023](#) – see para 52)

report to be compiled detailing the nature of the complaints, their outcomes, which areas actioned the investigations, their categories and the nationalities of the complainants. Its purpose was to inform senior management of all the complaints received during the previous month and to offer comparisons on a quarterly basis for trend analysis purposes.⁵⁸

23. During the relevant period, Ms Karen Goulder was the Complaints Administrator and maintained a Master Complaints Register or log.⁵⁹ The Inquiry has not seen evidence of monthly reports being produced or shared. Although Ms Goulder stated that a spreadsheet was sent to senior managers and directors on a monthly basis, the absence of any other evidence of this being produced or shared suggests that it is unlikely that this was correct.⁶⁰ One consequence of the lack of monthly reports is that the number of complaints made during the relevant period remains unclear.⁶¹ It is therefore difficult to see whether or how G4S could have undertaken any analysis of trends.

24. In its 2019 report, HMIP recommended that managers investigate and address the reasons for the low confidence of detained people in the complaints system, noting:

“During the last six months, 95 complaints had been dealt with by G4S, only one of which (1%) had been substantiated. We saw evidence that some of the unsubstantiated complaints should have been upheld.”⁶²

This had not been achieved by the time of HMIP’s 2022 inspection report (by which time Brook House was run by Serco), in which it was noted that there were fewer complaints and a higher proportion of them had been upheld.⁶³ Any complaints that were substantiated or involved staff members were sent to the Deputy Director to review, but no other quality assurance process for complaints was in place. The complaints were not discussed in detail at any meetings in order to identify patterns or emerging trends.⁶⁴

⁵⁸ [CJS000700](#)

⁵⁹ [SER000460_010-012](#) paras 39-46; [CJS001558](#)

⁶⁰ [SER000460_013](#) para 50

⁶¹ For example, G4S/IMB combined reports record 76 complaints during the relevant period ([CJS004580](#); [CJS004579](#); [CJS004586](#); [CJS004581](#); [CJS004585](#); [IMB000021](#); [IMB000050](#); [IMB000011](#); [IMB000047](#); [IMB000019](#)), but it is not clear if this means 76 different individuals or 76 different allegations, or whether the total number is of new complaints or a rolling total. Additionally, one G4S spreadsheet on complaints ([CJS000651](#)) suggests that 40 complaints were received during the relevant period, whereas another ([CJS001558](#) rows 56-149) suggests that this number is 94

⁶² [HMIP000674_035](#) para 2.19; [HMIP000674_054](#) para S48. HMIP noted that, during 2018, 8 per cent of complaints were fully substantiated ([HMIP000674_035](#) para 2.19)

⁶³ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022](#) (HMIP000702), HM Chief Inspector of Prisons, September 2022, p53

⁶⁴ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022](#) (HMIP000702), HM Chief Inspector of Prisons, September 2022, para 3.11

25. During the relevant period, Home Office staff were required to have undertaken “a monthly dip sample of responses in order to monitor the quality of initial responses”; this requirement continues today.⁶⁵ In addition, under the Complaints DSO (updated most recently in April 2023), the Home Office now requires an annual self-audit of complaint responses to be carried out by contractors and provided to the Home Office.⁶⁶ This may be helpful but, in my view, the Home Office should have a more active role in the complaints process – in order to assure itself that it understands the quality of contractors’ investigations, as well as to identify patterns or trends of complaints, whether by dip sampling or other means. More recently, since October 2022, the Home Office has introduced an ‘Independent Examiner of Complaints’ service, which is responsible for dealing with appeals against responses to service delivery and minor misconduct complaints.⁶⁷ Its efficacy is as yet unclear given its recent introduction.

26. With express consent, all complaints and responses were required to be sent to the IMB.⁶⁸ The IMB’s role was limited to monitoring the nature and extent of complaints and the timeliness of responses, rather than reviewing the investigations or outcomes reached.⁶⁹

Response to serious misconduct complaints

27. Complaints involving serious misconduct by staff at Brook House were required to be allocated to the PSU for investigation.⁷⁰ Such a complaint would only proceed further if a PSU senior investigating officer assessed that it met the threshold for investigation. If it did not, it would be reallocated to G4S.⁷¹

28. If a complainant was dissatisfied with the outcome of a PSU investigation, they could complain to the Prisons and Probation Ombudsman (PPO).⁷² The PPO is wholly independent of the Home Office.⁷³ In relation to allegations of inappropriate treatment during the relevant period at Brook House, the PPO appears to have received three complaints.⁷⁴ In response to complaints on behalf of D1527 and D687 against some of the findings of the

⁶⁵ [Detention Services Order 03/2015: Handling of Complaints \(CJS000727\)](#), Home Office, February 2017, para 41 (updated [April 2023](#) – see para 60). See also [HOM0331998_004](#)

⁶⁶ [Detention Services Order 03/2015: Handling of Complaints](#), Home Office, April 2023, para 64

⁶⁷ [Detention Services Order 03/2015: Handling of Complaints \(CJS000727\)](#), Home Office, February 2017 (updated [April 2023](#)), para 56. See also the guidance about [making a complaint to the Independent Examiner of Complaints](#)

⁶⁸ [HOM0331998_009](#) para 32. See also [CJS000727_015](#) para 45; [CJS000727_016](#) para 47

⁶⁹ [VER000138_009-010](#); [VER000138_012](#); [VER000138_017](#); [VER000138_019](#)

⁷⁰ [CJS0074041_024](#)

⁷¹ [HOM0331998_006](#) paras 21-22

⁷² [PPO0000034](#)

⁷³ [PPO000001_001](#) paras 1-2

⁷⁴ [PPO0000035](#)

PSU investigations into their original complaints, the PPO ultimately decided that a PPO investigation would not be worthwhile because this public inquiry had been set up and it would amount to a duplication of work.⁷⁵ In response to a complaint by D2034, the PPO concluded that the PSU's earlier investigation was complete and thorough, and that the decision not to substantiate D2034's complaint was reasonable.⁷⁶ There was also a complaint about staff bringing drugs into Brook House prior to the relevant period, which the PPO did not investigate on the basis that it was outside its remit.⁷⁷

29. Having reviewed all investigations carried out into allegations of serious misconduct during the relevant period, the Inquiry has identified a number of issues regarding the role and conduct of the Home Office and the PSU in relation to complaints.

Problems in the handling of serious misconduct complaints

30. Although most cases appear to have been allocated for investigation correctly, the Inquiry has seen a number of instances in which cases were not progressed as they should have been.

31. There were cases wrongly allocated by the Home Office Detention Services Customer Service Unit to G4S for investigation, rather than being forwarded to the PSU.⁷⁸

31.1 This happened, for example, in response to a complaint on behalf of D1538 regarding assault and homophobic abuse in August 2017.⁷⁹ Because of this misallocation, G4S carried out an initial investigation and the eventual PSU investigation, commissioned in November 2017, only amounted to a review of G4S's investigation.⁸⁰

31.2 Similarly, following the *Panorama* programme, the Home Office should have immediately commissioned the PSU or an external body to carry out the investigations into G4S staff, instead of choosing to rely on G4S to carry out its own investigations.⁸¹ As Mr Mark Hartley-King (Assistant Director at the PSU during the relevant period) noted, this was "*less than ideal*".⁸² The consequence was that, by the time the PSU was commissioned to investigate allegations (such as by D1527), many of the relevant officers were no longer employed by G4S and therefore

⁷⁵ [PPO000019](#); [PPO000035](#)

⁷⁶ [PPO000029](#)

⁷⁷ [PPO000034_006-007](#) paras 22-26

⁷⁸ [HOM0332031_014-015](#) para 75

⁷⁹ [CJS003348_006](#); [DL0000067_001-002](#)

⁸⁰ [HOM0331946_034-035](#) para 66

⁸¹ [HOM0331946_021-022](#) para 47

⁸² [HOM0331946_033](#) para 64; [HOM0332031_013](#) para 68

were not obliged to participate in the investigation.⁸³ This reduced the ability for there to be a proper investigation in these cases, and reflects one of the ongoing difficulties with PSU investigations, namely that former staff are not obliged to participate.

32. Both G4S and the Home Office failed to take any meaningful action on multiple occasions following complaints made by D2953, which are also discussed in Chapter C.10 in Volume I. D2953's complaints were regarding serious misconduct and therefore should have been referred promptly to the PSU.

32.1 D2953 called the Equality Advisory and Support Service (EASS) helpline, which was managed by G4S Government and Outsourcing Services (UK) Ltd, on 40 occasions between 10 June and 17 July 2017.⁸⁴ He had been given the EASS number by G4S staff.⁸⁵ In the last of seven calls to the helpline on 16 June 2017, D2953 said:

*"Guard hit me three times ... That man was aggressive to me, he apologised after. After [the] third time he hit me he sat on the bed next to me and was explaining something."*⁸⁶

32.2 The helpline call handler asked if they should call Brook House, to which D2953 said, *"I don't want to make things worse but you can."* The call handler did not contact Brook House.⁸⁷ Having offered to do so, the EASS call handler should have contacted someone at Brook House, who in turn should have referred the complaints to the PSU.

32.3 D2953 also made verbal complaints to staff (on 20 June, 29 June and 3 July 2017) that he had been *"hit"*, *"bitten"* or assaulted by a member of staff.⁸⁸ There is no evidence of any action taken by Ms Donna Batchelor, a Registered General Nurse, to raise these serious allegations with a manager or the Home Office. I also consider DCM Philip Page's

⁸³ [HOM0332030_006](#)

⁸⁴ [HOM032609_001](#). The EASS helpline is a UK-wide public advice service to assist individuals on issues relating to equality and human rights (see www.equalityadvisoryservice.com). It was operated by another G4S Group company, G4S Government and Outsourcing Services (UK) Ltd, to assist individuals on issues relating to equality and human rights. Mr Peter Neden was a director of both this company and G4S Care and Justice (see [Companies House appointments, Peter Neden](#)), but Mr Gordon Brockington (Managing Director of Justice and Government Chief Commercial Officer at G4S) stated that the former is not connected to G4S Care and Justice ([CJS0074041_025-026](#) paras 118-120)

⁸⁵ [HOM032609_002](#)

⁸⁶ [HOM032609_003](#); [CJS001506_029](#) para 6.65

⁸⁷ [CJS001506_029-030](#) para 6.65; [HOM032609_003](#)

⁸⁸ [CJS001506_030-031](#) paras 6.7.2-6.7.4; [CJS0073651](#); [CJS0073644_005](#); [CJS0073644_008-014](#); [HOM032247_009](#). There was some confusion regarding the nature of the assault. Although some of the documents refer to D2953 alleging he had been bitten, his English was poor and he said "hit" whenever he had an interpreter. He also clarified in his interview with Mr Stephen Cotter (G4S Investigation Officer) that he was trying to say he had been "hit" or punched ([CJS0073658_003](#))

actions (ie including the allegation in a large body of text about a different incident on 29 June 2017 rather than completing a separate incident report or Security Information Report) to have been insufficient.⁸⁹ Only DCO Kerry Copping responded adequately, passing the matter on to DCM Carrie Dance-Jones, who requested that DCM Steven Dix follow this up.⁹⁰ There is no contemporaneous evidence of any response. I think it is likely that Mr Dix did not in fact follow it up.⁹¹ Regardless, the matter was not passed to the Home Office or the PSU, nor was it investigated internally by G4S.

- 32.4** D2953's written complaint, submitted on 23 June 2017, contained allegations of repeated assaults by a member of staff (later identified as DCO Derek Murphy) over the previous two weeks, as well as complaints about his treatment by Healthcare staff.⁹² The Home Office's Detention Services Customer Service Unit failed to allocate this to the PSU for investigation at the time or at all.⁹³ Mr Paul Gasson (Home Office Contract Monitor) described this as an "*oversight*".⁹⁴ It was not until subsequent complaints were made that the matter was investigated, two to three months later. This was a significant failing by the Home Office that may have allowed an abusive member of staff to continue their conduct unchallenged.
- 32.5** By the time the PSU began investigating D2953's allegations in October 2017 (after a separate complaint had been made in September 2017), some potential witnesses could not be interviewed.⁹⁵ Three members of staff had left G4S and could not be compelled to cooperate with the investigation.⁹⁶ I do not accept G4S's submission that this was because the allegations were not raised until September 2017.⁹⁷ These witnesses could not be interviewed because of failings from G4S and the Home Office to promptly refer the initial complaints, made in June 2017, to the PSU.
- 32.6** Even when an investigation into the June 2017 complaints was eventually begun by G4S in September 2017, those conducting that investigation failed to refer the matter to the PSU until November 2017.

⁸⁹ See also Chapter C.10 in Volume I

⁹⁰ [CJS0073642](#)

⁹¹ Mr Cotter also reached the view that there were doubts about whether Mr Dix ever actually spoke to D2953 ([HOM032609_008-012](#)). Mr Dix was "*pretty sure*" he did speak to D2953 (see [CJS0073657](#))

⁹² [CJS001616_003-005](#)

⁹³ [HOM0332123_008-009](#) paras 36-38. The complaint about Healthcare staff was correctly passed to G4S Health Services for investigation and a response was provided on 5 July 2017 ([CJS001616_011-013](#))

⁹⁴ [Paul Gasson 15 March 2022 186/2-187/13](#)

⁹⁵ See [CJS001506_022](#) paras 1.2-1.3

⁹⁶ [CJS001506_026](#) para 5.8

⁹⁷ [CJS0074153_200-201](#) para 527

A reason given for not referring the matter earlier was that G4S “*had no evidence that an assault had taken place*”.⁹⁸ This was the wrong test to apply. It was an allegation of serious misconduct and therefore required investigation by the PSU.⁹⁹ Ms Rukshana Rafique, who became the PSU’s investigating officer for the case, noted: “*It raises some real questions including; how and why this matter was not referred to Detention Services and in turn PSU back in June 2017.*”¹⁰⁰

33. Mr Hartley-King said, “*The way things are being mishandled at Brook is not great.*”¹⁰¹ I agree.

Problems in the handling of complaints by the Home Office Professional Standards Unit

34. I have not considered the adequacy of each of the PSU’s investigations into allegations during the relevant period. I do not consider it proportionate to do so under the Inquiry’s Terms of Reference, which require me to investigate the adequacy of the complaints and monitoring mechanisms as a whole. During the relevant period, a number of investigations were conducted by the PSU where the approach seems to have been reasonably thorough and about which I make no specific criticisms.¹⁰² However, I have identified a number of concerning themes arising from the PSU’s investigations spanning the investigation process, the decision-making process and the communication of outcomes.

The investigation process

35. Once the PSU has accepted a complaint, it is allocated to an investigating officer.¹⁰³ That officer is responsible for identifying any relevant evidence and interviewing relevant witnesses (including the complainant and any staff who are subjects of the complaint, although only current employees can be required to attend).¹⁰⁴ On conclusion of the investigation, the investigating officer prepares a comprehensive report that reaches a finding about whether each aspect of the complaint is substantiated on the balance of

⁹⁸ [HOM005049](#)

⁹⁹ [Mohammed Khan 24 March 2022 26/10-15](#)

¹⁰⁰ [HOM005049_002](#)

¹⁰¹ [HOM005049](#)

¹⁰² For example, the investigations into complaints by D377 ([CJS001651_005-017](#)) and by D720 ([CJS001526_004-012](#))

¹⁰³ [HOM0331946_006](#) para 12. Investigating officers included Ms Helen Wilkinson ([HOM0332047](#)), Ms Galvin ([HOM0332030](#)) and Ms Rafique ([HOM0332123](#)). They were Higher Executive Officers (HEOs) within the civil service structure (eg [HOM0332047_001](#) para 3)

¹⁰⁴ [HOM0331946_007-008](#) paras 14-16; [Mohammed Khan 24 March 2022 38/7-12](#)

probabilities.¹⁰⁵ The report is reviewed by a senior investigating officer who has supervised the case, before being finalised.¹⁰⁶

36. There were several failures in the process by which some PSU investigations in the relevant period were carried out.

37. In his complaint in June 2017 concerning verbal abuse and physical assault by a member of staff, D1747 referred to two fellow detained people who he said had witnessed him being assaulted by Mr Murphy.¹⁰⁷ Inexplicably, instead of seeking to interview the witnesses himself, the PSU's investigating officer (Mr John Adamson) requested that G4S staff obtain statements from them.¹⁰⁸ The consequence was that one witness (D1686) apparently declined to give a statement when questioned by DCM Christopher Donnelly and DCO Aminul Hoque, despite remembering the incident.¹⁰⁹ In D71's case, the statement was written by DCM Dean Brackenridge.¹¹⁰ Neither the Inquiry nor the investigating officer had any way of knowing what conversation went on with the witness in each case. It was, in any event, inappropriate for G4S staff to be asked to obtain or record statements about whether a detained person supported D1747's allegations, particularly when they involved the conduct of a colleague.¹¹¹ This was not an isolated incident. In a similar vein, in the investigation into D1538's complaints, Mr Adamson relied on the evidence obtained by G4S instead of interviewing those subject to the complaints himself.¹¹²

38. The investigation into D1538's complaints also did not include interviews with any of the detained people who had witnessed an allegedly excessive use of force incident in the IT suite.¹¹³ The PSU should have considered the accounts of the other detained people who witnessed the interaction between D1538 and the two officers. Given the lack of audio on the closed-circuit television (CCTV) footage, this was particularly important.¹¹⁴

39. Some of those against whom D687 had made allegations of verbal and racist abuse between June and November 2016 (namely DCO Babatunde Fagbo and DCO Luke Instone-Brewer) were not invited to be interviewed by investigating officer Ms Helen Wilkinson.¹¹⁵ Ms Wilkinson could not recall the

¹⁰⁵ [HOM0331946_007](#) para 13; [HOM0331946_007](#) para 18. This means considering whether the alleged incident is more likely than not to have happened

¹⁰⁶ [HOM0331946_007-008](#) paras 13-18

¹⁰⁷ [HOM003522](#)

¹⁰⁸ [HOM003522_005](#)

¹⁰⁹ [HOM003493](#)

¹¹⁰ [HOM002419](#)

¹¹¹ Which Mr Khan appeared to accept ([Mohammed Khan 24 March 2022 42/3-14](#))

¹¹² [CJS003348_010](#) paras 6.2.1 and 6.3.1; [CJS003348_015-016](#) para 6.7

¹¹³ [CJS003348_007-016](#)

¹¹⁴ [Disk 4, UOF, 136.17 03 June 2017](#)

¹¹⁵ [Helen Wilkinson 24 March 2022 86/2-87/13](#) (complaint made in October 2017)

reasons for this, but suggested she may not have invited them because there was nothing substantiated against them.¹¹⁶ If this was her reason, it was illogical. As Mr Mohammed Khan (the PSU's Head of Operations) said, all those subject to allegations were expected to be invited to interview.¹¹⁷ Interviewing those against whom allegations were made should have been a key part of the investigation process, in order to assess whether allegations were substantiated.

40. There was also inappropriate conduct during the interviewing of witnesses.

40.1 As part of the PSU investigation into D87's complaints of excessive use of force in June 2017, investigating officer Ms Kim Shipp noted at the outset of interviews with three witnesses that she had "*no issue*" with the way that officers had dealt with D87, or the Control and Restraint (C&R) used.¹¹⁸ As Mr Khan accepted, it was not appropriate for this level of information to be given to a witness.¹¹⁹ The investigating officer also inappropriately shared with one interviewee her analysis of D87's allegation that DCO Sean Sayers and DCO Aaron Stokes had come to see him afterwards, apologised for the C&R and told him that they had been threatened with disciplinary action if they refused to be involved.¹²⁰ During an interview of Ms Sara Edwards (Brook House Duty Director on the day of the incident), the investigating officer expressed the view that "*it had probably been taken out of context*".¹²¹ It is of concern that the investigating officer had reached a conclusion about key issues (whether force used was excessive and whether it was necessary) purely on the basis of the camera footage and documentation, before interviewing all relevant witnesses.

40.2 When the investigating officer was interviewing Ms Edwards, it is clear that Ms Michelle Brown, a member of the Brook House Senior Management Team (SMT), was present only as a "*Colleague*".¹²² Ms Brown was also the subject of complaints, yet gave substantive answers to several of the investigating officer's questions. As Mr Khan accepted, the risk of effectively interviewing two people at the same time is that the evidence becomes contaminated.¹²³

¹¹⁶ [Helen Wilkinson 24 March 2022 86/12-15](#)

¹¹⁷ [Mohammed Khan 24 March 2022 9/21-10/19](#)

¹¹⁸ [HOM002355_001](#); [HOM002354_001](#); [HOM002353_001](#) (complaint made in July 2017)

¹¹⁹ [Mohammed Khan 24 March 2022 31/17-21](#)

¹²⁰ [HOM003153_025-026](#) paras 7.56-7.61

¹²¹ [HOM002355_012-013](#)

¹²² [HOM002355_001](#)

¹²³ [Mohammed Khan 24 March 2022 32/17-19](#)

41. There was no consistent practice by PSU investigators of showing relevant evidence to a complainant and allowing them to comment on it.¹²⁴

41.1 Ms Wilkinson said that she would show a complainant documentation or footage if it was inconsistent with their account to give them the opportunity to comment on it.¹²⁵

41.2 In his investigation into D1538's complaints, Mr Adamson relied heavily on CCTV footage of the incident but did not give D1538 or his representatives the opportunity to see or comment on this.¹²⁶ The PSU's report recorded that the CCTV showed DCO Edmund Fiddy raising his arm and pushing D1538 away with his open palm on three occasions.¹²⁷ However, when questioned by the Inquiry, Mr Fiddy accepted that the CCTV appeared to show that he had made contact with D1538's neck and that he had failed to put that in his incident report.¹²⁸

In my view, where there are inconsistencies between the accounts given of events, any evidence relating to those accounts (including footage and documentation) obtained by an investigating officer should be shown to the complainant and the subject of the complaint prior to reaching a conclusion. This would ensure fairness and may shed further light on what happened.

42. The nature and breadth of these issues suggest that the level of training given to investigating officers was inadequate for an organisation tasked with investigating serious misconduct against vulnerable people. Mr Khan told the Inquiry that PSU investigating officers have a baseline professional qualification and receive training on witness interviewing techniques, statement-taking, the use of force and areas such as harassment and discrimination.¹²⁹ Ms Wilkinson recalled having "*one lot of training*" at the beginning of her employment.¹³⁰ There was no specific training on the type of complaints she would be investigating, but rather she received general training in interview techniques.¹³¹ Ms Wilkinson also said that she had not had any training or guidance on interviewing vulnerable witnesses, which she thought would have been helpful.¹³² Mr Philip Riley, Director of DES, accepted that this was something to be considered.¹³³

¹²⁴ [Mohammed Khan 24 March 2022 12/14-19](#)

¹²⁵ [Helen Wilkinson 24 March 2022 56/16-57/5](#)

¹²⁶ [CJS003348_019](#)

¹²⁷ [CJS003348_019](#) paras 7.2.30-7.2.31

¹²⁸ [Edmund Fiddy 7 March 2022 170/21-172/11](#)

¹²⁹ [Mohammed Khan 24 March 2022 49/15-50/12](#)

¹³⁰ [Helen Wilkinson 24 March 2022 55/6-13](#)

¹³¹ [Helen Wilkinson 24 March 2022 106/7-9](#)

¹³² [Helen Wilkinson 24 March 2022 92/11-93/2](#)

¹³³ [Philip Riley 4 April 2022 164/2-165/8](#)

Decision-making

43. Based on a number of examples reviewed by the Inquiry, I have concerns about the decision-making of PSU investigators when determining whether allegations were substantiated or not.

44. There was no requirement for investigating officers to obtain or be provided with information about previous complaints against staff they were investigating – even where they concerned similar matters.¹³⁴ The consequences of this can be seen, for example, in the investigation into D1538’s allegation that Mr Tomsett had made a homophobic comment to him. The investigating officer did not identify that more than 10 allegations had been made against Mr Tomsett during the previous two years, including several of verbal abuse and discriminatory attitudes. His considerations, including *“the likelihood [sic] of such comments being made by a DCO to a detainee”*, therefore failed to take into account relevant information.¹³⁵ Mr Khan accepted that there was merit in the PSU having information about previous complaints.¹³⁶ Mr Riley was surprised that the PSU was not given that information, as the Home Office *“keep a very clear log that is discussed monthly about patterns of complaints against DCOs”*.¹³⁷ Investigating officers can decide what, if any, weight to attach to previous complaints (and the PSU may wish to issue guidance about this), but consideration of previous complaints reduces the risk that patterns are missed. It may tip the balance in situations where it is the detained person’s word against that of a staff member.

45. In July 2020, the Home Office said that it was seeking to require contractors to *“notify the Home Office of all cases where a staff member has been identified as being the subject of substantiated and repeated complaints”*.¹³⁸ However, no such requirement is included in the most recent Complaints DSO dated April 2023.¹³⁹ In any event, it would not go far enough. In my view, unsubstantiated complaints should also be notified to the Home Office so that this information can be provided to the PSU.

46. Even where some information about previous complaints was known, it was not always properly taken into account. For example, D668 complained that Mr Tomsett was rude to him, mocked him and frisked him aggressively.¹⁴⁰ The investigating officer was Ms Wilkinson, who carried out some checks for previous complaints against Mr Tomsett but received incomplete information

¹³⁴ [Mohammed Khan 24 March 2022 7/23-8/4](#)

¹³⁵ [CJS003348_021](#) para 7.3.9

¹³⁶ [Mohammed Khan 24 March 2022 8/11-9/20](#)

¹³⁷ [Philip Riley 4 April 2022 157/3-23](#)

¹³⁸ [HOM0331998_013](#) para 48vi

¹³⁹ See [Detention Services Order 03/2015: Handling of Complaints \(CJS000727\)](#), Home Office, February 2017 (updated [April 2023](#))

¹⁴⁰ [HOM002748_027](#); [HOM002748_031](#)

and was not aware of their full extent.¹⁴¹ Ms Wilkinson said in her statement that “*there was no record of other complaints or misconduct in relation to him*”.¹⁴² This was not accurate. In oral evidence to the Inquiry, she explained that she was focusing on racial or verbal abuse, but this was also not accurate, as Ms Wilkinson was aware of at least one allegation of racism and one of a homophobic comment.¹⁴³ She then sought to clarify that she meant substantiated complaints.¹⁴⁴ If true, this was not an adequate approach to analysing the evidence, as unsubstantiated complaints were also relevant.

47. Conversely, in the PSU’s investigation into D191’s complaint about excessive use of force in April 2017, the investigating officer considered it noteworthy that, during his time in detention, D191 had completed two complaint forms in 2016. The report noted that both complaints were dealt with by G4S and that D191 had received responses. The investigating officer therefore concluded that D191 was fully aware of the complaint procedure prior to the use of force on 27 April 2017 and “*chose not to raise this matter at the time*”.¹⁴⁵ While it is correct that he had used the complaints procedures before with a positive outcome, D191’s previous complaints had related to missing money and procedures around visits.¹⁴⁶ It is concerning that the investigating officer did not appear to appreciate the difference between a detained person complaining about procedures and administrative matters at Brook House on the one hand, and having sufficient faith in the complaints process to make an allegation of physical assault against a specific member of staff on the other. I consider it likely that a detained person would be more concerned about the potential consequences of making the latter type of complaint.

48. There were also instances where an investigator failed to take into account previous disciplinary action. In the PSU’s report into D687’s allegations, and then again in oral evidence, Ms Wilkinson said she was not aware that Mr Fagbo, one of the people against whom D687 made allegations of verbal and racist abuse, had been dismissed for verbal abuse towards a detained person.¹⁴⁷ I have some scepticism about that, given that she knew he was dismissed for “*inappropriate conduct with a detainee (heated exchange and waving hand movement)*”.¹⁴⁸ At the very least, she should have made further enquiries as to whether the “*heated exchange*” included verbal

¹⁴¹ [Helen Wilkinson 24 March 2022 61/1-69/8](#); [HOM002190](#)

¹⁴² [HOM0332047_011-012](#) para 41

¹⁴³ [Helen Wilkinson 24 March 2022 68/16-17](#); [HOM002748_032](#) para 7.4.5

¹⁴⁴ [Helen Wilkinson 24 March 2022 69/1-8](#)

¹⁴⁵ [HOM006052_024](#) paras 7.1.35-7.1.36

¹⁴⁶ [HOM006052_010](#) para 6.2.3

¹⁴⁷ [HOM002725_015](#) para 6.2.6; [HOM002725_032](#) para 7.1.1; [Helen Wilkinson 24 March 2022 84/9-11](#)

¹⁴⁸ [HOM002725_015](#) para 6.2.6; [HOM002725_032](#) para 7.1.1

abuse.¹⁴⁹ In any event, Mr Fagbo was in fact dismissed for verbal abuse, as discussed in Chapter D.9. Ms Wilkinson accepted that this was important to know and would have affected her decision regarding D687's allegations against Mr Fagbo.¹⁵⁰ Ms Wilkinson also knew that DCM Stephen Webb left G4S after admitting to making three inappropriate comments to a detained person.¹⁵¹ Despite this, she did not appear to take these matters into account as evidence supportive of D687's allegations of verbal abuse, and instead relied on specific dates and times of incidents not being provided as a basis for finding the allegation unsubstantiated.¹⁵² In my view, this set too high a bar for substantiating an allegation. Given the seriousness of the allegations she was investigating, as Ms Wilkinson accepted, she should have considered the nature of the allegations in the round when investigating complaints of verbal or racist abuse.¹⁵³

49. Also of concern was the fact that the Inquiry identified failures to look for potentially supportive evidence and a tendency to afford unequal weight to the evidence of staff and detained people.

49.1 Following allegations by D687 (discussed above), the investigating officer asked members of G4S staff (DCOs, DCMs and Healthcare) and staff from Forward Trust, a substance misuse charity, whether they had witnessed verbal or racist abuse, which they denied. These denials were not challenged by the investigating officer. She did not ask other detained people whether they had ever experienced racist comments from members of staff.¹⁵⁴ She also did not take into account the racist comments and verbal abuse shown on the *Panorama* programme, despite the investigation occurring some months after it was broadcast.¹⁵⁵ The PSU subsequently concluded that allegations were unsubstantiated.¹⁵⁶

49.2 In relation to D687's allegation that he had been pushed into his cell from the outside, the PSU concluded:

*"Given that [D687] said these two DCOs had called for assistance and four other DCOs had attended, I am satisfied that if this had occurred then one of these staff would have reported it."*¹⁵⁷

¹⁴⁹ [HOM002725_015](#) para 6.2.6; [HOM002725_032](#) para 7.1.1

¹⁵⁰ [Helen Wilkinson 24 March 2022 84/9-21](#)

¹⁵¹ [HOM002725_032](#) para 7.1.4; [Helen Wilkinson 24 March 2022 85/16-19](#)

¹⁵² [Helen Wilkinson 24 March 2022 88/5-89/2](#)

¹⁵³ [Helen Wilkinson 24 March 2022 80/21-24, 88/16-89/2](#)

¹⁵⁴ [Helen Wilkinson 24 March 2022 77/6-78/1](#)

¹⁵⁵ [Helen Wilkinson 24 March 2022 78/2-79/14](#)

¹⁵⁶ [HOM002725_032](#) para 7.1.3

¹⁵⁷ [HOM002725_033](#)

In my view, this assertion showed naivety and a lack of rigour. The investigating officer, Ms Wilkinson, subsequently accepted – “on reflection” – that she should have been “a bit more cynical” about this evidence.¹⁵⁸

- 49.3** When the investigating officer was considering the allegations of verbal abuse and assault against Mr Murphy by D1747 (discussed above), he did not consider the *Panorama* programme broadcast one week earlier for potentially supportive evidence. Instead, he found the allegation to be unsubstantiated, concluding that Mr Murphy’s:

*“experience as a DCO lends further credence to his assertion that he recognises the difference between nervous shouting and true anger and aggression. Available evidence supports his conviction that [D1747] constituted a threat and [Mr Murphy] was justified in pushing him.”*¹⁵⁹

- 49.4** In contrast, in an investigation into D2953’s allegations of assault also against Mr Murphy (discussed above), the investigating officer took into account Mr Murphy’s conduct as shown on the *Panorama* programme.¹⁶⁰ This was a good example of the PSU looking more widely for supportive evidence.

50. There were also examples of irrelevant considerations being taken into account. For example, when considering allegations that D687 had been verbally abused by staff, the investigating officer took account of the fact that D687 had been verbally abusive towards staff.¹⁶¹ It is difficult to see how this was relevant to the conduct of the staff.¹⁶²

51. It is particularly concerning that there was a tendency to find that use of force was justified. As a result, complaints about unjustified or excessive force were usually found to be unsubstantiated, unless there was video footage showing otherwise.

- 51.1** In relation to the use of force against D687 on 13 May 2017, also discussed in Chapter C.5 in Volume I, the PSU concluded that the restraint was reasonable, necessary and proportionate.¹⁶³ Despite noting that Mr Daniel Haughton (G4S Support Services Manager during the relevant period) had stated that his intention had not been to use force but only to remove the ligature, the investigating officer concluded that

¹⁵⁸ [Helen Wilkinson 24 March 2022 91/15](#)

¹⁵⁹ [HOM003522_017](#) paras 7.3.13-7.3.14

¹⁶⁰ [CJS001506_035](#) para 7.1.12. Mr Khan was supportive of this ([Mohammed Khan 24 March 2022 30/9-11](#))

¹⁶¹ [HOM002725_038](#)

¹⁶² [Helen Wilkinson 24 March 2022 89/9-90/5](#)

¹⁶³ [HOM002725_045-046](#) paras 7.5.37-7.5.42

the force used was necessary.¹⁶⁴ The Inquiry's use of force expert, Mr Jonathan Collier, concluded that force was not used as a last resort.¹⁶⁵

- 51.2** D1527 alleged unlawful use of force on 4 May 2017. Ms Galvin, the PSU's investigating officer, concluded that use by DCM Michael Yates of pain control (or a pain-inducing technique, discussed in more detail in Chapter C.4 in Volume I and Chapter D.7) was justified on the basis that CCTV supported his account of the level of disruption at that time.¹⁶⁶ In his evidence to the Inquiry, Mr Collier set out the limited circumstances in which pain-inducing techniques may be justifiable, and concluded that there was no evidence to suggest that *"there was such risk or such potential risk to staff or risk of harm that it was justified"*.¹⁶⁷
- 51.3** In relation to D2054's allegations of excessive use of force when being moved from his cell to Reception, the PSU concluded in the September 2017 investigation report that force was reasonable, necessary, proportionate and applied using approved techniques.¹⁶⁸ As Mr Collier noted, handcuffs were applied to D2054 when he was in the seated position.¹⁶⁹ This technique was removed from the training syllabus in 2015 due to concerns about its safety.¹⁷⁰ Mr Collier also noted that staff should have given consideration to removing their Personal Protective Equipment once initial control had been achieved, and that they could have de-escalated the situation by removing the head support position. He therefore concluded that continued use of force was not necessary or proportionate.¹⁷¹
- 51.4** In contrast to Mr Collier's expert evidence to the Inquiry, the PSU's investigation into D1234's complaints about the use of force against him did not conclude that an incorrect technique was used to carry D1234, that his head was pushed downwards or that there was an incorrect application of the handcuffs.¹⁷² Nor did it address the inappropriate wearing of a balaclava by Mr Murphy during the restraint. Instead, the investigation relied on the overall conclusion of the expert evidence from the National Tactical Response Group that the force used was

¹⁶⁴ [HOM002725_020](#) para 6.4.8

¹⁶⁵ [INQ000111_059](#) para 238

¹⁶⁶ [CJS001107_030](#) para 7.88

¹⁶⁷ [Jonathan Collier 30 March 2022 135/10-136/8](#)

¹⁶⁸ [CJS005991_023](#)

¹⁶⁹ [INQ000111_075](#) para 300

¹⁷⁰ [INQ000111_044](#) para 166; [INQ000111_075](#) para 300; [INQ000111_158](#) para 662

¹⁷¹ [INQ000111_075](#) para 301

¹⁷² As discussed in Chapter C.2 in Volume I (see also [INQ000111_037-044](#); [Jonathan Collier 30 March 2022 50/15-56/10, 71/24-73/1](#))

reasonable, proportionate and justified in the circumstances.¹⁷³ It is concerning that, although it noted that handcuffing behind the back when seated had been removed from Home Office approved techniques, the investigation went on to justify its use on D1234, stating: “*due to your continued resistance and non-compliance the video evidence showed that the officers struggled to apply approved locks on your arms*”.¹⁷⁴ This finding shows a lack of either understanding or recognition of the reason why this handcuffing technique should not be used. As the organisation responsible for investigating such serious incidents, the PSU’s finding on this issue is worrying.

As these examples demonstrate, some investigating officers did not have the depth of understanding or expertise to examine these allegations of excessive use of force in any meaningful way. Investigators had the option of seeking expert advice if necessary, but in the cases reviewed by the Inquiry they rarely did so.

Communication of outcomes

52. In most cases, the report detailing the outcome of a PSU investigation would be sent to DES and a separate, shorter letter would be sent to the complainant.¹⁷⁵ Ms Wilkinson, for example, did not know the reasons for having two separate documents.¹⁷⁶ Having a separate report and letter – where the letter truncates a full report – poses a risk that the complainant will not know the full basis for the decision. It also reduces the transparency of the investigation process and therefore potentially affects complainants’ confidence in that process. In my view, full reports should be sent to complainants (and their solicitors if applicable). Mr Khan also saw merit in this idea and indicated that it would be considered.¹⁷⁷

53. The Inquiry also received evidence about an outcome letter being amended by the Home Office before being sent. Ms Wilkinson drafted an outcome letter to be sent to D668, but sent it in draft to the DES team for them to send to him (as occurred in cases in which the investigation was commissioned by the Home Office). Two paragraphs at the end of the draft letter were unfinished, relating to policy issues on the use of the new psychoactive substance known as ‘spice’, Rule 35 of the Detention Centre Rules 2001 (regarding medical reports), toilet facilities, lock-up, and control of drugs coming into Brook House.¹⁷⁸ Ms Wilkinson said that she was anticipating others finalising those paragraphs before sending them out, but in fact the

¹⁷³ [HOM002750_031-032](#) para 7.2.21

¹⁷⁴ [CAP000519_002](#)

¹⁷⁵ [HOM0331946_013](#) para 29

¹⁷⁶ [Helen Wilkinson 24 March 2022 101/13-25](#)

¹⁷⁷ [Mohammed Khan 24 March 2022 17/21-19/14](#)

¹⁷⁸ [HOM002747_018](#)

paragraphs were removed before the letter was sent to D668's solicitors by DES in April 2018.¹⁷⁹ Mr Khan said he was not happy in principle with somebody taking out paragraphs or inserting them into a letter issued in the PSU's name.¹⁸⁰ I agree. It risks undermining the independence of the PSU.

54. There was also an example of an outcome being shown to G4S before being sent to a complainant. Once Ms Rafique had decided to find D2953's complaints substantiated in March 2018, she emailed the report to Mr Ian Castle (Home Office DES Area Manager for Brook House and Tinsley House IRC (Gatwick IRCs)) and then to Ms Michelle Smith (Home Office Service Delivery Manager for Gatwick IRCs during the relevant period) to enable them to give "*advance warning*" of the outcome to Mr Lee Hanford (Interim Director of Gatwick IRCs) "*so that they can make any necessary contingency arrangements if required*".¹⁸¹ The PSU did not agree to the report itself being shared with G4S, on the basis that this was not the purpose of giving advance notice.¹⁸² Despite this, G4S did in fact have sight of the report before it was sent to D2953.¹⁸³

55. Where an investigation had been commissioned by the Home Office (as was the case with the complaints made, for example, by D668, D687, D1527 and D1538), the outcome letter was sent to the complainant by DES rather than by the PSU investigator.¹⁸⁴ In the Home Office's Closing Statement, the PSU accepted that the way these letters were provided "*may have given the wrong appearance that Detention & Escorting Services were involved in the investigatory process*".¹⁸⁵ Such situations also increase the risk of compromising the independence of the PSU.

56. Overall, it is crucial that allegations of serious misconduct are referred to the PSU promptly and that adequate investigations are carried out, which reach robust and accurate conclusions. If this does not happen, there is a risk that staff who have been responsible for serious misconduct may remain in their roles and potentially cause further harm to detained people.

57. A number of concerning themes arose from the PSU's investigations, spanning the investigation process, the decision-making process and the communication of outcomes. These are likely to reflect, at least in part, the inadequate training of investigators. I am therefore recommending steps to improve the quality of investigations conducted by the PSU.

¹⁷⁹ [HOM0332047_016](#) para 50; [Helen Wilkinson 24 March 2022 102/15-104/19](#); [HOM0332165_057-058](#) para 186

¹⁸⁰ [Mohammed Khan 24 March 2022 25/10-14](#)

¹⁸¹ [HOM005200_003](#)

¹⁸² [Mohammed Khan 24 March 2022 22/18-20](#)

¹⁸³ [HOM005200_001](#)

¹⁸⁴ [HOM0331946_014](#) para 31; [HOM0332047_004](#) para 17 (see [VER000031](#))

¹⁸⁵ [HOM0332165_057](#) para 185

Recommendation 29: Improving investigations by the Home Office Professional Standards Unit

The Home Office must update Detention Services Order 03/2015: Handling of Complaints to clarify that, in investigations carried out by the Professional Standards Unit into allegations of serious misconduct against contractor staff:

- Professional Standards Unit investigators must carry out interviews themselves and not rely on contractors to do so.
- All staff against whom allegations are made must be invited to interview.
- Where there are inconsistencies between any accounts given of events, any evidence relating to those accounts (including footage and documentation) obtained by an investigating officer must be shown to the complainant and to the subject of the complaint prior to reaching a conclusion.
- The Professional Standards Unit must be given information about previous complaints made against alleged perpetrators, including unsubstantiated complaints.
- Previous disciplinary action against alleged perpetrators must be taken into account.
- Investigators must look for evidence that is both supportive and undermining of the complaint.
- Full reports must be sent to complainants (and their solicitors if applicable).
- Investigation reports and/or outcome letters must be sent directly from the Professional Standards Unit to complainants (and their solicitors if applicable).

The Home Office Professional Standards Unit must ensure that training about the updated guidance takes place on a regular (at least annual) basis for staff dealing with investigations, as well as those responsible for managing them. The training must be subject to an assessment.

The Professional Standards Unit must also review the training provided to investigators and ensure that investigators receive regular and adequate training, from a variety of perspectives, on issues including:

- the nature of immigration removal centres and issues that may arise;
- obstacles that detained people may face in making complaints;
- interviewing vulnerable witnesses; and
- use of force and assessing reasonableness of force.

The independence of the Home Office Professional Standards Unit

58. Given that its role is to investigate serious misconduct complaints, the independence of the PSU is therefore important for creating a fair process that detained people can have confidence in and that reaches reasonable decisions based on all the evidence.

59. The PSU is the responsibility of the Home Secretary, who is also responsible for IRCs. Despite this, the PSU asserted that it is independent from DES, pointing out that the PSU sits in a different division, under a different senior manager.¹⁸⁶ In a joint Closing Statement to the Inquiry, the Home Office and the PSU said:

“Whilst the Home Office is content to address issues relating to the PSU in this Closing Statement, it is vital to note that the PSU is independent from Immigration Enforcement.”¹⁸⁷

60. Although the Inquiry did not see any evidence of PSU decision-making being improperly influenced by the Home Office, there may be a reasonable perception held by detained people or formerly detained people that the PSU was not and arguably still is not independent.¹⁸⁸ This was compounded by the way in which the outcome of some PSU investigations was communicated, as discussed above. Some of my general concerns about PSU investigations, particularly the tendencies not to seek potentially supporting evidence and not to afford equal weight to evidence from staff members and detained people, may have been, albeit not consciously, affected by the fact that the PSU was part of the Home Office. Additionally, the Head of the PSU is a Grade 7 civil servant.¹⁸⁹ This is considerably more junior than the Heads of the relevant Home Office Immigration Enforcement teams. This may give the perception that the Home Office places insufficient importance on the role of the PSU.

61. There was a reasonable perception that the PSU was insufficiently independent from the Home Office to carry out its role in investigating serious misconduct complaints. I am therefore recommending improvements to enhance its independence.

¹⁸⁶ [Mohammed Khan 24 March 2022 5/6-10](#); [HOM0332165_055](#) para 178; [HOM0331946_002](#) para 5. The relevant senior manager is called a Director General

¹⁸⁷ [HOM0332165_055](#) para 178

¹⁸⁸ See the Closing Statement from Bhatt Murphy, legal representatives to a number of Core Participants, Brook House Inquiry, 3 May 2022 ([BHM000046_148-149](#) para 370). In administrative law, the determination of whether decision-making bodies are sufficiently independent is of “*apparent bias*” as opposed to actual bias, based at least partly on the fact that a perception of apparent bias may deter people from bringing complaints or cause them to lose trust in the complaints process. The test is whether the fair-minded and informed observer would conclude that there was a real possibility of bias (see [Magill v Porter \[2001\] UKHL 67](#))

¹⁸⁹ [HOM0331946_002](#) para 3; [HOM0332155_001](#) paras 1-3

Recommendation 30: Improving the independence of the Home Office Professional Standards Unit

The Home Office must:

- take steps to enhance the independence of the Professional Standards Unit from the Home Office and the perception of this independence; and
- increase the seniority of the Head of the Professional Standards Unit so that they are closer in status to the Heads of the relevant Home Office Immigration Enforcement teams.

Home Office Professional Standards Unit recommendations and lessons learned

62. Investigating officers included a range of recommendations at the conclusions of their reports. These included the following:

- G4S and DES should ensure that the complaints-handling process is sufficiently robust.¹⁹⁰
- Staff should be reminded of their responsibilities when a complaint is raised with them and when they are alerted to relevant allegations.¹⁹¹
- Accurate reports regarding use of force should be produced and thoroughly checked, as well as consideration given to who needs to complete incident reports.¹⁹²
- Body worn cameras should be used and the footage obtained from incidents monitored.¹⁹³
- Alternatives should be thoroughly explored prior to planning for use of force on individuals other than the main subject (eg a cell mate).¹⁹⁴
- Planned uses of force should be subject to a full and independent risk assessment, including a request for relevant health conditions.¹⁹⁵

63. These recommendations, along with the response of the Home Office and its contractors, and the status of that response, were recorded by DES on

¹⁹⁰ [CJS001506_036](#) para 8.1.3

¹⁹¹ [CJS001506_036](#) para 8.1.4; [HOM002748_045](#)

¹⁹² [HOM002725_048](#); [CJS005991_027](#); [CJS001107_042](#) paras 9.25-9.27; [HOM002725_049](#); [HOM0332029](#) row 41

¹⁹³ [HOM002725_049](#); [CJS001107_041-042](#) para 9.20

¹⁹⁴ [HOM0332029](#) row 28

¹⁹⁵ [HOM0332029](#) row 29

a 'Lessons Learned' spreadsheet.¹⁹⁶ The Inquiry was told that, from late 2019, the DES Audit and Assurance Team (DESAAT) took over the Lessons Learned role and has been collating recommendations arising out of PSU investigations and checking on the progress being made in implementing them.¹⁹⁷

64. The breadth and depth of the recommendations made by the PSU in relation to these investigations were impressive. The fact that most of them were implemented, though some only partially, is positive.¹⁹⁸

65. However, the extent to which those lessons were disseminated to staff at Brook House by either G4S or the Home Office is unclear, and in some cases it evidently did not happen. For example, DCM Shane Farrell was not spoken to after a recommendation was made relating to his failure to switch on his body worn camera and the need for officers to be reminded of the G4S policy on body worn cameras and monitored to ensure that they were wearing and utilising them.¹⁹⁹

66. Additionally, I have seen little evidence to suggest any more holistic consideration by the Home Office of the lessons to be learned from investigation reports, as opposed to the simple tracking of each individual recommendation. This was a missed opportunity to consider patterns relating to complaints and to address the underlying issues causing them. It would have been helpful for there to be, for example, a regular meeting at which the Home Office analysed patterns and themes arising from the PSU's findings and recommendations in relation to IRCs and considered whether any broader changes were required. The Home Office described a Borders, Immigration and Citizenship System Complaints and Correspondence Steering Group – formed in 2019 to share good practice, improve performance and drive quality standards – addressing recommendations made by the Independent Chief Inspector of Borders and Immigration (ICIBI).²⁰⁰ However, the Inquiry received no evidence of any output from it, and it is unclear whether it is supposed to deal with PSU recommendations.

67. There also appears to have been very little external oversight of the PSU's complaint investigations (unless a complainant chose to appeal), or of the Home Office's response to the findings and recommendations made within them, during the relevant period. The ICIBI has conducted at least three inspections into the Home Office's handling of complaints.²⁰¹ However, these did not cover complaints of serious misconduct or those about healthcare in

¹⁹⁶ [HOM0332029](#)

¹⁹⁷ [HOM0331998_008](#) para 30

¹⁹⁸ [HOM0332029](#) rows 29 and 31; [HOM0332040](#)

¹⁹⁹ [Shane Farrell 8 March 2022 110/13-17, 128/3-11](#)

²⁰⁰ [HOM0331998_010](#) para 40

²⁰¹ [HOM0331998_008](#) para 31

IRCs.²⁰² Further detail regarding monitoring and oversight of complaint processes by external bodies such as HMIP and the IMB is considered in Chapter D.11.

Whistleblowing

68. The term ‘whistleblowing’ commonly refers to employees raising concerns about wrongdoing within an organisation.²⁰³ The whistleblowing process in place at Brook House during the relevant period was G4S’s global whistleblowing system called ‘Speak Out’. However, in this Report, the Inquiry refers to whistleblowing to encompass all instances of staff raising serious concerns about issues at Brook House.

69. According to G4S’s whistleblowing policy, employees were “*strongly encouraged*” to report concerns about serious wrongdoing via a free telephone number or website, or to a manager.²⁰⁴ Initial complaints were triaged by an independent company, but the way in which this was organised was problematic (as discussed below).²⁰⁵ Additionally, the identity of this independent company and on what basis that company decided whether “*an investigation is required*” were unclear to the Inquiry.²⁰⁶ G4S said that any concerns raised via this process were investigated by a senior member of G4S staff outside of local reporting lines, and reviewed on a monthly basis by the Divisional Ethics Committee, which included Mr Peter Neden (G4S Regional President UK and Ireland during the relevant period).²⁰⁷

Responses to concerns

70. When concerns were raised, whether using the whistleblowing process or otherwise, there was often an inadequate response.

70.1 For example, Ms Stacie Dean (Head of Tinsley House) raised concerns (prior to the relevant period) about two members of staff bullying detained people.²⁰⁸ Neither of these individuals appear to have faced any

²⁰² *An Inspection of the Handling of Complaints and MP’s Correspondence by the Home Office Borders, Immigration and Citizenship System (BICS) February-May 2019*, Independent Chief Inspector of Borders and Immigration, July 2020, para 1.3

²⁰³ The legal definition of a ‘qualifying disclosure’ is set out within section 43B of the [Employment Rights Act 1996](#). If a worker makes such a disclosure to his employer or in certain other circumstances, as discussed below, they will be protected from dismissal or other negative treatment carried out because of that disclosure (see sections 43C-H, 47B and 103A)

²⁰⁴ [CJS000707](#)

²⁰⁵ [CJS0074040_026](#) para 142

²⁰⁶ [CJS0074041_028](#) para 131

²⁰⁷ [INQ000119_022](#) para 99; [CJS0074047_031](#) para 167

²⁰⁸ [CJS0073632](#); [CJS0073633_004-005](#); [CJS0073677_001-002](#)

disciplinary investigation in relation to these allegations, and the outcome logged by G4S did not address this complaint.²⁰⁹

70.2 Additionally, a small number of cases were logged as Speak Out investigations – despite the complaint not coming from a member of staff – including allegations of staff assaulting detained people²¹⁰ and bringing drugs into Brook House.²¹¹ The Inquiry saw no adequate investigation in any of these cases.

71. There were also instances where senior staff said that they raised concerns and received an inadequate response from the SMT, for which there was insufficient documentary evidence for me to reach a conclusion. Ms Dean told the Inquiry that she and Ms Brown had raised concerns about staff treatment of detained people and that the SMT was “*consistently uninterested*”.²¹² Similarly, Ms Brown said:

*“I investigated and substantiated several complaints regarding staff bullying each other, staff bullying Detainees, displaying racist and inappropriate conduct – dating back as far as 2012 but there was little/no outcome. I continued to raise concerns with Ben Saunders and Steve Skitt. I did not see an improvement and as previously disclosed in my statement, I used the Whistleblowing hotline to report.”*²¹³

Mr Ben Saunders, Centre Director for Gatwick IRCs during the relevant period, told the Inquiry, “*if [Ms Brown] or anybody else had raised concerns about staff treatment of detainees not being as we would expect it to [be], then we would have investigated that*”.²¹⁴

The extent of whistleblowing

72. Also of concern to the Inquiry was the extent of whistleblowing. From the perspective of most organisations, the ideal level of whistleblowing is inevitably a middle ground – too much may suggest that there are numerous problems, and too little may suggest that staff do not feel comfortable raising concerns. This was helpfully described by Mr Neden:

²⁰⁹ [CJS0073631_001](#)

²¹⁰ [HOM032609](#); [CJS0073631_002-003](#)

²¹¹ [CJS0073688](#); [CJS0073631_004-005](#)

²¹² [INQ000172_003](#) paras 8-9

²¹³ [INQ000164_057](#) para 119. The occasion when Ms Brown used the whistleblowing hotline appears to have been in 2016 and involved her reporting allegations of bullying behaviour towards staff ([INQ000164_016-017](#) para 25). This does not appear to have related to the treatment of detained people or been recorded as a Speak Out complaint.

²¹⁴ [Ben Saunders 22 March 2022 140/8-11](#)

“In some ways, an active whistleblowing line is a sign of a healthy culture, where people feel they can raise concerns. If you look at it another way, it is a sign of a certain degree of management failure, where those concerns aren’t just raised in the normal day-to-day running of business.”²¹⁵

73. Looking at Brook House specifically, from the evidence provided to the Inquiry, the number of whistleblowing cases is not entirely clear.²¹⁶ None were logged during the relevant period.²¹⁷ There were examples from outside the relevant period of staff raising concerns about issues such as staffing levels, bullying by senior managers, a lack of support from management and inappropriate engagement between a DCO and a detained person.²¹⁸

74. Some members of staff said that if they had heard or seen anything inappropriate, they would have reported it.²¹⁹ I have seen little evidence to suggest that there was a culture or practice of reporting colleagues for inappropriate behaviour towards, or poor treatment of, detained people. Moreover, some of those who made this assertion were recorded as being present when inappropriate things were being said or done and, in fact, did not report them.²²⁰

75. In any event, a large number of staff at Brook House witnessed inappropriate behaviour during the relevant period but did not use Speak Out or any other process to raise concerns about that behaviour.²²¹ This was in breach of their obligations under the Detention Centre Rules 2001 to inform the manager of Brook House and the Home Secretary promptly of “any abuse or impropriety” that came to their knowledge.²²²

76. There were several possible reasons for staff failing to raise concerns, some of which echo the reasons why detained people did not complain.

²¹⁵ [Peter Neden 22 March 2022 8/20-9/1](#)

²¹⁶ [INQ000119_016](#) para 67; [INQ000119_023](#) para 105; [CJS0074041_028](#) para 132

²¹⁷ [CJS0073631](#)

²¹⁸ [CJS0073631](#). See an anonymous complaint in 2016 ([CJS0073631_001](#)); a complaint by DCO David Waldock in early 2017 ([CJS0072826](#); [CJS0072913](#); [VER000061](#); [CJS0073634_004-007](#); [Peter Neden 22 March 2022 59/15-60/4](#)); an anonymous complaint ([CJS0073631_004](#)); and a complaint by DCO Tamzine McMillan in October 2017 ([CJS0073683](#))

²¹⁹ [Ryan Bromley 7 March 2022 125/22-23](#); [Aaron Stokes 9 March 2022 191/19-192/4](#); [Shayne Munroe 4 March 2022 18/7-15](#)

²²⁰ For example, DCO Ryan Bromley was present during the incident between Mr Farrell and D1538, and described it to Mr Tulley, saying, “He took his head clean off” ([TRN0000091_006](#)). He was also present when Mr Sayers described assaulting D313 (see [TRN0000093_031](#) and [Day 25 PM 7 March 2022; 00:29:20-00:31:03 \(KENCOV1036 - V2017061500019\)](#)). He did not report either of these incidents (see [Ryan Bromley 7 March 2022 128/22-129/9](#), [138/21-139/12](#))

²²¹ See [Closing Statement on behalf of G4S](#), Brook House Inquiry, 3 May 2022, para 136; [INQ000052_042](#) paras 167-168

²²² [Detention Centre Rules 2001](#), Rule 45(2)

- 76.1 Lack of awareness:** Some staff members said that they were not made aware of the Speak Out process during their initial training.²²³ Mr Fiddy did not know what Speak Out was when asked about it.²²⁴ DCO Callum Tulley said that he only came to know about it during a staff meeting held after the *Panorama* programme about Medway Secure Training Centre, broadcast in January 2016.²²⁵ Those who were not present at that staff meeting, or who joined G4S afterwards, might have been unaware of the process unless they were told about it during their training. Mr Jeremy Petherick, Managing Director of G4S Custodial and Detention Services during the relevant period, said in his statement to the Inquiry that he thought people were “*either unaware or nervous*” of using the whistleblowing process.²²⁶
- 76.2 Fear of repercussions from colleagues:** There was also a fear of reaction from colleagues. Mr Owen Syred, a DCO and Welfare Officer during the relevant period, said that he did not report witnessing Mr Murphy allegedly punching a detained person in the face because he thought he would be ostracised again, having faced abuse and harassment when he reported a colleague’s racist language in 2014.²²⁷ Several DCOs said that they would not raise concerns or report incidents because they feared being labelled a “*grass*”,²²⁸ being bullied²²⁹ or Brook House being made an “*awkward place to work*”.²³⁰ DCO Daniel Small said that this was a reason he did not report DCO John Connolly telling staff that they should drag D275 around the corner and beat him up.²³¹ When Speak Out posters were defaced with graffiti saying ‘snitches’ and ‘don’t be a rat’,²³² G4S did not take reasonably prompt action to remedy this, and the posters remained up for months.²³³
- 76.3 Culture of not ‘grassing’:** The Inquiry heard evidence of a culture of not ‘grassing’ or ‘snitching’. Two former staff members said that after reporting or challenging colleagues, they were called “*a snitch, a grass*” and a “*rat*”.²³⁴ DCO Daniel Lake thought that there was a culture of not

²²³ [Callum Tulley 29 November 2021 77/24-80/4](#); [Callum Tulley 30 November 2021 10/11-16](#); [Owen Syred 7 December 2022 121/12-123/6](#)

²²⁴ [Edmund Fiddy 7 March 2022 158/12-14](#)

²²⁵ [INQ000052_013 para 58](#); [Callum Tulley 29 November 2021 78/15-21](#)

²²⁶ [CJS0074047_031 para 168](#)

²²⁷ [Owen Syred 7 December 2022 117/3-20, 121/2-11, 126/10-14](#)

²²⁸ [Daniel Small 28 February 2022 112/15-113/6](#)

²²⁹ [INQ000052_018 para 75](#)

²³⁰ [Daniel Lake 1 March 2022 7/11-8/2](#)

²³¹ [Daniel Small 28 February 2022 158/10-164/10](#); [BDP000003_015-016](#)

²³² [Callum Tulley 29 November 2021 79/16-19](#)

²³³ [Callum Tulley 30 November 2021 9/15-23](#); [Ben Saunders 22 March 2022 138/7-16](#)

²³⁴ Assistant Custody Officer Stewart Davis ([VER000260_006](#)) and DCO Kye Clarke ([INN000012_013-014 para 52](#))

*“grassing” or “snitching” on fellow officers, and accepted that he fed into this culture, having not reported racist comments by Mr Small and having not reported Mr Murphy for an alleged “upper cut” to a detained person, because “reporting never happened in Brook House”.*²³⁵ Mr Instone-Brewer was recorded saying to Mr Tulley, *“No-one likes a snitch”,* and said he was aware of that as a culture.²³⁶ Mr Tulley also attributed staff bragging about *“the faith that they had in the culture of silence which allowed the abuse to persist because they knew staff would never complain”.*²³⁷

- 76.4 Fear of consequences for career:** There was some evidence to suggest that staff feared consequences for their own career for whistleblowing, such as being excluded from progression at Brook House or being *“pushed out”* of their job altogether.²³⁸ Several members of staff stated that they feared being targeted by managers if they reported wrongdoing.²³⁹
- 76.5 Lack of confidence:** The 2018 Verita report noted that staff had a lack of confidence or trust in reporting concerns.²⁴⁰ This was supported by Mr Tulley, who told the Inquiry that he did not follow advice to raise concerns with DCMs, because they were *“participating in the abuse”* and therefore it would be *“fruitless”*.²⁴¹ He did not go to the SMT because its members had close relationships with those DCMs, and he described a *“culture in Brook House which was so hostile to whistleblowing”*.²⁴² Mr Syred had a lack of trust in the whistleblowing process.²⁴³
- 76.6 Normalisation of inappropriate behaviour:** There was also evidence to suggest the presence of what was described by Professor Mary Bosworth (the Inquiry’s cultural expert) as an *“extensive normalisation of inappropriate ways of talking about people and acting towards the detained population”*.²⁴⁴ For instance, Mr Lake said he was not alarmed by a racist comment made by Mr Small because *“it was normal”*.²⁴⁵ In my view, the environment at Brook House did not encourage staff to report their concerns.

²³⁵ Daniel Lake 1 March 2022 47/14-19, 50/18-20, 54/11-16; BDP000002_016 para 49

²³⁶ TRN0000099_002-004; Luke Instone-Brewer 8 March 2022 69/9/13

²³⁷ INQ000052_042 paras 167-168; Callum Tulley 30 November 2021 23/11-24/15

²³⁸ DL0000141_105 paras 303-304; DL0000142; INQ000052_017 para 73; Callum Tulley 30 November 2021 1/24-7/16, 19/22-20/6; TRN0000065_005

²³⁹ VER000265_013; VER000254_028; VER000269_023

²⁴⁰ CJS0073709_030 para 1.135

²⁴¹ Callum Tulley 29 November 2021 78/1-3; Callum Tulley 30 November 2021 16/24-17/9, 24/3-15

²⁴² INQ000052_018 para 75

²⁴³ Owen Syred 7 December 2022 121/12-123/6

²⁴⁴ Professor Mary Bosworth 29 March 2022 81/11-17

²⁴⁵ Daniel Lake 1 March 2022 47/3

- 76.7 ‘Us and them’ culture:** As discussed in Chapter D.9, there was a pervasive culture of ‘us and them’, which led to junior staff relying on one other ‘against’ detained people. Staff formed a “*close-knit team*” when working in a challenging environment,²⁴⁶ which likely operated as a disincentive to reporting colleagues.
- 77.** One consequence was that some staff appear to have seen themselves as “*powerless*” to report abuse.²⁴⁷ While I do not agree that they were in fact powerless, this perception may have acted as a barrier.
- 78.** There was also a lack of understanding about the willingness of staff to use the processes in place and the reasons why they might not do so.
- 78.1** I was not impressed by the complacency of Mr Gordon Brockington (Managing Director of Justice and Government Chief Commercial Officer at G4S) when he said that staff “*chose not to use*” the whistleblowing process and stated, “*I can’t conclude as to why that happened.*”²⁴⁸ The possible reasons listed above for why staff did not raise concerns are not novel, nor are they difficult to ascertain. If Mr Brockington and G4S were not aware of these reasons during the relevant period, they certainly should have been aware of them by the time Mr Brockington gave evidence to the Inquiry.²⁴⁹
- 78.2** G4S asserted that Mr Tulley’s explanation for failing to use the Speak Out process (that posters had been vandalised) was “*not a plausible or cogent explanation*” because “*a significant number of other staff at Brook House felt able to utilise the ‘Speak Out’ whistleblowing process*”.²⁵⁰ This mischaracterises Mr Tulley’s evidence, which included various reasons for not reporting matters, and ignores that a large proportion of staff were clearly dissuaded. G4S also failed to provide any alternative explanation for the failures of staff to raise concerns about the treatment of detained people, including through the Speak Out process.
- 78.3** Mr Saunders and Mr Neden both suggested that Mr Tulley – and other staff – should have reported through appropriate processes.²⁵¹ Mr Saunders added that Mr Tulley might have acted for financial gain, and that “*he placed the safety and welfare of detained persons at*

²⁴⁶ [Stephen Loughton 1 March 2022 136/7-138/5](#); see also [INQ000001](#)

²⁴⁷ [Closing Statement on behalf of Charles Francis, Brook House Inquiry, 29 April 2022, para 99](#)

²⁴⁸ [Gordon Brockington 31 March 2022 51/5-52/17](#)

²⁴⁹ By this time, Verita had reported on some of the reasons in 2018, multiple staff members had explained their reasons in evidence to the Inquiry and Mr Brockington was aware of the defacing of Speak Out posters ([Gordon Brockington 31 March 2022 56/8-21](#))

²⁵⁰ [Closing Statement on behalf of G4S, Brook House Inquiry, 3 May 2022, para 136](#)

²⁵¹ [KEN000003_012 paras 63-64](#); [Ben Saunders 22 March 2022 136/10-137/1](#); [Peter Neden 22 March 2022 65/1-4](#)

risk".²⁵² Mr Tulley rejected both of these suggestions.²⁵³ Despite the events during the relevant period set out in this Report, Mr Tulley was the only staff member who raised concerns about the treatment of detained people. The fact that he did so is to his credit. In the circumstances, his decision to expose it via the media was a reasonable one.²⁵⁴

78.4 Mr Gasson told the Inquiry that he was surprised that the conduct shown on the *Panorama* programme was not raised by a whistleblower, because "*there are several instances where staff have raised concerns about the conduct of other staff and G4S were very quick to act in those instances*".²⁵⁵ Neither of these assertions were borne out by the evidence, and in light of the wider evidence suggesting that there was not a culture of reporting poor treatment of detained people, Mr Gasson should not have assumed that serious misconduct would be reported by other staff.

79. This shows a failure by some G4S senior staff, and also by the Home Office, to take full responsibility in this regard, as well as a continued defensiveness in relation to Mr Tulley's actions. However, in my view, the more significant issue was the structural and cultural failure – including in identifying and dealing with staff not having the confidence to report concerns – for which senior managers at G4S and the Home Office were responsible. This was reflected in a July 2018 report by Mr Stephen Shaw, a former PPO, in which he concluded that the whistleblowing policies used by G4S and other contractors were satisfactory, and that it was an issue of culture that was likely preventing staff from speaking out about wrongdoing. He recommended the development of 'safe spaces' where staff could reflect on what they had done well or where they had gone wrong, without fear of repercussions.²⁵⁶ Mr Neden accepted that "*There was clearly a failure in the whistleblowing system*" and that he was ultimately responsible for that failure.²⁵⁷

80. G4S's position was that the absence of concerns raised through the Speak Out process about inappropriate treatment did not mean that "*the policy was in any way lacking*".²⁵⁸ I do not accept this assertion. A failure of staff to report concerns in an institution is not inevitably due to an ineffective policy, but in this case it was a factor. As identified in the 2018 Verita report,

²⁵² [KEN000003_012](#) para 65

²⁵³ [Callum Tulley 9 March 2022 110/17-111/25](#)

²⁵⁴ Employees may make legally protected disclosures to the media (and other external bodies) in certain circumstances (see [Employment Rights Act 1996](#), section 43H(1)-(2))

²⁵⁵ [Paul Gasson 15 March 2022 218/7-219/3](#)

²⁵⁶ [Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons](#), Stephen Shaw, Cm 9661, July 2018, para 6.30

²⁵⁷ [Peter Neden 22 March 2022 64/15-20](#)

²⁵⁸ [CJS0074041_028](#) para 132

references to commercial wrongdoing and issues with senior staff undermined the policy's relevance to ordinary staff who may wish to raise issues about inappropriate behaviour.²⁵⁹ G4S should have had a more relevant policy for the detention environment that, for example, referred explicitly to the need to report concerns about the treatment of detained people and did not refer to things like "*price fixing*" and "*insider trading*".²⁶⁰ I do not think that this would have undermined the process or disincentivised reporting.²⁶¹

81. Even Mr Petherick and Mr Hanford were "*unimpressed*" with the process;²⁶² when they tried to use it to report bullying at Brook House, the whistleblowing line said "*we don't deal with that*".²⁶³ One member of staff reported that, when he asked about a UK call centre in front of Ms Lorraine Higgins (appointed as the Speak Out Champion at Brook House after the *Panorama* programme), she replied, "*now we know who the whistleblowers are*".²⁶⁴ There were also issues with the Speak Out call handlers having minimal understanding of English and not knowing of Brook House's existence.²⁶⁵

82. The whistleblowing processes in place during the relevant period were inadequate, ineffective and did not specifically relate to Brook House or IRCs. Most staff failed to raise concerns, some were unaware of the processes in place and there was an inadequate response to concerns that were raised.

Steps taken after the relevant period

83. Following the *Panorama* programme, G4S acknowledged that there was a need to build more trust in the whistleblowing process.²⁶⁶ However, the steps subsequently taken appeared to have been simpler ones to raise awareness, such as posters, contract cards and staff meetings, rather than substantive changes to build trust.²⁶⁷ An organisation might, for example, demonstrate its commitment to improving practices by actively encouraging staff to raise concerns and ensuring that they are not subject to management criticism if they do so. By contrast, G4S made a number of public criticisms of Mr Tulley, as discussed above.

84. HMIP's 2019 inspection report noted that all staff said they would report inappropriate behaviour.²⁶⁸ On the basis of the evidence to the Inquiry, this is not

²⁵⁹ [CJS0073709_225-226](#) paras 13.46-13.50

²⁶⁰ A similar point was made in the 2018 Verita report ([CJS0073709_225](#) para 13.48; [CJS0073709_225](#) para 13.50)

²⁶¹ This was contrary to the position set out in Mr Brockington's corporate statement ([CJS0074041_029-030](#) paras 140-142)

²⁶² [CJS0074047_031](#) para 168

²⁶³ [VER000239_027](#)

²⁶⁴ [VER000260_014](#)

²⁶⁵ [VER000260_014](#)

²⁶⁶ [IMB000026_002](#)

²⁶⁷ [CJS0073709_030](#) para 1.134; [CJS0074041_029](#) para 139

²⁶⁸ [HMIP000685_046](#) para 117

credible. In its 2022 inspection report, HMIP noted that, although processes for reporting concerns had been used since Serco took over Brook House in May 2020, “a sizeable minority of respondents to our staff survey said they would either not raise concerns about detainee welfare if they had them or were not sure if they would”.²⁶⁹ Only 14 per cent of staff who had raised concerns thought that effective action had been taken in response.²⁷⁰ It is important that those who manage Brook House are not complacent about the willingness of staff to report inappropriate behaviour and the adequacy of responses.

85. Separately, the Home Office’s DESAAT reviewed whistleblowing processes within the immigration detention estate in 2019.²⁷¹ It was noted that, in Brook House and other IRCs, improper conduct was not reported through the processes already in place. The team sought to understand why.²⁷² Various recommendations were made as part of the review, including the introduction of a whistleblowing DSO, the publication of an annual Lessons Learned whistleblowing bulletin and further examination by the Home Office of the reasons for staff having such low confidence in current whistleblowing processes.²⁷³ In July 2020, the Home Office introduced Detention Services Order 03/2020: Whistleblowing – The Public Interest Disclosure Act 1998.²⁷⁴ This stressed the requirement for staff in IRCs to report wrongdoing, explained why whistleblowing is important, sought to establish “*consistent overarching principles for reporting a concern about wrongdoing*” and set out the need for contractors to train staff on and promote these procedures.

86. While these changes are welcome, in my view they do not go far enough and do not address some of the specific concerns I have identified above. I am therefore recommending improvements to whistleblowing policies and processes.

²⁶⁹ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022, para 2.15

²⁷⁰ [2022 HMIP Brook House Staff Survey Q6.6](#)

²⁷¹ [HOM018708](#)

²⁷² [HOM018708_002-004](#)

²⁷³ [HOM018708_011-012](#)

²⁷⁴ [Detention Services Order 03/2020: Whistleblowing – The Public Interest Disclosure Act 1998](#), Home Office, July 2020

Recommendation 31: Improving the process for and response to whistleblowing

The Home Office must update Detention Services Order 03/2020: Whistleblowing – The Public Interest Disclosure Act 1998 to require contractors that run immigration removal centres to:

- have a whistleblowing policy and procedure that is specific to the immigration detention environment;
- ensure that the whistleblowing mechanism is not limited to a hotline and allows for anonymous reporting of concerns;
- ensure that those who receive whistleblowing concerns have an understanding of immigration removal centres;
- take active steps to encourage staff to use whistleblowing processes, for reasons including those set out at paragraph 10 of Detention Services Order 03/2020; and
- ensure that whistleblowing concerns are investigated thoroughly by someone external to the immigration removal centre, and that the Home Office is informed of the nature of the concern and the investigation carried out.

The Home Office must ensure that training about the updated guidance takes place on a regular (at least annual) basis for staff dealing with whistleblowing, as well as those responsible for managing them. The training must be subject to an assessment.

Chapter D.11:

Inspection and monitoring

Introduction

- 1.** Primary responsibility for the welfare of people detained at Brook House during the relevant period (1 April 2017 to 31 August 2017) and for compliance with rules and procedures lay with the Home Office and G4S.
- 2.** Scrutiny is provided by HM Inspectorate of Prisons (HMIP), which undertakes in-depth, periodic inspections of places of detention including immigration removal centres (IRCs).¹ Brook House was inspected in 2016 and 2019, but not during the relevant period. Volunteer boards (ie Independent Monitoring Boards or IMBs) undertake independent monitoring, reporting on the conditions in detention and the treatment of those detained.² HMIP and IMB, along with other organisations, form part of the UK National Preventive Mechanism (NPM), which was set up under the United Nations (UN) Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) to prevent inhuman treatment in places of detention.³ The NPM's duties and powers derive from ministerial statements to Parliament; it does not have any legislative footing. Formalisation of the NPM's position was recommended by the UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) during a visit to the UK in September 2019.⁴
- 3.** Neither the Independent Monitoring Board at Brook House (Brook House IMB) nor HMIP identified the abuses shown on the *Panorama* programme. It is unsurprising that they did not see overt abuse or inappropriate conduct. No

¹ [Prison Act 1952](#), section 5A

² The [Prison Act 1952](#) and the [Immigration and Asylum Act 1999](#) require every prison and IRC to be monitored by an independent board appointed by the Secretary of State from members of the community in which the establishment or IRC is situated

³ A total of 21 statutory bodies are members of the NPM. See [Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment](#) (OPCAT), United Nations, which was ratified by the UK on 10 December 2003; see [NPM0000001](#); [NPM0000002](#)

⁴ [Visit to the United Kingdom of Great Britain and Northern Ireland Undertaken from 9 to 18 September 2019: Recommendations and Observations Addressed to the State Party](#), Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 31 May 2021, CAT/OP/GBR/ROSP/1

monitoring body is likely to directly witness events such as those captured in the covert footage considered by this Inquiry. For this reason, it is important that the IMB and HMIP consider, and report on, more insidious signs of ill treatment. It is also critical that the Home Office and its contractors understand that external inspection and oversight are intended only to supplement, not to replace, their own internal processes.

Over-reliance on external organisations

4. The Brook House IMB did not identify the ill treatment of detained people during the relevant period, and it told the Inquiry that it had seen no *"indications that it might be happening"*.⁵ Detention Custody Officer (DCO) Callum Tulley said he was *"never aware of any abusive language or treatment being demonstrated in front of the IMB"*.⁶ The Brook House IMB, however, fell short during the relevant period. It did not take sufficient proactive steps to monitor the treatment of detained people and it had developed too close a relationship with the Home Office and G4S.

5. HMIP did not carry out an inspection during the relevant period. However, as discussed below, the 2016 HMIP inspection report (published in January 2017) was overly positive in places and did not adequately reflect some of the adverse evidence about Brook House obtained by HMIP.

6. The Inquiry heard from many present at Brook House, in different roles, who said that they were unaware of the treatment of detained people shown on the *Panorama* programme.⁷ However, the IMB and HMIP are specifically tasked with upholding the UK's commitment to prevent torture and ill treatment, and therefore they should be expected to identify indications of welfare concerns, even if they are missed by others. Some such concerns were identified by HMIP shortly before the relevant period, as discussed below, but they were insufficiently reflected in HMIP's report.

7. The Home Office and G4S placed wholly inappropriate weight on what they saw as reassurances from both the Brook House IMB and HMIP around the time of the relevant period. Neither the IMB nor HMIP can be expected to provide the level of scrutiny that G4S and the Home Office appear to have expected during the relevant period. Bodies such as the IMB and HMIP can only ever supplement – and not replace – the internal processes of the Home

⁵ [VER000138_004](#)

⁶ [Callum Tulley 29 November 2021 106/12](#)

⁷ See, for example, Mr Stephen Skitt, Deputy Director of Brook House during the relevant period ([SER000455_096-097](#) para 377); Detention Custody Manager Christopher Donnelly ([SER000444_016](#) para 85); Mr Daniel Haughton, G4S Support Services Manager during the relevant period ([SER000453_006-007](#) para 21; [SER000453_022-023](#) para 91; [SER000453_033](#) paras 147 and 148); DCO Shayne Munroe ([INN000013_003](#) para 11; [INN000013_048](#) para 148); Ms Anna Pincus, current Director of Gatwick Detainees Welfare Group ([DPG000002_027-028](#) paras 70-75)

Office and its contractors to satisfy themselves about the treatment of detained people.

8. Mr Ben Saunders (Centre Director for Brook House and Tinsley House (Gatwick IRCs) during the relevant period) said that he was reassured by the Brook House IMB presence. He noted that reports and audits at the time did not raise the sorts of issues that were identified in the *Panorama* programme.⁸ Mr Jeremy Petherick (Managing Director of G4S Custodial and Detention Services during the relevant period) said that, had anything been seriously wrong, he would have expected the signs to have been picked up by the Brook House IMB.⁹ His manager, Mr Peter Neden (G4S Regional President UK and Ireland), took comfort from the presence of the IMB and the fact that HMIP conducted unannounced inspections.¹⁰ However, Mr Neden accepted that he and the G4S management team “*must have over-relied*” on external bodies regarding the welfare of detained people.¹¹ Mr Philip Dove (Director of G4S Health Services) found it difficult to understand why, if there were issues relating to Rule 35 of the Detention Centre Rules 2001, they were not raised by the Brook House IMB, HMIP or the Care Quality Commission, despite later acknowledging that the IMB had in fact raised concerns about the lack of Rule 35(1) and Rule 35(2) reports. He was unable to say whether this led to any action.¹² The Inquiry found that it did not (see Chapter D.5).

9. Commenting on the evidence of G4S managers, the Brook House IMB noted:

“You may wonder how it is that a company the size of G4S, employing as many people as it did, operating a contract valued in the millions, say they came to rely quite so heavily on occasional HMIP visits and the nine unpaid members of the IMB.”¹³

10. That criticism also applies to the Home Office. Despite staff attending regular meetings and producing reports on matters at Brook House, the meetings and reports did not address the overall welfare of detained people.¹⁴ Ms Michelle Smith (Home Office Service Delivery Manager for Gatwick IRCs during the relevant period) said that she would have expected HMIP or the Brook House IMB to report on the overall welfare of detained people and that there was no requirement for the Home Office at Brook House to do so.¹⁵

⁸ [Ben Saunders 22 March 2022 105/2-13, 109/9-13](#)

⁹ [Jeremy Petherick 21 March 2022 143/23-144/11](#)

¹⁰ [Peter Neden 22 March 2022 6/18-23](#)

¹¹ [Peter Neden 22 March 2022 56/15-24](#)

¹² [Philip Dove 31 March 2022 121/3-125/18, 140/21-141/23](#)

¹³ [Closing Statement on behalf of the IMB 6 April 2022 45/13-17](#)

¹⁴ See, for example, [HOM0332004_003-004](#) paras 8b and 8g; [HOM0332004_007](#) para 18; see also Chapter D.2

¹⁵ [Michelle Smith 23 March 2022 129/22-24](#)

11. Inspection and monitoring bodies have an important role to play in monitoring welfare standards in IRCs, but they are only one element of what should be a robust internal and external monitoring system. IMBs are staffed by volunteers. Their access to IRCs, is limited by the number of visits they are afforded. They do not have specific training in issues such as the lawful use of force, nor do they have access to the contract for managing Brook House – much less a formal contract monitoring role. While they can raise concerns, they have no power to issue sanctions or otherwise enforce compliance.

12. Critically, the duty to ensure that detained people are treated properly lies with the Home Office and its contractors. The Home Office has the primary responsibility for detained people and for ensuring that contractors comply with rules and contractual obligations in their management of Brook House. Contractors have the primary responsibility for day-to-day treatment of detained people and for the management of Brook House. There was a fundamental over-reliance by senior management within G4S and the Home Office on external organisations.¹⁶

Independent Monitoring Boards

The role and powers of Independent Monitoring Boards

13. IMBs operate within IRCs to provide regular and independent oversight with a focus on the welfare of detained people, in accordance with the Immigration and Asylum Act 1999 and the Detention Centre Rules 2001 (the Rules).¹⁷

14. Each IMB is a separate entity with its own statutory duties, and its members (including an elected Chair and Vice Chair) are volunteers drawn from the local community. Members receive training centrally before working within IRCs, followed by a probationary period that includes shadowing existing members.¹⁸ IMBs meet around once a month, while members are required to visit the IRC at least once a week.¹⁹ ‘Rota reports’ reflect these visits and are discussed at monthly meetings. IMB members also receive ‘applications’ (requests and complaints) from detained people. In addition, members are required to be informed by the IRC of certain events, including the use of force,

¹⁶ The same issue had been identified in a report following the previous *Panorama* programme relating to a G4S-run centre. As discussed in Part B in Volume I, the Medway Improvement Board found that the Youth Justice Board had been over-reliant on external organisations, and that there had been a general and mistaken belief that, because Medway was being visited by multiple organisations, it was “safer” (INQ000010_039 para 3.62)

¹⁷ Immigration and Asylum Act 1999, section 152; Detention Centre Rules 2001, Part VI

¹⁸ Jacqueline Colbran 25 March 2022 4/13-17

¹⁹ IMB000199_003-004 paras 9-10; Detention Centre Rules 2001, Rule 60 and Rule 63(1)

the invocation of Rule 40 and Rule 42 of the Rules, and serious incidents such as death or serious injury of a detained person, ‘concerted indiscipline’ or a security breach by outsiders.

15. IMBs have important powers in IRCs. Members are permitted to access any area of the IRC at any time, to speak privately with any detained person and to access any records held by the IRC (save for certain confidential or classified information). They must satisfy themselves of the state of the premises and the treatment of detained people, and they are required to inform the Secretary of State of certain welfare concerns.²⁰ They must also report annually to the Secretary of State.²¹

16. While IMBs must alert managers to problems, raise concerns with the Secretary of State and make recommendations, they have no power to enforce change.²²

The Independent Monitoring Board at Brook House during the relevant period

17. The Chair of the Brook House IMB during the relevant period was Ms Jacqueline Colbran; the Vice Chair was Mr Richard Weber. There were seven other board members.²³ In 2017, members visited Brook House 205 times; these visits included a mixture of weekly rota visits, meetings and attendances at serious incidents.²⁴

18. The weekly rota reports completed by Brook House IMB members varied in quality; some were brief and vague.²⁵ All followed the same style, describing the IRC wing by wing, then describing other areas, such as the kitchen and gym, and providing a description of the people detained there. A new framework for weekly reporting was adopted in 2020 that emphasises welfare and rights-based issues, with headings such as “*safety*” and “*health and wellbeing*”.²⁶ Ms Mary Molyneux, Chair of the Brook House IMB after the relevant period and a current member of the IMB at Gatwick IRCs, told the Inquiry that the adoption of this new approach had led to more detailed consideration of issues underlying the behaviour of detained people.²⁷ I agree with Professor Mary Bosworth, the Inquiry’s cultural expert, that such a thematic, rights-based approach is preferable. It is a welcome development that should be considered by other IMBs.

²⁰ [Detention Centre Rules 2001](#), Rule 61(1) and Rule 61(4)

²¹ [Detention Centre Rules 2001](#), Rule 64

²² [IMB000199_003](#) para 8

²³ [IMB000004](#)

²⁴ [IMB000135](#); [IMB000204_006](#) para 14

²⁵ [IMB000041](#); [IMB000059](#)

²⁶ [IMB000200](#)

²⁷ [Mary Molyneux 25 March 2022 99/13-21](#)

19. During the relevant period, monthly Brook House IMB meetings were attended by IMB members, G4S management (usually Mr Saunders) and Home Office representatives including Mr Paul Gasson (Contract Monitor at Brook House) and occasionally Mr Ian Castle (Home Office Detention and Escorting Services (DES) Area Manager) or Ms Smith.²⁸ Before each meeting, the Brook House IMB received a “combined report” from G4S and the Home Office containing data such as occupancy, the number of Rule 35 reports and how many had led to release, instances of the use of force, the number of detained people subject to Rule 40 and Rule 42, and the number of acts of self-harm.²⁹ Minutes were taken by the ‘IMB clerk’, a Home Office employee based at Brook House who performed this function among others. Parts of the meeting held without Home Office presence were minuted by an IMB member, although the minutes were signed off by the Brook House IMB Chair.³⁰ I consider it inappropriate that minutes at IMB meetings were taken by Home Office employees. The IMB should always be aware of the importance of maintaining independence and the perception of independence.

20. The 2016 IMB report raised some concerns, including about access to mental healthcare, the introduction of a third bed into some cells and the duration of some detention periods.³¹ The report, however, was overly positive:

“Once again the IMB judges Brook House IRC to be a well-run establishment, providing a decent environment where detainees awaiting removal are treated humanely and fairly ... There is a real will among the management team to seek to improve and a ‘can-do’ culture of transparency. This attitude permeates to the officers in their attitude to the IMB, which is one of cooperation and helpfulness.”³²

In the 2017 IMB report, referring to the *Panorama* programme, the Brook House IMB expressed horror at the “unacceptable behaviour of the small group of staff shown in the footage”, recording that the IMB had neither witnessed any such ill treatment nor had any indication that it was happening.³³ The IMB subsequently accepted “that the mistreatment and abuse within Brook House was even more widespread than was shown on *Panorama*”.³⁴

²⁸ [Jacqueline Colbran 25 March 2022 43/3-21](#)

²⁹ [IMB000021](#); [IMB000050](#); [IMB000011](#); [IMB000047](#); [IMB000019](#)

³⁰ [Jacqueline Colbran 25 March 2022 44/8-18](#)

³¹ [IMB000121_008](#); [IMB000121_007](#) para 4.2

³² [IMB000121_007](#) para 4.1

³³ [VER000138_004](#)

³⁴ [Closing Statement on behalf of the IMB, Brook House Inquiry, 29 April 2022, paras 12 and 13](#)

Adequacy and limitations of the Independent Monitoring Board during the relevant period

21. Evidence disclosed to the Inquiry by the IMB showed that members frequently raised concerns about individuals and about conditions at Brook House more generally.³⁵ Examples included concerns raised in monthly meetings about the use of handcuffs and waist restraints, and the increased use of Rule 40 and Rule 42.³⁶

22. However, a variety of factors limited the Brook House IMB's ability to monitor the welfare of detained people and to identify the risk of, or actual, poor treatment during the relevant period:

- The IMB was not sufficiently challenging of G4S or the Home Office.
- Many detained people did not know about the IMB.
- IMB members were and continue to be volunteers, lacking expertise and knowledge in some areas they were expected to monitor.
- The IMB does not have a national statutory basis or the power to enforce change.

Failing to challenge G4S or the Home Office

23. Effective oversight by the IMB requires uncompromising independence and the willingness to raise concerns robustly. Evidence has demonstrated that this was not always the case.

23.1 Serious concerns, even when identified, were pursued insufficiently. For example, Brook House IMB documents from May 2017 show that two members were separately concerned that Healthcare was “*very busy*” and unable to carry out initial health assessments within a suitable time frame, which “*may place vulnerable arriving detainees at risk*”.³⁷ When raised at the monthly meeting, the minutes simply read “*DW [Mr Weber] asked if any impact had been noticed from the increase in population. SS [Mr Stephen Skitt, Deputy Director of Brook House during the relevant period] had not been made aware of any issues.*”³⁸ It was insufficient simply to ask G4S about any impact. The IMB should have raised this as a serious failure, asking both G4S and the Home Office what was going to be done to ensure that health assessments were undertaken within the appropriate timescale and the identification of vulnerable people was not delayed. Ms Colbran suggested that there “*would have been more discussion*” that was not recorded in the

³⁵ [IMB000222_021-024](#) para 56

³⁶ [IMB000222_021-024](#) para 56; [IMB000055_006](#); [IMB000005_002](#); [IMB000014_001](#); [IMB000062_002](#)

³⁷ [IMB000009_002](#); [IMB000012_003](#)

³⁸ [IMB000030](#)

minutes.³⁹ In my judgement, that is unlikely. Had there been an appropriate discussion about these concerns, it would likely have been recorded.

23.2 The Inquiry heard that the Brook House IMB requested from the Home Office, but did not receive, detailed data on the number of Rule 35 reports.⁴⁰ Ms Colbran did not consider that the Home Office was trying to be “*difficult*”, although she later accepted that this was information the IMB was entitled to see, that it should have been simple to provide and that she could have taken further steps to obtain it.⁴¹ In addition, the continued very low number of Rule 35(1) and Rule 35(2) reports was not mentioned in the 2017 IMB report.⁴² The IMB should have pressed harder for the data or escalated the issue. Ms Colbran, in particular, was too willing to accept without due challenge the Home Office’s excuses for refusing to provide the information.⁴³ IMB members must be made aware of their specific legal powers under the Rules, including powers to access records, and they must be empowered to exercise these powers where appropriate. However, the underlying failure here was with the Home Office for failing to provide data that the IMB had requested and was entitled to receive.

23.3 HMIP and the IMB are intended to have separate but complementary roles. Dr Hindpal Singh Bhui, Inspection Team Leader at HMIP, referred to the risk of over-empathising with the establishment. He considered maintaining independence to be difficult for part-time volunteers.⁴⁴ An email from Ms Colbran to Dr Singh Bhui on 14 November 2016 demonstrates that this was a problem at Brook House. The Brook House IMB, having seen an HMIP post-inspection debrief, wrote to inform HMIP that the IMB “*finds Brook House to be a well-run establishment, aiming to improve and with a remarkable attitude of care to the detainees from the staff*”, adding that it was “*a shame*” that HMIP’s evaluation did not exceed “*reasonably good*” in any category.⁴⁵ In my view, this was an entirely inappropriate attempt by the IMB to influence HMIP’s assessment of Brook House. It demonstrated that the IMB was too closely aligned to the establishment and failed to appreciate the vital role of both the IMB and HMIP in “*the prevention of torture and other cruel, inhuman or degrading treatment or punishment*”, as required by

³⁹ [Jacqueline Colbran 25 March 2022 60/5-13](#)

⁴⁰ [Mary Molyneux 25 March 124/9-126/20](#); [Jacqueline Colbran 25 March 2022 56/23-25-57/19](#); [Mary Molyneux 25 March 2022 126/7-20](#)

⁴¹ [Jacqueline Colbran 25 March 2022 56/23-25-57/19](#)

⁴² [VER000138_020](#) para 8.12

⁴³ [Jacqueline Colbran 25 March 2022 56/23-57/2](#)

⁴⁴ [Dr Hindpal Singh Bhui 24 March 2022 141/9-14](#)

⁴⁵ [HMIP000148](#)

OPCAT. Ms Colbran denied that this was her intention.⁴⁶ However, Ms Molyneux considered that the email was inappropriate.⁴⁷

23.4 Further concern arises from the relationship between the Brook House IMB and Gatwick Detainees Welfare Group (GDWG) during the relevant period. The IMB was aware of the level of “*suspicion*” the Home Office held towards GDWG.⁴⁸ Correspondence between the IMB and GDWG suggested an obstructive attitude. For example, the IMB’s response to GDWG raising concerns about a disputed minor was that it was “*outside our remit*”.⁴⁹ At a meeting in November 2017, the IMB repeated a list of G4S complaints about GDWG, and Ms Colbran described much of the *Panorama* programme as “*dramatic music, blurry images giving the impression of chaos, and ‘fluff’*”.⁵⁰ GDWG was later informed by an external evaluator that the IMB felt that GDWG “*sometimes strayed over the boundaries and gave advice to detained persons*”.⁵¹ Ms Molyneux told the Inquiry that she now accepted that the IMB was too affected by Home Office and G4S managers’ views of GDWG.⁵² She agreed that the IMB should have formed its own views on GDWG, commenting that the IMB was working to improve that relationship and to overcome “*understandable mistrust*”.⁵³

24. This insufficiently challenging approach continued even after the *Panorama* programme. The 2017 IMB report referred to unacceptable behaviour by a “*small number of staff*” and said that Brook House largely kept detained people as safe as it could.⁵⁴ Ms Colbran subsequently accepted that this was a “*misjudgement*” and that the report “*should have been more critical and challenging*”.⁵⁵ It is concerning that, even after the abuses during the relevant period were known, the IMB seemed unwilling to criticise obvious failures and remained too sympathetic towards G4S and the Home Office.

25. Evidence of more recent practice by the IMB (such as the new rights-based forms) and its recognition of the importance of its role and independence provides some reassurance.⁵⁶ The Inquiry also heard evidence of

⁴⁶ [Jacqueline Colbran 25 March 2022 32/23-33/12](#)

⁴⁷ [Mary Molyneux 25 March 2022 106/23-107/5](#)

⁴⁸ [Jacqueline Colbran 25 March 2022 15/12-17; GDW000007_001](#)

⁴⁹ [GDW000003_038](#)

⁵⁰ [VER000110; IMB000204_053](#) para 155; [GDW000001_020-021](#) para 62. Ms Pincus felt that this reflected the IMB’s tendency to accept uncritically what went on at Brook House ([DPG000002_071](#) para 199; Anna Pincus 9 December 2021 [120/12-17](#))

⁵¹ [DPG000002_068](#) para 191

⁵² [Mary Molyneux 25 March 2022 148/11-17](#)

⁵³ [Mary Molyneux 25 March 2022 150/3-17](#)

⁵⁴ [VER000138_007](#)

⁵⁵ [IMB000204_062-063](#) para 186

⁵⁶ [IMB000217](#)

more recent and useful work conducted between the IMB and HMIP to resolve specific concerns.⁵⁷ However, IMB members must be aware of the risks of ‘institutionalisation’ and be prepared to take robust positions to protect detained people’s welfare.

Many detained people did not know about the Independent Monitoring Board

26. The Inquiry heard and received evidence from a number of formerly detained people who had not heard of the IMB and did not understand its role or how to complain.⁵⁸ Witnesses to the Inquiry, and Brook House IMB’s own records, showed that there were issues with IMB forms not being placed on the wings, necessitating “*a constant chasing exercise with G4S*”. Ms Molyneux attributed this to overworked staff rather than deliberate obstruction.⁵⁹ The Inquiry was told that this is no longer an issue.⁶⁰

27. Some detained people did not see the IMB as an independent body.⁶¹ The IMB acknowledged that some detained people believe that it is part of the Home Office.⁶² Mr Jamie Macpherson, a GDWG visitor, also told the Inquiry that the IMB was seen by some detained people as “*part of the system*”, in part due to members’ free access around Brook House.⁶³ Ms Molyneux did not agree.⁶⁴ She accepted that evidence showed that some detained people were not aware of the IMB, an area that she acknowledged requires work.⁶⁵

Knowledge and experience of members

28. During the relevant period, the volunteer members of the IMB were at times expected to reach a view on matters about which they had insufficient understanding. This understandably risked the IMB failing to uncover issues or being inappropriately reassured by G4S and the Home Office.

29. The IMB was required to be notified when force had been used. Members were entitled to observe planned uses of force if they were present in the IRC, or otherwise to review paperwork and footage following the event.⁶⁶ As noted by Dame Anne Owers, National Chair of the IMB, and as was apparent in IMB meeting minutes from the relevant period, the Brook House

⁵⁷ [IMB000217](#)

⁵⁸ [DL0000229_091](#) para 299; [DL0000143_029](#) para 108; [DL0000288_013](#) para 53; [D643 22 February 2022 68/5-7](#)

⁵⁹ [Mary Molyneux 25 March 112/13-113/5](#); see, for example, [IMB000012_002](#)

⁶⁰ [Mary Molyneux 25 March 112/13-113/18](#)

⁶¹ [DPG000021_039](#) paras 115 and 116

⁶² [IMB000222_014](#) para 36c(ii); [DPG000021_039](#) para 116

⁶³ [Jamie Macpherson 8 December 2021 196/13-197/5](#)

⁶⁴ [IMB000203_016-017](#) para 51

⁶⁵ [IMB000203_015](#) para 47

⁶⁶ [IMB000199_014-015](#) paras 42 and 43

IMB was not always proactively provided with Use of Force paperwork.⁶⁷ IMB members were invited to Use of Force scrutiny meetings, of which there were four in 2017. The purpose of these meetings was said to be to review data on use of force along with written reports and footage. Ms Molyneux recalled that the IMB member attending “*may be asked ... for our impressions of footage reviewed*” but considered that the IMB’s “*primary focus was on governance: seeing how the meeting was run and what kinds of issues were covered*”.⁶⁸

30. Brook House IMB members received no training on the use of force, apart from a session on defensive techniques led by DCO John Connolly that was designed to protect members, not to teach them about the lawful use of force on detained people.⁶⁹ While it is important that an independent observer is present, wherever possible, when there is a use of force, and that they provide oversight of unplanned events by way of review, there was a lack of clarity over IMB members’ role at use of force incidents. Their role at such incidents is not made explicit by the Home Office in any written policy. IMB members’ views will be limited by a lack of expertise in the lawful and proportionate use of force, and their oversight role cannot eclipse the primary responsibility for ensuring that force is used lawfully, which lies with the Home Office and its contractors.

31. The Inquiry also heard that the Brook House IMB “*could not see the contract between the Home Office and G4S as it was commercially sensitive*”, although Ms Smith appeared to believe that the IMB had some role in scrutinising contractual self-reporting.⁷⁰ IMB members are not and should not be acting as contractual monitors, checking compliance or raising concerns that a contractor is not meeting its obligations to the Home Office. I agree with Ms Molyneux, who considered that this was a role for the Home Office itself:

“I do not think that is the IMB role, to be checking whether a supplier is complying with the contract or the laws or whatever. I think we do, as we said at the beginning ... treatment, conditions, administration.”⁷¹

Inconsistent legislation and lack of enforcement powers

32. The Inquiry heard evidence of a disconnect between what the IMB is required by legislation to do and what in fact occurs. For instance, the Rules provide that an IMB member must, within 24 hours, visit any detained person subject to Rule 40 (removal from association), Rule 42 (temporary

⁶⁷ [IMB000199](#) para 42

⁶⁸ [IMB000203_028-029](#) paras 87-89

⁶⁹ [Jacqueline Colbran 25 March 2022 60/5-13](#)

⁷⁰ [IMB000204_029](#) para 88; [Michelle Smith 23 March 2022 126/10-21](#)

⁷¹ [Mary Molyneux 25 March 2022 172/2-18](#)

confinement) or Rule 43 (under special control or restraint).⁷² This did not happen, as the Home Office and G4S were aware.⁷³

33. Dame Anne Owers explained that the Rules “*are out of date and do not properly reflect current best practice*”, and that the Home Office had declared its intention to update them.⁷⁴ The IMBs made representations on this issue in 2018, yet no new rules have been laid before Parliament.⁷⁵ It is inexplicable that the legislation governing the IMB’s important safeguarding role has not been updated for so long.

34. While each IMB has an independent status and powers derived from legislation, there is no statutory basis for the National Chair and Management Board of the IMBs. This national body is responsible for setting strategies and procedures for the work of the 127 individual IMBs and for working with unpaid regional representatives. The national IMB can provide advice, guidance and training to IMBs. However, as each IMB is a separate entity, the structure does not allow for supervision at a national level.⁷⁶ Dame Anne Owers also told the Inquiry that the Government has committed “*in principle*” to providing a statutory basis for the national IMB, but that no action has been taken.⁷⁷ This significantly limits the extent to which individual IMBs and their members can be supported and supervised by the National Council for IMBs.⁷⁸ A Memorandum of Understanding between the Home Office and the Management Board of the IMBs was signed in June 2020, setting out some of the IMBs’ roles in IRCs.⁷⁹ However, this does not have the force of law.

35. More fundamentally, the IMB is limited in what it can achieve. Even a robust and well-informed IMB can only raise concerns. It lacks the power to enforce change.

35.1 In its report for 2016, for example, the IMB clearly stated that the Care and Separation Unit was inappropriate for detained people with mental health issues. Its view was that a solution was required to address long-term detention, and it suggested mental health training for officers.⁸⁰ At the time of the Inquiry’s hearings, these issues remained unresolved.⁸¹

35.2 Ms Molyneux also gave evidence about poor compliance with Rule 35 practice after the relevant period. She told the Inquiry that there had

⁷² [Detention Centre Rules 2001](#), Rule 62(1); [IMB000204_034-035](#) para 103

⁷³ [IMB000030_001](#)

⁷⁴ [IMB000199_006-007](#) para 17; [IMB000199_015](#) para 44

⁷⁵ [IMB000199_006-007](#) para 17

⁷⁶ [IMB000199_001](#) para 2; [IMB000199_020](#) para 62

⁷⁷ [IMB000221_009](#) para 32

⁷⁸ [IMB000199_006-007](#) para 17; [IMB000199_008](#) para 23; [IMB000199_020](#) para 62

⁷⁹ [IMB000187](#)

⁸⁰ [IMB000121_008](#); [IMB000121_016](#) para 5.7.5

⁸¹ [PPG000205](#)

been no Home Office action on these issues and that the IMB would need to repeat the recommendations in its next report and look to find different ways to monitor the Rule 35 process.⁸² Ongoing monitoring of Rule 35 is important and must continue. However, this issue illustrates the limits of the IMB's power. Repeating the same concern in annual reports does not mandate any action by the Home Office, contractors or others. The IMB can make a difference only if the Home Office (or other relevant entity) is willing to listen to and address concerns.

The Independent Monitoring Board at Brook House since the *Panorama* programme

36. Some of the changes to the Brook House IMB after the relevant period, such as the use of rights-based forms for rota visits and the relationship with GDWG, demonstrated a significant level of reflection by the IMB on the relevant period and a commitment to improvement. This is to be commended and must be maintained. The UN SPT, during its visit to Heathrow immigration removal centre in September 2019, commended the dedication of IMB volunteers there and welcomed the IMB's presence in the IRC. It also noted concerns that the IMB was regarded more as a body that monitored day-to-day life in the IRC rather than as an "*interlocutor working for human rights of persons deprived of their liberty*".⁸³ The rights protection role of IMBs must remain at the front and centre of their work.

37. One particular example of action taken by the Brook House IMB since the *Panorama* programme demonstrates the improvements to the organisation while underlining the limits of its power. In late 2020, Brook House housed asylum seekers due to be removed on a concentrated programme of charter flights to European Union (EU) countries, prior to the UK's withdrawal from the EU. In a letter dated 2 October 2020, Ms Molyneux and Ms Lou Lockhart-Mummery of the IMB set out the effects of the charter programme on the detained people in robust and clear terms, which they said amounted to "*inhumane treatment*".⁸⁴ The criticism was not of Brook House staff but of the circumstances around detention and removal, which were leading to markedly increased levels of self-harm and distress among those being removed, a backlog in the Rule 35 process and an overall ill-effect on the wider Brook House population. The letter was sent to Mr Chris Philp MP, then Minister for Immigration Compliance and Courts, pursuant to the IMB's obligation to report

⁸² [Mary Molyneux 25 March 2022 132/22-24; IMB000203_021-022](#) para 66

⁸³ [Visit to United Kingdom of Great Britain and Northern Ireland Undertaken from 9 to 18 September 2019: Recommendations and Observations Addressed to the National Preventive Mechanism, Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 26 February 2020, CAT/OP/GBP/RONPM/R.1](#)

⁸⁴ [DL0000140_113-116](#)

such matters.⁸⁵ Many other Home Office officials received a copy. It was appropriate to raise these issues in this way given the urgency and the gravity of the concerns, and the letter was well supported by evidence and squarely focused on the IMB's remit: the welfare of detained people.

38. It is unacceptable, given the obvious urgency of the issues raised, that no response was received from the Home Office until 25 November 2020.⁸⁶ Ms Molyneux's view was that the response did not answer the concerns in a meaningful way; it was "*all about process*" rather than engaging with the impact of the flights on the detained people.⁸⁷ I agree. The response arrived on the day when Ms Molyneux and Dame Anne Owers were due to give evidence before the Home Affairs Select Committee in relation to Channel crossings, migration and asylum-seeking routes through the EU. I share Ms Molyneux's impression that the timing was a cynical attempt by the Home Office to head off any criticism for not responding.⁸⁸

39. Ms Molyneux told the Inquiry that writing such a letter was practically "*the limit*" of the power the IMB can exercise: "*you hope you never have to get to that*".⁸⁹ I agree that, despite the inadequacy of the response, there was value in sending the letter. The wilful inaction shows, however, that while the IMB can monitor and raise concerns, preventing ill treatment requires those concerns to be heeded.

40. IMBs cannot be expected to be the sole monitors of detained people's welfare; ultimate responsibility lies with the detaining organisations. However, independent, robust and properly governed IMBs are an important safeguard in the immigration detention setting. I am therefore recommending that their concerns be publicly addressed and consideration be given to their legal status.

⁸⁵ [Detention Centre Rules 2001](#), Rule 61(3) and Rule 61(5)

⁸⁶ [IMB000206](#)

⁸⁷ [Mary Molyneux 25 March 2022 162/1-21](#)

⁸⁸ [Mary Molyneux 25 March 2022 163/2-13](#)

⁸⁹ [Mary Molyneux 25 March 2022 163/22, 154/21-22](#)

Recommendation 32: Enhancing the role of the Independent Monitoring Boards

The government must:

- respond to and publish responses to all concerns raised by any Independent Monitoring Board regarding immigration removal centres;
- take steps without further delay to amend the Detention Centre Rules 2001, in so far as they govern Independent Monitoring Boards, in order to accurately reflect their current role; and
- consider whether to put the National Chair and Management Board of the Independent Monitoring Boards on a statutory footing.

HM Inspectorate of Prisons

41. HMIP is the sole statutory body responsible for conducting inspections of Brook House. The statutory purpose of its inspections of IRCs is to report on the treatment of detained people and on conditions in detention centres.⁹⁰ Dr Singh Bhui described the purposes of an HMIP inspection of a centre such as Brook House as including making sure that “*nothing is hidden*”, that the experiences of people in detention are publicised, and that if centres are not doing well enough these things are highlighted and improved upon.⁹¹

42. The Inquiry focused on HMIP’s inspections in 2016 and 2019 and its work between and after that period. However, Brook House was also inspected by HMIP in 2010, 2011, 2013 and 2022.⁹²

Process

43. The assessment criteria used by HMIP are set out in its *Expectations* document.⁹³ IRCs are assessed against four ‘healthy establishment’ tests: for safety, respect, activities, and preparation for removal and release. Each of these is broken down into more detailed descriptions of the standards of treatment and conditions expected, with indicators listed for whether they are being met.

⁹⁰ [Prison Act 1952](#), section 5A(3) and section 5A(5B)(b)(ii)

⁹¹ [Dr Hindpal Singh Bhui 24 March 2022 108/2-14](#)

⁹² [HMIP000685_004](#) para 9; [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Inspectorate of Prisons, September 2022

⁹³ [HMIP000644](#) (2012 version); [INQ000134](#) (2018 version)

44. HMIP’s inspection methodology is set out in an *Inspection Framework* document.⁹⁴ The following aspects of HMIP’s process were particularly relevant.

- 44.1 Triangulation:** One part of HMIP’s methodology is that inspectors seek to triangulate evidence before reaching findings, meaning that a source of evidence should be supported by at least two other sources.⁹⁵ This was criticised in a paper by the Strategic Public Law Clinic as leading to “*systemic unfairness*”, because three of the five sources of evidence⁹⁶ considered by HMIP are institutional sources.⁹⁷ Dr Singh Bhui’s response was that HMIP can still mention single pieces of evidence, but that triangulation is about ensuring that findings are rigorously sourced.⁹⁸
- 44.2 Frequency and timing of inspections:** IRCs are subject to inspection at least once every four years, but usually more often. The timing of an inspection will depend on information received about possible risk – a planned inspection might be brought forward if HMIP becomes aware of issues such as multiple reports of disorder, violence, abuse or self-harm.⁹⁹
- 44.3 Unannounced:** I was satisfied that inspections were in fact unannounced.¹⁰⁰ Mr Tulley gave evidence to the Inquiry that he knew that the 2016 inspection was coming as he had been told a couple of days before. However, it is likely that this was because HMIP had already completed the first week of its inspection and he was being told about it in advance, or at the time, of the second week.¹⁰¹
- 44.4 Length and nature of inspections:** At the time of HMIP’s 2016 inspection, inspections lasted two weeks.¹⁰² In week 1, inspectors would gather the views of detained people and a coordinating inspector had a “*very quick look around*” to see if there were any immediate issues.¹⁰³ The safeguarding inspector assessed how vulnerable detained people had been treated on the basis of the records.¹⁰⁴ A selection of detained

⁹⁴ [HMIP000643](#) (2016 version); [HMIP000638](#) (2019 version)

⁹⁵ [HMIP000685_009](#) para 27; [HMIP000643_014](#) paras 3.24 and 3.25

⁹⁶ The five sources of evidence as of 2016 were observation, detained person surveys, discussions with detained people, discussions with staff and relevant third parties, and documentation ([HMIP000613_012](#) para A8)

⁹⁷ [GDW000011_007](#) para 7

⁹⁸ [Dr Hindpal Singh Bhui 24 March 2022 168/10-169/11](#)

⁹⁹ [Dr Hindpal Singh Bhui 24 March 2022 122/2-123/1](#)

¹⁰⁰ [Dr Hindpal Singh Bhui 24 March 2022 109/2-20](#). According to Dr Singh Bhui, they have been so since 2013-14

¹⁰¹ [Callum Tulley 30 November 2021 97/22](#); [Callum Tulley 9 March 2022 144/20](#); [Dr Hindpal Singh Bhui 24 March 2022 116/13-117/3](#)

¹⁰² It changed to a three-week process as part of the enhanced methodology after the *Panorama* programme (see [Dr Hindpal Singh Bhui 24 March 2022 114/13-21](#))

¹⁰³ [Dr Hindpal Singh Bhui 24 March 2022 110/11-25](#)

¹⁰⁴ [Dr Hindpal Singh Bhui 24 March 2022 112/6-113/19](#)

people were offered interviews and some staff members would be spoken to.¹⁰⁵ At the end of the first week, a pre-inspection report was prepared.¹⁰⁶ In week 2, the full inspection team liaised with third-party organisations, reviewed additional documents, and further engaged with staff and detained people.¹⁰⁷ Inspectors sought to triangulate evidence. On the final day, key findings and conclusions were presented verbally, followed shortly afterwards by a written debrief.

- 44.5 Work done during inspections:** Both Reverend Nathan Ward (former Head of Tinsley House) and Mr Tulley gave evidence suggesting that, after the first week, “*extensive work*” would be done by senior management within Brook House to ensure the best possible outcome. This included portraying Brook House in a way that was not accurate in relation to staffing levels and ensuring that staff were on their “*best behaviour*” in front of inspectors.¹⁰⁸ According to Reverend Ward, the phrase Mr Saunders would use was: “*If the Queen was coming around your house for tea, you would get the best china out.*”¹⁰⁹ Dr Singh Bhui said that such work was of limited effectiveness, as inspectors factored it into their assessments and would hear if things had changed only in the past few days.¹¹⁰ Mr Saunders said that, although G4S was keen to present the best of what it did to HMIP, managers did not take artificial steps such as transferring detained people out of E Wing or transferring in extra staff, as Mr Tulley had alleged.¹¹¹ Given these conflicting accounts, I am unable to reach any firm conclusion as to whether deliberate steps were taken to deceive inspectors.
- 44.6 Fact-checking:** Once HMIP finalised its report internally, it was sent to the Home Office (which would liaise with the contractor) for fact-checking.¹¹² Dr Singh Bhui explained that this was done to present an accurate report and to avoid the risk of it being undermined, not to allow the Home Office to dispute HMIP’s conclusions.¹¹³ When the draft 2016 HMIP inspection report was sent to the Home Office for fact-checking, one inspector felt that a suggested change was made by the Home Office as “*an attempt to insulate their decision making from legal*

¹⁰⁵ [Dr Hindpal Singh Bhui 24 March 2022 113/20-114/6](#). As discussed below, after the *Panorama* programme, this was changed so that every detained person is offered a confidential one-to-one interview, and a mechanism was implemented for gathering views from all staff members

¹⁰⁶ [Dr Hindpal Singh Bhui 24 March 2022 129/15-19](#); see, for example, [HMIP000128](#)

¹⁰⁷ [HMIP000685_008](#) para 25; [HMIP000643_012-013](#) paras 3.15-3.21

¹⁰⁸ [Reverend Nathan Ward 7 December 2021 196/21-197/23](#); [Callum Tulley 30 November 2021 100/14-102/1](#); [CPS000024_009](#)

¹⁰⁹ [Reverend Nathan Ward 7 December 2021 197/18-21](#)

¹¹⁰ [Dr Hindpal Singh Bhui 24 March 2022 117/22-119/3](#)

¹¹¹ [Ben Saunders 22 March 2022 115/4-12](#)

¹¹² [HMIP000685_010](#) para 31; see, for example, [HMIP000667](#)

¹¹³ [Dr Hindpal Singh Bhui 24 March 2022 181/24-182/10](#)

challenge".¹¹⁴ Dr Singh Bhui felt that the Home Office's approach was inappropriately defensive and insufficiently focused on HMIP's concerns.¹¹⁵

44.7 Recommendations: HMIP is unable to compel the Home Office or a contractor to accept recommendations,¹¹⁶ which Dr Singh Bhui thought helped to ensure HMIP's independence. At the time of his evidence to the Inquiry, he considered that recommendations and findings were taken "*pretty seriously*" by the Home Office, describing a change from a previously "*very defensive*" attitude in 2016.¹¹⁷ Dr Singh Bhui thought that this was due to a change in personnel.¹¹⁸ While this is a positive development, it is concerning that the Home Office's response to HMIP's recommendations may depend on personnel changes. In practice, under 50 per cent of recommendations from each inspection of Brook House were classified by HMIP as having been achieved by the next inspection.¹¹⁹ The Home Office accepted that, in the past, it did not have sufficient dedicated staffing in IRCs to ensure that recommendations were being delivered. It says that it does now and that the new Serco contract also requires Serco to implement recommendations.¹²⁰ Mr Philip Riley, Director of DES within the Home Office, accepted in oral evidence that, at times, the Home Office needed to move faster on recommendations, and he described the situation as a "*work in progress*".¹²¹ In my view, it is inherent to the appropriately limited function of an inspectorate that it cannot enforce adherence to its recommendations. The onus is on the Home Office and its contractors to respond properly to recommendations and to accept them wherever feasible.

Activity outside inspections

45. Dr Singh Bhui described HMIP's role in relation to Brook House between inspections as "*very minimal*", explaining that its task was to conduct occasional deep-dive inspections rather than regular monitoring.¹²² HMIP receives some information (described sometimes as 'intelligence') from various sources between inspections, but my impression is that this is sporadic and,

¹¹⁴ [HMIP000164_002; HMIP000667_005](#)

¹¹⁵ [Dr Hindpal Singh Bhui 24 March 2022 184/4-8](#)

¹¹⁶ [Dr Hindpal Singh Bhui 24 March 2022 175/8-18](#)

¹¹⁷ [Dr Hindpal Singh Bhui 24 March 2022 185/6-15](#)

¹¹⁸ [Dr Hindpal Singh Bhui 24 March 2022 184/17-185/15, 209/6-18](#)

¹¹⁹ [DL0000270_183](#) para 350

¹²⁰ [HOM0332165_061](#) paras 194 and 195; [Philip Riley 4 April 2022 98/10](#)

¹²¹ [Philip Riley 4 April 2022 128/7-12](#)

¹²² [Dr Hindpal Singh Bhui 24 March 2022 120/18-121/5](#)

in the main, relies on an individual or organisation deciding to raise a matter with HMIP.¹²³

46. No intelligence about poor treatment was sent to HMIP during the relevant period. Outside the relevant period, there were two examples.

46.1 In 2015, a doctor was concerned that G4S was flouting guidance and compromising patient care by failing to remove detained people's restraints during hospital escorts.¹²⁴ Although HMIP responded expressing concern and asking for consent to pass the doctor's email to the Home Office, Dr Singh Bhui believed that such consent was never received and therefore the email was not passed on.¹²⁵

46.2 In May 2018, a new employee at Brook House, who had staff shadowing him after having been on the wing for only a week, informed HMIP that a female member of staff had been sexually assaulted by a detained person, that they were very short-staffed and that Brook House was "*out of control and volatile*".¹²⁶ HMIP passed this information to the Brook House IMB, which followed it up with the Home Office and G4S senior management within Brook House.¹²⁷

The 2016 inspection of Brook House

47. The 2016 inspection assessed Brook House as being 'reasonably good' against all of its 'healthy establishment' tests: for safety, respect, activities, and preparation for removal and release.¹²⁸ In my view, the inspection report was overly positive in places.

47.1 Overly positive introduction: The introduction to the inspection report described it overall as being an "*encouraging inspection*" and noted that there had been "*excellent progress*" from when Brook House first opened. However, it also referred to major concerns about the physical environment and said that HMIP had made a number of detailed recommendations about the treatment of detained people.¹²⁹ Although 'reasonably good' in fact means "*evidence of adverse outcomes for detainees in only a small number of areas*", Mr Saunders took it to be a "*very positive report*".¹³⁰ As discussed above, G4S and the Home Office bear the primary responsibility for over-relying on HMIP's inspections

¹²³ Dr Singh Bhui said that information about deaths or concerted disorder would always be sent to them (Dr Hindpal Singh Bhui 24 March 2022 [122/10-14](#))

¹²⁴ [HMIP000657_001](#)

¹²⁵ [HMIP000658](#); Dr Hindpal Singh Bhui 24 March 2022 [125/11-128/25](#)

¹²⁶ [HMIP000690](#)

¹²⁷ [HMIP000690](#); [IMB000217](#)

¹²⁸ [HMIP000643_009](#); [HMIP000643_015](#); [HMIP000613_015-019](#)

¹²⁹ [HMIP000613_007](#)

¹³⁰ [HMIP000613_011](#) para A4; Ben Saunders 22 March 2022 [113/8-11](#)

and for interpreting them too favourably. However, HMIP's characterisation of the 2016 inspection as an "*encouraging inspection*" was too positive, given the contents of the report and the other information available to inspectors.

47.2 Governance of use of force: Overall, HMIP reported that governance of use of force was very good and that all incidents of force were reviewed by a manager.¹³¹ In my view, it is unlikely that sufficient and adequate reviews were being carried out by G4S at the time of HMIP's 2016 inspection, given my conclusions about the relevant period in Chapter D.7. It is more likely that HMIP did not identify this issue and inadequately scrutinised the governance of use of force. There is no reference to weekly or monthly Use of Force Committee or scrutiny meetings in the HMIP report. On balance, I think it is likely that they were not being carried out.¹³² Although Dr Singh Bhui thought that HMIP did not mention these meetings because they were being carried out, the Inquiry did not see any positive evidence to suggest that they were occurring at the time of the inspection.¹³³

47.3 Mental health training: On healthcare more broadly, HMIP described it as "*commendable*" that more than half of DCOs had received mental health awareness training as part of their staff induction.¹³⁴ This was an overly positive interpretation, which Dr Singh Bhui accepted, given that "*half the staff not being trained is not good enough*".¹³⁵

48. There were also areas in which HMIP was critical, but it did not go far enough.

48.1 Use of force: HMIP reviewed the use of force at Brook House by looking at a sample of forms and video recordings.¹³⁶ It was noted that the number of use of force incidents had increased since the last inspection and that video footage revealed mixed practice, including some incidents that showed unnecessary and excessive force.¹³⁷ Despite this, the only recommendation was a generic one – "*All use of force should be necessary, proportionate and competently applied*" – rather than anything that recommended changes to be made to achieve that outcome.¹³⁸ G4S's response merely set out what the position should have been: "*Any use of restraint, including equipment, is only used*

¹³¹ [HMIP000613_015-016](#)

¹³² The latest evidence of a Use of Force Committee meeting dates from between February and June 2016 ([CJS0073064_001](#)); see also [CJS0073709_207-208](#)

¹³³ [Dr Hindpal Singh Bhui 24 March 2022 137/4-9](#)

¹³⁴ [HMIP000613_040](#) para 2.57

¹³⁵ [Dr Hindpal Singh Bhui 24 March 2022 166/8-167/2](#)

¹³⁶ [HMIP000685_022-023](#) para 62

¹³⁷ [HMIP000613_016](#) para S9; [HMIP000613_028](#) para 1.53; [HMIP000613_049](#) para 4.22

¹³⁸ [HMIP000613_028](#) para 1.58

where it is necessary, reasonable and proportionate having regard to the relevant circumstances.”¹³⁹ This was evidently untrue, as demonstrated by HMIP’s own findings and even more so by my findings throughout this Report (and particularly in Part C in Volume I). As discussed in Chapter D.7, the problem of unnecessary and excessive use of force continued or increased during the relevant period.

48.2 Rule 35: Although there were some criticisms of Rule 35 reports and the Home Office’s responses to them, HMIP gave an incorrect definition of Rule 35.¹⁴⁰ It also made no reference, in the 2016 HMIP inspection report, to the fact that there had been no reports under Rule 35(2) and few reports under Rule 35(1), although this should have been apparent.¹⁴¹ This situation was subsequently identified in the 2019 HMIP inspection report, when HMIP started to hone in on the discrepancy between the large number of detained people on constant watch and the absence of Rule 35(2) reports, although HMIP still failed to identify the lack of Rule 35(1) reports.¹⁴²

49. Additionally, there were some areas in which HMIP’s criticisms provide useful context for the state of Brook House during the relevant period.

49.1 In the introduction to the 2016 HMIP inspection report, HMIP warned that the proposal to use a third bed installed in 60 cells would lead to a decline in living standards.¹⁴³ No specific recommendation was made because, according to Dr Singh Bhui, this was only a potential future outcome.¹⁴⁴ As set out in Chapter D.3 of this Report, these beds were brought into use in 2017. Dr Singh Bhui was noted as having said in October 2017: “Having three detainees in a cell is ‘playing with fire’ but means G4S will make more money from the contract.”¹⁴⁵ In oral evidence, he suggested that his concerns were due to overcrowding and ventilation.¹⁴⁶

49.2 One of HMIP’s main concerns was the physical environment in which detained people lived. The 2016 HMIP inspection report noted lack of ventilation, detained people being locked in cells overnight, ingrained dirt, no curtains in many cells and many toilets in an unsanitary condition.¹⁴⁷ It recommended concerted action in this regard, which was

¹³⁹ [VER000116_005](#)

¹⁴⁰ [HMIP000613_030-031](#); [Dr Hindpal Singh Bhui 24 March 2022 164/12-22](#)

¹⁴¹ [DL0000140_175-180](#)

¹⁴² [Dr Hindpal Singh Bhui 24 March 2022 165/23-25](#)

¹⁴³ [HMIP000613_007](#)

¹⁴⁴ [HMIP000697_006](#) para 18. The decision to approve the use of the 60 beds was made in January 2017 (CJS0074084)

¹⁴⁵ [VER000193](#)

¹⁴⁶ [Dr Hindpal Singh Bhui 24 March 2022 173/20-174/2](#)

¹⁴⁷ [HMIP000613_024](#); [HMIP000613_033](#)

“partially accepted” by the Home Office and G4S.¹⁴⁸ Dr Singh Bhui described the response as not being very convincing, and he said that he thought that many parts of the action plan were more about managing HMIP rather than focusing on what could be done to improve matters.¹⁴⁹ In fact, HMIP has made recommendations on issues such as cleaning, toilets, curtains, ventilation and lock-in timings in every inspection since 2010.¹⁵⁰ Many HMIP recommendations were rejected or responded to inadequately by the Home Office.¹⁵¹ The issues continued during the relevant period, as discussed in Chapter D.3.

49.3 HMIP also made significant criticisms of the approach to vulnerable detained people, including the lack of oversight, failure to determine the impact of detention on mental health and lack of training.¹⁵²

50. Aside from my concerns about the view taken by HMIP on certain issues at Brook House, I consider that, in a number of places, the 2016 HMIP inspection report did not adequately reflect some of the adverse evidence about Brook House that was obtained by HMIP.

50.1 Detained people feeling unsafe: Although 37 per cent of detained people surveyed by HMIP said that they felt unsafe at Brook House, Dr Singh Bhui told the Inquiry that this level was not unusual and no recommendations were made about it.¹⁵³ While I understand the rationale for measuring the welfare of detained people against a baseline of respondents at other IRCs, it is objectively concerning that more than a third of detained people reported feeling unsafe. I was not convinced by Dr Singh Bhui’s suggestion that one of the reasons for this may be psychological insecurity about the prospect of removal.¹⁵⁴ The context of the survey questions suggests that ‘unsafe’ is more likely to refer to feeling victimised, threatened or intimidated by staff or other detained people.¹⁵⁵ G4S said that it conducted further surveys to monitor how safe detained people felt.¹⁵⁶ One such survey in 2017 recorded that 45 detained people (35 per cent of people who responded) felt unsafe or very unsafe in Brook House.¹⁵⁷

¹⁴⁸ [HMIP000613_020](#) para S36; [VER000116_001](#) para 5.2

¹⁴⁹ [Dr Hindpal Singh Bhui 24 March 2022 153/3-11](#)

¹⁵⁰ [DL0000167_024-025](#); [DL0000167_052](#); [DL0000167_055](#); [DL0000171_013](#); [DL0000171_051](#); [HMIP000311_016](#); [HMIP000311_025](#); [HMIP000311_033](#); [HMIP000311_046](#)

¹⁵¹ [DL0000270_065](#) para 92

¹⁵² [HMIP000613_024-025](#) paras 1.28-1.33

¹⁵³ [HMIP000685_027](#) para 74; [HMIP000685_028-029](#) para 78

¹⁵⁴ [Dr Hindpal Singh Bhui 24 March 2022 142/20-143/11](#)

¹⁵⁵ [HMIP000613_079](#)

¹⁵⁶ [CJS0074522_001](#) para 3

¹⁵⁷ [CJS0074154_004](#) p4, question 6

- 50.2 Detained people reporting physical and verbal abuse:** HMIP’s survey identified that 22 people said they had been ‘victimised’ (either insulted or assaulted) by a member of staff and that four said they had been physically abused by a member of staff.¹⁵⁸ While I acknowledge the difficulty of following up responses given as part of an anonymous survey, the fact that four people alleged physical abuse by staff, as part of a snapshot survey, should have caused greater concern on the part of HMIP and should have merited greater prominence in its report.
- 50.3 Lack of staff:** HMIP recorded evidence that “*Lack of staff makes it harder for them to pick up on warning signs*”, as well as that staff retention had been a challenge.¹⁵⁹ Neither issue was included by HMIP in its report. Dr Singh Bhui thought that, if staffing had been a major concern at the time of the inspection, it would have emerged “*quite strongly from other evidence*”.¹⁶⁰ However, there were signs that there was or had been a lack of staff.¹⁶¹ Even though there was a temporary increase due to Tinsley House closing for refurbishment and staff moving over to Brook House, HMIP should have flagged the temporary nature of this and identified the issues with staffing levels prior to its inspection.¹⁶²
- 50.4 Attitudes of staff:** HMIP also noted in its record of group interviews with detained people that “*most staff quite good, but some rude and don’t take detainees seriously*”.¹⁶³ According to Dr Singh Bhui, this was not included in the report because of other evidence suggesting that detained people found staff to be respectful and due to the lack of further evidence in this regard.¹⁶⁴ In my view, the inclusion of the more negative information would have provided the fullest possible picture of what detained people had told inspectors.
- 50.5 Approach to complaints:** The group interviews also revealed that one or more detained people said that they had “*No faith in complaints system*”.¹⁶⁵ Additionally, according to HMIP’s survey, less than half of detained people who said that they had been victimised by other detained people or by staff had reported it.¹⁶⁶ Despite this, neither of these matters were included in HMIP’s report on the issue of complaints.¹⁶⁷ Dr Singh Bhui agreed that, in hindsight, HMIP should have

¹⁵⁸ [HMIP000613_079](#) paras Q50 and Q51; [HMIP000685_028](#) para 75

¹⁵⁹ [HMIP000160_001](#); [HMIP000128_002](#)

¹⁶⁰ [Dr Hindpal Singh Bhui 24 March 2022 150/13-15](#)

¹⁶¹ [HMIP000160_001](#); [HMIP000128_002](#); [HMIP000613_033](#) para 2.5

¹⁶² [Callum Tulley 9 March 2022 149/10-151/5](#)

¹⁶³ [HMIP000160_001](#)

¹⁶⁴ [Dr Hindpal Singh Bhui 24 March 2022 150/20-151/12](#)

¹⁶⁵ [HMIP000160_001](#)

¹⁶⁶ [HMIP000613_079](#) para Q52

¹⁶⁷ [HMIP000613_036](#)

reached a conclusion that there was not enough faith in the complaints system, and it should have reported what detained people were saying about the complaints system.¹⁶⁸

50.6 Attitudes of Healthcare staff, including approach to self-harm:

One of the observations from the group interviews was that *“Healthcare staff can be abrupt or rude and quality of treatment can be poor”*.¹⁶⁹ G4S’s initial response was that it was *“not aware of particular problems with healthcare. For mental health care have an RMN [Registered Mental Health Nurse] always on duty”*, which did not show a great deal of reflection.¹⁷⁰ These comments were not included by HMIP in its report. One detained person said in the anonymous survey that *“the nurses are very rude and very bad people”* and that *“people try to hang [themselves] and they say he’s faking it who would fake something like that ... the Home Office and G4S are very bad people”*.¹⁷¹ Despite this, HMIP concluded that *“all incidents of self-harm were well investigated”*, which Dr Singh Bhui explained as referring to all of the cases it looked at in detail.¹⁷² He said that HMIP does not include individual comments that it does not think represent the overarching position.¹⁷³ The difficulty with this approach is that it can lead to significant issues not being identified in the report. Indeed, as discussed in Chapter D.8, the evidence the Inquiry heard suggested a culture within Healthcare in which doctors and nurses characterised behaviour as wilfully disobedient and obstructive, instead of countenancing the idea that the behaviour may have been a manifestation of mental anguish or ill health. This attitude accords with the allegation of a detained person being accused of *“faking it”*.

51. One of the main reasons why many of these issues were not included in the report appears to be HMIP’s approach to triangulation. Contrary to what HMIP told the Inquiry in its Closing Statement, on some occasions single sources of evidence were not sufficiently taken into account.¹⁷⁴ Although HMIP insisted that its approach is a strength of the process, Dr Singh Bhui accepted that HMIP could do better in reporting what detained people say.¹⁷⁵ He suggested that HMIP was thinking, in the future, of including what detained people had told inspectors, and then going on to explain whether HMIP agrees with those claims or, if not, why it cannot find other evidence to support

¹⁶⁸ [Dr Hindpal Singh Bhui 24 March 2022 156/18-157/18](#)

¹⁶⁹ [HMIP000160_001](#)

¹⁷⁰ [HMIP000160_001](#)

¹⁷¹ [HMIP000165_008](#)

¹⁷² [HMIP000613_023](#) para 1.21

¹⁷³ [Dr Hindpal Singh Bhui 24 March 2022 160/21-161/14](#)

¹⁷⁴ [HMIP000699_006](#) para 19

¹⁷⁵ [HMIP000699_006](#) para 19

them.¹⁷⁶ In my view, this would be a huge improvement on the current approach of excluding individual criticisms or complaints if supportive evidence cannot be found. HMIP's 2022 report did give some prominence to the reported experiences of detained people, although, as the Inquiry has not seen the underlying evidence, it is not possible to be sure that all significant issues raised by detained people were included.¹⁷⁷

52. Although there are inherent limitations to what can be identified during a two-week inspection, the 2016 HMIP inspection report overall did not properly reflect the evidence HMIP obtained of the experiences of detained people. HMIP's methodology at the time of the 2016 inspection was not sufficiently sensitive to the needs of an IRC. In such settings, signs of abuse may be more difficult to identify because of factors such as language barriers, a high turnover of detained people and detained people's fear of speaking out because of the perceived risk of it having an impact on their immigration case. Higher staffing levels at the time of the inspection may also have made things appear better than they were during the relevant period.¹⁷⁸

Reaction to the *Panorama* programme and changes made by HM Inspectorate of Prisons

53. HMIP said that it was "*very concerned*" about the behaviour shown in the *Panorama* programme. Dr Singh Bhui's view was that it became clear that there was a "*pernicious sub-culture*" whereby staff were able to treat detained people badly without colleagues challenging them or whistleblowing.¹⁷⁹ He noted that "*there was not only a few individuals who were behaving badly*", but also "*other people who knew they were behaving badly but said nothing*".¹⁸⁰

54. Dr Singh Bhui said that HMIP did not find evidence of the type of behaviour shown in the *Panorama* programme.¹⁸¹ However, as outlined above, HMIP did have the following:

- evidence of four detained people saying that they had been physically assaulted by a member of staff;
- evidence of 22 people saying that they had felt victimised (assaulted or insulted) by staff, including in seven instances where the respondent believed that the victimisation was because of their nationality;¹⁸²

¹⁷⁶ [Dr Hindpal Singh Bhui 24 March 2022 169/24-170/15](#)

¹⁷⁷ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022, pp3-4

¹⁷⁸ [HMIP000699_009-011](#) paras 29-36

¹⁷⁹ [HMIP000685_034](#) para 96; [HMIP000671_001](#)

¹⁸⁰ [Dr Hindpal Singh Bhui 24 March 2022 186/9-17](#)

¹⁸¹ [HMIP000685_034](#) para 97

¹⁸² [HMIP000613_079](#)

- a finding that the supply and misuse of drugs were “*the most significant threat to security*” in Brook House;¹⁸³
- allegations that some staff were rude;
- allegations that some Healthcare staff did not believe detained people;
- evidence of detained people saying that they had no faith in the complaints system; and
- evidence of allegations against staff of racism.¹⁸⁴

Taken together, this is broadly similar to some of the behaviour shown on the *Panorama* programme, but it was not highlighted as such. To the extent that HMIP was not able to identify what was shown in the *Panorama* programme, that reflects a limitation of the inspection process.

55. In a review conducted by HMIP immediately after the *Panorama* programme, HMIP noted that it could improve its methodology, starting at Harmondsworth immigration removal centre, which it said “*may be worse than Brook House in many ways given the large amount of intelligence received about it*”.¹⁸⁵

56. Following this review, HMIP introduced an ‘enhanced methodology’, including offering every detained person a confidential interview, asking non-governmental organisations (NGOs) to encourage detained people to speak with HMIP inspectors, encouraging NGOs to speak with HMIP directly and introducing a confidential staff survey, random staff interviews and changes to the detained person survey.¹⁸⁶ In October 2017, HMIP identified that its new methodology was causing “*considerable unease*” in the Home Office. Dr Singh Bhui thought that this was because the Home Office felt that HMIP might “*find more things and ... it would all be critical*”.¹⁸⁷ A 2020 review of the enhanced methodology found that it should continue because, despite costing more, it increased the level of scrutiny.¹⁸⁸ HMIP deserves credit for its swift and proactive response to the *Panorama* programme, and the enhanced methodology now in use is an improvement on the previous approach.¹⁸⁹

57. Indicators of abuse can be insidious. It is vital that oversight bodies are alert to the signs of ill treatment and that their methodologies for identifying

¹⁸³ [HMIP000613_027](#) para 1.46

¹⁸⁴ [HMIP000165_009](#); [HMIP000128_005](#)

¹⁸⁵ [HMIP000165_013](#)

¹⁸⁶ These were subsequently discontinued because HMIP found that they were receiving very similar information to that received during the survey. HMIP replaced them with interviews with staff who provided information of concern and were willing to be identified ([HMIP000685_037-038](#) para 99c; [HMIP000685_035-040](#) paras 98-101)

¹⁸⁷ [Dr Hindpal Singh Bhui 24 March 2022 197/8-19](#); [HMIP000156](#); [HMIP000688_002](#)

¹⁸⁸ [Dr Hindpal Singh Bhui 24 March 2022 195/4-196/4](#); [HMIP000671_003](#); [HMIP000671_005](#)

¹⁸⁹ [HMIP000699_002](#) para 3d; [Reverend Nathan Ward 7 December 2021 197/8-11](#)

abuse are effective. I am therefore recommending HMIP and IMBs ensure that their approaches are sufficiently robust and take account of the specific needs of the detained population.

Recommendation 33: Improving the investigation and reporting of HM Inspectorate of Prisons and Independent Monitoring Boards

HM Inspectorate of Prisons and Independent Monitoring Boards working within immigration removal centres must ensure that they have robust processes for:

- obtaining and reporting on an enhanced range of evidence and intelligence from detained people and those who represent or support them, staff and contractors, including that which is received outside of inspections or visits; and
- reporting on any concerns about the Home Office and contractors.

The 2019 inspection of Brook House

58. In its 2019 inspection of Brook House, HMIP found that there was no evidence that an abusive culture was present and found that no assaults had been reported in confidential interviews.¹⁹⁰ However, this presented a somewhat misleading picture given that (as in 2016) at least four detained people reported when surveyed that they had been physically assaulted by staff.¹⁹¹ Because these responses were anonymous, Dr Singh Bhui said they could not be followed up.¹⁹²

59. HMIP also reported that no Brook House staff saw any unjustified use of force and that all staff said they would report any inappropriate behaviour.¹⁹³ Dr Singh Bhui said that this was reporting what HMIP had been told and that *“unless we can find other evidence to corroborate or disprove what they’re saying ... that’s what we are left with”*.¹⁹⁴ Despite what staff said, it is difficult to believe that either of those things were an accurate reflection of the true position – particularly that all staff would report inappropriate behaviour – in light of the evidence the Inquiry has heard suggesting that there was no culture of reporting (as discussed in Chapter D.10).

¹⁹⁰ [HMIP000685_046](#) para 117; see also [HMIP000674_015](#) para S12; [HMIP000674_027](#) para 1.37; [HMIP000674_030](#) para 1.64

¹⁹¹ [HMIP000674_085](#)

¹⁹² [Dr Hindpal Singh Bhui 24 March 2022 201/17-21](#)

¹⁹³ [HMIP000674_014](#) para S8; [HMIP000674_025](#) para 1.23; [HMIP000674_030](#) para 1.64

¹⁹⁴ [Dr Hindpal Singh Bhui 24 March 2022 201/25-202/3](#)

60. However, HMIP did identify that a number of concerns remained, including about detention being maintained after Rule 35 reports, detained people being confined to cells overnight, the accommodation remaining prison-like and restraints being applied during escorts with insufficient justification.¹⁹⁵ The fact that these concerns had not been resolved from previous inspections shows some of the limitations of HMIP's role.

Current overview of HM Inspectorate of Prisons

61. At the time of the Inquiry's hearings, HMIP said that it was adding a section on leadership in future reports, which it hoped would lead to more focused reporting on staffing.¹⁹⁶ However, no such section appears in the 2022 HMIP inspection report on Brook House.¹⁹⁷

62. At the time of the Inquiry's hearings in March 2022, HMIP was also consulting on a change to the way in which it reports inspection findings, including a proposal no longer to make recommendations and instead to report a small number of 'concerns', some of which will be identified as 'priority concerns'.¹⁹⁸ This was described as being partly in response to frustration that recommendations are not always achieved, particularly when they relate to matters that have an impact on the safety of detained people.¹⁹⁹ Dr Singh Bhui described the intention as focusing minds on the key concerns and getting managers to spend time on those, rather than creating a lengthy action plan and addressing the low-level recommendations.²⁰⁰ In May 2022, HMIP announced that it was making the proposed changes in relation to recommendations in some of its inspections, but that piloting and consultation for immigration detention settings were ongoing.²⁰¹

63. In August 2022, HMIP published its most recent inspection report on Brook House.²⁰² I have referred to its findings throughout this Report when considering current practice, but more broadly I note that HMIP:

¹⁹⁵ [HMIP000685_046](#) para 118

¹⁹⁶ [HMIP000683_006](#) para 14; [HMIP000639](#)

¹⁹⁷ In a subsequent report on a different IRC, published in December 2022, a section on 'Leadership' was included (*Report on an Unannounced Inspection of Derwentside Immigration Removal Centre 8–25 August 2022*, HM Chief Inspector of Prisons, December 2022)

¹⁹⁸ [HMIP000685_011](#) para 34; *From Recommendations to Concerns*, HM Inspectorate of Prisons, undated

¹⁹⁹ [HMIP000683_010-012](#) paras 24-29

²⁰⁰ Dr Hindpal Singh Bhui 24 March 2022 [205/17-207/12](#)

²⁰¹ *From Recommendations to Concerns*, HM Inspectorate of Prisons, undated

²⁰² *Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022* (HMIP000702), HM Chief Inspector of Prisons, September 2022

- found that of the 12 recommendations made about key concerns in its 2019 report, one had been achieved, three partially achieved and eight not achieved;²⁰³
- assessed Brook House as being ‘reasonably good’ against three of HMIP’s four ‘healthy establishment’ tests (safety, respect, and preparation for removal and release) and ‘not sufficiently good’ in relation to activities;
- noted six ‘priority concerns’, including the “*unacceptably long*” length of detention in some cases, that Brook House “*did not provide an open or relaxed environment suitable for immigration detainees*”, and that it “*did not meet the needs of the high number of detainees with mental health problems*”;²⁰⁴ and
- identified nine other ‘key concerns’, including poor identification and management of risks on arrival, failure to use the Rule 35 report process to its fullest extent, inadequate case management of detained people at risk of suicide or self-harm, detained people being inappropriately locked in cells overnight, insufficiently professional supervision of units by staff and insufficiently robust governance of health services.²⁰⁵

64. This report did not include any recommendations, which suggests that the proposed changes have now been made to HMIP’s inspections of immigration detention settings. It is my hope that HMIP will monitor the impact of this change on IRCs specifically.

The challenges for the future

65. While Ms Molyneux noted a number of ongoing issues with Serco – including the fairness of the complaints system – her general impression was that Serco was aware of, and open to discussing, ongoing challenges such as the increasing population and pressures caused by the charter flights programme.²⁰⁶ Her primary concerns related to healthcare and Rule 35 assessments, as well as a number of other matters within the Home Office’s control, such as the “*inhumane*” treatment of detained people in late 2020, the Adults at Risk and Home Office Detention Gatekeeper policies, detained people’s inability to see caseworkers and the length of detention of some “*who appear to be stuck in the system*”.²⁰⁷ The 2021 IMB report concluded that Serco had “*met expectations of providing a respectful, caring environment*

²⁰³ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022, para 1.4

²⁰⁴ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022, p48

²⁰⁵ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022, p49

²⁰⁶ [Mary Molyneux 25 March 2022 162/5-8, 168/3-169/21](#)

²⁰⁷ [Mary Molyneux 25 March 2022 162/5-8, 168/15-169/10](#)

(for a detention centre)", generally focusing on welfare. Despite these efforts, it also concluded that Brook House was "*not a safe or appropriate environment for the few men who have arrived in 2021 with severe mental health issues or have significantly deteriorated while in detention*", referring to the failure of the Home Office Detention Gatekeeper system in such cases.²⁰⁸

66. The efficacy of external oversight is undermined by the Home Office's failure to act on serious issues and concerns – such as those frequently raised by the IMB – in relation to safeguarding vulnerable detained people and the 2020 charter flights programme discussed above. During the relevant period, there was an inappropriate reliance by the Home Office and G4S on the fact that the Brook House IMB and HMIP did not identify abuse. I find that the Home Office's engagement with many of the concerns that were properly raised by the oversight bodies has been inadequate.

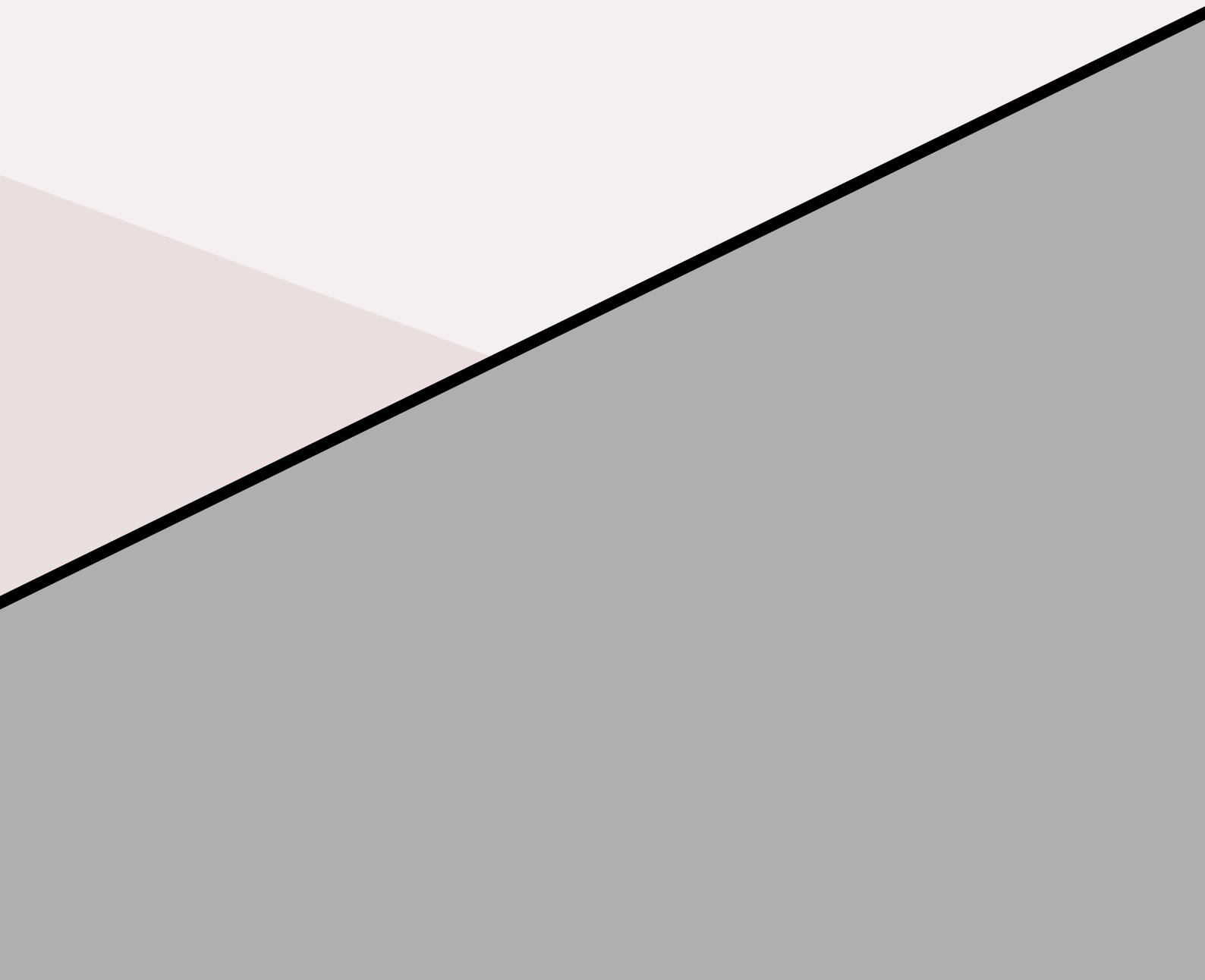
67. The Home Office attempted to explain its failures to implement recommendations by oversight bodies by referring to the "*complex*" nature of immigration detention and the "*polarised and entrenched*" debate around migration.²⁰⁹ These are inadequate excuses. Many of the issues repeatedly raised not only by the IMB and HMIP but also in numerous reports by Mr Stephen Shaw (a former Prisons and Probation Ombudsman), the Home Affairs Select Committee and other experienced bodies concern failures by the Home Office to adhere to its own rules to protect the vulnerable and to guard against breaches of human rights legislation. It was and remains completely inappropriate to place significant reliance on either a small group of IMB volunteers or very infrequent inspection visits by HMIP, particularly where some fundamental concerns, when raised, go unheeded. Moreover, it is simply not credible to suggest that complexity or polarised public opinion is an explanation for failures on these fronts where basic issues of human rights and welfare are at issue.

²⁰⁸ *Annual Report of the Independent Monitoring Board at Gatwick IRC: For Reporting Year 1 January–31 December 2021*, IMB, June 2022, para 3.3. The Home Office Detention Gatekeeper is an official who makes decisions about whether to detain an individual ([CJS000731_007](#) para 11)

²⁰⁹ [HOM0332165_061](#) para 196; Philip Riley 4 April 2022 104/23-105/17, 128/1

Part E

Recommendations to prevent recurrence of mistreatment



Recommendations to prevent recurrence of mistreatment

Introduction

1. The Inquiry identified a number of issues relating to the methods, policies, practices and other arrangements at Brook House. These factors contributed, critically, to conditions where mistreatment was more likely to occur. Throughout this Report, I have set out the changes that I consider to be necessary – at Brook House, but also more widely – to ensure that the purpose of immigration detention is properly reflected and maintained in centres at which individuals are detained prior to their removal from the UK. That purpose is expressly stated, in the secondary legislation governing these settings, to be to provide “*secure but humane accommodation*”.¹

2. While those running immigration removal centres must of course maintain “*a safe and secure environment*”, the law states that they must do so “*whilst respecting in particular [detained people’s] dignity and the right to individual expression*”.² The recommendations made by this Inquiry are intended to support this balance, and to ensure that the safeguards put in place to protect those detained are properly implemented by the third parties managing the centres and suitably verified by the Home Office.

3. This chapter sets out a summary of the changes that I am recommending to help to prevent a recurrence of mistreatment such as that set out in this Report. While I do not make recommendations specifically in relation to the incidents described in Part C in Volume I, many of the themes that I identify there – for example, the inappropriate use of force, the desensitisation of and lack of compassion from staff, and the inappropriate use of isolation – are explored more widely in Part D, the structure of which is followed here.

The contract to run Brook House

4. The initial contract to operate, manage and maintain Brook House was awarded to another company, which was acquired by G4S Care and Justice

¹ [Detention Centre Rules 2001](#), Rule 3

² [Detention Centre Rules 2001](#), Rule 3

Services (UK) Ltd (G4S) in May 2008. In addition to provisions requiring compliance with the Detention Centre Rules 2001, the Detention Services Operating Standards Manual and detention services orders, the contract included a lengthy list of high-level requirements set by the Home Office and specifications for how these requirements should be met.

5. There were concerns about aspects of the bid (including the available activities and a *“long lockdown period”*).³ While the evaluation criteria, in theory, weighted the operational ‘quality’ of each bid and the cost equally, rather than using its budget to ensure that a suitable operational contract was in place, the primary motivation of the Home Office appeared to be cost-saving, with care and welfare sidelined. The Inquiry was told that there is now a *“far bigger drive ... for value for money and quality”*.⁴

6. The monthly fee paid by the Home Office to G4S was subject to performance-related deductions, based on 30 key performance indicators. Some gave rise to a set financial penalty if not met, and some incurred points, which had a value that varied over time. The penalty structure of the contract set by the Home Office emphasised security over care. Compliance with these measures was monitored by G4S; as one senior Home Office official described it, *“we did rely on honesty and integrity from G4S”*.⁵ The Home Office conceded that its contract *“did not give the Home Office sufficient leverage”* to hold G4S to account in delivering services in accordance with the contract or the requirements of the Detention Centre Rules 2001 and other guidelines.⁶ There were also insufficient Home Office staff to properly monitor the contract during the relevant period and it appeared to pay only superficial attention to welfare standards, which should have been the fundamental concern.

7. The Home Office stated that improvements were made in the contract with Serco Group PLC (Serco), which took over the management of Brook House in May 2020, noting:

“Overall, the new contract has been designed to have a much greater focus on the safety and welfare of those detained.”⁷

Compliance continues to be monitored by a combination of self-auditing by Serco and oversight by the Home Office. It appears that there is still significant room for improvement. I am therefore recommending an active and robust approach to performance management by the Home Office, which retains ultimate responsibility for the welfare of detained people.

³ [DL0000140_073](#)

⁴ [Gordon Brockington 31 March 2022 76/12-16](#)

⁵ [HOM0332165 para 106](#); [Ian Castle 15 March 2022 21/5-12](#). See also [HOM0332004_006-007 paras 14-17](#); [HOM0332152_003-006 paras 12-25](#); [Michelle Smith 23 March 2022 114/21-133/6, 143/13-21](#)

⁶ [HOM0332005_011 para 31](#)

⁷ [SER000226](#); [HOM0332165 para 102](#). See also [HOM0332005_009 para 26](#); [HOM0332051_006-007 paras 28-29](#)

Recommendation 1: Robust monitoring of contract performance

The Home Office must actively and robustly monitor the performance of the Brook House contract, including satisfying itself that any self-reported information is accurate. This may include engagement with monitoring bodies and appropriate stakeholders. Penalties must be attached to inadequate self-reporting.

- 8.** The contract under which G4S managed Brook House during the relevant period was *“likely designed in 2004 or 2005”*.⁸ The Inquiry was told that Home Office contracts are now awarded on the basis of value for money, with 35 per cent of the assessment weighting attributed to cost, and the remaining 65 per cent made up of *“quality”*, *“social”* and *“value”* elements.
- 9.** In any event, the tendering process for awarding contracts to manage an immigration removal centre should include and properly reflect the overriding purpose set out in Rule 3 of the Detention Centre Rules 2001.

Recommendation 2: Contractual term requiring compliance with the overriding purpose of Rule 3 of the Detention Centre Rules 2001

The Home Office must ensure that each contract for the management of an immigration removal centre must expressly require compliance with the overriding purpose of Rule 3, which is to provide *“the secure but humane accommodation of detained persons in a relaxed regime with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environment, and to encourage and assist detained persons to make the most productive use of their time, whilst respecting in particular their dignity and the right to individual expression”*.

The provisions and operation of each contract must be consistent with and uphold the requirements of the Detention Centre Rules 2001, the Adults at Risk in Immigration Detention policy and the safeguards contained in detention services orders (including those concerning the use of force).

⁸ [HOM0332165 para 97](#); [Philip Riley 4 April 2022 34/24](#)

The physical design and environment

10. The environment at Brook House was influenced by its physical design, facilities and other decisions made by the Home Office and G4S, all of which contributed to the harshness of the experience for detained people as well as staff. As one senior G4S staff member described it, *“it was designed more like a prison and it felt like a prison”*.⁹ As a result of its *“small footprint ... the facilities are rather cramped”*.¹⁰ This was in part due to its design to hold detained people on a short-term basis. Concerns about poor conditions were identified in every inspection report since 2010 but problems remained, including a lack of ventilation and unscreened and unclean toilets. Despite improvement plans and a change in management of Brook House, HM Inspectorate of Prisons (HMIP) has remained critical of the current environment under Serco. One senior Serco manager told the Inquiry that the building and the restrictions that went with it posed challenges for the delivery of a *“human[e] regime”*.¹¹

11. Whatever future plans the Government has regarding immigration detention, they should take account of what this Inquiry has found regarding the impact of the physical environment. In my view, the delivery of humane conditions is made significantly more difficult when the accommodation is inherently unsuitable for immigration detention.

12. The Home Office’s decision in early 2017 to convert some cells from two-person to three-person cells (known as the Extra Beds Programme) was criticised by external sources, both before and after the changes were implemented, as well as by G4S staff. The programme resulted in overcrowding and had a significant adverse impact on welfare. Although it was discontinued in May 2018, capacity in the immigration estate should never again be increased by adding extra beds to cells designed for fewer occupants. I am therefore recommending a limit on the maximum number of detained people sharing each cell at Brook House.

Recommendation 3: Limit on cell sharing

The Home Office must ensure that a maximum of two detained people are accommodated in each cell at Brook House.

⁹ [KEN000001_011-012](#) para 56

¹⁰ [KEN000001_011-012](#) para 56

¹¹ [Steven Hewer 1 April 2022 87/3-7](#)

13. The Detention Centre Rules 2001 provide that a comprehensive range of activities must be provided to meet “*recreational and intellectual needs*” and relieve “*boredom*”.¹² While G4S’s internal policy reflected this requirement, the 2016 Independent Monitoring Board report identified a “*noticeable shortage of space for activities*” at Brook House.¹³ Similarly, in May to June 2022 HMIP found that the number of activity places was not sufficient to occupy the population of Brook House, with a number of the facilities too small. From the lack of space and other resources allocated, it appears that activities were not seen as important by the Home Office and G4S for detained people, who were only supposed to be accommodated at Brook House for very short periods of time. Such an impoverished regime is likely to have contributed to boredom and frustration.

14. Computer and internet access at Brook House was also poor and did not meet Detention Services Order 04/2016: Detainee Access to the Internet (the Internet DSO). Detained people (as well as some others working at or visiting immigration removal centres) are not permitted to have internet-enabled devices, such as smartphones, and so relied upon the computer and internet access provided at the centre. However, there were problems with computer and internet speeds, blocked websites and access to working computers. Some detained people told the Inquiry that internet access failed shortly before they or others were deported. Personal email accounts should not have been blocked, not least because, in some cases, it appears to have had the effect of reducing access to justice. Only certain categories of website (such as social networking, pornographic material, and extremist and radicalising material) should have been prohibited. I am therefore recommending that reasonable access to computers and the internet be provided, reflecting the requirements of the Internet DSO.

¹² Detention Centre Rules 2001, Rule 17; CJS000680_005-006

¹³ IMB000121_006 para 3.7

Recommendation 4: Ensuring computer and internet access

The Home Office and its contractors must ensure reasonable access to computers and the internet.

Contractors must comply in full with Detention Services Order 04/2016: Detainee Access to the Internet, in particular:

- Computers and the internet provided for detained people's use must be maintained and fixed, if broken, within a reasonable time period, in order to allow detained people to access the internet for a minimum of seven hours per day, seven days per week.
- Websites containing personal internet-based email accounts must not be blocked, since this is not a prohibited category of website.
- Websites facilitating the provision of legal advice and representation must not be blocked, as this is not a prohibited category of website.

Detained people's safety and experience

15. As reflected in the Detention Centre Rules 2001, as well as the G4S contract, people detained at Brook House were entitled to be treated humanely and with care, and to reside in an environment that ensured their safety and security. However, the evidence received by the Inquiry revealed several issues that had a detrimental impact on their quality of life.

16. There was a significant drug problem during the relevant period at Brook House, particularly with a new psychoactive substance known as 'spice'. For example, on 15 June 2017, there were four medical responses to spice attacks, three of which took place simultaneously. While Brook House was not unique in experiencing this problem, the Inquiry's cultural expert considered the extent of its drug problem to be "*shocking*".¹⁴ The frequent use of drugs and the consequences suggest that there was a failure by both the Home Office and G4S to take sufficient or adequate steps to control the availability and use of drugs, both prior to and during the relevant period. This failure likely contributed to an environment that felt unsafe.

17. A large proportion of people detained at Brook House did not have a good understanding of English, creating additional difficulties and being a "*key contributing factor to the anxiety and frustration of the detained population*".¹⁵

¹⁴ [Professor Mary Bosworth 29 March 2022 9/13-20](#)

¹⁵ [Professor Mary Bosworth 29 March 2022 17/5-6](#). See also [HMIP000613_82](#); [HMIP000613_072](#); [HMIP000613_074](#)

Language barriers also reduced the ability of detained people to interact with staff, access healthcare, make complaints and communicate with visitors. Insufficient steps were taken during the relevant period to reduce these barriers, which contributed to conditions where poor treatment was more likely to occur. Detention Services Order 02/2022: Interpretation Services and Use of Translation Services (the Interpretation and Translation DSO, introduced in June 2022) now makes clear that in-person or telephone interpretation services should be used for all essential interactions where accuracy is of significant importance.

18. Despite the requirements of Detention Services Order 12/2012: Room Sharing Risk Assessment, there also appears to have been an inadequate process for assessing risk when allocating detained people to cells. For example, one detained person was placed with a cell mate who subjected him to “*terrifying*” violence, despite him informing staff beforehand that there was a war between their countries of origin.¹⁶ There were also problems with allocation regardless of risk assessment. Assessments must be properly conducted to avoid unnecessary risk, and capacity issues should not be prioritised over the welfare of detained people. I am therefore recommending steps to assess and manage risks related to cell sharing.

Recommendation 5: Undertaking and complying with cell-sharing risk assessment

The Home Office must ensure that adequate risk assessment for cell sharing is carried out by contractors in relation to every detained person. This must be done at the outset of detention and then repeated at reasonable intervals (at least every 14 days) or following any relevant change in circumstances.

In the event that an immigration removal centre is unable to detain someone in accordance with the outcome of a risk assessment (due to capacity or for other reasons), the Home Office must ensure that the individual does not remain at that centre.

19. Violence and bullying among detained people was undoubtedly part of life at Brook House during the relevant period. Although G4S had procedures for addressing bullying among detained people, these were not always followed. Some detained people also told the Inquiry about a lack of intervention from staff, albeit that the ability of staff to prevent and respond to violence and bullying was affected by insufficient staffing levels.

20. Before and during the relevant period, detained people at Brook House were locked in their cells from 21:00 to 08:00 every day and during two daily

¹⁶ [DPG000039_028](#) para 108

30-minute roll calls. The harshness of this regime was flagged during the procurement process prior to the opening of Brook House. Concerns about the length and time of the lock-in period have also been raised repeatedly by HM Inspectorate of Prisons (HMIP), which queried *“why detainees needed to be locked in their rooms at all”* and described detained people being locked in their cells overnight as *“inappropriate”*.¹⁷ It has recommended – four times – that Brook House reduce the length of the lock-in period and institute a later lock-in. The Home Office and its contractors have failed repeatedly to engage adequately with the issues at the heart of those recommendations. HMIP noted: *“it is, fundamentally, a staffing issue”*.¹⁸

21. In Detention Services Order 04/2018: Management and Security of Night State (the Night State DSO), it is suggested that a night state, or lock-in:

“creates a clearly defined day/night routine and offers detainees the opportunity to rest in a quiet and private space in contrast with the constructive activities available during the day time”.¹⁹

This explanation is likely to be an attempt retrospectively to justify a situation that was understood to be unjustifiable at the outset. In reality, I consider that one of the drivers for this highly restrictive regime was financial. In my view, the lock-in regime up to and during the relevant period conflicted with Rule 3 of the Detention Centre Rules 2001, which requires as much freedom of movement and association as possible.

22. The individuals concerned are subject to the administrative process of immigration detention; they are not prisoners. Any time during which they are locked in their cells must be justified by the strongest reasoning. I am therefore recommending that this practice be reviewed, to allow greater free movement.

Recommendation 6: Review of the lock-in regime

The Home Office, in consultation with the contractor responsible for operating each immigration removal centre, must review the current lock-in regime and determine whether the period of time during which detained people are locked in their cells could be reduced.

The Inquiry does not consider cost alone to be a sufficient justification for extensive lock-in periods.

¹⁷ [HMIP000311_016](#) para S23; [HMIP000613_016](#) para S8. See also [HMIP000674_005](#); [HMIP000674_020](#) S46, para 1.46

¹⁸ [Dr Hindpal Singh Bhui 24 March 2022 176/2-11](#)

¹⁹ [Detention Services Order 04/2018: Management and Security of Night State](#), Home Office, December 2018, para 3. See also [DL0000082_007-009](#)

23. ‘No-notice removals’ is a term that is usually used to describe a three-month window given to detained people when – after an initial short period (of 72 hours, to include two working days) during which there was no risk of removal – they could be removed from the UK with no further notice. As one Home Office staff member described:

*“the first thing the person knew when they were leaving was when the room door was opened and three officers in full personal protection kit stepped in and they were taking them down to reception. That was just a very grisly, unnecessary set of circumstances and failed communications.”*²⁰

24. The use of this approach during the relevant period appears to have had a detrimental impact on detained people, increasing levels of uncertainty and fear as well as undermining trust in staff. The Inquiry was told that no-notice removals were a *“significant contributing factor to the number of uses of force we have observed”*.²¹

25. There was and is no fixed or maximum period of time for which someone may be detained at Brook House or at any other immigration removal centre; it is also unclear, when an individual is detained, for how long detention will last. This is sometimes referred to as ‘indefinite detention’. Despite being designed to detain people on a short-term basis, the average stay at Brook House in July 2017 was 44 days; five people had been there for one to two years. The Inquiry received clear evidence that indefinite detention caused uncertainty, frustration and anxiety for detained people, with a negative impact on their health and wellbeing that left some detained people in *“ever-spiralling circles”*.²² As one member of G4S staff put it:

“if you lock people in what is effectively a prison for an indefinite amount of time then ultimately, however good the care is, they are going to suffer, particularly in respect of their mental health”.²³

26. A time limit on immigration detention has previously been recommended by various organisations. In my view, this would constitute a significant improvement to the treatment and wellbeing of those detained in immigration removal centres. Home Office guidance states that removal can be said to be imminent where, among other things, *“removal is likely to take place in the next four weeks”*.²⁴ I consider that 28 days would be a reasonable time limit on detention.

²⁰ [VER000264_016](#)

²¹ [Lee Hanford 15 March 2022 87/7-8](#). See also [CJS0074041_035](#) para 176 and [Jonathan Collier 30 March 2022 61/1-62/3](#)

²² [Stephen Skitt 17 March 2022 48/8-17](#)

²³ [MIL000003_022](#) para 107

²⁴ [Home Office Enforcement Instructions and Guidance](#), Chapter 55.3.2.4, Application of the factors in 55.3.1 to criminal casework cases

Recommendation 7: A time limit on detention

The government must introduce in legislation a maximum 28-day time limit on any individual's detention within an immigration removal centre.

Safeguards for vulnerable individuals

27. There are a number of critical provisions that seek, collectively, to provide safeguards for those individuals who may be vulnerable to suffering harm in detention. These include Rule 34 and Rule 35 of the Detention Centre Rules 2001, and the statutory guidance Adults at Risk in Immigration Detention (Adults at Risk policy).

28. Rule 34 – which requires a medical examination of every detained person by a GP within 24 hours of their arrival at an immigration removal centre – functions to identify the immediate health needs of a detained person. It is also an important safeguard to identify vulnerable people who should not be in detention. Where the criteria for a Rule 35 report are met (where the health of a detained person is likely to be injuriously affected by continued detention or any conditions of detention, where it is suspected that a detained person has suicidal intentions, or where there is a concern that a detained person may have been a victim of torture), this should be completed by the GP and raised with the Home Office “*without delay*”.²⁵ Its completion might be at a Rule 34 examination, so that detention can be reviewed at a very early stage. This enables an individual's continued detention to be reviewed promptly by the Home Office and, unless there are exceptional circumstances, for them to be removed from detention. In this way, the two rules are designed to work together as a safeguard for vulnerable detained people at the start of detention.

29. This safeguard was not operating effectively at the outset of detention in 2017 and evidence indicated that this remained the case at the time of the Inquiry's hearings. A nursing screen was sometimes the only appointment that occurred. Those GP appointments that did take place within the first 24 hours of arrival were scheduled to last for five minutes, which is insufficient time to complete an adequate mental and physical examination. Even when vulnerabilities (such as torture or mental health concerns) were identified, this did not always lead to a Rule 35 assessment or report. A practice also arose whereby Rule 35 reports were not written, or indeed considered, at the Rule 34 assessment; instead, a second later assessment was booked. In my view, Rules 34 and 35, operating together, require a proactive approach to the identification of vulnerabilities and acting upon any such vulnerabilities without

²⁵ Detention Centre Rules 2001, Rule 35

delay. Disconnecting them was inappropriate. It is likely to have caused some detained people to have suffered actual harm – for example, through a deterioration in their mental or physical health. It left vulnerable detained people in particular exposed to a risk of incidents of mistreatment, such as the inappropriate use of segregation and the rapid resort to use of force to manage incidents of self-harm and mental health crisis. It also meant that vulnerable people, for whom detention was not appropriate, were being detained.

30. A key contributing factor in the failure of the safeguards is likely to have been the unacceptable lack of training on Rules 34 and 35 (and on the Adults at Risk policy) in Brook House, which appears still to be the case. A comprehensive mandatory programme of training should have been prioritised for relevant staff in Brook House, to ensure that they understood their obligations under the Rules and how to properly apply the policy. In its response to the 2023 inspection report of the Independent Chief Inspector of Borders and Immigration (ICIBI), the Home Office accepted a recommendation about training for doctors. Based upon the evidence available, it is not clear what training has been delivered, and I am therefore recommending that a comprehensive training programme be rolled out as a matter of urgency, to ensure the immediate safety of detained people.

Recommendation 8: Mandatory training on Rule 34 and Rule 35 of the Detention Centre Rules 2001

The Home Office (in collaboration with NHS England as required) must ensure that comprehensive training on Rule 34 and Rule 35 of the Detention Centre Rules 2001 is rolled out urgently across the immigration detention estate. Staff must be subject to refresher training, at least annually.

Attendance must be mandatory for all staff working in immigration removal centres and those responsible for managing them, as well as GPs and relevant Home Office staff. Consideration must be given as to whether such training should be subject to an assessment.

31. A presumption applied under the Adults at Risk policy that adults at risk would not be detained. Detention would only be appropriate where immigration control considerations outweighed the risk factors identified, such as having a mental health condition or impairment or having been a victim of torture. The vast majority of reports in the relevant period related to a concern that a detained person might have been a victim of torture (Rule 35(3)); the Inquiry's medical expert considered that around 75 per cent of those reports he reviewed were inadequately completed. In the whole of 2017, only eight Rule 35(1) reports were completed (where it is likely that a detained person's health would be injuriously affected by continued detention). No Rule 35(2)

reports were completed in 2017, 2018, 2019, 2020 or 2021 (where it is suspected that a detained person has suicidal intentions). Healthcare staff resorted to the inappropriate use of alternatives (such as Part C forms and the Assessment Care in Detention and Teamwork (ACDT) process) not designed for – and not capable of – adequately fulfilling the purpose of ensuring the safety and wellbeing of detained people.

32. The failure to complete Rule 35 reports in appropriate circumstances resulted in the deterioration in the mental health of detained people, increased their risk of self-harm and suicide, and therefore left them more vulnerable to harm. Deterioration was not detected or monitored adequately. More importantly, the person remained in detention with the risk potentially to materialise, causing harm. The Home Office was not informed and therefore did not review detention and consider release. These were serious systemic failures, indicating a wholesale breakdown in the system of safeguards designed to protect vulnerable detained people.

33. The Inquiry has not received any evidence of any fundamental changes to the system of safeguards since 2017. There has been no amendment to Rules 34 and 35, nor any significant change in relation to their application in practice, and there have been no material changes to the Adults at Risk policy. Concerns in these areas were not raised for the first time in this Inquiry. Most recently, in January 2023, the ICIBI stated that *“the Rule 35 process needs to be called out for what it is – ineffective”*.²⁶ In my view, there is clearly a deeply rooted, systemic problem in relation to the adequacy of the operation of the safeguards under Rule 35. I do not consider that immigration detention practices have significantly or sufficiently addressed these issues and am therefore recommending a review of the implementation of Rule 35 across the immigration detention estate.

²⁶ Inspection report published: Third annual inspection of ‘Adults at risk in immigration detention’, June–September 2022, Gov.uk; see Third Annual Inspection of ‘Adults at Risk in Immigration Detention’, Independent Chief Inspector of Borders and Immigration, January 2023

Recommendation 9: Review of the operation of Rule 35 of the Detention Centre Rules 2001

The Home Office must, across the immigration detention estate, assure itself that all three limbs of Rule 35 of the Detention Centre Rules 2001 (reports by a medical practitioner where: (i) it is likely that a detained person's health would be injuriously affected by continued detention (Rule 35(1)); (ii) it is suspected that a detained person has suicidal intentions (Rule 35(2)); or (iii) there is a concern that a detained person may have been a victim of torture (Rule 35(3))) are being followed, are operating effectively and are adequately resourced, in recognition of the key safeguarding role that the Rule plays.

The Home Office must also regularly audit the use of Rule 35 in order to identify trends, any training needs and required improvements.

Restrictions on detained people

34. The Detention Centre Rules 2001 contain powers that restrict the rights of detained people, segregating them to some degree from others. Rule 40 allows the removal of a detained person from association where "*it appears necessary in the interests of security or safety*", initially for up to 24 hours but up to a maximum of 14 days.²⁷ This power was used on 241 occasions at Brook House during the relevant period (1 April 2017 to 31 August 2017). Rule 42 contains a power to confine a "*refractory [ie difficult to control or unwilling to obey authority] or violent detained person*" in "*special accommodation*", but it cannot be used as a punishment or after a detained person has ceased to be refractory or violent. Confinement under Rule 42 cannot exceed 24 hours without a written direction from an officer of the Secretary of State. Even then, it can only be extended to a maximum of three days. These powers must be balanced with "*the need to have due regard to the dignity and welfare of the individual*" and "*must be used only as a last resort, when all other options have been exhausted or are assessed as likely to fail or to be insufficient*".²⁸ This reflects that the use and misuse of these powers can have very harmful consequences.

²⁷ Detention Centre Rules 2001, Rule 40(3) and 40(4)

²⁸ CJS000676 paras 2 and 19

35. Authorisation of these powers may only be granted by the Secretary of State (or an appropriate Home Office official to whom powers have been delegated), other than in cases of urgency when *“the manager of a contracted-out removal centre may assume the responsibility of the Secretary of State”*.²⁹ During the relevant period, the manager of Brook House for these purposes was Mr Ben Saunders, as Centre Director for Brook House and Tinsley House immigration removal centre, and the Inquiry saw no evidence of him authorising the use of Rule 40 during the relevant period. Only four instances were authorised by Mr Paul Gasson (the Home Office Contract Monitor at Brook House at the time). Instead, uses of Rule 40 and Rule 42 were routinely authorised at Brook House by Duty Managers other than Mr Saunders, and by Detention Custody Managers who were not acting as Duty Managers. Evidence received gave the impression of widespread confusion and apparent misunderstanding at an organisational level about who could authorise use of these Rules, even among senior managers at both the Home Office and G4S. A number of related documents – including an interim instruction issued by the Home Office in October 2016, the Detention Services Operating Standards Manual for Immigration Service Removal Centres (the Operating Standards Manual, January 2005), and Detention Services Order 02/2017: Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42) (the Restrictions DSO, dated July 2017), as well as the G4S contract – may have contributed to this confusion. The Inquiry also heard evidence that Rule 40 might have been used in Brook House without Home Office authorisation, even where there would have been sufficient time to seek it.

36. This appears to have been perpetuated by inadequate training. While the Inquiry did not examine any recent individual uses of Rule 40 or Rule 42, it is concerning that misunderstandings about who can authorise use of these Rules appear to persist under Serco, exacerbated by the terms of the Restrictions DSO in particular. It is extremely important that both the Home Office and Serco take steps to ensure that Rule 40 and Rule 42 are used only where permitted by law, which includes proper authorisation. I am therefore recommending that the Home Office clarify the authorisation process as a matter of urgency.

²⁹ Detention Centre Rules 2001, Rules 40(2) and 42(2)

Recommendation 10: Clarification on the use of Rule 40 and Rule 42 of the Detention Centre Rules 2001

The Home Office must amend, as a matter of urgency, Detention Services Order 02/2017: Removal from Association (Detention Centre Rule 40) and Temporary Confinement (Detention Centre Rule 42) and, if necessary, the Detention Services Operating Standards Manual for Immigration Service Removal Centres, to clarify who can authorise use of Rule 40 and Rule 42 of the Detention Centre Rules 2001, in both urgent and non-urgent circumstances, including providing a definition of the term ‘manager’ in Rule 40(2) and Rule 42(2).

In anticipation of the update to Detention Services Order 02/2017, the Home Office must issue an immediate instruction to communicate this clarification to staff and contractors operating immigration detention centres.

37. The Inquiry also received detailed evidence about the inappropriate use of these Rules.

38. Although those subject to Rule 40 or Rule 42 must be accommodated in a room designed and certified for that purpose, the Inquiry heard conflicting evidence about whether this was the case during the relevant period. Housing detained people temporarily removed from association or confined as a result of their behaviour on E Wing resulted in them living alongside vulnerable detained people who were suffering from mental health disorders or who required protection from other detained people. It appears that this practice continues under Serco’s management of Brook House. I am therefore recommending a review of the multi-purpose use of E Wing.

Recommendation 11: Review of the use of E Wing at Brook House

The Home Office and the current operator of Brook House must keep under review the appropriateness of the multi-purpose use of E Wing, particularly in relation to its suitability as a location to detain vulnerable people.

39. Rule 40 was improperly used as a punishment by some members of staff at Brook House, even in response to minor behavioural issues (such as stealing coffee), notwithstanding the fact that this was not permissible. Some detained people were moved to E Wing and additionally placed subject to Rule 40, seemingly for reasons of pure administrative convenience. This is significant because a detained person held on E Wing under Rule 40 would be restricted in their ability to associate with others and move around the centre. More recent evidence indicates that there may be continuing problems with the use of segregation for the convenience of staff under Serco's management of Brook House.

40. Where a detained person has been identified as being at risk of suicide or self-harm, Rules 40 and 42 should only be used in "*exceptional circumstances*", for the "*shortest time possible*" and "*as a last resort*".³⁰ Despite this clear mandatory guidance, there was evidence that Rules 40 and 42 were used inappropriately by some members of staff to manage detained people with mental ill health during the relevant period. Segregation is not a mental health treatment. Rather, as Dr Rachel Bingham, clinical advisor to Medical Justice (a charity that provides medico-legal reports and advice to detained people), told the Inquiry: "*it's actually something that would harm ... mental health*".³¹ It is particularly concerning that this approach was pervasive during the relevant period. To the extent that Rules 40 and 42 are still being used to manage detained people with mental ill health in a manner that is not in accordance with the Restrictions DSO, that remains inappropriate. The Home Office and Serco should seek to assure themselves that the practice is not continuing.

41. These issues further demonstrate why it is so important that Rule 40 and Rule 42 should only be used where appropriate. I am therefore recommending that action be taken to improve the understanding of staff, both from the Home Office and from contractors, about the proper operation of these Rules.

³⁰ [CJS000676_010](#) para 25

³¹ [Dr Rachel Bingham 14 March 2022 54/5-8](#)

Recommendation 12: Training in relation to Rule 40 and Rule 42 of the Detention Centre Rules 2001

The Home Office and contractors operating immigration removal centres must provide regular training, at least annually, on the operation of Rule 40 and Rule 42 of the Detention Centre Rules 2001, which must include:

- that Rules 40 and 42 are the only powers under which detained people in immigration removal centres can be removed from association and/or located in temporary confinement;
- who is permitted to authorise use of those Rules and in what circumstances they may be authorised;
- that Rules 40 and 42 cannot be used as a punishment or solely for administrative convenience before a planned removal or transfer; and
- the need to assess any adverse effect that use of Rule 40 or Rule 42 could have on a detained person's physical or mental health, and to consider any steps that could be taken to mitigate those effects.

Attendance must be mandatory for all staff working in immigration removal centres and those responsible for managing them. The training must be subject to an assessment.

42. There should be ongoing monitoring of the use of Rule 40 and Rule 42 by the contractor of an immigration removal centre in a contracted-out centre, with oversight by the Home Office. G4S failed to identify and act upon any of the significant issues identified by the Inquiry in relation to the use of Rules 40 and 42. Although the Home Office identified failings in compliance, very little substantive action was taken and the Home Office undertook no generalised monitoring.

43. Whenever a detained person is subject to Rule 40 or Rule 42, the Independent Monitoring Board (IMB) should be given notice and visit them within 24 hours, although the Inquiry was told that it was not possible to undertake all such visits. However, the Brook House IMB did not check any individual uses of Rule 40, for example, to satisfy itself that it had been appropriate to use it in the specific circumstances. When HM Inspectorate of Prisons (HMIP) conducted inspections, it considered "*a sample of cases to work out whether or not separation has been justified*".³² Despite the significant body of evidence demonstrating that authorisation of the use of Rule 40 and Rule 42 was a serious issue at Brook House during the relevant period (which was only five months after HMIP's 2016 inspection), no such issue was

³² [Dr Hindpal Singh Bhui 24 March 2022 179/13-19](#)

identified by HMIP. It appears that many of the concerns noted by the Inquiry still persist under Serco's operation of Brook House. This remains an area where greater scrutiny would be beneficial, and I consider that there is room for improvement in the operation of these critical oversight functions.

Recommendation 13: Audit of use of Rule 40 and Rule 42 of the Detention Centre Rules 2001

The Home Office must regularly (and at least quarterly) audit the use of Rule 40 and Rule 42 across the immigration detention estate, in order to identify trends, any training needs and required improvements.

In addition, HM Inspectorate of Prisons and the National Chair and Management Board of Independent Monitoring Boards must review processes to consider how they fulfil their oversight role in respect of Rule 40 and Rule 42, and report on the monitoring of the use of Rules 40 and 42 going forward.

Use of force

44. The term 'use of force' has a particular meaning in the context of immigration detention. It can only be used by officers on detained people in particular circumstances and as a last resort, reflecting the possibility of causing serious harm.

45. However, the Inquiry heard evidence that unauthorised and potentially highly dangerous techniques were used on several occasions during the relevant period. This included the most serious incident where one officer – deliberately and intending to provoke and punish him – placed his hands around D1527's neck and said: *"You fucking piece of shit, because I'm going to put you to fucking sleep."*³³ On several occasions, staff used an unauthorised and dangerous technique, namely, the handcuffing of detained people with their hands secured behind their back when seated. This creates a risk of causing positional asphyxia (whereby a person's ability to breathe is impeded because of the way they are being restrained). This practice was removed from the Use of Force Training Manual in 2015, following the death of Mr Jimmy Mubenga on 12 October 2010, after he was restrained by G4S officers. No explanation was provided about the continued use of this dangerous technique and I am therefore recommending that the Home Office ensure that all staff are aware that it is not permitted.

³³ [Day 2 AM 24 November 2021 00:53-01:23:53 \(KENCOV1007 - V2017042500021\)](#). See also [INQ000111_013 para 29](#); [INQ000111_146 para 637](#)

Recommendation 14: Handcuffing behind backs while seated

The Home Office and contractors operating immigration removal centres must ensure that all staff are aware that the technique of handcuffing detained people with their hands behind their back while seated is not permitted, given its association with positional asphyxia.

46. Staff also incompetently used authorised techniques (such as the ‘prone position’) in a way that became dangerous and increased the risk of injury.

47. There was also considerable evidence that, during many incidents, officers were too quick to employ force. Attempts to de-escalate incidents were often non-existent, compounded by the unnecessary use of Personal Protective Equipment (PPE), reflecting a “*cultural process of automatically resorting to PPE*” among Brook House staff.³⁴

48. Many of the above issues demonstrate that the application of Prison Service Order 1600: Use of Force (the Use of Force PSO) to govern the use of force inside immigration removal centres (IRCs) is inappropriate. IRCs have a different purpose, populations and issues when compared with prisons. Reliance by IRC staff on a variety of sources for rules and guidance on the use of force (including the Use of Force PSO, the Detention Centre Rules 2001 and the Detention Services Operating Standards Manual) has created unnecessary complexity and confusion. This is best demonstrated by the majority of the 109 use of force incidents recorded during the relevant period being in order to “*maintain good order and discipline*”.³⁵ However, this is not listed as a justification for force in Rule 41 or any of the other Detention Centre Rules, nor is it mentioned in the Detention Services Operating Standards Manual. Given the breadth of significant issues identified by the Inquiry, I am recommending the introduction of comprehensive and mandatory guidance about the appropriate use of force in IRCs.

³⁴ [INQ000185_039](#); [INQ000111_145-146](#) para 636 (use of force incidents involving D1914 on 27 May 2017 [134/17], D1234 on 28 March 2017 [81/17], D2054 on 28 June 2017 [162/17], 86/17 and 108/17); [INQ000111_011-012](#) paras 19-20; [Jonathan Collier 30 March 2022 91/7-10](#); [INQ000111_012](#) para 24; [INQ000111_156](#) para 658 (incidents 164/17 and 165/17)

³⁵ [CJS000905_006](#); [CJS000908_010](#); [CJS000914_008](#); [CJS000910_010](#); [CJS000619_10](#)

Recommendation 15: A new detention services order about the use of force

The Home Office must introduce, as a matter of urgency, a new and comprehensive detention services order to address use of force in immigration removal centres.

The detention services order must include the following issues:

- the permissible justifications for the use of force within immigration removal centres, based on the key principle that force must not be used unnecessarily and must be used only as a last resort;
- the use of Personal Protective Equipment (PPE), including that it must be subject to a dynamic risk assessment before and during any use of force incident;
- the protection of dignity when force is used on a naked or near-naked detained person;
- the circumstances in which force can be used against a detained person with mental ill health; and
- monitoring, oversight and reporting of use of force by contractors and by the Home Office.

The Home Office must ensure that training about the application of the new detention services order and use of force techniques takes place on a regular (at least annual) basis for all detention staff as well as healthcare staff. Attendance must be mandatory for all staff working in immigration removal centres and those responsible for managing them. The training must be subject to an assessment.

In anticipation of a new detention services order on the use of force in immigration detention, the Home Office must issue an immediate instruction to its contractors managing immigration removal centres that force must be used only as a last resort, using approved techniques.

49. The Inquiry also saw force being routinely used on mentally unwell and vulnerable detained people, with an *“unusually high”* number of instances.³⁶ It was often used as a response to, and a form of management of, symptoms of mental ill health, which were wrongly treated as non-compliance and disruptive behaviour. There was routine and quick resort to force in response to incidents of self-harm. Use of force can lead to a serious worsening of

³⁶ [Jonathan Collier 30 March 2022 61/22-62/8](#). See, for example, [Day 41 AM 30 March 2022; CJS0074115 UOF 88 17 BWC 8:50-17:35; INQ000111_076 para 302; Day 41 PM 30 March 2022 00:34:02-00:40:32 \(S1970002 \[CJS0074113\]\); SER000437_006 para 22](#)

symptoms of mental ill health and deter detained people from engaging with clinical care. In my view, a person's mental health should be taken into consideration when deciding whether and when to use force and, in particular, if and when to apply certain techniques. I am therefore recommending, in advance of the introduction of a new detention services order, that there be a thorough review of the use of force on detained people with mental ill health.

Recommendation 16: Urgent review of use of force on detained people with mental ill health

The Home Office must urgently commission an independent review (with the power to make recommendations) of use of force on detained people with mental ill health within immigration removal centres.

The review must consider:

- how, when and whether to use force on detained people with mental ill health (including the application of pain-inducing techniques);
- the likely effect of the use of force on a detained person's mental health;
- the use of individual risk assessments for detained people, which could be conducted by personal officers and healthcare professionals; and
- the increased use and prioritisation of de-escalation techniques for those who have mental ill health.

The review must take place in consultation with relevant stakeholders, including detained people's representative groups and mental ill health experts.

The recommendations of the review must be incorporated in the new detention services order regarding the use of force (see Recommendation 15), in respect of which additional, regular (at least annual) training must then be provided.

50. These serious problems with the way force was used at Brook House were not identified or rectified, because the system of reviewing and monitoring use of force incidents was completely ineffectual. The lack of managers to supervise and witness how staff were behaving was particularly acute during use of force incidents and, in my view, their absence allowed (and in some cases may have encouraged) the Detention Custody Officers and Detention Custody Managers to act with impunity. Despite policies in place during the relevant period, the Inquiry found that there was no body worn or handheld camera footage for a large number of use of force incidents during the relevant period. The Inquiry was not provided with many videos of debriefs conducted by officers after use of force incidents, although it is unclear whether the debriefs did not occur or were not filmed.

51. The internal review process was cursory and of poor quality, with long delays between the incident and the review, and scrutiny meetings with more senior G4S staff were often cancelled due to the lack of another Control & Restraint (C&R) coordinator and C&R trainers to view the footage. The Home Office's role in the oversight of use of force was also inadequate, with a failure to make inappropriate use of force incidents themselves into contractual performance measures. Use of force incidents must be comprehensively reviewed to ensure that force has been used appropriately and to identify any necessary improvements to practice or training. I am therefore recommending urgent action to address this, in advance of the introduction of a new detention services order.

Recommendation 17: Urgent improvement of use of force reviews

The Home Office must ensure, as a matter of urgency, that training is delivered on how to conduct an effective use of force incident debrief, ensuring that issues of detained person and staff welfare, as well as training needs, are covered. The training must be mandatory for all immigration removal centre contractor employees who conduct such reviews and those who manage them.

The Home Office must also require that use of force incidents be reviewed, at a minimum, at the following levels:

- Within 36 hours of each use of force incident, the Use of Force Coordinator must conduct a thorough incident review, ensuring that all documentation and footage are collated and preserved, and with a view to taking emergency action in instances of unlawful or inappropriate force. On a weekly basis, all use of force incidents must be reviewed (including all necessary paperwork and available video footage) at a formal meeting by the Use of Force Coordinator and a suitable manager in order to review each incident and to identify any issues or further action required.
- On a monthly basis, immigration removal centre contractor senior management must arrange meetings with other stakeholders (including detained people and representatives of non-governmental organisations) to review use of force trends.
- Periodically, the Home Office (or its Professional Standards Unit if the Home Office considers it more appropriate) must review use of force at Brook House and across the immigration detention estate, to identify trends and to direct the implementation of any changes and improvements that are required.

This review process must be reflected in the new detention services order regarding the use of force – see Recommendation 15 – in respect of which additional, regular (at least annual) training must then be provided.

Healthcare

52. There are challenges to providing healthcare services in immigration detention (including the recruitment and retention of staff, a prevalence of mental ill health among those detained, and a lack of access to a full range of therapeutic interventions). However, inadequacies in healthcare provision risk deterioration in the health of detained people (particularly those who are vulnerable), as well as misinterpretation of their conduct, and may potentially expose them to incidents of abuse.

53. Detained people are entitled to the same range and quality of healthcare services as the general public receives in the community. Nonetheless, the Inquiry heard evidence indicating that doctors and nurses were, on occasions during the relevant period, dismissive of detained people and exhibited a lack of care or empathy. One detained person said that he:

*“felt that the doctors and nurses were part of the system and they had the same lack of care and disrespect for the detainees as the guards”.*³⁷

54. It was apparent, for example, that the issue of food and fluid refusal – for which, at any one time during the relevant period, between one and eight detained people were being monitored – was not afforded the attention it merited. Instead, it was sometimes dismissed as manipulative behaviour by detained people, a form of protest, or attention seeking. This could not always be reliably concluded without carrying out mental state, mental health or mental capacity assessments, and without more detailed exploration of the reasons for food and fluid refusal. One witness described this as *“mental health symptoms ... reinterpreted as behavioural symptoms”*.³⁸ Rule 35 procedures (discussed above) were not routinely considered in cases of food and fluid refusal, even where this should have prompted concerns about mental health deterioration or risk of self-harm or suicide. As a result, vulnerable detained people were allowed to deteriorate and were exposed to a risk of harm in detention. I am therefore recommending an urgent update to the relevant guidance to immigration removal centres.

³⁷ [DL0000226_036](#) paras 144-145

³⁸ [Dr Rachel Bingham 14 March 2022 20/3-22](#)

Recommendation 18: Urgent guidance in relation to food and fluid refusal

The Home Office must, as a matter of urgency, update Detention Services Order 03/2017: Care and Management of Detained Individuals Refusing Food and/or Fluid, to ensure that it deals with:

- food and fluid refusal being clearly and directly linked to consideration of the Rule 35 process and whether a detained person is defined as an 'adult at risk';
- the consideration by the healthcare provider at each immigration removal centre, upon an incidence of food and fluid refusal occurring, of assessments of mental capacity, of mental state, and under Rule 35, and the conduct of these where indicated, as well as ensuring compliance with Adults at Risk in Immigration Detention policy and making sure that decisions made in relation to these are recorded;
- the notification to the Home Office of the numbers of detained people refusing food and fluid, and the reasons for such refusal, on a monthly basis (in the same way that incidents of self-harm are notified); and
- the monitoring by the Home Office of the compliance by healthcare providers with Detention Services Order 03/2017 and the numbers of detained people refusing food and fluid, and the reasons for such refusal, in order to identify any patterns of concern and take appropriate action.

The Home Office must ensure that mandatory training about the application of the updated detention services order takes place on a regular (at least annual) basis for all detention staff and healthcare staff, as well as those responsible for managing them. Attendance must be mandatory for all staff working in immigration removal centres and those responsible for managing them. The training must be subject to an assessment.

In anticipation of the update to Detention Services Order 03/2017, the Home Office must issue an immediate instruction to communicate this clarification to those operating immigration detention centres.

55. The Inquiry was also concerned about the role of healthcare staff in incidents involving use of force, discussed more generally above. Healthcare staff have an important safeguarding role, which includes raising concerns about any use of force and identifying contraindications (clinical reasons not to use force on a particular detained person), both in advance and during an incident. The use of force on D1914, for example, who had a serious heart condition, lasted for approximately 18 minutes, was positively harmful and put him at further risk. There is a tension between the healthcare professional's obligation to act in the best interests of the patient and their involvement in a use of force incident in custodial settings. Regardless, all healthcare staff should be vigilant in acting on concerns about their patients.

56. Healthcare staff are also responsible for monitoring the safety and wellbeing of a detained person during the course of a use of force incident. They have the power and duty to intervene or declare a medical emergency, and to issue an instruction to immediately stop restraint or other use of force. During the relevant period, there did not seem to be an understanding or recognition among Healthcare staff of this role. For example, Healthcare staff did not intervene when D2159 was held and handcuffed for five minutes in an incident involving a four-man team in full Personal Protective Equipment (PPE), even though he was in an obviously weakened physical state. This contributed to an unnecessary and disproportionate use of force on a vulnerable detained person. D1527 was the subject of an unplanned use of force as a result of an attempt to strangle himself, during which one officer restrained him including using a 'chokehold' (placing hands on the neck) and said, "*I'm going to put you to fucking sleep.*"³⁹ The present Healthcare staff did not raise any concerns throughout the entirety of the use of force and restraint or afterwards, but should have challenged the actions of the other staff at the time in the strongest possible terms and should have reported the incident immediately to relevant managers.

57. Although the Inquiry understands that more bespoke training is planned for healthcare staff, it is unclear whether sufficient action has been taken to address the deficiencies relating to the role of healthcare staff in use of force incidents. Given that the risk of the inappropriate use of force on vulnerable detained people may well persist, I am recommending the issuing of guidance and the introduction of mandatory training for healthcare staff in immigration removal centres, to ensure that they fulfil their role appropriately.

³⁹ [Day 2 AM 24 November 2021 00:53-01:23:53 \(KENCOV1007 - V2017042500021\)](#)

Recommendation 19: Guidance and training for healthcare staff on the use of force

The Home Office must ensure that guidance is issued to healthcare staff in immigration removal centres clarifying their role in use of force incidents. It must liaise as necessary with NHS England and any relevant medical regulators.

The Home Office must ensure that mandatory training is introduced for healthcare staff, and those responsible for managing them, on their roles and responsibilities in relation to planned and unplanned use of force (liaising with NHS England and any other relevant parties). The training must be subject to an assessment.

58. The Inquiry also heard evidence of a practice by the Home Office of asking Brook House GPs to write letters regarding the fitness to fly and fitness for detention of individuals. There appeared to be no adequate physical or mental examination carried out immediately prior to the writing of such a letter by a GP. On some occasions, limited details about an individual's medical history were referred to in 'fit to fly and fit for detention' letters but significant concerns or contraindications were not routinely raised; in other cases, no such details were referred to at all when making an assessment that a detained person was fit to fly and fit for detention. Sometimes this practice extended to pre-emptive positive approval by the GP for a planned use of force on a detained person. This sanctioning of force is completely inappropriate and of serious concern. It is important that GPs and healthcare staff do not involve themselves in custodial management decisions, to maintain their independence and their important safeguarding roles. I am therefore recommending that updated guidance and training be provided to doctors working within the immigration detention estate about their duties and responsibilities in this context.

Recommendation 20: Updating guidance regarding ‘fit to fly and fit for detention’ letters

The Home Office must review and update Detention Services Order 01/2016: The Protection, Use and Sharing of Medical Information Relating to People Detained Under Immigration Powers, to ensure that guidance given to GPs working in the immigration detention estate in relation to their duties and responsibilities in writing ‘fit to fly and fit for detention’ letters is clear. It must liaise with NHS England and any relevant medical regulators as necessary.

The Home Office must ensure that training about the updated guidance takes place on a regular (at least annual) basis for GPs working in the immigration detention estate and those responsible for managing them. The training must be subject to an assessment.

The Home Office must monitor compliance with this updated guidance at least annually.

59. There were also concerns that the processes to deal with detained people with mental ill health (who might be more vulnerable to losing their capacity to make decisions about their medical care and treatment) were ineffective. For example, despite bizarre and aggressive behaviour, D1275’s severe mental ill health was not identified or managed, and he received no mental health treatment. He missed 13 appointments for a mental health assessment between May 2017 and January 2018, but the Inquiry did not see any evidence that his non-attendance was followed up by Healthcare staff. There should have been a more proactive investigation into the reasons D1275 had missed so many appointments. His mental health continued to deteriorate and, after his release, D1275 was diagnosed with schizo-affective disorder and assessed as lacking capacity to make decisions about medical appointments.

60. The Inquiry also did not hear any evidence of a system in existence or guidance available to staff for the routine transfer of relevant information about mental health concerns from residential wings to Healthcare staff. Detention Services Order 04/2020: Mental Vulnerability and Immigration Detention: Non-Clinical Guidance does not adequately address concerns about the efficacy of the safeguards for vulnerable people concerning missed healthcare appointments. The provisions in relation to assessments of mental capacity, mental health and mental state are also inadequate (for example, the DSO does not contain any provision for independent advocacy). As there remain gaps, I am recommending an update to the guidance to ensure effective communication of medical information between staff in immigration removal centres.

Recommendation 21: Ensuring effective communication of medical information

The Home Office must review and update Detention Services Order 04/2020: Mental Vulnerability and Immigration Detention: Non-Clinical Guidance to set out comprehensive guidance for detention and healthcare staff where there are concerns that a detained person is suffering mental ill health or lacks mental capacity. This must include an appropriate system for:

- the routine handover or sharing of relevant information between detention custody staff and healthcare staff (for example, in Security Information Reports and Anti-Bullying Support Plans);
- the identification and follow-up of missed medical appointments;
- the assessment of mental capacity where indicated; and
- mental health assessment where indicated.

The Home Office must ensure that training about the updated guidance takes place on a regular (at least annual) basis for detention and healthcare staff, as well as those responsible for managing them. The training must be subject to an assessment.

61. The Inquiry received evidence of the complaints made about healthcare during the relevant period. None of the complaints recorded appear to relate to verbal or informal complaints, which were covered by Detention Services Order 03/2015: Handling of Complaints (the Complaints DSO), and the Inquiry did not receive any evidence to suggest that verbal or informal complaints were investigated by the Healthcare department. In my view, they should have been. Staff were also left to use their own judgement as to what amounted to a serious complaint.

62. During the relevant period, 53 written complaints relating to healthcare were received by the Healthcare department. It is likely that there were barriers to the making of complaints about healthcare similar to those discussed below in relation to detention staff. Only two complaints were made directly to NHS England or were referred to NHS England by G4S Health Services. The Clinical Lead at Brook House investigated and determined the outcome of the remaining 51, without any training or any particular written guidance. The investigations and resulting reports were cursory; routinely, responses merely offered an apology that the detained person was unhappy with the medical treatment and advised them to attend the Healthcare department if required.

63. A robust and effective complaints procedure in any healthcare setting is important to explain problems to patients, to promote accountability, to help the healthcare provider and healthcare staff learn, and to improve the quality of care they provide. I am therefore recommending improvements to the handling and audit of healthcare complaints.

Recommendation 22: Improving the handling and audit of healthcare complaints

The Home Office must review and update Detention Services Order 03/2015: Handling of Complaints to ensure that appropriate guidance is given to healthcare providers on the investigation and handling of complaints specific to the provision of healthcare in an immigration detention setting.

The Home Office must ensure that training about the updated guidance takes place on a regular (at least annual) basis for staff dealing with healthcare complaints, as well as those responsible for managing them. The training must be subject to an assessment.

Healthcare providers in immigration removal centres must ensure that all healthcare complaints are robustly investigated in accordance with the updated guidance. The methodology and outcomes must be clearly communicated, including to the detained person. They must also ensure that appropriate, regular (at least annual) training and guidance is provided to those holding responsibility for the investigation of healthcare complaints.

Staffing and culture

64. During the relevant period, G4S and the Home Office did not provide a sufficiently caring, secure or decent environment for detained people or staff at Brook House.

65. The Inquiry identified a number of issues relating to staffing, both by G4S and the Home Office. It is difficult to say whether contractually prescribed levels were adequate, and there was also evidence of problems with recruitment and retention. Nonetheless, it is clear that actual staffing levels achieved by G4S were insufficient for much of the relevant period, as those working at Brook House (both from G4S and the Home Office) were aware. The Serco contract allows for significantly higher minimum staff numbers at Brook House than during the relevant period. Insufficient staffing levels had a detrimental – and sometimes significant – impact on safety, as well as resulting in detained people being unable to access services and activities to which they were entitled. My view is that staff, in turn, saw detained people

and their needs as problems rather than the reason why the staff were there. I am therefore recommending that the Home Office and those managing immigration removal centres undertake regular and ongoing assessments of staffing levels.

Recommendation 23: Ongoing assessment of staffing levels

The Home Office and contractors operating immigration removal centres must ensure that there is ongoing assessment of staffing levels (at least on a quarterly basis), so that the level of staff present within each centre is appropriate for the size and needs of the detained population.

The Home Office must also ensure that the detained population does not increase at any immigration centre unless staffing is at an adequate level.

66. There was evidence questioning “*the quality and content*” of some of the training offered to staff (the content of which was set by G4S, although its plan was approved by the Home Office).⁴⁰ There were also a number of areas in which there was insufficient or no training, including mental health and working with vulnerable people. The consequence of inadequate training and development during the relevant period was that staff were left unprepared and unable to do their jobs properly, without the required complex combination of skills, including resilience, compassion, strength and authority. I am therefore recommending that the training provided to detention staff be improved – it should be at least equivalent in depth and breadth to that received by prison officers.

⁴⁰ [CJS0073709_013 para 1.38](#); [Professor Mary Bosworth 29 March 2022 23/16-23](#); [DL0000175_0007 para 14](#)

Recommendation 24: Mandatory training for immigration removal centre staff

The Home Office, in conjunction with contractors, must ensure that all relevant immigration removal centre staff receive mandatory introductory and annual training on:

- mental health;
- race and diversity;
- a trauma-informed approach;
- their own resilience;
- drug awareness; and
- the purpose of immigration removal centres.

This training must include the perspectives of, or be conducted in consultation with, detained people.

The Home Office must also ensure, in conjunction with contractors, that new joiners must start on probation on completion of introductory training and be adequately supervised for a period of time as necessary to establish their competence to work independently.

67. Many staff who gave evidence to the Inquiry felt that the G4S Senior Management Team (SMT) was “*not visible*”, insufficiently accessible and “*notoriously unavailable*”.⁴¹ The Inquiry also heard evidence of dysfunctional relationships within the SMT. A steep hierarchy was compounded by shift patterns that meant there were long periods with limited SMT (and indeed Detention Custody Manager) presence. This likely contributed to a feeling that the Detention Custody Officers and Detention Custody Managers were largely left to manage on their own ‘against’ the detained people, with their actions neither under sufficient scrutiny from, nor of particular concern to, senior managers. It also reduced the ability of SMT members to recognise and to act proactively upon behavioural and cultural issues. I am therefore recommending that contractors managing immigration removal centres ensure that senior managers are more accessible to other staff.

⁴¹ [INN000007_006 para 21](#); [Daniel Lake 1 March 2022 8/24-9/15](#); [Callum Tulley 30 November 2021 158/2](#); [INN000013_005 para 15](#); [SER000459_009 para 43](#); [MAR000002_006 para 47](#); [Derek Murphy 2 March 2022 4/9-5/5-8](#); [INQ000087_003](#); [Edmund Fiddy 7 March 2022 157/16-20](#); [Ben Saunders 22 March 2022 85/2-14, 87/17-88/1](#)

Recommendation 25: Improving the visibility of senior managers within centres

Contractors operating immigration removal centres must ensure that senior managers are regularly present and visible within the immigration removal centre and are accessible to more junior detention staff.

68. Home Office staff at Brook House were not caseworkers or decision-makers, but there was still a lack of interaction with detained people during the relevant period, which was indicative of a general ‘hands-off’ culture. There was also a lack of concern by some for the welfare of those detained at Brook House. Had there been more present and actively involved Home Office staff, there might also have been opportunities to identify and challenge poor culture and behaviour, and to better assess the welfare of detained people. I am therefore recommending that the Home Office take action to improve the visibility of its staff within Brook House.

Recommendation 26: Improving the visibility of Home Office staff

The Home Office must ensure that its staff are regularly present and visible within each immigration removal centre.

69. The culture at Brook House, particularly among staff, set the tone for interactions with and the treatment of detained people. Abusive and derogatory language was used towards and about many detained people. I observed explicit racism and tolerance of racism by others, along with a desire by some staff to ‘fit in’ and to appear ‘tough’ or masculine by adopting the aggressive culture of some existing staff. These aspects of staff behaviour cannot be separated from cultural issues.

70. Some staff *“thought they were working in a prison”*.⁴² This ‘prisonisation’ (a non-prison setting being treated in effect as a prison, with detained people treated as criminal and dangerous) manifested in the way that staff interacted with detained people. Closely related to this was the existence of an ‘us and them’ mentality among staff towards detained people, which resulted at times in desensitisation to detained people’s needs and ultimately to their dehumanisation by staff. There was repeated emphasis on the risks of escape, physical assault and radicalisation. Examples of friendly rapport-building stood in stark contrast to many interactions between staff and detained people. This culture played a part in enabling poor treatment of detained people, who were

⁴² INN000013_013 para 41

seen as ‘other’, while simultaneously making it less likely that staff would challenge or report each other. It led to those who spoke out being seen as ‘grasses’ and traitors.

71. There was a lack of appreciation of the inevitable power imbalance between the detained population and staff by many working at Brook House. It is entirely credible that matters about which staff may not have thought deeply (such as delivery of letters regarding a detained person’s immigration case) or conduct that they may have seen as ‘banter’ (such as delaying access to basic necessities such as toilet roll) felt both intimidating and humiliating to detained people, who were in an inherently more vulnerable position.

72. There were numerous examples of abusive and derogatory language – as well as childish behaviour – by G4S staff towards and about detained people, ranging from demeaning comments to direct verbal abuse. Violence and violent language were extreme manifestations of the toxic culture and bravado. Such violent language included comments such as:

“We should just go back to putting them to sleep mate really ... Get the gas, chuck it in there, they’re all knocked out ... needle in, he wakes up in fucking wherever.”⁴³

73. The Inquiry also saw evidence of racist beliefs and words becoming part of the culture and being seen by some as a way to ‘fit in’. Although it was relatively rare for directly racist language to be used by staff towards detained people, it is likely that racially charged language towards detained people was more prevalent (such as “go back to your own country”, given the number of allegations about this kind of comment) and that racist comments among staff were common.⁴⁴ When abusive language was reported, there is some evidence that G4S took disciplinary action, but on many other occasions this does not appear to have been the case.

74. The extent to which staff raised grievances about one another appears to have been a significant aspect of the culture at Brook House. The consequences were “difficult dynamics”, a “hostile and awkward” environment, a poor management culture, and a distraction from the core business of detaining people safely and decently.⁴⁵

75. The Inquiry was told about a number of efforts that Serco has made to improve culture. The 2022 HMIP inspection report, about an unannounced inspection of Brook House between 30 May and 16 June 2022, noted “promising” work to understand staff culture, but it also identified that “a large number” of staff were “inexperienced and operational leaders did not provide

⁴³ TRN0000084_010

⁴⁴ See, for example, DPG000040_014-015 paras 62-64; DPG000021_026-027 paras 83 and 87; HOM002190_001 row 3; DPG000002_024 para 63; GDW000010_004-005

⁴⁵ INQ000164_008 para 10; CJS0073709_066 para 7.3; CJS0073663_007

them with enough support in the unit".⁴⁶ I am also troubled that some staff involved in problematic events during the relevant period are now in senior roles, with responsibility for setting the culture, despite showing little or no real reflection on their actions. I am therefore recommending that action be taken to improve the culture among staff.

Recommendation 27: Developing a healthy culture among staff

Contractors operating immigration removal centres must develop and implement an action plan to ensure a safe and healthy staff culture in immigration removal centres. The action plan must address:

- the identification of and response to any sign of desensitisation among staff;
- training staff on coping mechanisms and secondary trauma awareness; and
- maintaining an appropriate balance between care and safety or security.

The Home Office must regularly monitor each contractor's compliance with their action plans.

Complaints and whistleblowing

76. Complaints and whistleblowing processes should have been an important safeguard against poor treatment or abuse of detained people.

77. Some detained people did not understand how to complain or what safeguards should be in place, or did not have confidence in making a complaint or reporting poor treatment by staff. The Inquiry received evidence setting out various possible reasons why detained people felt unable to complain about poor treatment, either at the time or at all, including a fear of repercussions. I am therefore recommending that both the Home Office and contractors take further action to improve the processes by which detained people can make complaints, and the handling of those complaints.

⁴⁶ [Report on an Unannounced Inspection of Brook House Immigration Removal Centre 30 May–16 June 2022 \(HMIP000702\)](#), HM Chief Inspector of Prisons, September 2022

Recommendation 28: Action to address barriers to making complaints

The Home Office and its contractors operating immigration removal centres must take steps to identify and address the barriers to making complaints that are faced by detained people, including a fear of repercussions. This must include training for staff on their role in enabling detained people to overcome these barriers.

78. Complaints involving serious misconduct by staff at Brook House were required to be allocated to the Home Office’s Professional Standards Unit (PSU) for investigation. The Inquiry saw a number of occasions in which cases were not progressed as they should have been because, for example, cases were wrongly allocated to G4S for investigation. It also identified some concerns arising from the PSU’s investigations spanning the investigation process, the decision-making process, and the communication of outcomes. For example, there were investigations that did not include interviews with key witnesses. There was no consistent practice by PSU investigators of showing relevant evidence to a complainant and allowing them to comment on it where there were inconsistencies. There was also no requirement for investigating officers to obtain or be provided with information about previous complaints against staff they were investigating – even where they concerned similar matters – which resulted in some investigations failing to take into account relevant information. In addition, the Inquiry identified failures to look for potentially supportive evidence and a tendency to afford unequal weight to the evidence of staff and detained people, as well as to find that use of force was justified.

79. In most cases, the report detailing the outcome of a PSU investigation would be sent to the Home Office Detention and Escorting Services, and a separate, shorter letter would be sent to the complainant. Having a separate report and letter – where the letter truncates a full report – poses a risk that the complainant will not know the full basis for the decision. It also reduces the transparency of the process and potentially confidence in it.

80. These concerning themes are likely to reflect, at least in part, the inadequate training of investigators. I am therefore recommending steps to improve the quality of investigations conducted by the PSU.

Recommendation 29: Improving investigations by the Home Office Professional Standards Unit

The Home Office must update Detention Services Order 03/2015: Handling of Complaints to clarify that, in investigations carried out by the Professional Standards Unit into allegations of serious misconduct against contractor staff:

- Professional Standards Unit investigators must carry out interviews themselves and not rely on contractors to do so.
- All staff against whom allegations are made must be invited to interview.
- Where there are inconsistencies between any accounts given of events, any evidence relating to those accounts (including footage and documentation) obtained by an investigating officer must be shown to the complainant and to the subject of the complaint, prior to reaching a conclusion.
- The Professional Standards Unit must be given information about previous complaints made against alleged perpetrators, including unsubstantiated complaints.
- Previous disciplinary action against alleged perpetrators must be taken into account.
- Investigators must look for evidence that is both supportive and undermining of the complaint.
- Full reports must be sent to complainants (and their solicitors if applicable).
- Investigation reports and/or outcome letters must be sent directly from the PSU to complainants (and their solicitors if applicable).

The Home Office Professional Standards Unit must ensure that training about the updated guidance takes place on a regular (at least annual) basis for staff dealing with investigations, as well as those responsible for managing them. The training must be subject to an assessment.

The Professional Standards Unit must also review the training provided to investigators and ensure that investigators receive regular and adequate training, from a variety of perspectives, on issues including:

- the nature of immigration removal centres and issues that may arise;
- obstacles that detained people may face in making complaints;
- interviewing vulnerable witnesses; and
- use of force and assessing reasonableness of force.

81. Given its role, the independence of the PSU is important for confidence and fairness. The PSU is the responsibility of the Home Secretary, who is also responsible for immigration removal centres. Although the Inquiry did not see any evidence of PSU decision-making being improperly influenced by the Home Office, there is a reasonable perception held by detained people or formerly detained people that the PSU was not and arguably still is not independent. This was compounded by the way in which the outcome of some PSU investigations was communicated, as discussed above. The disparity in seniority between the Head of the PSU and the Heads of the relevant Home Office Immigration Enforcement teams may give the perception of insufficient importance being placed on the PSU's role. I am therefore recommending improvements to enhance the independence of the PSU.

Recommendation 30: Improving the independence of the Home Office Professional Standards Unit

The Home Office must:

- take steps to enhance the independence of the Professional Standards Unit from the Home Office and the perception of this independence; and
- increase the seniority of the Head of the Professional Standards Unit so that they are closer in status to the Heads of the relevant Home Office Immigration Enforcement teams.

82. Although G4S's whistleblowing policy "*strongly encouraged*" employees to report concerns about serious wrongdoing, there was often an inadequate response and the Senior Management Team (SMT) was described by one G4S staff member as "*consistently uninterested*".⁴⁷ Some members of staff said that if they had heard or seen anything inappropriate they would have reported it. I saw little evidence to suggest that there was a culture or practice of reporting colleagues for inappropriate behaviour towards, or poor treatment of, detained people. G4S failed to take adequate steps to make staff aware of the process and encourage them to use it, or to counter any fear of repercussions or a culture of not 'grassing'. Mr Callum Tulley, a Detention Custody Officer until July 2017, described a "*culture in Brook House which was so hostile to whistleblowing*".⁴⁸ Whistleblowing processes in place during the relevant period were inadequate, ineffective and did not specifically relate to Brook House or immigration removal centres. Subsequent changes are welcome but, in my view, they do not go far enough and do not address some of the specific

⁴⁷ [CJS000707](#); [CJS0073632](#); [CJS0073633_004-005](#); [CJS0073677_001-002](#); [CJS0073631_001](#); [HOM032609](#); [CJS0073631_002-003](#); [CJS0073688](#); [CJS0073631_004-005](#); [INQ000172_003](#) paras 8-9

⁴⁸ [INQ000052_018](#) para 75

concerns identified above. I am therefore recommending improvements to whistleblowing policies and processes.

Recommendation 31: Improving the process for and response to whistleblowing

The Home Office must update Detention Services Order 03/2020: Whistleblowing – The Public Interest Disclosure Act 1998 to require contractors that run immigration removal centres to:

- have a whistleblowing policy and procedure that is specific to the immigration detention environment;
- ensure that the whistleblowing mechanism is not limited to a hotline and allows for anonymous reporting of concerns;
- ensure that those who receive whistleblowing concerns have an understanding of immigration removal centres;
- take active steps to encourage staff to use whistleblowing processes, for reasons including those set out at paragraph 10 of Detention Services Order 03/2020; and
- ensure that whistleblowing concerns are investigated thoroughly by someone external to the immigration removal centre, and that the Home Office is informed of the nature of the concern and the investigation carried out.

The Home Office must ensure that training about the updated guidance takes place on a regular (at least annual) basis for staff dealing with whistleblowing, as well as those responsible for managing them. The training must be subject to an assessment.

Inspection and monitoring

83. It is critical that the Home Office and its contractors understand that external inspection and oversight are only intended to supplement, not replace, their own internal processes. The Home Office and its contractors retain the primary responsibility for the welfare of detained people and for compliance with rules and procedures, with scrutiny provided by periodic inspections from HM Inspectorate of Prisons (HMIP), and by the relevant Independent Monitoring Board (IMB), a volunteer body attached to each immigration removal centre (IRC), which reports on conditions.

84. While members of the Brook House IMB frequently raised concerns about individuals, and about conditions at Brook House more generally, there were several factors that limited the IMB's ability to identify the risk or fact of poor treatment. Many detained people did not know about the IMB and did not

understand its role or how to complain; some did not see it as an independent body. It was not sufficiently challenging of G4S or the Home Office. IMB members were and continue to be volunteers, lacking expertise in or knowledge of some areas they are expected to monitor. There is not a national statutory basis for IMBs nor the power to enforce change, and the Inquiry was told that the Detention Centre Rules 2001 “*are out of date and do not properly reflect current best practice*”.⁴⁹ Independent, robust and properly governed IMBs are an important safeguard in immigration detention settings. I am therefore recommending that their concerns be publicly addressed and that consideration be given to their legal status.

Recommendation 32: Enhancing the role of the Independent Monitoring Boards

The government must:

- respond to and publish responses to all concerns raised by any Independent Monitoring Board regarding immigration removal centres;
- take steps without further delay to amend the Detention Centre Rules 2001, in so far as they govern Independent Monitoring Boards, in order to accurately reflect their current role; and
- consider whether to put the National Chair and Management Board of the Independent Monitoring Boards on a statutory footing.

85. IMBs provide regular and independent oversight with a focus on the welfare of detained people, and have important powers in IRCs. Members are permitted to access any area of the IRC at any time, to speak privately with any detained person, and to access any records held by the IRC (save for certain confidential or classified information). They must satisfy themselves of the state of the premises and the treatment of detained people, and are required to inform the Secretary of State of certain welfare concerns. They must also report annually to the Secretary of State. Their access to IRCs is limited by the number of visits they are afforded. They do not have specific training in issues such as the lawful use of force, nor do they have access to the contract for managing Brook House – much less a formal contract-monitoring role. While they can raise concerns, they have no power to issue sanctions or otherwise enforce compliance. This was demonstrated by the IMB requesting, but not receiving, from the Home Office detailed data on the number of Rule 35 reports. IMB members must be made aware of their specific legal powers under the Detention Centre Rules 2001, including to access records, and must be empowered to exercise these powers where appropriate.

⁴⁹ [IMB000030_001](#); [IMB000199_006-007](#) para 17; [IMB000199_015](#) para 44; [IMB000199_001](#) para 2; [IMB000199_020](#) para 62; [IMB000221_0009](#) para 32; [IMB000187](#)

86. The statutory purpose of inspections of IRCs by HMIP is to report on the treatment of detained people and conditions in detention centres. Its 2016 inspection assessed Brook House as being ‘reasonably good’ against the four ‘healthy establishment’ tests. The 2016 HMIP inspection report was overly positive in places, including in relation to the governance of use of force. It is likely that HMIP did not identify this issue and inadequately scrutinised the governance of use of force; there was no reference to weekly or monthly committee or scrutiny meetings in its report, and the Inquiry did not see any positive evidence to suggest that they were occurring at the time of the inspection. While there were some areas in which HMIP’s criticisms provide useful context for the state of Brook House during the relevant period, the 2016 HMIP inspection report did not adequately reflect some of the adverse evidence about Brook House that was obtained by inspectors. Its methodology at the time was not sufficiently sensitive to the needs of an IRC, where signs of abuse may be more difficult to identify because of factors such as language barriers, a high turnover of detained people, and detained people’s reluctance to speak out for fear of negatively impacting their immigration cases.

87. IMBs and HMIP can only ever supplement – but not replace – the internal processes of the Home Office and its contractors to satisfy themselves about the treatment of detained people. While neither body identified the ill treatment of detained people during the relevant period, changes have been introduced, including HMIP’s ‘enhanced methodology’, which incorporates offering every detained person a confidential interview, as well as a confidential staff survey. Given that indicators of abuse can be insidious, oversight bodies must be alert to the signs of ill treatment and have effective methodologies for identifying abuse. I am therefore recommending that HMIP and IMBs ensure that their approaches are sufficiently robust and take account of the specific needs of the detained population.

Recommendation 33: Improving the investigation and reporting of HM Inspectorate of Prisons and Independent Monitoring Boards

HM Inspectorate of Prisons and Independent Monitoring Boards working within immigration removal centres must ensure that they have robust processes for:

- obtaining and reporting on an enhanced range of evidence and intelligence from detained people and those who represent or support them, staff and contractors, including that which is received outside of inspections or visits; and
- reporting on any concerns about the Home Office and contractors.

Concluding remarks

88. It is not the role of this Inquiry to consider recent developments in immigration detention policy or proposed legislative changes. Its work has focused on a number of “*appalling*” events that took place some time ago. However, many of the safeguards designed to protect vulnerable detained people failed at Brook House during the relevant period and I remain concerned about how those safeguards are operating currently. In my view, the prompt and full implementation of these 33 recommendations is necessary to “*prevent a recurrence of any identified mistreatment*”, such as that reflected in this Report. Many of the issues identified relate to a failure to follow the safeguards already established in rules and procedures. Too often it was the application, knowledge or understanding that was deficient and the embedding of this, including through the adequate training of staff, will therefore be critical to avoid recurrences of incidents of the kind seen at Brook House.

89. The government and organisations identified in the recommendations that I am making must publish details of the steps they will take in response to each recommendation, including the timetable involved, within six months of the publication of this Report.

90. A copy of this Report will be sent to the Home Affairs Select Committee and the Joint Committee on Human Rights so that, in due course, implementation of or compliance with the Inquiry’s recommendations will be regularly monitored and reported upon.

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