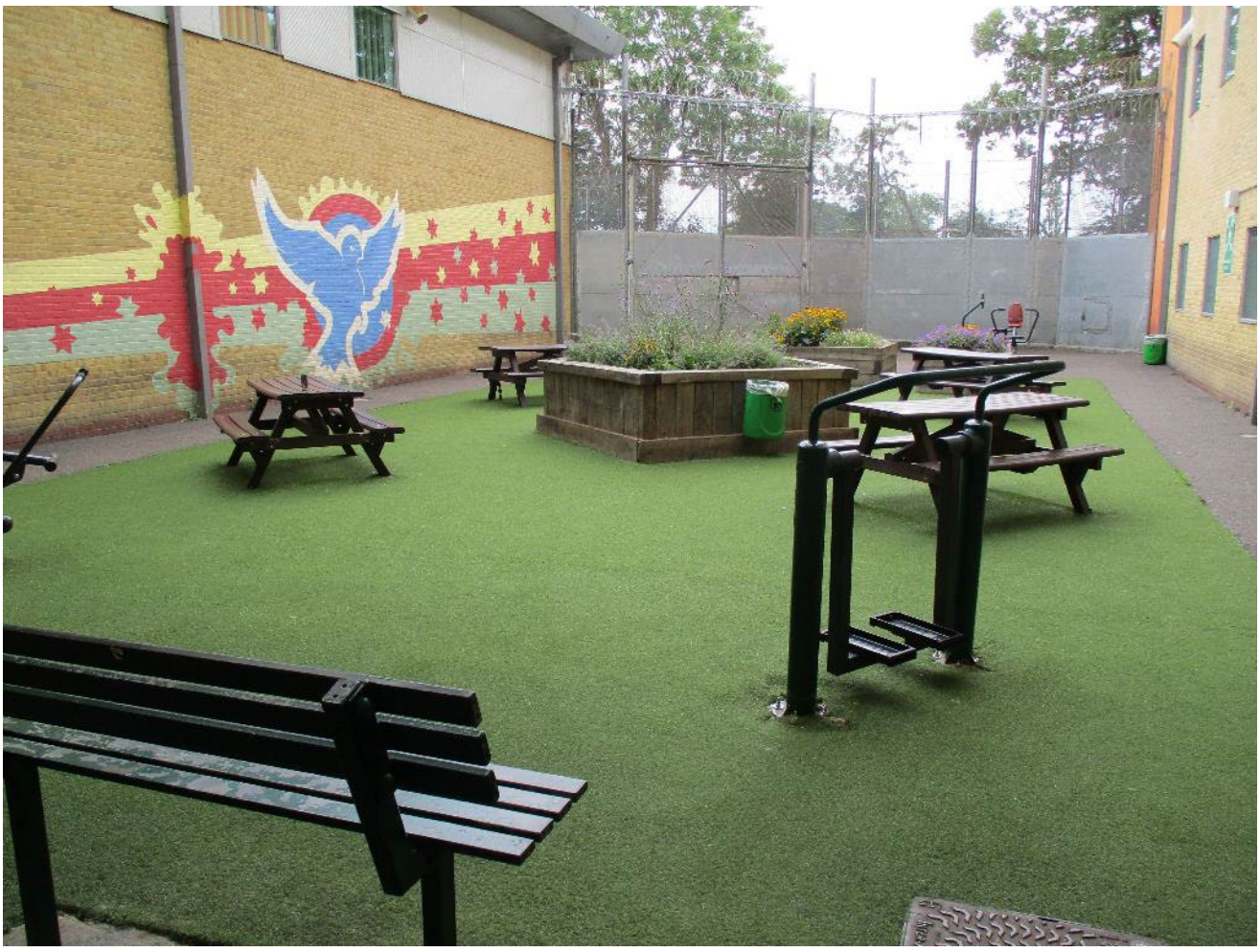
Report on an independent review of progress at

Brook House Immigration Removal Centre

by HM Chief Inspector of Prisons

29 – 31 July 2025



Contents

Section 1 Chief Inspector's summary

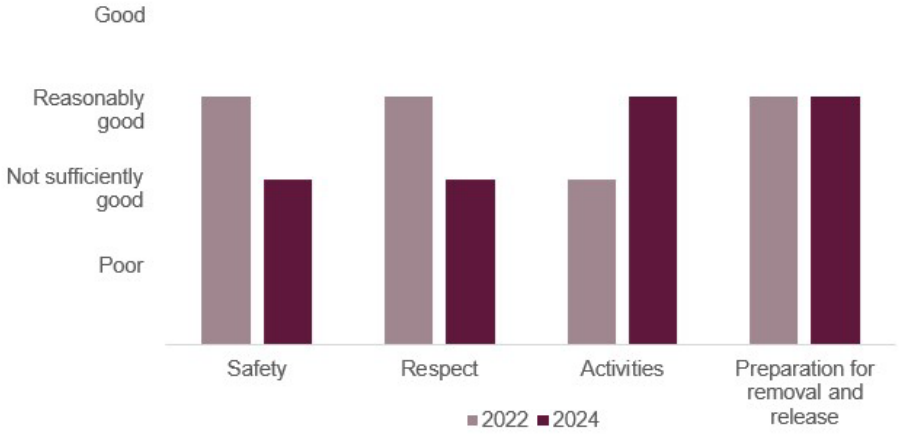
1.1 Brook House is an immigration removal centre (IRC) next to Gatwick airport, which is run for the Home Office by Serco. At the time of our visit, there were 192 detainees, compared to 327 at the full inspection in August 2024.

1.2 This review visit followed up on the concerns we raised at that inspection.

What we found at our last inspection

1.3 At our previous inspections of Brook House IRC in 2022 and 2024, we made the following judgements about outcomes for detainees.

Figure 1: Brook House IRC healthy establishment outcomes in 2022 and 2024



1.4 At our full inspection, outcomes in both safety and respect had deteriorated significantly. There had been a concerning and substantial rise in violence and self-harm, and the centre's data analysis was not sophisticated enough to understand the underlying causes. Some aspects of security were disproportionate for a detainee population, and not enough had been done to soften the prison-like environment. The centre felt crowded and did not have enough experienced staff to manage an increasingly vulnerable population. A high number of detainees reported mental health problems and there had been a serious deterioration in health care provision. People were held for even longer than at previous inspections, with 10 detained for over a year and one man for over 500 days, all unacceptably long periods of administrative detention.

1.5 There were several positive areas of work, including commendable improvements to activities, more jobs and an increase in physical education space. Welfare work was good but understaffed, and the Home Office Detention Engagement Team had substantially increased the quality of its work with detainees.

What we found during this review visit

1.6 We found that leaders had invested heavily in improving the number and capability of staff. Detainee custody officers and front-line managers were more visible on the wings and we saw mature and effective staff management of tense situations. Staff attrition rates had dropped very significantly and functional leadership had been strengthened across key areas, including health care, reception and welfare services. Detainees were very positive about the way that staff treated them.

1.7 While the centre still resembled a prison, there had been good investment in the physical environment, entailing the closure of units on a rolling programme to allow for redecoration and refurbishment. The library had been significantly improved and now provided a relaxed and welcoming space for detainees. The progress made in tackling the ingress of illicit drugs was particularly notable and included use of new detection technology and better cooperation with the police.

1.8 However, despite some good work by the Home Office Detention Engagement Team, there was limited progress on the priority concern over support for the most vulnerable detainees. Too many detainees were still held for excessive periods and Rule 35 safeguards (see Glossary) were not working effectively enough.

1.9 While the previous rise in violence had been arrested, there were still too many incidents, and data analysis remained weak. Routine handcuffing for external escorts persisted. The culture and service provided by health care had improved, but senior-level partnership working was still problematic and continued to affect service delivery.

1.10 While there was much that remained to be done by both Serco and the Home Office, there had been commendable progress since the critical inspection.

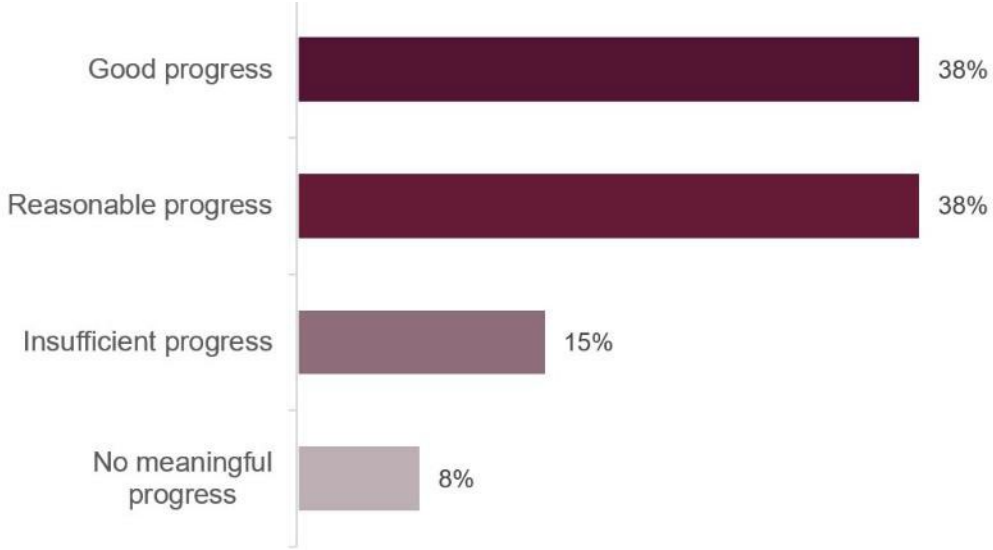
Charlie Taylor
HM Chief Inspector of Prisons
August 2025

Section 2 Key findings

2.1 At this IRP visit, we followed up 13 concerns from our most recent inspection in August 2024.

2.2 HMI Prisons judged that there was good progress in five concerns, reasonable progress in five concerns, insufficient progress in two concerns and no meaningful progress in one concern.

Figure 2: Progress on HMI Prisons concerns from 2024 inspection (n=13)



Notable positive practice

2.3 We define notable positive practice as:

> Evidence of our expectations being met to deliver particularly good outcomes for detainees, and/or particularly original or creative approaches to problem-solving.

2.4 Inspectors found no examples of notable positive practice during this IRP visit.

Section 3 Progress against our concerns

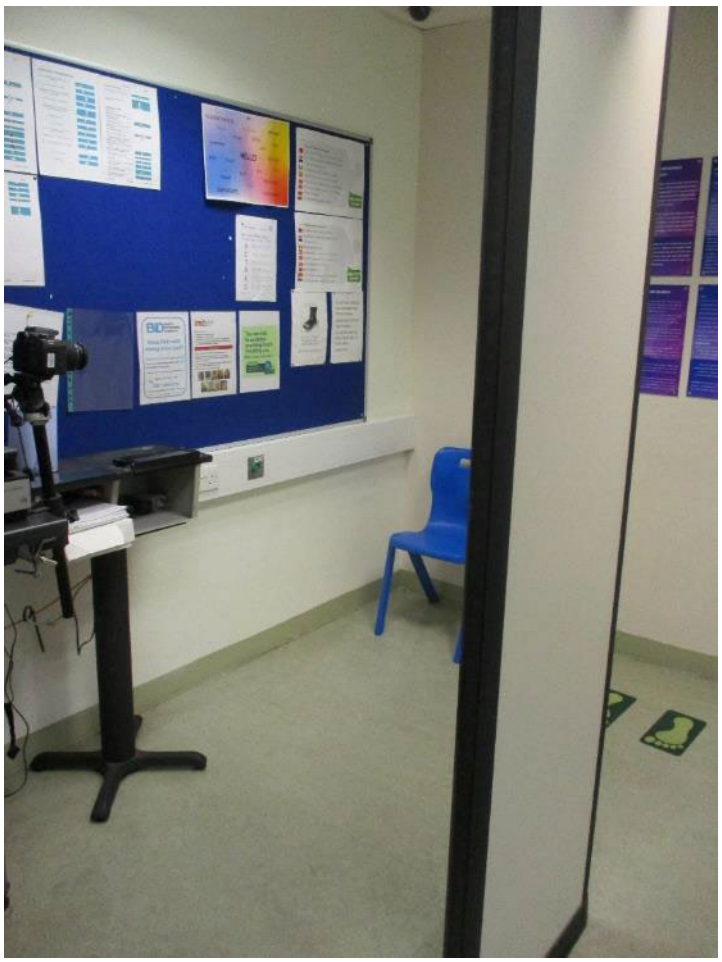
The following provides a brief description of our findings in relation to each concern followed up from the full inspection in 2024.

Arrival and early days in detention

Concern: Not enough care was given to detainees on arrival and during their early days in detention. The reception area was chaotic, and induction was not carried out consistently.

3.1 Leaders had reviewed and changed reception processes. We saw a more ordered and professional atmosphere in reception than at the full inspection. Reception staff were polite and welcoming and appropriately prioritised adults at risk. Detainees we spoke to were very positive about their experience on arrival.

3.2 A new risk interview process had been introduced, which took place in a search room. While this offered some privacy, the door was not always closed during interviews and the room was not big or welcoming enough. There was only one chair, which meant that the interviewing member of staff had to stand. Some centre staff continued to use the reception area as a thoroughfare for entry to the centre, which was distracting for detainees during their booking-in.



Search room in reception

3.3 Distraction activities had been placed for detainees in the reception waiting area, including table tennis equipment and a few games.

Waiting room in reception showing table tennis and other games available

3.4 Induction started as soon as a detainee arrived on one of the units and was generally informative. However, management oversight of the early days support did not always identify inconsistencies in the quality of induction.

3.5 We considered that the centre had made good progress in this area.

Safeguarding of vulnerable adults

Concern: Policies and procedures to minimise the length of detention and protect the most vulnerable were not effective enough. The centre was unaware of 31 detainees assessed at the higher levels of the adults at risk policy, and Rule 35 reports (see Glossary) were not always submitted when necessary. The length of detention had increased and case progression was often slow.

3.6 The average cumulative length of detention was still high, but had reduced from 78 to 69 days, and fewer detainees were held long term: three had been held for over a year compared with 10 at the full inspection.

3.7 However, the longest stay was over 550 days, and 67% of detainees had been held in Brook House for over two months, compared with 46% at the full inspection, and 27% at the inspection before that.

3.8 The Home Office had not used the reduction in the detainee population to reduce the level of vulnerability in the centre. In fact, 42% of detainees were now assessed at one of the two higher levels of risk, compared with 25% in 2024.

3.9 The Home Office did not always identify or sufficiently explore vulnerability before deciding to detain individuals. In one case we reviewed, the decision-maker said a detainee had no known vulnerabilities, despite him telling immigration staff that he had a brain injury, depression and PTSD (post-traumatic stress disorder), and medical records confirming that he had been assessed with a learning difficulty and was prescribed medication for depression.

3.10 Home Office processes to ensure the Centre was aware of all detainees assessed to be at risk had greatly improved and were now good.

3.11 Local Home Office teams were well focused on the need for health care to improve the reporting of safeguarding need and had introduced monitoring and weekly meetings to improve performance. However, there were still significant weaknesses in the Rule 34 and 35 processes (see Glossary).

3.12 It could take up to three weeks to schedule a Rule 35 appointment, which was far too long. There was an almost routine failure to submit Rule 35 reports when detainees were suspected of being suicidal. Only three such reports had been submitted in the previous six months;

during the same period, 28 detainees had been placed on constant watch because of concerns about imminent self-harm. In one case, health care failed to submit a report for someone who had attempted suicide.

3.13 In another, a detainee struggling with his mental health told health care staff he would kill himself and his cellmate said that he had twice stopped him from attempting to hang himself. The detainee was kept on constant watch for 66 hours, but no Rule 35(2) report was submitted.

3.14 Ten Rule 35(1) reports concerning detention having an adverse effect on a detainee's health had been submitted in the previous six months, but this did not reflect need. In one case, no report was made when health care staff became concerned that an increasingly psychotic detainee lacked mental capacity, nor when a psychiatrist subsequently recommended he be sectioned under the Mental Health Act 1983.

3.15 Despite the delivery of Rule 35 training to medical professionals, the quality of most Rule 35(3) reports on torture was still poor. Most lacked necessary detail, medical assessments were limited, and some did not contain an assessment of the impact of ongoing detention on the health of the detainee. Conversely, the quality of most Rule 35(1) reports we saw was good and contributed to better Home Office assessment of the risk of detention on detainees' health.

3.16 Home Office Rule 35 responses were mostly timely, but did not always show an appropriate assessment of risk. In two cases, caseworkers incorrectly failed to assess detainees at the highest level of risk, despite doctors making a clear finding that their poor mental health was likely to deteriorate if they were not released.

3.17 The Rule 35 safeguard was not effective in reducing the high level of vulnerability in the centre. In the previous six months, only 16% of detainees who had a Rule 35 report were released, compared with 32% at the full inspection.

3.18 There was poor case progression in most cases in our sample and one detainee waited five months for a decision on his asylum claim. In some cases, there had been little or no case progression when detainees were held in prison, which prolonged their subsequent detention under immigration powers. There were some long delays in documenting detainees and in the provision of release accommodation for those for whom bail had been agreed.

3.19 Most case progression action plans included actions for caseworkers to monitor the work of other Home Office teams, rather than set time limits for tasks to be completed. It was not clear from these reviews where ultimate responsibility lay for driving progression.

3.20 Detainees continued to have good access to the Detention Engagement Team (DET) and provision was developing well. Detainees could attend drop-in DET surgeries on weekday mornings

and afternoons. Face-to-face detainee contact was carefully monitored, and staff had met detainees more than 400 times in each of the previous two weeks, when the population had been less than 200. Where a detainee had not had in-person contact with the DET in the previous 21 days, DET staff and managers actively sought them out.

3.21 The team was better integrated with other Home Office casework teams and it was positive that DET managers were identifying and escalating concerns about cases in which there had been slow progression.

3.22 These and other DET initiatives had the potential for a positive impact on overall case progression times, but this was not yet reflected in outcome data.

3.23 We considered that the centre had made insufficient progress in this area.

Personal safety

Concern: The number of recorded fights, assaults on staff and uses of force had risen substantially since the previous inspection, and leaders had not made sufficient use of data to understand why this was the case.

3.24 Levels of violence were still high but had stabilised and, in some areas, slightly reduced. Force was used less often and there had been no group protests in the 11 months since the full inspection, compared to four in the first seven months of 2024.

3.25 Detainees we spoke to said they felt safe. Staff were visible and more experienced than at the inspection, and we noted good de-escalation of a verbal conflict between detainees.

3.26 There had been some useful initiatives to address the level of violence. For example, training had been provided on the centre's 'Monitor, Challenge and Support' process; 39 detainees were now being supported through it, compared to 13 at the full inspection when the population was much higher.

3.27 However, there were still not enough data on violence and little analysis of trends. In contrast, there was much improved analysis of data on the use of force. In both cases, there was no documented action on the data discussed in meetings over the previous six months.

3.28 We considered that the centre had made reasonable progress in this area.

Security

Concern: Some security measures were disproportionate. In particular, the centre was now routinely handcuffing detainees on external escorts.

3.29 Nearly everyone (95%) was still handcuffed on hospital escorts and there were no plans to address this concern.

3.30 While freedom of movement for detainees was reasonable during unlock periods, this still only amounted to about 11 hours a day. Detainees, especially those with no previous custodial experience, found being locked in cells difficult to manage.

3.31 A change in approach to risk assessment for charter removals had resulted in a substantial increase in the use of segregation. In the last six months, 358 detainees had been segregated compared with 283 at the last inspection, when the population was much larger. We were told this change had resulted from more attempts by detainees to frustrate their removal. However, there was insufficient analysis and review of data to show that the increased use of segregation was proportionate and justified.

3.32 We considered that the centre had made no meaningful progress in this area.

Concern: There was increasing availability of illicit drugs in the centre, but planning and resources to tackle the problem were inadequate.

3.33 Unlike at the full inspection, none of the detainees we spoke to said they were aware of drugs in the centre, and we could not smell drugs as we walked around. Leaders had implemented several positive initiatives, which included perimeter checks, staff searches, the use of 'ioniser' scanning machines to check all mail and the x-raying of parcels.

3.34 Staff had identified drugs being thrown over an external fence into one of the courtyards as a particular concern; as a result, it was checked before detainees used it and was closed during the hours of darkness. This had resulted in a significant reduction in the number of suspected throwovers. Visits staff now received a daily briefing from security staff highlighting potential risks. This had led to drug finds in visits and the individuals involved being referred to the police.

3.35 The appointment of a drug strategy lead had been approved and was planned for the near future, and a new drug strategy was about to be introduced. There was also more coordination of work with the health care team and with Sussex Police, who had appointed a dedicated liaison officer for the centre.

3.36 Security meetings were held monthly and were well attended, but it was not always clear what discussions took place and there were no documented actions.

3.37 We considered that the centre had made good progress in this area.

Staff-detainee relationships

Concern: Over half of operational staff had less than two years' experience, there were pockets of immature and unprofessional behaviour. Some officers continued to congregate in offices instead of proactively managing the wings.

3.38 Detainees continued to report positively on staff behaviour and we saw many courteous and constructive interactions. Leaders had addressed problems in a small number of work areas, such as reception, where negative or uncommitted staff cultures had taken root. This had led to more professional behaviour and better outcomes for detainees.

3.39 The Positive Detention Project noted at the full inspection was now very well embedded and helping to improve day-to-day staff supervision of detainees. There was some evidence that this was resulting in a better presence and influence of staff in detainee areas, although low-level behaviours such as vaping in communal areas were continuing.

3.40 The number of staff with less than two years' experience had dropped from 54% to 44% in the 11 months since the last inspection, and the rate of attrition had dropped by almost a third in the first half of 2025.

3.41 This reflected stronger processes of screening and sifting new detainee custody officer applicants, fewer of whom went through from application to appointment. More direct experience on the wings was being built into the training programme and a start had been made on systematic mentoring in the probationary period and beyond.

3.42 We considered that the centre had made good progress in this area.

Living conditions

Concern: The centre continued to look and feel like a prison, and not enough had been done to improve the environment.

3.43 The centre continued to look and feel like a prison and detainees remained frustrated with the inadequate ventilation of cells and their inability to open the sealed windows.

3.44 However, there had been substantial investment in making environmental improvements through a rolling programme of

renovation. Cells on A and C units and some showers had been refurbished, and D unit was closed for refurbishment during our visit.

3.45 There had been some attempts to soften the environment through a much-improved library and artworks displayed on walls through the centre. New furniture had been placed in the care and separation unit (CSU) and new equipment had been installed in the cultural kitchen. Cleanliness throughout the centre was now good.



New furniture in CSU (top, left), Cultural kitchen (top, right), C-wing artwork (bottom, left) and Welcome to Brook House sign (bottom right)

3.46 We considered that the centre had made reasonable progress in this area.

Equality, diversity and faith

Concern: Leaders had limited awareness of diverse needs in the centre as protected characteristic information about detainees was not systematically captured on their arrival.

3.47 There had been some improvement in the gathering of information about each detainee on arrival. Reception and welfare staff asked questions which covered many of the protected characteristics, but this was not comprehensive.

3.48 The identification of disability focused mainly on physical disabilities. Several staff said that they were not confident that people with neurodivergent characteristics were being identified and given appropriate support.

3.49 However, the support on equality, diversity and inclusion issues was much improved. Two enthusiastic coordinators were now in post whereas there had been no one at the full inspection. The coordinators were improving month-on-month the analysis and interpretation of data and raising the profile of the work.

3.50 There was still room for improvement in action planning and oversight meetings. Senior managers had been given lead roles in specific protected characteristics (see Glossary), but this had not resulted in significant changes; for example, there were no detainee consultation forums.

3.51 We considered that the centre had made reasonable progress in this area.

Health services

Concern: There were serious problems affecting the staffing, culture and morale of the health services team, which was not delivering a good enough service to detainees. Partnership working to help resolve these issues was poor.

3.52 Staff morale and the culture of the health services team had significantly improved. Despite still carrying large workloads, staff told us they were optimistic about the future of the service. This was due to an increase in staff and the direction provided by the new service managers; mainly those in primary care and substance misuse services.

3.53 Care for detainees within primary care had improved, particularly for those with long-term conditions. There was better access to medicines on arrival, as well as to immunisations and vaccinations.

3.54 Health partnership working had improved at a local operational level, with good relationships between wing staff and nurses. However, there were weaknesses at a senior level. Oversight meetings were in place, but partnership minutes lacked a focus on meaningful consultation and risk management.

3.55 A severe lack of space was the biggest risk to the provision of an effective service. The mental health and substance misuse teams shared a room to deliver one-to-one assessment, which was inadequate for a joint staff group of 10. There was no longer any room for the mental health team to deliver psychology group work and drop-in sessions, both of which had ceased. Consultation and joint planning to ensure alternative permanent accommodation had been inadequate.

3.56 The mental health team had offered to undertake assessments and interventions in detainees' cells as an interim solution, but this did not provide a sufficiently therapeutic or confidential setting and was not sustainable in the longer term.

3.57 Governance and oversight of health had improved, including the investigation and monitoring of adverse clinical incidents and complaints. Audits were now more frequent, but quality and action planning were not good enough. There had been improvements in mandatory training, management supervision and reflective practice in the primary care team. Mental health services had not ensured that supervision of reflective practice was comprehensively recorded.

3.58 The new safeguarding lead had helped to improve identification and management of vulnerable detainees. The lead was working on increasing information-sharing with the Home Office.

3.59 The Care Quality Commission (CQC) judged that improvements to governance and staffing were sufficient to meet their requirements, and the CQC action plan was closed.

3.60 We considered that the centre had made reasonable progress in this area.

Activities

Concern: The education provision had been poorly attended for a long time, but little had been done to review the curriculum to make it more appealing to detainees.

3.61 There was early evidence that a recent change to a new provider of online learning had been reasonably effective. A wider range of learning was available, in topics both work-related and for personal development, and detainees were using this material frequently, with a high completion rate of 87%.

3.62 Work had been done to raise the quality and profile of education delivery, but there was limited evidence of higher levels of achievement overall. A quality assurance process had been introduced for education shortly before the full inspection. It was now more embedded and was supplemented with quarterly learner surveys and regular in-service training days for the experienced and committed team of teachers.

3.63 Teaching staff were putting energy into promotion around the centre, with regular competitions and displays in different languages.

3.64 Overall, reasonable work had been done to raise the quality and profile of education delivery, but the inadequate analysis of data made it hard to demonstrate tangible outcomes.

3.65 We considered that the centre had made reasonable progress in this area.

Concern: The library was poor and little used. The room was no longer suitable for library activities, and most of the book stock had been removed, with the remaining collection held in cupboards.

3.66 The library had been markedly improved and had returned to its intended function now that it was no longer routinely used for other purposes. Books were on open display and were more clearly categorised, labelled and displayed through the efforts of a detainee custody officer, which was welcome after a long period of decline. Foreign language books formed a good proportion of the limited stock and were also clearly labelled.

Library bookshelves and seating

3.67 Reference books, borrowing records and other features of a functioning library were now in place. Four tablets were also available for detainees and were imminently to become more useful with the roll-out of individual detainee log-ins. Some Kindles were available for loan and a wide range of material on them was well organised by an activities officer.

3.68 The library was now an attractive and calm space. While it was still used by only a small number of detainees, a good start had been made on improving the offer.

3.69 We considered that the centre had made good progress in this area.

Welfare

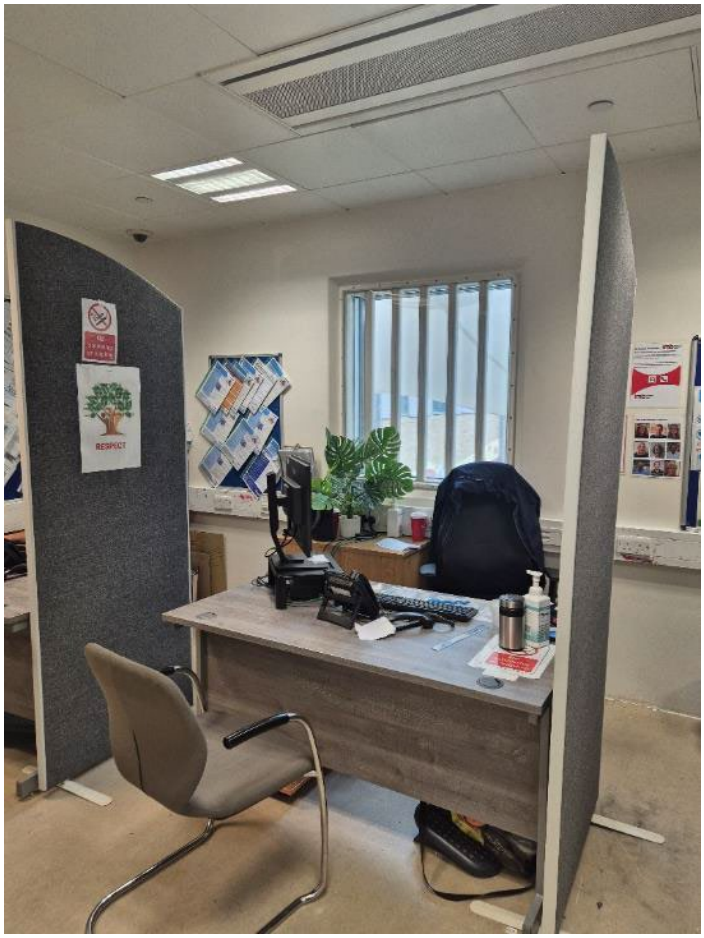
Concern: The welfare service was under-resourced and staff lacked space to see detainees privately.

3.70 Since the full inspection, the number of staff in the welfare service had increased significantly and there were now enough to provide a consistent service. There were 21.5 staff working across both Brook House and Tinsley House IRCs, and few vacancies. There had been significant investment into upskilling the team, with 16 having achieved level 1 accreditation by the Office of the Immigration Services Commissioner. This enhanced their ability to provide information and

direct detainees to sources of support. Staff we spoke to told us they felt supported, although they were still regularly affected by cross-deployment.

3.71 The number of contacts with detainees had been steadily increasing and welfare staff were now also conducting exit interviews, although we were not shown any analysis of these. The removal of an afternoon appointment system allowed for more open access to the service, which was good. Staff also visited the CSU each day to offer support to those being held there. Detainees we spoke to were positive about the support they received.

3.72 The ability to see detainees privately was still an issue. The screens that had been put in place for confidential appointments were largely ineffective. The office set-up did not allow for a waiting area, and we observed detainees listening to private conversations.



Welfare office screens

3.73 We considered that the centre had made good progress in this area.

Leaving the centre

Concern: In the previous year, at least 20 detainees had been released homeless, including people assessed as vulnerable.

3.74 In the previous 12 months, 10 detainees had been released homeless. Data collection was now more rigorous and the centre was confident that all homeless detainees were being counted. Although the number had decreased from the full inspection, so too had the number of detainees being held in the centre, and a lack of accommodation remained a significant problem.

3.75 Three people designated as adults at risk (see Glossary) were among those released homeless in the previous year, and multidisciplinary meetings were not taking place for all such detainees to provide extra support. No meetings at all took place for anyone who was not considered an adult at risk. During our visit, steps were being taken to improve the poor record-keeping in the multidisciplinary meetings.

3.76 There was very limited engagement with charities to explore possible community support. The Gatwick Detainee Welfare Group were not consistently informed of detainees who required support, but we were told that efforts to strengthen links with them were now under way. There was better communication between DET, reception and welfare about detainees due to be released.

3.77 We considered that the centre had made insufficient progress in this area.

Section 4 Summary of judgements

A list of the HMI Prisons concerns followed up at this visit and the judgements made.

HMI Prisons concerns

Priority concerns

The number of recorded fights, assaults on staff and uses of force had risen substantially since the previous inspection, and leaders had not made sufficient use of data to understand why this was the case.
Reasonable progress

Policies and procedures to minimise the length of detention and protect the most vulnerable were not effective enough. The centre was unaware of 31 detainees assessed at the higher levels of the adults at risk policy, and Rule 35 reports (see Glossary) were not always submitted when necessary. The length of detention had increased and case progression was often slow.
Insufficient progress

Over half of operational staff had less than two years' experience, there were pockets of immature and unprofessional behaviour. Some officers continued to congregate in offices instead of proactively managing the wings.
Good progress

The centre continued to look and feel like a prison, and not enough had been done to improve the environment.
Reasonable progress

There were serious problems affecting the staffing, culture and morale of the health services team, which was not delivering a good enough service to detainees. Partnership working to help resolve these issues was poor.
Reasonable progress

Key concerns

Not enough care was given to detainees on arrival and during their early days in detention. The reception area was chaotic, and induction was not carried out consistently.
Good progress

Some security measures were disproportionate. In particular, the centre was now routinely handcuffing detainees on external escorts.
No meaningful progress

There was increasing availability of illicit drugs in the centre, but planning and resources to tackle the problem were inadequate.
Good progress

Leaders had limited awareness of diverse needs in the centre as protected characteristic information about detainees was not systematically captured on their arrival.
Reasonable progress

The education provision had been poorly attended for a long time, but little had been done to review the curriculum to make it more appealing to detainees.
Reasonable progress

The library was poor and little used. The room was no longer suitable for library activities, and most of the book stock had been removed, with the remaining collection held in cupboards.
Good progress

The welfare service was under-resourced and staff lacked space to see detainees privately.
Good progress

In the previous year, at least 20 detainees had been released homeless, including people assessed as vulnerable.
Insufficient progress

Appendix I About this report

HM Inspectorate of Prisons (HMI Prisons) is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, court custody and military detention.

All visits carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

Independent reviews of progress (IRPs) are designed to improve accountability to ministers about the progress prisons make in addressing HM Inspectorate of Prisons' concerns in between inspections. IRPs take place at the discretion of the Chief Inspector when a full inspection suggests an establishment would benefit from additional scrutiny and focus on a limited number of the concerns raised at the inspection. IRPs do not therefore result in assessments against our healthy establishment tests. For immigration detention, HM Inspectorate of Prisons' healthy establishment tests are safety, respect, activities and preparation for removal or release. For more information see our website: Expectations – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)

The aims of IRPs are to:

- assess progress against selected priority and key concerns
- support improvement
- identify any emerging difficulties or lack of progress at an early stage
- assess the sufficiency of the leadership and management response to our concerns at the full inspection.

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each concern we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in August 2024 for further detail on the original findings (available on our website at Our reports – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)).

IRP methodology

IRPs are announced at least three months in advance and take place eight to 12 months after a full inspection. When we announce an IRP, we identify which concerns we intend to follow up. In most cases this will be all concerns (usually no more than 15). Depending on the concerns to be followed up, IRP visits may be conducted jointly with the Care Quality Commission. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

During our three-day visit, we collect a range of evidence about the progress in implementing each selected concern. Sources of evidence include observation, discussions with detainees, staff and relevant third parties, documentation and data.

Each concern followed up by HMI Prisons during an IRP is given one of four progress judgements:

No meaningful progress
Leaders had not formulated, resourced or begun to implement a realistic improvement strategy to address this concern.

Insufficient progress
Leaders had begun to implement a realistic improvement strategy (for example, with better and embedded systems and processes), but detainee outcomes were improving too slowly or had not improved at all.

Reasonable progress
Leaders were implementing a realistic improvement strategy, with evidence of sustainable progress and some early improvement in outcomes for detainees.

Good progress
Leaders had already implemented a realistic improvement strategy to address this concern and had delivered a clear improvement in outcomes for detainees.

Inspection team

This independent review of progress was carried out by:

Hindpal Singh Bhui	Team leader
Deri Hughes-Roberts	Inspector
Martin Kettle	Inspector
Chelsey Pattison	Inspector
Fiona Shearlaw	Inspector
Tania Osborne	Health and social care inspector
Mark Griffiths	Care Quality Commission inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find.

Adults at risk policy
This Home Office policy sets out what is to be taken into account when determining whether a person would be particularly vulnerable to harm if they remained in detention. There are three risk levels under the policy.

Care Quality Commission (CQC)
CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: http://www.cqc.org.uk.

Protected characteristics
The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

Rule 34 Detention Centre Rules
Requires a medical examination of every detained person by a GP within 24 hours of their arrival at an immigration removal centre.

Rule 35 Detention Centre Rules
Provides that:

(1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.
(2) The medical practitioner shall report to the manager on the case of any detained person they suspect of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of their treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.
(3) The medical practitioner shall report to the manager on the case of any detained person who they are concerned may have been the victim of torture.
(4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.
(5) The medical practitioner shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements) which appear necessary for their supervision or care.

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

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