**BROOK HOUSE INQUIRY**

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**First Witness Statement of Hindpal Singh Bhui**

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I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 5th July 2021. I have been authorised by Her Majesty's Chief Inspector of Prisons ('HMCIP') of 3rd Floor, 10 South Colonnade, Canary Wharf, London, E14 4PU to provide this witness statement on behalf of Her Majesty's Inspectorate of Prisons ('HMIP'). Insofar as the contents of this statement are within my personal knowledge, they are true, and, insofar as the contents of it are not within my personal knowledge, they are true to the best of my knowledge and belief.

## Section A - Introduction

1. I am an Inspection Team Leader at HMIP and have been employed by HMIP for 17 years, about 14 of which have been as an Inspection Team Leader. I have previously worked as a probation officer in the community and in prison, where one of my specialisms was in work with foreign national prisoners. I have also been a university lecturer and research coordinator and was formerly a professional and academic journal editor. I hold a PhD from the Law School, Lancaster University, and I am currently a Visiting Professor at the Centre for Criminology at Oxford University, undertaking research and teaching criminology and prison studies. I have published widely on prisons, probation, immigration detention, and race and criminal justice.

2. I lead HMIP's immigration detention work. I have led all of the previous HMIP inspections of Brook House from when it opened in 2009 up to the present date, including the 2016 and 2019 inspections. I contributed to the Independent Investigation into concerns about Brook House Immigration Removal Centre, November 2018 ('The Lampard Review'). I have also given evidence to the Home

Affairs Select Committee and an All Party Parliamentary Group on Immigration Detention about Brook House.

3. As a result of my prior experience and first-hand involvement with Brook House I am making this statement on behalf of HMIP to assist the Inquiry with:
   a) The inspection process and methodology (Section B)
   b) The 2016 inspection of Brook House (Section C)
   c) The Panorama Programme and the enhanced methodology (Section D)
   d) The 2019 inspection of Brook House (Section E)
   e) Learning and reflection within HMIP (Section F)

4. Charlie Taylor, HM Chief Inspector of Prisons, is also making a statement on behalf of HMIP about his own role, the purpose of an inspection and the approach of HMIP to carrying out its role.

## Section B - The Inspection Process and Methodology

5. This section outlines some general points relating to HMIP's inspection process. The information here primarily relates to the position as it was in 2016. I have highlighted significant changes since 2016 within this section for ease of reference, and provided full details about those changes in Section D below.

### B (i) HMIP Inspection Guidance Documents

6. There are two key documents for inspections of Immigration Removal Centres ('IRC's), exhibited as follows:

   a) Inspection Framework, February 2016 ('2016 Framework'), marked Exhibit 'HS1'. The 2016 Framework sets out the methodology and process for the conduct of HMIP inspections and how HMIP works with partner organisations. This version was current at the time of the 2016 Brook House inspection.

b) Expectations, Criteria for assessing the conditions for and treatment of immigration detainees, Version 3, 2012, ('2012 Expectations') marked Exhibit 'HS2'. The 2012 Expectations set out the criteria used during inspections to assess the treatment and conditions of those held in IRCs and were current at the time of the 2016 Brook House inspection. A new set of Expectations was published in 2018. Expectations assess outcomes for detainees against four healthy establishment tests; safety, respect, activities and preparation for removal and release. Each individual expectation within the set describes an outcome for detainees. For each expectation there is a list of indicators that helps inspectors reach a judgement about whether the outcome has been achieved or not. Indicators are not intended to be exhaustive or prescriptive and establishments may demonstrate that they have achieved the outcome in other ways.

7. Inspection Frameworks and Expectations are drafted and published by HMIP. Both documents are subject to consultation but the inspection methodology and criteria are ultimately determined by HMIP. The 2016 Framework and 2012 Expectations were the documents used during the 2016 Brook House inspection and set out the methodology and inspection criteria applied during that inspection.

8. In addition to the Framework and Expectations, inspectors are also aided in their work by a Guide for Inspectors and the version that applied during the 2016 inspection is the Guide for Inspectors 2016 (marked Exhibit 'HS3'). Members of the inspection team are required to be familiar with this Guide. The Guide sets out some background information about HMIP's operating context, some detail about the process of inspections and information about professional standards. The Guide sets out the actions to be taken by HMIP staff on receipt of serious allegations against establishment staff from detainees and action to be taken in response to safeguarding concerns.

B (ii) Timing and Scheduling of Inspections

9. Paragraph 3.2 of the 2016 Framework describes the minimum inspection cycle that HMIP has set for IRCs. They are subject to an inspection at least once every four years, but most IRCs can expect to be inspected every two to three years. Brook House opened in 2009 and has been inspected by HMIP in 2010, 2011, 2013, 2016 and 2019. In addition, Brook House was one of several IRCs visited in May 2020 for a 'short scrutiny visit'; these inspections applied a temporarily shortened methodology that was used during the early stages of the COVID-19 pandemic to maintain independent oversight while minimising the risks of virus transmission. These short inspections are explained further in Section E, below.

10. HMIP's decision about exactly when to inspect an establishment is influenced by intelligence received about current concerns and risks. This is considered alongside other information set out at paragraph 3.3 of the 2016 Framework. We currently have a Delivery Board that meets monthly and is attended by senior managers; deciding whether to undertake an inspection based on possible risk is part of its remit. The Head of Research provides information and advice to the Board about intelligence received, and I may also contribute information that has been received by any member of the immigration inspection team. The Delivery Board then jointly considers what risk an establishment may pose to detainees and plans the inspection schedule accordingly. This process was also in place in 2016.

B (iii) Overview of the Inspection Process

11. The process of the inspection as it was in 2016 is set out in detail in section 3 of the 2016 Framework. Paragraph 3.23 of the 2016 Framework sets out the five key sources of evidence to be obtained during the inspection, from:

    i. Observation
    ii. Detainees
    iii. Staff

iv. Third Parties

v. Documentation

12. The inspection team has access to the entire establishment during its time on site and there is no area that is off limit to them. I am unaware of the inspection team at any Brook House inspection being denied access to relevant documents, facilities, the physical estate, detainees or staff.

13. The 2012 version of the Expectations document describes the criteria to be used during inspections to assess the treatment and conditions of those held in IRCs. Pages 7 and 8 of the 2012 Expectations document set out a list of areas considered within the four healthy establishment tests, including, for example, early days in detention, self-harm prevention, residential units, complaints, health services and substance misuse services. As is demonstrated by that document, the inspection is intended to be a thorough, in-depth examination of the treatment of and conditions for detainees in the establishment.

14. Most inspections are unannounced and in 2016 they took place over two weeks. On Monday morning of the first week of an inspection, the establishment will be contacted and usually given no more than 30 minutes' notice of the arrival of HMIP staff, so they can organise keys and quick access to the establishment. The first members of the HMIP inspection team on site are the coordinating inspector, a safeguarding inspector with legal knowledge (at the time of the 2016 inspection, this inspector was called the 'casework inspector') and members of the 'research, development and thematics' ('RDT') team, who conduct the detainee survey.

15. A number of sources of information are gathered in the first week of inspection: the coordinating inspector carries out initial observations of the establishment and asks the centre for its data; the casework inspector carries out reviews of casework; the RDT team undertakes the detainee survey (and now distributes the staff survey).

16. Shortly after arrival, the coordinating inspector takes an immediate look around the establishment, especially at areas that we consider to be high risk, such as the separation unit. The coordinating inspector then prepares a report on their initial observations for the full team. They also request relevant data from the establishment, including, for example, figures on assaults and use of force. That data is made available to the full team before they arrive at the establishment during the final (main) week of the inspection.

17. The main task of the safeguarding inspector is to assess how vulnerable detainees have been treated and supported. During the first week of the inspection, they review records for individual detainees in the establishment who could be considered especially vulnerable because of, for example, experiences of trauma and torture, or particularly lengthy administrative detention. This inspector reads Home Office case notes on such detainees, examines a sample of Rule 35 reports and will speak to a sample of vulnerable detainees who are still in the establishment.

18. The RDT team also attends during the first week. The team gathers feedback and views from detainees by way of a survey of a representative sample of detainees. The sample size is calculated to ensure that the survey findings will reflect the experiences of the whole population. HMIP routinely 'oversamples' to ensure the minimum number of responses required is achieved. The respondents to the survey are then selected randomly. The 70 questions asked of detainees in the survey used during the 2016 inspection are based on the 2012 Expectations and are listed in full at pages 72-79 of the 2016 Inspection Report. They cover a wide range of topics that aim to capture the experience of detainees, including safety, healthcare and activities. The survey has changed slightly since 2016 as a result of the updated Expectations and other ad hoc reviews and I have explained the key changes at section D below. The RDT team may also interview detainees who cannot complete the survey because they have difficulty reading or writing or do

not speak one of the languages into which the survey is translated. The survey was available in 20 languages at the time of the 2016 inspection and responses were received in 15 different languages.

19. Inspectors always speak to some detainees individually and in groups at IRC inspections, and did this in 2016. Since 2017, we have offered every detainee a confidential one-to-one interview that asks, amongst other things, how staff and other detainees treat them. Further information about this change is at section D below.

20. Staff views are also gathered during the inspection. In 2016, our inspection process involved inspectors speaking to a wide range of staff from different grades during the main inspection week, but there was no staff survey or formal interview process. More detail about the changes in respect of gathering staff evidence since 2016 is at section D below.

21. The information gathered from all of these sources is collated and is normally provided to the full inspection team before they commence their work on site in the main week of the inspection; sometimes it may arrive during the early stages of their time on site.

22. A full team includes between four and six core inspectors depending on the size and complexity of the establishment, plus inspectors covering various specialities, for example, health. Either the Chief Inspector ('CI') or Deputy Chief Inspector ('DCI') will normally also attend the establishment on the penultimate and final days of the inspection.

23. At the 2016 Brook House inspection, in addition to the five core HMIP inspectors with various experience and expertise (see biographies in Section C(ii) below), the following specialists also attended on site:

a) Healthcare Inspector, employed by HMIP
b) Pharmacist, employed by the General Pharmaceutical Council ('GPhC')
c) Care Quality Commission ('CQC') Inspector, employed by the CQC
d) Ofsted Inspector, employed by Ofsted

The relationship between HMIP and the CQC is set out in a Memorandum of Understanding, a copy of which is exhibited marked Exhibit 'HS19'.

24. The make-up of the inspection team has changed slightly since 2016, in that we no longer have an Ofsted Inspector as part of the team, as Ofsted withdrew their inspectors from IRC inspections in 2017. However, specialist activities inspectors (with substantial experience of working with Ofsted) have instead been directly contracted by HMIP. Pharmacists do not routinely attend IRC inspections because of the lack of registered dispensaries on site. When they do attend, it is primarily to inspect medicines optimisation, with a focus on prescribing. That was the case in 2016, when a pharmacist attended the Brook House inspection. If there is no pharmacist in attendance, HMIP and/or CQC or Health Improvement Scotland inspectors (who attend inspections taking place in Scotland) are experienced in inspecting the relevant areas.

25. Paragraphs 3.15 – 3.21 of the 2016 Framework set out the actions taken during the main inspection week when all members of the team are on site. This includes arrangements for meeting with third party organisations, for example the Independent Monitoring Board ('IMB'); reviewing additional documents; and further observations and engagement with staff and detainees.

26. Throughout the inspection there is regular and ongoing engagement between the inspection team and the management of the establishment, as set out at paragraph 3.26 of the 2016 Framework. The Inspection Team Leader will discuss emerging findings with the Centre Manager and other senior managers daily, so that they have the opportunity to challenge findings and provide further evidence.

27. A key feature of the inspection methodology is that the inspectors will seek to triangulate evidence from multiple sources before finalising findings and judgments on particular issues. This process is explained further at paragraphs 3.24 – 3.25 of the 2016 Framework. In short, inspection findings or judgements are, wherever possible, based on multiple evidence sources (although on occasion an incident may be evidenced by a single source). Triangulation means an evidence source is corroborated by at least two other sources.

28. Key findings and conclusions are presented verbally to the establishment on the final day of the inspection. A written debrief is also provided to the establishment within one to two working days of the completion of the inspection.

29. While inspections reach triangulated and consequentially strong conclusions, they may also find evidence that may be of concern, but which inspectors have not been able to triangulate or otherwise make a firm judgement about. Such evidence then requires further investigation by senior managers, who should assure themselves that there are no concerns they need to address in relation to that evidence.

B (iv) Overview of the Post-Inspection Process

30. Once the inspection team has concluded its site visit, the inspectors will bring together their findings and comments and prepare draft report sections. The coordinating inspector then gathers in the various sections and collates them all into a template, checks for consistency and makes sure all areas set out in the Expectations have been covered across the report. The report is then sent to a professional editor for proofing, and there is an iterative process between the editor and the coordinator to ensure clarity and consistency. The final edited version is sent to the Inspection Team Leader who undertakes a thorough review of the report and sends questions to the various contributing team members where further clarification is necessary. Once the report is signed off by the Inspection Team Leader, it is sent to the CI or DCI for review. The CI / DCI will raise any queries with the Inspection Team Leader, and will either write the introduction or edit the

draft introduction provided by the Inspection Team Leader to ensure that they are content with it.

31. Once the report is finalised internally at HMIP it is sent to the Home Office for fact checking, in accordance with paragraph 30 and 31 of the Memorandum of Understanding between the Home Office (Immigration Enforcement) and HMIP – Immigration Detention and Escort Arrangements ('the MOU'). I exhibit a copy of the MOU, marked Exhibit 'HS4'. The Home Office will liaise with the relevant contractor at the establishment as part of this process. This is an opportunity for the Home Office and contractors to ensure that the content of the report is accurate. It is not an opportunity for them to provide alternative interpretations of the evidence or attempt to influence the considered judgements of HMIP. If no evidence is provided in support of a claim of factual inaccuracy, then the report will not be amended. By the end of the process, while the Home Office might disagree with the conclusions in the report, there should not be any disagreement as to the evidence that has led to those conclusions.

32. In 2016, Ofsted, the GPhC and the CQC also received a copy of the draft report before publication, given their involvement and provision of inspectors. Now, only the CQC or Health Improvement Scotland receive a copy of the draft report because Ofsted and the GPhC do not routinely take part in the HMIP immigration inspections.

33. The different layers of the report preparation and fact checking process are intended to ensure that HMIP inspection reports are thorough and well evidenced. The finalised report is published on the HMIP website within 18 weeks. In 2016, hard copies of the reports were also sent out to the Home Office and any other appropriate organisations, for example NGOs. The report is published alongside a press release and often the CI / DCI will engage with the media in respect of the report.

B (v) Recommendations

34. As set out in Charlie Taylor's statement, HMIP is currently consulting on a change to the way that it reports its inspection findings. This includes a proposal to no longer make recommendations but instead report a smaller number of 'concerns', some of which will be identified as 'priority concerns'. Senior managers will be expected to formulate a bespoke plan to address the concerns identified. The concerns will be based on the evidence that has been gathered by HMI Prisons and subject to the fact-checking process outlined above. The intention is to promote greater leadership focus on and ownership of the actions that are necessary to correct the concerns that HMI Prisons identifies. We do not therefore expect any concerns to be rejected as is sometimes the case with recommendations. The information set out below refers to the process of making recommendations that was in place during the 2016 and 2019 inspections of Brook House (and which will be in place until the completion of the consultation toward the end of March).

35. The Inspection Team Leader, with prior input from the CI / DCI, gives the establishment a verbal debrief on the last day of the inspection. This includes a summary of the key findings that will be described in the report and will lead to recommendations. The main aim of this debrief is to ensure that the establishment is aware of the most pressing concerns immediately and can begin to take remedial action without delay. It is also provided to the establishment in writing within one to two working days of the end of the inspection.

36. The full recommendations are provided with the report. The majority of recommendations are made to the Home Office and / or the contractor running the establishment. The Home Office may be required to liaise with other organisations to address some recommendations. On occasion we refer recommendations on to other interested organisations, so they are aware of our concerns.

37. The Home Office in tandem with the contractor will prepare an action plan (sometimes called a service improvement plan) in response to the report, in line with paragraph 3.34 of the 2016 Framework and paragraph 24 of the MOU. The action plan is required within three months of the report's publication and must specify whether HMIP recommendations have been accepted, partially accepted or rejected. At the time of the 2016 inspection, the Home Office also sometimes accepted recommendations 'subject to resources'. If a recommendation is accepted/partially accepted, the action plan will explain how and when it will be implemented. If a recommendation is not accepted, the action plan should explain the reasons for rejection. On rare occasions, action plan responses may demonstrate that a recommendation has been misunderstood; if this happens, HMIP will contact the Home Office to provide clarification.

38. HMIP does not have any enforcement or regulatory powers in respect of recommendations and action plans. The onus is on the Home Office and the establishment contractor to implement the recommendations and take action in response to HMIP's concerns, and ultimately it is a matter for those organisations as to what steps they take. HMIP will review previous recommendations, action plans and progress made at the next inspection of the establishment, in line with paragraph 3.35 of the 2016 Framework. There is no formal process in place for monitoring progress against recommendations in-between immigration detention inspections, although HMIP continues to receive and monitor intelligence on establishments and may update its risk assessment and inspection scheduling accordingly.

39. I believe that the process of making recommendations provides establishments with sufficient clarity and direction to start to address the safety and welfare concerns identified by HMIP. However, while recommendations are intended to provide a clear focus for remedial action, the entire process of an inspection, and the full inspection report, highlight immediate concerns about safety, welfare and risk factors which, if not addressed, could lead to ill-treatment. This process

includes feedback provided throughout the inspection, including during the verbal debrief, and the full explanation of findings in the inspection report, which may include information that requires further investigation by managers. In addition, inspectors may raise safeguarding concerns about individual detainees, which we expect managers to follow up on to make sure the concerns are addressed. As noted above, HMIP is currently consulting on changes to the way in which it reports its findings with the aim of increasing the focus on the most urgent concerns, which would include the safety and welfare of detainees.

## Section C – The 2016 Inspection of Brook House

### C (i) –The Report & Key Documents

40. I exhibit a copy of the Report on an unannounced inspection of Brook House Immigration Removal Centre 31.10.16 – 11.11.16 ('2016 Inspection Report'), marked Exhibit 'HS5'. I also exhibit a copy of the written debrief that was provided to the establishment at the end of the inspection, in advance of the full report, in accordance with the process outlined at paragraph 35 above, marked Exhibit 'HS6'.

41. I am not aware of anything significant relating to the conditions at Brook House during our 2016 inspection that is not included in the inspection report, although background documents might include more detail. Judgements are made in inspection reports when inspectors have reasonable confidence in them following the process of triangulation.

### C (ii) - Inspection Team

42. Appendix I of the 2016 Inspection Report, at page 55, includes a complete list of the inspection team for the 2016 inspection. The only other people involved but not named in that list were:
    a) An observer, Professor Mary Bosworth, who attended for part of the first day of the main inspection week. She attended in order to observe the process of an immigration detention inspection and I asked her provide feedback. In the

event, she was unable to stay as a result of other work pressures and she was therefore unable to provide such feedback. At the time, Professor Bosworth and I were working together on a research project on human rights based detention monitoring in four countries, Greece, Turkey, Hungary and Italy. Professor Bosworth accompanied me to two of these countries, Greece and Hungary.

b) An observer, Tamara Pattinson, who attended to shadow inspectors as she was shortly due to join HMIP as a secondee.

c) Administrators and the editor of the draft report (none of whom attended on site at Brook House).

None of these additional people listed made any contribution to the substantive content of the inspection or report.

43. The inspection team for the 2016 inspection was an experienced team and one with a range of specialisms.

44. Peter Clarke was the CI for the 2016 inspection at Brook House. Mr Clarke's background is published and still available via the gov.uk website,[1] and I have drawn the following information about his experience from there. Mr Clarke was appointed to the role of Her Majesty's Chief Inspector of Prisons on 1 February 2016. He was a retired senior police officer, who served in the Metropolitan Police Service for more than thirty years. He rose to the rank of Assistant Commissioner and also served as Head of the Anti-Terrorist Branch and National Co-ordinator of Terrorist Investigations. In 2014 he was appointed Education Commissioner for Birmingham to conduct an inquiry into the allegations concerning Birmingham schools. Mr Clarke also served on the Board of the Charity Commission until January 2016. I understand Charlie Taylor's statement provides more detail about the CI and DCI roles and responsibilities.

[1] https://www.gov.uk/government/news/extension-of-peter-clarke-s-tenure-as-hm-chief-inspector-of-prisons

45. I have set out my experience and expertise relevant to the role of Inspection Team Leader at paragraph 1 above. As at 2016, I had twelve years' service with HMIP. For nine and a half of those years I had been the Inspection Team Leader for immigration detention establishments, although my role also routinely involved prison inspections. The Inspection Team Leader role is a senior Grade 6 role within the civil service. I exhibit the Inspection Team Leader person specification, marked Exhibit 'HS7'.

46. The Inspector role is a Grade 7 role within the civil service. I exhibit the person specification, marked Exhibit 'HS8'. Inspectors usually join HMIP as senior experienced practitioners with a background in the criminal justice system or related professions, and often with direct experience of managing custodial facilities. There were five core HMIP inspectors on the 2016 Brook House inspection team and I have gathered the following information from the inspectors about their background expertise:

    a) Beverley Alden – Ms Alden was an inspector with HMIP from 2010 until 2019. Ms Alden had an academic background in Law and Criminal Psychology and worked for several years in the Norfolk Youth Justice Service where she held the Prevention and Restorative Justice strategic portfolio. She had previously led on the joint commissioning of drug and alcohol services for the London Boroughs of Havering and neighbouring Barking and Dagenham. She worked closely with the local Community Safety Strategic Partnership on the issue of drug-related crime. Immediately prior to joining HMIP, Ms Alden worked for two years in the voluntary sector as the area development manager for criminal justice services within a regional children's charity, developing services in the eastern region prison estate for prisoners' children and families.

b) Colin Carroll – Mr Carroll joined HMIP in 2009 as an inspector specialising in immigration detention and foreign national prisoners. By 2016 he was an experienced inspector of detention settings including prisons, immigration removal centres, police custody, young offender institutions and removals of detainees under escort (overseas). He inspected a wide range of subjects including the use of force, segregation, control and restraint, safeguarding and staff-detainee relationships. Mr Carroll had extensive experience of reporting on outcomes for detainees including the application of rules 35, 40 and 42 of the Detention Centre Rules. Prior to joining HMIP, Mr Carroll worked for nine years at the third sector organisation Refugee and Migrant Justice (RMJ) (formally the Refugee Legal Centre) - first as a caseworker and latterly as a senior manager. RMJ provided legal advice and representation to asylum seekers and immigration detainees. Mr Carroll was accredited as a supervising senior caseworker under the Law Society's Immigration and Asylum Law Accreditation scheme. Before joining RMJ Mr Carroll completed a master's degree in Migration Studies at the University of Sussex.

c) Martin Kettle – Mr Kettle joined the inspectorate in November 2008 as a full-time inspector, on secondment from the prison service. He has worked with HMIP consistently since then, full-time for five years and as an associate inspector for seven years. Between 2008 and 2016 he was a member of the immigration team at HMIP, inspecting immigration detention facilities as well as prisons. Prior to HMIP, he joined the prison service as a prison officer in 1998, and became a governor grade at HMP Whitemoor in 1999, managing various departments including segregation, special units and the operational side of healthcare delivery. From 2001 to early 2004 he worked in a policy role at the headquarters of the prison service, returning to HMP Whitemoor where he occupied senior roles including acting deputy governor. In these roles he dealt closely with the management of separation, support for those at risk of suicide or self-harm, use of force, and control and restraint.

d) Deri Hughes-Roberts joined HMIP in 2013 since when he has been an associate inspector, working across all detention settings but specialising in immigration detention. He trained as a solicitor and from 1992 was employed by Refugee and Migrant Justice (RMJ) (formerly Refugee Legal Centre) for 17 years, first as a caseworker, and then as a casework manager and latterly as director of casework. He has published research into various aspects of asylum work, including legal aid provision.

e) Karen Dillon – Ms Dillon was an inspector from 2008 to 2018. Ms Dillon was formerly a police constable and joined the prison service in 1988, serving in several roles including as a PE Instructor, control and restraint (C&R) instructor on both a local and national level, and as a head of function in several prisons, including local and category C men's prions and a women's prison. During her time in the prison service, Ms Dillon held the role of Head of Healthcare at HMP The Mount and assisted clinical staff in developing specifications for delivery of both physical and mental health care within a detention setting. Ms Dillon has undertaken training for adults at risk and safeguarding both within the prison service and within HMIP. At HMP Styal Ms Dillon had responsibility for the safety and welfare of up to 400 women as Head of Safety and Residential.

f) Paul Tarbuck –Mr Tarbuck was seconded from the National Health Service (NHS) to HMIP in 2010 and was directly employed as Head of Health and Social Care Inspection from 2015-2018, when he retired. Since then he has been an associate healthcare inspector. Mr Tarbuck is a nurse, registered with the Nursing and Midwifery Council. Other relevant education includes DipM, DipN, BaTheol and English National Board for Nursing certifications. He is a former chairperson of the Royal College of Nursing forum for nursing in secure environments. Mr Tarbuck retired from the NHS in 2015 after 42 years. His most recent roles were in directing secure mental health services in the NHS and criminal justice sectors. He has worked in general and mental

health care settings in clinical, managerial, research and academic roles in the UK and abroad in public, private and charitable sectors. He has edited professional textbooks and published in peer reviewed journals on nursing and professional issues including mental health and control and restraint. He has experience in providing health care in places of custody and in inspecting health services in places of custody, including immigration removal centres, and rule 35.

47. The requirements placed upon inspectors are detailed in our Inspection Framework and Guide for Inspectors documents. All new inspectors are trained on an individual one-to-one basis, usually requiring an induction that lasts for a minimum of three inspections. During these inspections, the new inspector will initially observe the practice of a mentor before actively assisting in the inspection process. Taking on more responsibility, they continue to be supervised and mentored before being allocated specific areas (themes) to inspect. This process is part of an agreed programme for each individual, which will also include the deployment across the Inspectorate's various teams. This ensures the greatest possible exposure to different custodial settings and different ways of working. Throughout, the new inspector will remain subject to close supervision and support from their team leader and assigned mentors.

48. As part of the induction process, new inspectors are introduced to our Guide to Inspectors document and given guidance on subjects that require specific insights. These include:
    - Adults at Risk Policy;
    - Detention Centre Rules 2001, especially Rules 35, 40, 42 and 43;
    - Use of Force;
    - Control and Restraint (C&R); and
    - Adequacy of healthcare for detainees, including mental health care.

49. Inspectors attend quarterly HMIP 'development days' where they receive training and attend a series of talks that are relevant to their inspection practice. For the immigration team, practice development and discussion also take place during team meetings and during what were, until the COVID-19 pandemic, away days held every 12-18 months (see section F for more detail). Initial training for all inspectors also includes the use of keys and conduct in a custodial environment, often referred to as 'jail craft' training, approved break-away techniques for self-protection, introductions to HMIP policy and practice, and standard civil service mandatory training.

50. The inspection process is a collaborative process. Inspectors support and challenge one another during the inspection week and their evidence is also interrogated by the Inspection Team Leader. HMIP encourages a culture of respectful but robust professional challenge, where inspectors present their observations and findings for scrutiny by their colleagues, to ensure that evidence and emerging findings are thoroughly explored. None of the inspectors on the 2016 inspection team were new to HMIP and all had gained years of experience on inspections in respect of the subject areas listed at paragraph 47 above.

51. I cannot comment in any detail on the specific qualifications and experience of the Pharmacist, Ofsted and CQC inspectors attending the 2016 inspection of Brook House as they were not HMIP employees. To the best of my knowledge I believe that they were capable professionals able to undertake a thorough inspection of their specialist areas.

52. The research team in the 2016 inspection was comprised of a Senior Research Officer (civil service grade SEO – senior executive officer), two Research Officers (civil service grade HEO – higher executive officer) and a Research Trainee (civil service grade AO – administrative officer). Induction for researchers includes the standard HMIP induction and training plus research and development team training, which covers principles of conduct, safety and security. There is also a comprehensive system of shadowing and supervision for new research team

members and they are not allowed to be on a wing in establishments by themselves until they have been on 10 site visits or with HMIP for six months. I exhibit the person specifications for the research team, marked Exhibit 'HS9'.

53. While the inspection schedule may be changed in response to specific intelligence about current risks (see paragraph 10), the scheduling of inspections and selection of team members is normally undertaken on an annual basis and planned in advance around availability of team members. Due to the specialist nature of immigration detention inspections, there is a core of regular immigration detention specialists who will be allocated to IRC inspections as a priority. The inspectors Colin Carroll, Bev Alden and Deri Hughes-Roberts from the 2016 Brook House inspection team were all members of the core immigration detention specialist team. Martin Kettle had also previously been a member of that team and was therefore also considered to be an immigration specialist.

54. The inspection team members are allocated areas of responsibility during the inspection, which cover each expectation area encompassed within the four healthy establishment tests. I have exhibited a copy of the allocations for the 2016 inspection, marked Exhibit 'HS10'.

C (iii) - Intelligence pre-2016 inspection

55. HMIP had received four pieces of intelligence relating to Brook House prior to the 2016 inspection. I exhibit copies of the four emails, marked Exhibit 'HS11'. Three of the emails were received in 2015, with the final email received in May 2016.

56. When HMIP receives intelligence about an immigration establishment it is usually sent to me as the Inspection Team Leader for immigration detention inspections and saved in the establishment file, usually by members of the HMIP Secretariat staff. Such information is then shared with the whole team before an inspection.

All relevant information about an establishment is collated to ensure that the Head of RDT can also review it when considering risk and how it might affect the inspection schedule.

57. None of the intelligence we received about Brook House prior to the 2016 inspection led us to consider that the risk was raised to the extent that we needed to amend or bring forward our planned inspection of the establishment. The 2016 inspection was scheduled to commence on the 31st October 2016 and took place in accordance with that original timetable.

58. I do not remember my exact thinking at the time on the four pieces of intelligence received; however, on reviewing them now I am confident that they were not, singly or in combination, sufficient to trigger an earlier inspection. Such triggers would normally be, for example, multiple reports of disorder, violence, abuse or self-harm. The intelligence we received was as follows:

a) An email from a hospital doctor dated 7 May 2015, who was concerned about G4S failing to remove a detainee's restraints during a hospital escort. I attach a copy (marked Exhibit 'HS12') of the response sent to the complainant by the Chief Inspector at the time, Nick Hardwick, explaining that it would be added to the intelligence files for the establishment and, if the doctor consented, be passed to the Home Office for investigation. This issue was a concern that HMIP identified and raised with the establishment during the inspection in 2016, as is outlined at paragraph 1.43 and the recommendation at paragraph 1.48 of the 2016 inspection report.

b) An email from CQC dated 24 December 2015 which related to complaints about a GP at Brook House dating back to early 2014. The CQC correspondent noted that the complainant had already taken appropriate action and reported the matter to the GMC.

c) A brief local newspaper report about a fire in a room at Brook House (9 December 2015).

d) A suggestion by a national newspaper reporter of a concerted indiscipline, which was discussed with HMIP's then Chief Communications Officer on 25 May 2016. At that time, the Brook House inspection had already been scheduled for the autumn of 2016.

59. Before the full inspection team attend the establishment, a pre-inspection report is prepared and disseminated to them, highlighting some factual information and information gathered during the early stages of the inspection. I exhibit a copy of the pre-inspection report prepared in the 2016 inspection, marked Exhibit 'HS13'. Paragraph 2.37 of the Guide for Inspectors sets out the full details of what inspectors receive prior to their attendance on site during the second week of the inspection. In 2016 that information was collated in hard copy and provided to the inspectors.

C (iv) - Use of Force ('UoF')

60. The 2012 Expectations document sets out at expectation 17 in respect of UoF the expectation that '*Detainees are only subject to force which is legitimate, used as a last resort and for no longer than necessary*'.

61. On attendance at the establishment, the coordinating inspector requests UoF data. We expect every custodial facility to keep routine data about UoF, to include high level statistical data as well as all the relevant paperwork that is filled in and retained on each occasion when force is used. The pre-inspection report details the preliminary data gathered by the research team in respect of UoF.

62. During the 2016 inspection, Colin Carroll was the inspector allocated to inspect UoF. The UoF inspector will consider whether the use of force is in line with our

Expectations and employ a number of means to reach their judgements. Firstly, the inspector will review a sample of forms and start to build a picture of the circumstances in which force is being used at the establishment and the degree to which the records can demonstrate proportionality. The initial sample size is usually around 5-10 incidents over the previous six months where force has been used. The quality of the record-keeping is also assessed as this is important to ensuring accountability. The forms are reviewed to determine whether the accounts provided by staff make sense; whether they demonstrate de-escalation so that force is only used as a last resort; and whether concerns about proportionality, necessity or use of force techniques are identified and addressed, which is a key responsibility for counter-signing managers. The inspector will also review a sample of available recordings, usually of body-worn camera footage but sometimes from hand-held cameras if these have been used. Where there is a recording relating to an incident for which we have also reviewed paperwork, we will compare the footage against the account provided in the paperwork to check the consistency, quality and accuracy of the information recorded. We will also review a randomly selected dip sample of incidents occurring in the previous six months for which footage is retained.

63. As well as reviewing the samples of forms and footage, if we are alerted to a concerning use of force during our time in the establishment – for example, by detainees, detention staff, healthcare staff or outside agencies – we will request relevant records and footage. We will then triangulate the evidence in accordance with our inspection methodology and gather the information we can to reach a conclusion.

64. We do not routinely request video footage of overseas removals of detainees collected from the IRC, as most of that footage would be recorded outside of the establishment (and we undertake separate dedicated inspections of overseas escorts). However, if we have concerns about removal practice and footage is available within the establishment, we will review it. We would also review any

such footage if it came up within the dip sample. Paragraph 1.54 of the 2016 Inspection Report records that in the Brook House inspection Colin Carroll viewed footage regarding the practices of the escorting services provider, which at the time was Tascor.

65. During regular team meetings throughout the inspection, inspectors will discuss cases and information they may have come across individually to help build the picture of usual establishment practices and ensure that evidence is cross-referenced. For example, if the healthcare inspector discovers that the establishment's healthcare team has concerns about the use of handcuffs during hospital escorts, they will discuss this with the UoF inspector who can then look at a sample of UoF records to examine the justification for the use of handcuffs during external escorts. Inspectors may also discover and further examine apparent discrepancies – for example, if they find that an individual detainee's record refers to a UoF but cannot find a completed UoF form, this will be raised with managers and the concern will be reflected in the report.

66. We do not simply accept what the establishment tells us without challenge. We are to an extent reliant on the establishment recording data accurately, but may identify concerns about the veracity of the data, e.g. if we discover missing records in relation to identified uses of force, or discrepancies in use of force reports, or the paperwork does not accord with what detainees say (see further at paragraphs 62-64). I do not recall such concerns being identified during the 2016 inspection.

67. During the first week of the Brook House inspection a member of our RDT team witnessed a use of force. The standard procedure if a member of the RDT team witnesses a UoF is for them to move away from the incident if they do not think they can safely observe it, or will be in the way. I have recently asked that member of staff about the incident. Although he cannot recall much about it, he does remember that he did not feel he could safely observe and therefore removed himself to the wing office. I do not have any further recollection of the matter.

However, the pre-inspection report (which describes the initial observations of the coordinating inspector) at HS13 includes a description of that specific use of force, as well as comments about a positive use of de-escalation that was also witnessed during the inspection.

68. I do not have specific details of how many UoF incidents Mr Carroll assessed during the 2016 inspection, but I exhibit the bullet points that he submitted to me at the end of the inspection, marked Exhibit 'HS14'. As is my standard practice, I would have discussed these points with Mr Carroll before a team discussion to go through all relevant emerging findings. In respect of UoF, Mr Carroll's initial conclusions were as follows:

- *The number of incidents involving force has increased since our last inspection.*
- *Paperwork justifying force is completed to a high standard, and all incidents are reviewed by a manager.*
- *Video footage has shown mixed practice. Briefings prior to planned uses of force are very good, verbal reasoning is used well but some incidents have taken too long to resolve once force has been initiated.*
- *We are not assured that Tascor overseas escorts use waist restraint belts as a last resort or apply them safely.*

69. The records we reviewed were completed well and suggested proportionality and necessity in most cases. We raised concerns about specific instances of force that we had seen on video recordings, which we did not believe were proportionate or necessary, as is outlined at paragraphs 1.53 and 1.54 of the 2016 Inspection Report. As the report explains, in the first of these cases, a detainee resisted removal by laying passively in his bed. Staff made concerted but unsuccessful efforts to encourage him to leave with them. They then used a shield to restrain him, which we considered unnecessary and excessive, given he was passively resisting. He was escorted under restraint to the separation unit, wearing underpants and a t-shirt with no effort made by staff to encourage him to dress.

The second concern related to force used by the overseas escort contractor, which at the time was Tascor. In all of the video footage that we reviewed, Tascor escort staff used waist restraint belts, suggesting routine rather than last resort use of the belts. We were also concerned about a lack of competent application of restraints in one case, where four Tascor escorts took 12 minutes to apply a waist restraint belt in a chaotic use of force. The longer such incidents continue, the greater the risk of injury.

70. We recommended that the centre manager and escort contractor ensure that all force was necessary, proportionate and competently applied, as outlined at paragraph 1.58 of the 2016 Inspection Report.

71. I have confidence in Colin Carroll's professionalism and competence, and in the rigour of the team deliberation process. The inspection team comes to joint conclusions after discussing all of the key evidence, and I have a particular responsibility for the quality and rigour of the inspection and of the report.

C (v) - Information from Third Party Organisations

72. I and some of my colleagues meet with third party organisations / NGOs to discuss our work and also give talks about our work when requested. This helps us to explain the role of HMIP to others and we encourage organisations to share their concerns and send relevant intelligence to us about individual establishments. I exhibit a copy of the HMIP social media activity during the 2016 inspection, marked Exhibit 'HS15', publicising our attendance and ongoing inspection of Brook House. In 2016, I do not recall any evidence from third party organisations being received over and above that outlined at section C(iii) above. In 2017, the immigration team started directly emailing NGOs on the first day of each inspection to ask for relevant information and request that they encourage any individuals they are in contact with, who may want to speak to us about the

establishment we are inspecting, to make contact with us. I have explained that change in more detail at section D below. It was a change that we introduced to systematize our processes in light of the learning we took from the Panorama programme.

73. At every IRC inspection, I meet with the local IMB to establish if monitors have any concerns that are not already included in their most recent report. Where specific new concerns are raised, I brief the inspection team to help guide inspectors' inquiries. At the time of the 2016 Brook House inspection, the IMB's most recent report covered the year to December 2015 and was largely positive. I met with the chair of the IMB at the 2016 inspection as usual. I do not recall the contents of the conversation but the fact that I did not alert the team to any particular concerns being raised suggests that there was nothing significant added to what was already in the IMB's report. The only other contact I had with the chair of the IMB, was when she wrote to me having considered the written version of the debrief on the Brook House inspection. I exhibit a copy of that email correspondence, marked Exhibit 'HS16'.

C (vi) - Gathering of Detainee Views and Experiences

74. In line with the 2016 Framework our team of researchers conducted a detainee survey at Brook House during the 2016 inspection, the details of which are at page 69 of the 2016 inspection report. The process for conducting the detainee survey is set out at paragraph 3.11 of the 2016 Framework. At Brook House, the total detainee population on 31 October 2016 was 392. The survey was issued to a sample of 209 detainees. The response rate within the sampled group was 76%. As I mentioned at paragraph 18 above, detainees who cannot complete the survey because it is not available in the language they speak or because they have difficulty reading or writing can be assisted by a member of the research team who will help them to complete the survey. This happened with one detainee during the 2016 inspection.

75. I have been asked to comment on some of the specific survey response statistics, namely:

a) Q47 - 37% of detainees felt unsafe in the centre.
b) Q50 – 18% had been victimised by a member of staff
c) Q51 – 3% had been physically abused by a member of staff
d) Q52 – around half of those that had been victimised by a member of staff did not report it
e) Q54 – 12% had felt threatened or intimidated by a member of staff

76. Survey findings are a valuable indication of potential concerns which inspectors use to guide the focus of their inspecting during the week. From page 80 of the 2016 Inspection Report, the detainee survey results are compared with results from detainees surveyed in all other removal centres and results from the previous inspection of Brook House in 2013. While none of the responses to the questions highlighted above are shown in the comparator as being significantly worse at Brook House than the comparator figure, or the figure from the 2013 inspection, we were still concerned to explore the results further.

77. If individual detainees report concerns and give their name on the survey return (which is not required), an inspector will also go to speak to them. Eleven detainees made confidential comments in 2016, mainly on three areas: healthcare (9 comments); Home Office casework or length of detention (5 comments); and G4S detention staff (4 comments). Three comments specifically talked about lack of staff care and poor treatment, but none mentioned abuse or use of force by staff. I do not recall the outcomes of inspectors' discussions with these detainees.

78. Noting Q47, it is not unusual for a significant percentage of detainees to tell us they feel unsafe in IRCs. An important task for us as an inspection team is to try and establish if detainees feel unsafe because of a concern about their physical

safety, or because they feel insecure about their immigration status. The evidence from our observations and discussion with detainees, including group meetings (see paragraph 80-82 below) during the inspection, led us to conclude that it was primarily the latter. We often find that detainees feel less secure when they are in establishments near to an airport where they are more likely to see others being removed and may have the fear of their own potential removal in mind. As some people resist removal, there is also a greater likelihood of detention and escort contractors using force to take them to the airport. This means that people in establishments near airports tend to have more awareness of force being used; as some remain in the centre following failed attempts to remove them, they may also be more likely to have experienced force, and to report concerns about victimisation or physical assaults associated with removal attempts.

79. Inspectors have particular regard to survey findings relating to their allocated areas during the main inspection week and use them to triangulate findings. The figures on assaults and victimisation (Q50 and Q51) are kept in mind while other evidence, such as UoF recordings, observations around the establishment and discussions with detainees and staff, are examined.

80. In respect of Q52, above, the wording from the survey used in 2016 is as follows: 'If you have been victimised by detainees or staff, did you report it?' The responses indicated that 46% of those victimised by detainees or staff had not reported it, but the question did not relate solely to victimisation by staff. I exhibit a copy of an email in relation to the survey, marked Exhibit 'HS17'. Inspectors were advised by our research team to take particular care in interpreting the results of this question because when changes were made to the IRC survey a prompt, that should have directed respondents from the victimisation by detainees question straight to the victimisation by staff question, was not included. This did not prevent detainees from answering the question about staff and it is not possible to tell why any non-respondents might have missed out this or other questions. About

three-quarters of detainees who responded to the survey did answer the victimisation by staff question and that number of responses provided valid data.

81. We do not base conclusions on survey responses alone. For example, as well as speaking to detainees individually during the inspection week, the inspection team holds group meetings with detainees on the first day of the main inspection week to help explore survey findings in more detail using interpreters as needed. At Brook House, three detainee groups were held with a total of 13 detainees attending: one group was with Nigerians (7 attended), one with Pakistanis (4 attended) and one was a mixed group of detainees (2 attended). After taking feedback on the group meetings from inspectors, I wrote a summary, a copy of which is exhibited marked Exhibit 'HS18'. This summary draws out the common themes reported by the groups and I wrote the following about safety: *'Feel safe overall, not seeing physical assaults but mentally torturous.'* I discussed this with the Brook House senior management team that evening (comprised of contractor staff) and wrote the following note as a result of their comments: '*Have been some incidents that may have skewed perceptions of assaults in survey: some related to Spice, a lot of finds. One serious assault in March related to NPS and theft. A lot of people involved in some incidents (4.7% of population involved in altercations last month acc. to Michelle). But spikes rather than a trend and only two assaults last month.'* I also wrote, *'Lack of staff makes it harder for them to pick up on warning signs.'* This observation was not commented on by the Brook House senior managers.

82. In relation to staff, I also wrote that detainees had reported: *'Most staff quite good, but some rude and don't take detainees seriously.'* This was also not commented on by Brook House senior managers. It is rare for a manager to comment on every single piece of feedback and I infer no conclusion from a lack of comment as this could be for many reasons. For example, the manager may be surprised by what they hear and want to think further on it; they may decide to cascade feedback down to other staff and ask someone to investigate what has been fed back before

providing a response to HMIP; or they may simply accept or reject the validity of the feedback but decide not to share that conclusion with HMIP. The note, including any comments that were made by senior managers, was then shared with the inspection team to contribute to the evidence base.

83. Each of the three detainee groups were also asked about the 'main positive' and 'main negative' aspects of their experiences in Brook House. Two groups said 'staff' were a main positive. One group said that 'mental stress of being in detention' was a main negative.

84. Detainees often report concerns to HMIP in the confidential survey, group meetings or while we are walking around the establishment. Concerns are also reported on their behalf through NGOs or legal representatives. However, there are some common factors that may limit what we are told during inspections. The first is that detainees are often worried that if they complain to us it might be held against them by the Home Office and affect their case. To try to mitigate this, we reassure them that they are not identified to the Home Office and can speak in confidence. When inspecting immigration detention, inspectors also make a point of stressing the human rights dimension of our work as this is usually understood by detainees and reassures them about the purpose of our work. Language is another common problem. HMIP staff use professional interpretation for formal interviews and they may also use professional telephone interpretation with detainees during the many casual encounters they have with people as they walk around the centre. Some inspectors also speak languages other than English and some detainees ask other detainees to interpret for them. However, during casual interactions on residential units, English speakers inevitably have more sustained access to inspectors.

85. Any reluctance to speak to us is also mitigated to an extent through the information that we provide for detainees. For example, posters in multiple languages advertise who we are; we inform community and voluntary sector groups of our presence and encourage them to reassure detainees; and we explain who we are when we

invite detainees to complete surveys and attend interviews or when they attend group meetings with us, which in turn helps to spread that information when those detainees speak to others. The poster used in 2016 was amended by 2019 to include detail on sanctions. It now states that, 'No-one should get into trouble for speaking to inspectors. If you have concerns, please contact the Independent Monitoring Board (IMB) or write to us and we will deal with it.'

86. HMIP has a process for responding to concerns that detainees have suffered adverse consequences, or 'sanctions', as a result of communicating with HMIP. As set out in the Guide for Inspectors (at para 2.68 of the 2016 guide), if an inspector believes a detainee has been or may be subject to sanctions then they must immediately inform the inspection team leader. The CI or DCI should also be informed. HMIP will then follow the steps in the Protocol it has agreed with the Prisons and Probation Ombudsman (PPO) and IMB, including to prevent further risk to the detainee if necessary. Under the Protocol, HMIP is able to directly refer possible sanctions cases to the PPO for investigation.

87. The mitigations in paragraphs 83-85 were all in place during the 2016 inspection.

C (vii) - Healthcare

88. The healthcare element of the 2016 inspection is also undertaken in accordance with the 2016 Framework and 2012 Expectations documents. Expectations relating to health issues and care are included throughout the four healthy establishment tests but are primarily set out under "Respect" at Expectations 23-35 of the 2012 Expectations document. The health inspector will also refer to national clinical guidance and standards where appropriate in making their judgements. Broadly speaking, the health inspector is looking for the healthcare offered in the establishment to be equivalent to that offered in the community, and to meet the needs of detainees.

89. Paul Tarbuck was the Head of Health and Social Care Inspection at HMIP in 2016 and was the inspector with responsibility for the healthcare element of the 2016 Brook House inspection. His qualifications and experience are detailed at paragraph 45(f) above. He was a very experienced clinician and inspector at the time of the 2016 inspection.

90. As is shown by the allocations list at Exhibit 'HS10', Mr Tarbuck's focus during the inspection was on health services and substance misuse. The CQC inspector, Malcom Irons, conducted his inspection alongside HMIP, in line with the handbook used by CQC inspectors and with regard to our 2012 Expectations document. If the CQC finds any regulatory breaches they will take appropriate action and attach a regulatory notice to the report, but none were found in the 2016 inspection as is confirmed at paragraph 2.26 of the 2016 Inspection Report.

91. The health inspector accesses a wide range of clinical records and documents at the establishment as part of the evidence-gathering process. The complete list of healthcare information requested from the establishment at the outset of the inspection is at Appendix N at page 40 of the Guide for Inspectors. The health inspector will also speak to staff and detainees and observe the environment and clinical interactions. If there are any specific concerns raised the health inspector would investigate further, for example any complaints or any incidents of concern included on the daily report.

92. There is always a risk on an inspection that clinical interactions observed will not reflect the usual approach, as people may adapt their behaviour slightly in front of an inspector (indeed this is an observation which can be made in all areas). We take that into account when we weigh information in the balance and make judgements during an inspection and the triangulation method mitigates this risk, as we are not making conclusions based on just one source of evidence.

93. I exhibit a copy of the summary Paul Tarbuck sent to me at the end of the inspection, for use in preparation of the report, marked Exhibit 'HS20'. The joint conclusions of HMIP and the CQC in relation to health and social care provision are outlined at pages 35-40 of the 2016 Inspection Report.

94. The recommendations process is the same for healthcare recommendations as it is for non-healthcare recommendations, as described at section B(v). If CQC has issued any regulatory notices during an inspection, they will follow up to check that the requirements in that notice have been met.

C(viii) Post-Inspection

95. As I have explained at section B above, following the inspection the draft report is prepared and sent to the Home Office for fact checking. I exhibit a copy of the table showing the points raised by the Home Office and HMIP's response, marked Exhibit 'HS21'. The Home Office then subsequently prepared an action plan (service improvement plan), a copy of which is exhibited marked Exhibit 'HS22'.

## Section D – The Panorama Programme and the Enhanced Methodology

96. HMIP was very concerned about the behaviour shown in the Panorama programme. Since the airing of the programme and as a result of the various investigations and reviews that have taken place since, it has become clear that there were problems in the staff culture at Brook House which meant that staff who treated detainees badly were able to do so without their colleagues challenging them or whistle-blowing.

97. While there were some causes for concern in our 2016 survey and other findings, as recorded in the 2016 report, HMIP did not find evidence of the type of behaviour shown in the 2017 Panorama documentary. After seeing the documentary, we reviewed our methodology in order to ascertain whether we could increase the likelihood of identifying both individual instances of mistreatment and systemic risks in IRCs.

98. If abusive behaviour does not take place within the course of the inspection, or takes place away from cameras, and is not revealed in UoF forms or other written records, it becomes very difficult for inspectors to identify unless detainees or staff tell us. Our focus when we reviewed our methodology following Panorama was therefore on the way we speak to and gather information from detainees and staff. I am confident that the inspection methodology used in the 2016 inspection was robust in gathering the views of a large number of detainees. However, following Panorama, we were concerned to further increase the opportunities for detainees to identify concerns to us confidentially and, in addition, to provide more systematic opportunities for staff to tell us about what was happening in the centre. Before Panorama, HMIP had utilised what we described as an "enhanced methodology" during an inspection of an IRC where we had specific evidence that detainees might be at particular risk. This enhanced methodology, which requires the deployment of more inspectors for longer, formed the basis for the changes we made following the Panorama programme: instead of it being used exceptionally, it is now used on all inspections of IRCs. The changes set out below at paragraphs 98 to 100.

99. An internal review of the methodology was carried out in September 2017. I exhibit a copy of my notes in respect of that internal review, marked Exhibit 'HS23'. The key changes which HMIP implemented between the 2016 and 2019 inspection methodology for immigration detention inspections are listed below. The rationale for the changes is described below, but they essentially allow us to gather more information from a wider group of detainees and staff.

    a) Detainee Interviews – we now offer every detainee a confidential interview, using interpretation where necessary. Up until 2017 we would speak to detainees in groups at the start of an inspection and individually as we went around the establishment, approaching some people randomly and others if we had been alerted to specific concerns about their welfare. This was in

addition to the confidential detainee survey. Since 2017, we have further strengthened our approach by providing *every* detainee with an opportunity to speak to an inspector in confidence. Inspectors deliver invitation slips to all detainees and are able to verbally explain to them what the interviews are about while they go around the establishment. We also issue a call to immigration detention NGOs, requesting that they encourage detainees they are in contact with to speak to us; and that they put us in contact with people who would like to speak to us having already left a removal centre. Take-up varies, but this approach ensures that detainees have more opportunities to speak to us confidentially.

b) Staff survey – HMIP's work has always been concerned with giving primacy to the voices of detainees in our assessments of outcomes. For that reason, we placed a great deal of focus on the detainee surveys and groups, but less on feedback from staff. One key lesson taken from the Panorama programme was that we needed to put more resource and effort into gathering information from staff. Corrupt or other illicit behaviour might be well hidden and detainees currently in a centre may be unaware of events that took place more than a few weeks ago because the turnover of immigration detainee populations is usually fast. As a result, we developed a confidential staff survey which gives staff a chance to provide us with information on potential safeguarding concerns and on matters relating to staff culture. We are provided with staff contact details by the establishment and we send the survey link to all staff for them to complete anonymously online. The survey does not have to be completed by staff while in the establishment and gives them a discreet way to raise concerns around safeguarding and mistreatment with inspectors. It also gives HMIP the chance to better understand the culture of the establishment. I exhibit a copy of the staff survey, marked Exhibit 'HS24'. The survey includes, for example, questions about whether staff have seen detainees treated inappropriately by any agency, whether they would raise concerns to their managers and if they believe they would be

taken seriously, as well as broader questions about the support that staff receive from managers, whether they have sufficient training for their role and what their view is of the centre's culture. The staff survey first used in IRCs from 2017 has also now been adapted for use at all of our prison inspections.

The staff survey also helps to understand concerns about staffing levels from the point of view of staff themselves. HMIP assesses outcomes rather than processes, which means that we do not employ a formula to show whether staff numbers are sufficient for the size of the establishment. Rather, we assess whether staff capability, to which the number of staff is relevant, is sufficient to complete important tasks such as responding to cell bells or incidents promptly, and if they have time to deal properly with day-to-day problems with which detainees may require assistance. Factors such as good staff recruitment, staff competence, a caring attitude, and a positive leadership tone can be just as important as having sufficient staff to ensure basic levels of safety. We have inspected custodial establishments with relatively high staffing levels but poor outcomes and vice versa.

We are currently updating the staff survey used in IRCs as a result of a planned change to the *Expectations* to introduce a section on leadership, which I understand is discussed in Charlie Taylor's statement.

c) Staff interviews – in 2017, we also introduced random staff interviews alongside the survey. This was to allow us to get a more in-depth view from staff and see if there were any emerging themes that we could investigate further. We continued these random interviews until 2021 alongside our staff survey. However, there was no guarantee that the same staff who completed surveys were not also being interviewed, and we found that we were receiving very similar information from the interviews and the survey. We therefore no longer select a random sample of staff to be interviewed during the inspection;

instead, we will invite to interview any staff who provide information of concern and identify themselves in the survey; and we continue to talk to staff and managers as we inspect the establishment.

d) Detainee Survey – this has been updated and amended since 2016. The updated version is included from page 77 of the 2019 Inspection Report and is available in 23 languages. Although survey response rates are generally good (at Brook House the response rates were 76% in 2016 and 65% in 2019), it is possible that some detainees might not fill in the survey; the offer of the one-to-one interviews described in paragraph 98(a) above helps to mitigate this concern. I have specifically been asked to comment on the difference between the following two questions:

   i. **Q52 2016 survey**: If you have been victimised by detainees or staff, did you report it?
   ii. **Q9.7 2019 survey**: If you were being bullied or victimised by staff here, would you report it?

There are two main changes here and both are improvements that allow us to gather better information. The first is the tense, which broadens the scope of the question and asks if detainees would report in principle, regardless of current experience of victimisation. In addition, the researcher has replaced a single question with two questions. The original covered both staff and detainees, making it impossible to disaggregate the answer to establish if, for example, detainees would report victimisation by other detainees (questions 9.4 and 9.5 in the 2019 survey) but not by staff. Now there are separate questions about detainees and staff.

e) Information from third party organisations - we now proactively contact NGOs and third party organisations involved with IRCs we are inspecting.

This is to make them aware that we are on site and to encourage them to provide feedback or make us aware of any particular concerns that they want us to investigate during the inspection.

100. Under the methodology that was in place during the 2016 inspection, the inspection took place over two weeks. An IRC inspection using the enhanced methodology now runs over three weeks to allow more time for interviews to be conducted and analysed. Under the enhanced methodology, in week one the coordinator and researchers are on site and interviews begin. Interviews may carry on in to week two if there are a large number of detainees and staff to interview. Week two is also the week that analysis of the interviews takes place. If there are only a few interviews, inspectors will use their time to do what they can remotely (look at data, etc). Week three is what we consider to be the main inspection week – the full inspection team is on site to inspect and deliberate, and feedback to managers takes place.

101. The changes described here were considered and discussed thoroughly within HMIP, drawing on the specialist knowledge of inspectors and research staff. The methodology was also reviewed by all inspection team leaders as part of internal approval processes. Furthermore, we sought external challenge and comment on the enhanced methodology: the interview proformas and survey were reviewed for us by a detention researcher at Oxford University, Professor Mary Bosworth, and one of the Brook House whistle-blowers, Reverend Nathan Ward. The enhanced methodology was amended following discussions with them. The decision to apply the enhanced methodology at the next planned immigration removal centre inspection was made on 18 September 2017. That inspection started on 2 October 2017 at Harmondsworth IRC. We asked the international NGO, the Association for the Prevention of Torture (APT), to attend the inspection of Harmondsworth IRC where the methodology was to be used for the first time, in order to provide us with expert independent peer review. The APT attended the entire inspection and provided supportive and positive feedback on the rigour of HMIP's processes.

I exhibit a copy of the paper subsequently submitted to the Management Board dated the 26th January 2018, asking the Management Board to approve the use of the enhanced methodology in IRCs for the coming year, marked Exhibit 'HS25'. We then carried out an internal review of the enhanced methodology in early 2020 to consider its effectiveness and decided to continue with it. I exhibit a copy of the comments we received from inspectors as part of that review, Appendix 1 of exhibit HS26. The paper considered by the HMIP's Delivery Board in respect of the review is exhibited, marked Exhibit 'HS26'. The minutes of the Delivery Board of the 25th February 2020 record that the Delivery Board agreed with the proposals in the paper. I exhibit an extract of those minutes, marked Exhibit 'HS27'.

102. I was interviewed in connection with the Lampard Review and have read the review and its conclusions. I have been asked to comment on whether I agree with the following conclusions insofar as HMIP is concerned.

*14.8 The HMIP report published in January 2017 after an unannounced inspection at the end of October 2016, was less generous than the IMB report in its praise of the management of Brook House and the treatment of detainees but it was positive. [...]*

*14.10 The inspectors make a passing reference to staff being "under pressure". The main concerns and recommendations in the report relate to the time detainees spent in detention and the prison-like living conditions. [...]*

*14.12 It is not possible for us to judge the precise state of affairs in relation to the management and culture of Brook House and the care and treatment offered to detainees at the time that the IMB and HMIP produced their reports in early 2017. However, a number of issues such as lack of staff, the disaffection and turnover of staff and the weaknesses in management arrangements and behaviours, all of which might adversely affect the treatment of detainees, had begun to be evident from at*

*least the middle of 2016. We do not suggest that either the IMB or HMIP should have uncovered or predicted behaviours of the type shown in the Panorama film, but we think that more focused questioning of staff and frontline managers might have more clearly identified some of the issues that played a significant part in the matters raised in the Panorama programme and their potential consequences [...]*

103. The changes that we made to the methodology, as set out above, are aligned with the recommendation at paragraph 14.12 of the Lampard Review and had already been implemented by the time of the Lampard Review (and I was able to explain the enhancements to Kate Lampard and Ed Marsden when I was interviewed by them). While I agree with the comment in the Lampard Review that 'we do not suggest that ... HMIP should have uncovered or predicted behaviours of the type shown in the Panorama film', I believe that HMIP's enhanced methodology would have increased the chances of us doing so. Inspection can and does uncover indicators of concern and provide information that can help managers to improve treatment and conditions. However, it is also not realistic to view necessarily infrequent inspection as a process that can identify and address every occurrence of abuse; that is primarily a task for managers and is assisted by them providing clear leadership and working to create a staff culture where poor behaviour by staff or colleagues is not tolerated.

104. Inspections are intended both to provide an immediate assessment of the current outcomes for detainees, and to help prevent future harms by identifying structural weaknesses. Such weaknesses may include poor accountability practices or corrosive staff cultures that increase the risk of poor behaviours. While our inspections may not find everything that is happening in an establishment in live time, they should contribute to a longer-term view of the health of an establishment.

105. The greater focus that we now have on obtaining information from staff helps us to better understand staff culture and identify the type of cultural problems that

were subsequently highlighted in the Lampard Review. While staff are unlikely to behave poorly in front of inspectors and we cannot be certain that inspection will always uncover such behaviour, it can provide an assessment of the risks of it emerging. There are many reasons why 24-hour surveillance would not be possible or desirable, and I think there will always remain a risk that such behaviour may go undetected by an inspectorate body. As the Panorama programme shows, poor behaviour could happen away from cameras, for example in detainees' bedrooms or in washrooms where surveillance systems would be an unacceptable intrusion on privacy and dignity. Abuses may also be hidden from view if accountability mechanisms are not properly observed – for example, if use of force forms are not completed by staff or body-worn cameras are not carried or switched on during incidents. Inspection therefore encourages leaders to take responsibility for making positive changes in their establishments and ensuring that staff understand and support high standards of behaviour, rather than simply responding to the risk of discovery.

106. We are sometimes told by detainees, staff or both that extra staff have been brought on duty during the main inspection week (week three under the current methodology), and they usually go on to tell us about normal staffing levels. There may be legitimate reasons for bringing more staff on duty, as inspectors often have to take numerous staff away from their duties for a period while they interview them. Managers will also sometimes cancel leave to be available to us during our visits. As mentioned in my notes from the internal review of the inspection methodology (Exhibit 'HS 23'), this was something which we were told after the 2016 inspection of Brook House and which I took into consideration during the review. We can build a reasonable picture of usual staffing levels in an IRC through various means, including the coordinating inspector's initial observations in the centre on day one of the inspection, conversations and interviews with staff and detainees, and staff absence records.

107. Our aim is to prevent mistreatment and human rights abuses within places of detention. We are not a regulator, nor are we managers of establishments with a permanent on-site presence. We inform managers of concerns based on the evidence we find and we expect managers to investigate and act on those concerns. HMIP is one part of a system of collective responsibility across a number of organisations aimed at preventing mistreatment.

108. Following the 2016 Brook House inspection, HMIP continued to engage with organisations involved with Brook House, review any intelligence received, and keep the risk assessment under review. The value of undertaking a snap inspection was discussed after the Panorama programme was aired, but we concluded that the case for doing so was weak. It is not the role of inspection to investigate problems once they have been uncovered. There was already a great deal of attention on the IRC from Home Office and G4S managers and it was not long before an independent review (the Lampard Review) was announced. In such circumstances, an inspection would have added little that would have helped us genuinely to improve the experiences of detainees. A further HMIP unannounced inspection of Brook House took place in 2019.

**Section E - The 2019 Inspection of Brook House**

109. I refer to the copy of the Report on an unannounced inspection of Brook House Immigration Removal Centre that took place between 20 May 2019 and 7 June 2019 ('2019 Inspection Report'), attached as Exhibit 'HS28'. I repeat the comments I made at paragraph 40 above in respect of anything not included within the inspection report. Those comments apply equally to the 2019 inspection report.

110. I have exhibited the following documents, which relate to HMIP practices as at the time of the 2019 inspection:

a) Inspection Framework, March 2019 ('The 2019 Framework'), marked Exhibit 'HS29'. The 2019 Framework sets out the methodology and process for the conduct of HMIP inspections and how HMIP works with partner organisations. This sets out the general process for inspections, but in practice it is adapted slightly for immigration removal centres and so some of the changes referred to above are not expressly included in the 2019 Framework, but do occur in every inspection of an immigration removal centre.

b) Expectations for immigration detention, Criteria for assessing the conditions for and treatment of immigration detainees, Version 4, 2018, ('the 2018 Expectations') marked Exhibit 'HS30'. The 2018 Expectations set out the criteria used during inspections to assess the treatment and conditions of those held in IRCs. The 2018 Expectations are the fourth version of the Expectations for immigration detention. The process of revision took place over much of 2017 and included scoping the relevant human rights treaties and standards to inform the drafting and a public consultation process. Following public consultation, the Expectations were reviewed and agreed by all inspection team leaders and the DCI and CI. As with previous sets of immigration Expectations, the 2018 version takes account of the fact that immigration detention is administrative rather than carceral. Changes made in the 2018 version included publishing specific Expectations for women. We also carefully considered the findings of Stephen Shaw's 2016 report, *Review into the Welfare in Detention of Vulnerable Persons: A Report to the Home Office* and spent much time discussing how to conceptualise and inspect provision for vulnerable detainees, recognising that vulnerability may change over time. The review of the Expectations had started before the Panorama programme was shown but we considered the findings of the programme along with other evidence while undertaking the review.

111. I also exhibit a copy of the 2018 Guide for Inspectors, which was current at the time of the 2019 inspection of Brook House, marked Exhibit 'HS31'.

112. The enhanced methodology, comprising the changes outlined at Section D, above, was used in the 2019 inspection of Brook House.

113. As part of the 2019 inspection, the progress against recommendations made in the 2016 report was considered. Appendix II at page 59 of the 2019 inspection report summarises the position as to whether each of the recommendations from the 2016 inspection had been achieved, partially achieved or not achieved. That summary includes healthcare recommendations. The report also confirms that 15 of the recommendations from the 2016 Inspection were either rejected, partially accepted or accepted subject to resources by the Home Office. I refer to Exhibit 'HS22,' the Service Improvement Plan completed by the Home Office following the 2016 inspection, which details their reasons for accepting, partially accepting or rejecting the recommendations made. I refer to my explanation at section B(v) above in respect of HMIP's powers in respect of recommendations.

114. The summary of the staff survey results from 2019 appears at paragraph A10 at page 10 and Appendix VI at page 75 of the 2019 inspection report. The staff survey has given us a richer source of data about potential structural and cultural problems in detention settings even when current evidenced outcomes for detainees look reasonably good. For example, at the largely positive 2021 inspection of Dungavel IRC, the staff survey results indicated that many detainee custody officers had low morale and were concerned about understaffing. In that report, the CI's introduction noted, 'While we saw no evidence that this discontent had yet affected the treatment of detainees or safety in the centre, it had the potential to become a more significant concern as the population increased and required sustained leadership attention.' The summary of the staff interview results at the 2019 Brook House inspection also appear at page 75 of the 2019 inspection report. We interviewed 37 centre staff working in operational roles, including detainee custody officers, health services staff and staff in the Home Office teams, and the electronic staff survey elicited 43 responses.

115. I exhibit a copy of the email sent to various organisations in connection with the 2019 inspection, marked Exhibit 'HS32'. I also exhibit copies of HMIP social media activity during the 2019 inspection, marked Exhibit 'HS33'.

116. The enhanced methods used to gather evidence from detainees in the 2019 inspection are set out in paragraph A9 and Appendix V at page 73 of the 2019 Inspection Report. In addition to our detainee survey, which had a response rate of 65% (158 individuals), 65 detainees took up the offer of a confidential interview, including 12 who were interviewed with an interpreter. In addition, we interviewed two ex-detainees who came forward following our invitation to those released from Brook House to speak with us. The population of the centre at the time was about 240, compared to 400 in 2016.

117. The main findings are reported in the 2019 inspection report. They included the fact that we found no evidence that the abusive culture shown by the Panorama programme was present among the staff group at Brook House in 2019. In our confidential interviews with detainees, none said they had been assaulted by staff. No staff said they had seen unjustified use of force in our survey or interviews. G4S whistleblowing procedures were promoted widely throughout the centre, and all staff in our survey said that they would report inappropriate behaviour, usually to managers, and most thought they would be taken seriously if they raised concerns. The training for staff had been redesigned and placed greater focus on the detainee experience – new staff we interviewed were positive about the changes in the training.

118. However, we reported a number of concerns in 2019 that we had also raised at the 2016 inspection. They included, for example, the fact that Rule 35 reports were often accepted by case owners as evidence of torture, but detention was nevertheless maintained. Detainees were still inappropriately confined to cells overnight and the living accommodation remained prison-like.

119. In relation to the use of force, we found that a high proportion of detainees (82%) were handcuffed during escorts to external appointments and there was insufficient individual justification for this in several of the cases we reviewed. The number of incidents involving force was also high without a clear analysis of the reasons for the increase, although there was evidence of paperwork being completed for all incidents, no matter how minor. We also noted that, 'In addition to the incidents reported in the [Panorama] documentary, there was evidence of further abuse at around the time of the events shown. In a very concerning case, the Home Office Professional Standards Unit (PSU) found that an officer had assaulted a detainee on three occasions in June 2017. The same officer was shown in the Panorama documentary to have engaged in poor, unprofessional, insulting and possibly physically abusive behaviour…. The PSU also found that excessive force had been used against a detainee in October 2017 during the removal of his cell mate for a night-time escort.'

120. During the COVID pandemic, from April 2020 to April 2021, we temporarily amended our methodology for health and safety reasons. During this period, we introduced two new methodologies - Short Scrutiny Visits (SSVs) and then the more in-depth Scrutiny Visits (SVs). SSVs and SVs were intended to allow HMIP to continue to provide effective scrutiny of places of detention while also minimising the risk of spreading infection. The number of inspectors on site and the time which inspectors spent on site was therefore considerably reduced. Inspectors did not assess establishments against our full Expectations but instead considered a number of key areas. I exhibit a copy of the methodology for these visits to IRCs marked as Exhibit 'HS34' and the IRC SSV report on Brook House, Morton Hall and Yarl's Wood IRCs dated the 12th May 2020, marked as Exhibit 'HS35'.

121. The intention was always to return to full inspections of IRCs as soon as it was safe to do so and this was kept under constant review. Full inspections resumed

from May 2021. None of the shortened methodologies applied to short term holding facilities or overseas escort inspections, mainly because there was much less risk of inspectors spreading infection in these settings.

**Section F – Learning and reflection within HMIP**

122. At each team meeting (every 2-3 months) the HMIP immigration team discusses how each inspection has gone and if we need to consider changes. If any incidents or reviews come up outside of that reflective process, as the Panorama documentary about Brook House did, we conduct a review at that time. Other than during the COVID-19 pandemic, we also hold away days every 12-18 months, where a routine task is to review our methodology. We invite external stakeholders to come to those days and provide commentary on our effectiveness and how we might improve as an inspectorate.

123. For example, the last away days held before the pandemic were in November 2018 and included speakers from the Association of Visitors to Immigration Detainees, Asylum Aid, the Migrants Resource Centre and Bail for Immigration Detainees. Stephen Shaw also attended to discuss lessons from his two reviews into vulnerability in detention for the Home Office and specifically to help the team think about implications for HMIP's work. He suggested, for example, that HMIP could have a greater focus on adults at risk and that it would be useful to discuss how our work might coordinate and/or overlap with that of the Independent Chief Inspector of Borders (ICIBI). We subsequently met with the ICIBI and have continued to have a strong focus on adult safeguarding in our reports since that time. We have also worked collaboratively with the ICIBI on a number of occasions, most recently during an inspection of contingency asylum accommodation in February 2021 and inspections of detention facilities at Dover and Folkestone in October and November 2021.

124. HMIP encourages other organisations to have an openness to feedback and embrace continuous learning, and we have the same objective for ourselves. We will welcome suggestions or learning which may come from this inquiry in an open and constructive spirit, and apply ourselves to making prompt changes where necessary.

| **Statement of Truth** | |
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| I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.<br><br>I am content for this witness statement to form part of the evidence before the Brook House Inquiry and to be published on the Inquiry's website. | |
| Name | Hindpal Singh BHUI |
| Signature | **Signature** |
| Date | 14.3.22 |