

Brook House Inquiry

Supplementary report of Professor Mary Bosworth

9 February 2022

1. Overview and Context

- 1.1. In this supplementary report I have been invited to provide further opinion on some aspects of the preliminary report. I have also been asked to comment on additional material shared with me by the Inquiry, paying particular attention to a range of issues including: the Adults at Risk policy in place during the relevant period and the treatment of vulnerable people in detention; the impact and nature of staff training; staff relationships; barriers to reporting concerns and whistleblowing; the presence and involvement of Home Office staff; the role and effect of contractual compliance; the impact of the prison-like built environment; the benefit to detained persons of greater awareness of their rights; and the culture and attitude of staff working on E-wing with attention to particular demands and pressures of working there.
- 1.2. Finally, I have been asked to consider the relevance of the 2005 report by Stephen Shaw in his role as Prisons and Probation Ombudsman into allegations of racism and mistreatment of detainees at Oakington Immigration Reception Centre for preventing or addressing harmful cultures within IRCs.
- 1.3. The new material I have been provided reaffirms the preliminary conclusions I made in my first report dated November 2021, that Brook House in 2017 was an institution that, notwithstanding efforts from individual staff members, was a low-trust, high-pressure environment, that was neither sufficiently safe nor sufficiently caring. And that as a result, the detained men were not always treated in an appropriate manner that recognised their inherent worth and dignity as human beings.
- 1.4. In this supplementary report I have been asked to provide suggestions of possible ways to reduce the likelihood of events like those which occurred in 2017 from recurring.
- 1.5. In each of the sections below I identify the need for greater transparency about policies and practices; for greater formal and informal engagement with the detained population in designing, implementing and critiquing policies and practices; for more information-sharing among stakeholders and the public; and for a stronger role for the Home Office staff within the centres and in relation to staff training.
- 1.6. While I offer these practical suggestions based on the evidence I have been given as well as on my own research knowledge, I remain unconvinced that reforming individual processes and policies will fully eradicate the risk of recurrence. In taking this view, I find Mr Stephen Shaw's 2005 report into *Allegations of Racism and Detainee Mistreatment at Oakington Immigration Reception Centre and While Under Escort*¹ to be particularly instructive.
- 1.7. As he wrote then, the problem in trying to prevent detainee mistreatment, rests in "the very purpose of immigration detention", which, he defined as one that is designed "to exercise coercive power over foreigners prior to their removal from the country."²

¹ [INQ000109].

² Ibid, p. 3.

Given this purpose, he went on, "It is perhaps not a surprise that this function, combined with the attitude towards asylum-seekers and other would-be immigrants of some sections of the media, can become a breeding ground for racist and abusive word and deed."³

- 1.8. While the issue remains outside the remit of this Inquiry and my instructions, this finding, together with the evidence I have consulted, leads me to restate the points I suggested in §2.27 - §2.28 of the preliminary report that "the events of Brook House in 2017, combined with the current low numbers of detention... invite a bold response," starting with the introduction of a time-limit to the period of immigration detention.
- 1.9. For as I note in §2.29 of that report, "the only sure way to avoid the kind of events filmed in Brook House would be to stop detaining people in this way and manage everyone's immigration case in the community."

Statement of Truth

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

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.

Signed: **Signature**

Name: Mary Bosworth

Date: 9/02/2022

³ Ibid, p. 3.

2. Adults at Risk and the treatment of vulnerable people in detention

- 2.1. I have been asked to comment on the Adults at Risk (AAR) policy in Brook House during the relevant period, the treatment of vulnerable detained persons generally, and the training of staff in working with them. I have also been asked to consider staff knowledge of the ACDT processes and any training they received about ACDT.
- 2.2. In my assessment of the treatment of vulnerable people in detention, I defer to the expertise of Dr James Hard, who has produced a preliminary report on the medical and clinical care issues in Brook House. I note that in his report dated November 2021 he concludes that in Brook House Immigration Removal Centre during the relevant period: “the system for Rule 35 and Adults at Risk policy was inadequate.”⁴
- 2.3. In the original set of materials that I reviewed for the preliminary report, there was little explicit reference to the Adults at Risk (AAR) system. Thus, for example, in the minutes provided from the Gatwick IRCs Senior Management Team Meetings for the months of April, May and June 2017, under the category of ‘Safer Custody’, the terminology of ‘Adults at Risk’ simply does not appear. Instead, the minutes refer to ACDTs and SLPs (Supported Living Plans).⁵
- 2.4. In the supplementary materials that I have consulted for this report, there is also little mention made of the AAR policy in place during the relevant period. By contrast, the materials provided by SERCO concerning the current contractual arrangements describe weekly, multidisciplinary team meetings about Adults at Risk.⁶
- 2.5. In her witness statement, Ms Michelle Smith, the Home Office Service Delivery Manager, explains the relatively scant evidence of the policy during the relevant period in 2017 by noting that she had “reviewed the implementation of the AAR DSO at Brook House on 03 March 2017 in conjunction with G4S and G4S Health [and] identified the following failings:
 - a. G4S had not got a handle on the adults at risk within their population – there was no register of AAR cases.
 - b. G4S had not carried out a review of the existing population since the introduction of the new policy to identify existing AAR cases and ensure these were recorded and managed as such by agencies on site and the Home Office
 - c. AAR, as defined by the policy, had not been identified as such and were not all on care plans.
 - d. There was no system in place to review care plans in line with the policy (initial 7 days and agreed frequency thereafter)
 - e. The risk assessment carried out on arrival did not consider AAR factors effectively.
 - f. Risks that were identified were recorded on the IS91 part C but this was not clearly labelled as an AAR referral and was therefore not identified/easily identified as such by DEPMU

⁴ [INQ000075] §4.1.

⁵ [CJS000582], [CJS000575], [CJS000503].

⁶ [SER000193], §11.

- g. The form IS91 part C was not being sent to the case owner as well as to DEPMIU as per the DSO.
 - h. Cases were not being flagged by case owners as AAR in line with the policy [...]
 - i. Cases had arrived at Brook House that met the AAR criteria but had not been recorded as such on the movement order, nor that there been a safer detention referral [...]
 - j. Absence of awareness/systems in place for AAR multiagency meetings concerning removal or release..."⁷
- 2.6. These concerns, she reports, were, at the time, "escalated to [the] Director of Detention."⁸
- 2.7. In response, "the AAR register was introduced in May 2017, compiled by G4S in conjunction with the Home Office team. It lists all those in the centre at the time who are AAR."⁹
- 2.8. In addition, G4S agreed to review their policy and include AAR levels in Supported Living Plans (SLPs) from April 2017 (i.e. within the relevant period); the AAR Detention Service Order¹⁰ and local policy would be included on the Initial Training Courses; and "Part C risk reporting processes... between healthcare and case owners would be monitored to ensure comprehensive reporting."¹¹
- 2.9. From this statement, it seems likely that, while the AAR policy was in place during the relevant period, it may have still been relatively unfamiliar to many members of staff as it had only recently been introduced, and its introduction occurred in stages over at least two months.
- 2.10. Ms Clare Checksfield, then Head of Detention and Escorting Services at the Home Office, offers corroboration of this view in her witness statement in which she reports that "The Inquiry's relevant period covers a relatively early stage in the implementation of the AAR policy".¹²
- 2.11. It is unclear from Ms Phillips' or Ms Checksfield's statements how existing officers were informed about the AAR policy. There is at present no further information from G4S for me to consider; and, therefore, on the basis of the information I have seen, I can only conclude that even though the AAR policy was officially in place during the relevant period it was not widely understood.
- 2.12. Even if staff were unfamiliar with the Adults at Risk Policy, however, they should have been aware of the Rule 35 and the ACDT processes, both of which are longstanding

⁷ [INQ000057], §33, pp. 11- 12.

⁸ Ibid., §34, p. 12.

⁹ Ibid., §34, p. 12.

¹⁰ [HOM002519].

¹¹ Ibid., §34, p. 12.

¹² [HOM0331981], p. 6.

processes designed as safeguards for vulnerable people in detention. Below, I deal with each of these processes in turn.

2.13. Rule 35

2.14. A Rule 35 assessment is a clinical assessment that can only be carried out by a medical practitioner. During the relevant period, as set out in the Detention Centre Rules 2001, a Rule 35 report could take one of three forms:

35.—(1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.

(2) The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.

(3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.¹³

2.15. The need for a Rule 35 assessment should be established during the first healthcare screening which includes a question about the experience of torture. This screening is meant to occur shortly after people arrive in detention as part of their admissions process. If they answer 'yes' to the question about torture or otherwise give an indication that they may have been a victim of torture an appointment with an IRC doctor must be made.¹⁴

2.16. If for some reason a request for a Rule 35 assessment is not made at that point, one can be sought at any time by any member of staff or by the detained person.

2.17. In his report, Dr Hard concludes that "Broadly speaking, and on initial inspection, the system for the undertaking of a rule 35 (1) and (3) reports appeared to be adequate."¹⁵

2.18. However, Dr Hard also reports that "It was not clear that there was a defined or consistent approach for detained persons who either wanted or required a Rule 35(3) report;"¹⁶

¹³ *The Detention Centre Rules 2001.*

¹⁴ Home Office (2016) *Detention services order 09/2016 Detention centre rule 35 and Short-term Holding Facility rule 32*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/783642/Detention_rule_35_process.pdf [FFT000002]

¹⁵ [INQ000075], §6.2.3.1.

¹⁶ *Ibid* §6.2.3.2 and §6.2.4.1.

- 2.19. He notes concerns from a group of detained men interviewed by Ms Kate Lampard and Mr Ed Marsden in 2018 about the independence and relevant qualifications of the GP undertaking the Rule 35 (3) reports;¹⁷
- 2.20. And he characterises the training given to the GPs in respect of the assessment of detained persons who may require a Rule 35 (1) or Rule 35(3) report as “ad hoc.”¹⁸
- 2.21. In terms of understanding the events of 2017 and in thinking about how to prevent similar actions from recurring, Dr Hard finds that “In my opinion, GPs are not normally adequately skilled to provide an opinion or make a determination on the validity or otherwise of the information provided to them by a detained person in respect of ill-treatment or torture.”¹⁹
- 2.22. Finally, and related to the point above, Dr Hard identifies “one of the most significant inadequacies in the completion of the Rule 35(3) reports was limited completion of section 6 by GPs, specifically in respect of the impact of ongoing detention.”
- 2.23. Together, Dr Hard’s report draws into question the safeguarding effectiveness of the Rule 35 process in Brook House during the relevant period.
- 2.24. Further evidence of the kinds of concerns raised by Dr Hard appear in witness statements to the Inquiry by men who had been detained in Brook House who report failings in the implementation of the Rule 35 system in their cases.
- 2.25. For example, while the solicitor of D1527 requested an independent Rule 35 assessment prior to his detention, D1527 was neither assessed then nor in a timely fashion upon arrival in Brook House.²⁰
- 2.26. When D668 reported to the nurse that he had been assaulted by the police at a protest rally in his country of birth, his disclosure did not trigger a Rule 35 appointment with the doctor as it should have.²¹
- 2.27. These individual statements are echoed by Freedom from Torture witness evidence, which identifies a number of men whose Rule 35 process took an unduly long time.²²
- 2.28. Mr Owen Syred, a former DCO who had worked on welfare likewise reported that “In the early days the process was slow and it could take months.”²³

¹⁷ Ibid §6.2.3.3.

¹⁸ Ibid §6.2.3.4.

¹⁹ Ibid §6.2.4.4.

²⁰ [DL0000144]

²¹ [DL0000153], §9.

²² [FFT000012], p.1.

²³ [INN000007], §156.

- 2.29. The effectiveness of the Rule 35 process as a safeguarding mechanism is further drawn into question by Freedom from Torture who found that a determination of torture did not necessarily lead to release during the relevant period even though “Clinically, it is well understood that torture survivors are particularly vulnerable to harm in detention.”²⁴
- 2.30. Since the introduction of the Adults at Risk policy, the Home Office has continued to refine its systems, and, these days, the detention gatekeeper should screen out vulnerable people like D1527. However, at least as such matters pertain to victims of torture like D668, the IMB reports for 2019 and 2020 suggest that matters may not have changed substantially since Panorama.
- 2.31. In 2019, the IMB stated that “victims of torture continue to be held in detention for significant periods of time after acceptance of their Rule 35 claims.”²⁵
- 2.32. The following year, in 2020, when Brook House was used frequently to hold asylum seekers who were being returned to EU member states under the Dublin Convention, following travel to the UK on small boats across the Channel, the IMB reported “serious delays in access to Rule 35 assessments during August through December.”²⁶ On occasion, “nearly half the detainees in the centre had claims under Rule 35,” a situation which “overwhelmed the capacity for GP appointments”, and lead to delays of up to three weeks.²⁷
- 2.33. Together these examples offer evidence that the Adults at Risk Policy may not be effectively diverting the most vulnerable people from detention, nor identifying them while they are detained.

2.34. ACDT

- 2.35. Whereas a Rule 35 report can only be written by a medical practitioner, any member of staff can open an ‘Assessment, Care in Detention and Teamwork’ case (ACDT) if they have concerns that a detained person may be at risk of suicide or self-harm.
- 2.36. A number of the witness statements I have consulted mention the ACDT process. From these statements it appears that, unlike the wider AAR policy, Healthcare and custodial staff were familiar with the ACDT process and had received training in it during the relevant period. Numbers of people on ACDTs were recorded and reported to the SMT. The IMB were also made aware of this information.
- 2.37. The ACDT system is adapted from the HMPPS’s Assessment, Care in Custody and Teamwork (ACCT) process. It is, in other words, a policy that is based on one designed for use in prisons.

²⁴ [FFT000012], p. 1.

²⁵ [INQ000096], p. 4 ; section 4.7.

²⁶ [INQ000107], p. 6; sections 4.4 and 6.3.

²⁷ Ibid.

- 2.38. All staff receive training about the ACDT system in their ITC. They are also meant to attend regular refresher courses on it. Some staff undergo additional training to become ACDT assessors. In this role they are meant to interview detained persons within 24 hours of the ACDT case being opened.
- 2.39. In his statement, Mr Owen Syred, who was an accredited ACDT assessor in Brook House in the relevant period, describes the process:
- “The assessment process involved an interview with the detainee to assess the potential risks, and a report was then generated within the ACDT log. Potential outcomes from the assessment would be encouragement to keep in contact with friends and family, and arranged contact with the chaplaincy, charities and legal representation. The assessor would also recommend the level of observations to be undertaken and in extreme cases this could include constant observations (which would need to take place on E-Wing). It would be for the DCM to review the recommendations and to decide whether they should be implemented.”²⁸
- 2.40. In his subsequent witness statement, Mr Owen Syred reports that “some ACDT assessments were of a high standard, and some were poor.”²⁹
- 2.41. Decisions to close an ACDT case can only be made by a DCM or someone more senior. Until that action is taken, the detained person is meant to receive additional care and oversight from staff.
- 2.42. In practical terms, the ACDT system requires officers to engage in regular interactions with and to perform visual checks on detained individuals. All interactions must be recorded in the ACDT booklet. Detention Custody Managers (DCMs) must read and sign the open booklets each day.
- 2.43. The frequency of observations varies, depending on how vulnerable the person is considered to be. The most vulnerable people are placed on constant watch, during which they must be observed at all times by a member of staff, even when they are sleeping.
- 2.44. During the relevant period men on constant watch were all managed on E-Wing. This strategy of grouping the most distressed people in one section of Brook House seems to have created some difficulties for the men and for the staff on E-Wing. Matters were compounded by the way in which E-Wing was also used for men who had been taken off the wings for other reasons, including for fighting or disorderly behaviour, drug use, or in advance of their deportation.

²⁸ [INN000007], §72.

²⁹ [INN000010], §16.

- 2.45. As I noted in the preliminary report, this arrangement mixed men with highly complex needs who were placed under the care of a small complement of staff who received no additional training or support.
- 2.46. The layout of the building, in which the entrance to E-Wing is located on a lower floor to the main entrances used for the other housing units, meant that staff and the detained men there felt cut off from the rest of the institution.
- 2.47. In his witness statement to the Inquiry, the man identified as D1527 recalls that “E-wing was more frightening than being on the main wing,”³⁰ and “Being on E-wing felt like banishment.”³¹

2.48. Additional safeguards for vulnerable people in detention

- 2.49. In addition to the formal processes associated with the Adults at Risk Policy, Rule 35, and ACDT, during the relevant period, staff from the Forward Trust offered psychosocial support around drug and alcohol addictions for the detained population. In that role they also ran some training sessions for staff to help them identify potential referrals.³²
- 2.50. Volunteers and representatives from the Gatwick Detainee Welfare Group (GDWG) offered social visits and held regular drop in sessions, during which they could try to signpost people in need to external or institutional sources of help.
- 2.51. Welfare staff, like DCO Owen Syred, who has given evidence to the Inquiry, also offered additional layers of support for the detained men, for example, in locating and communicating with their family members or in trying to recuperate personal items from their house, prison, or police custody. Welfare staff assisted detained men in filling out paperwork, e.g. requests for immigration bail.
- 2.52. Finally, members of the Chaplaincy team, Healthcare, and the IMB all also, to varying degrees, have some responsibility for oversight and care of vulnerable people in detention. While I have not seen any evidence submitted by the Chaplaincy team thus far, they usually play an important role in any IRC.
- 2.53. With regard to current practice, my understanding is that the additional safeguards described above are still in place. Further, in the materials submitted by Serco, it seems that they have made the telephone number of the Samaritans available on the back of the identity cards that the detained people are issued in Brook House.³³
- 2.54. I understand that new contractual arrangements, with the Practice Plus Group, are in place, and involve changes to the number and scope of healthcare workers and reorganisation of distinct groups to work together as one healthcare team.

³⁰ [DL0000144], §25.

³¹ Ibid, §26.

³² [FWT000001].

³³ [SER000038], §18.1.

2.55. While I understand that SERCO has continued to subcontract the charity Hibiscus to offer additional support and information for the detained population in Tinsley House pre-departure accommodation around resettlement and return,³⁴ there is no directly equivalent organisation working in Brook House.

2.56. Conclusions and Suggestions

2.57. In assessing the treatment of vulnerable people in detention, I have been asked to pay particular attention to the policies in place during the relevant period, the nature of the training, and its impact on culture and behaviour.

2.58. While it is important to acknowledge the actions of custodial and healthcare staff who worked hard to support vulnerable men in Brook House, the evidence I have consulted suggests that there were gaps in training and understanding particularly around the Rule 35 process and the Adults at Risk policy.

2.59. On their own, such matters could be solved by developing better and/or more extensive training. However, a number of witness statements suggest there was a wider set of issues which adversely affected the treatment of vulnerable people in detention and which are harder to address.

2.60. Thus, for example, Ms Anna Pincus, from GDWG refers to “a culture of disbelief in those working in Brook House... including in healthcare.”³⁵

2.61. In his statement, Dr Dominic Aitken notes that some of the G4S staff he spoke to during the relevant period believed those who self-harmed were being “manipulative.”³⁶ According to Dr Aitken, staff also “differentiated between nationalities”, being more sympathetic to, or believing of some, over others.³⁷

2.62. In his evidence, more generally, Mr Callum Tulley refers to “an ‘us and them’ mentality amongst Brook House staff with regard to detainees.”³⁸

2.63. In addressing these more subtle issues of staff culture, training, policy, and oversight certainly have a role to play. However, alone, they are unlikely to change people’s views or behaviour.

2.64. As the authors of a recent study of prison officers point out, staff treatment of vulnerable people hinges on their view of the purpose of their job. In their study, specifically, they found that: “officers’ attitudes seem to vary dependent on how important they view care as an aspect of their job, with officers demonstrating more

³⁴ Representatives from this organisation who were working at Tinsley House during the relevant period were interviewed by Ms Kate Lampard and Mr Ed Marsden in 2018 as part of the Verita investigation into Brook House [VER000274].

³⁵ [DPG000002], p. 125.

³⁶ [INQ000094], p. 44.

³⁷ [INQ000094], pp. 59 – 61.

³⁸ [INQ000052], p. 71.

favourable attitudes towards offenders and suicide-related behaviour when they see care as their primary job role”.³⁹

- 2.65. In their witness statements, some of the former staff do mention attempts they made to help the detained men.⁴⁰ Such statements suggest a certain commitment to care. However, their statements also depict a highly stressful workplace, and a physically demanding job, that they did not enjoy.⁴¹ The work was also bureaucratic, requiring paperwork and adherence to a chain of command, in which responsibility was passed over to the Oscar 1 or another DCM.⁴²
- 2.66. As I noted in my preliminary report, the ‘caring’ aspect of the DCO role was further minimised by staff training material, which communicated to staff that their role was primarily related to security and managing risk.
- 2.67. The built environment of Brook House, including the metal doors, bars, razor wire, and lack of fresh air and natural light reinforce such security concerns.
- 2.68. I have been provided with some policies and materials now in use at Brook House. While the materials provided by SERCO set out detailed processes for whistleblowing,⁴³ a new ‘staff code of conduct’,⁴⁴ and a commitment to developing what they refer to as a ‘positive detention culture’,⁴⁵ through work with the ‘Appreciative Partnership’, the ITC course still predominantly appears to emphasise security issues.⁴⁶
- 2.69. While the materials shared with me include training in ‘interpersonal skills’⁴⁷, ‘Equality Awareness’,⁴⁸ and ‘Human Rights’⁴⁹, the Training Syllabus breakdown over the seven-week period, is, as it was in 2017, skewed heavily towards matters of security.
- 2.70. Thus, there are four full days devoted to ‘Control and Restraint’ in addition to one full day on ‘Personal Protection’, then additional sessions on ‘personal security,’ and many different ones on different kinds of searches.⁵⁰
- 2.71. I note that there are two full days on Mental health first aid, and one day that includes ‘Diversity’ and ‘Transgender Awareness’, plus nearly a whole day devoted to ‘Human Trafficking’. Likewise, there are sessions labelled ‘Safeguarding’.

³⁹ F. Sweeney, J. Clabour & A. Oliver. (2018). ‘Prison officers’ experiences of working with adult male offenders who engage in suicide-related behaviour’, *The Journal of Forensic Psychiatry & Psychology*. 29(3), pp. 468 – 469.

⁴⁰ [INN000007], §62.

⁴¹ [IPA000001], §7, [MIL000001], §13, [SER000432], §96.

⁴² See, for example, [BDP000001], §13.

⁴³ [SER000164].

⁴⁴ [SER000164].

⁴⁵ [SER000023].

⁴⁶ [SER000034].

⁴⁷ [SER000250].

⁴⁸ [SER000278].

⁴⁹ [SER000351].

⁵⁰ [SER000256].

- 2.72. However, the safeguarding training includes sections on ‘understanding pathways to terrorism’ and ‘radicalisation and extremism.’⁵¹ While such matters may well be necessary under the Prevent duty, they suggest that the population continues to be viewed primarily in terms of risk and security, rather than care, even when they are vulnerable.
- 2.73. Such views, in 2017, as today, are reinforced by the physical design of Brook House and the daily routines of staff, to lock and unlock doors and to search for contraband, which in practical and in more symbolic ways, communicate that the primary role of a DCO is one concerned with security, rather than with care.
- 2.74. The daily timetable of the Brook House likewise continues to rely on periods of lock up, during which all the detained men must return to the rooms for roll count, in an organisational practice which is derived from prisons.
- 2.75. D1527 describes the impact of this emphasis on security in his treatment. “When someone is trying to end the life,” this man states, “you need someone to come and help you. You are in a crisis, and you need someone to get you down from that crisis”⁵² [but] “the officers don’t do that. They use force, they bend you and squeeze you, they make you feel more pain.”⁵³
- 2.76. It is my view based on the materials I have seen, including his statement to the Inquiry⁵⁴, that D1527 should never have been detained at all and had the Adults at Risk policy been properly implemented in his case, he would not have been. He was, in other words, particularly vulnerable and, to that extent, is an extreme case.
- 2.77. Nonetheless, his testimony raises a challenge both in making sense of his treatment in 2017 and in trying to ensure that it is not repeated.
- 2.78. On the one hand, staff have a duty of care to prevent suicide and self-harm. At times, as indeed it can in a hospital, this care may require physical restraint. In applying restraint staff members must follow the appropriate protocol which they learn in their ITC and about which they receive annual refresher training.
- 2.79. On this view, D1527’s experience might appear to be merely one of poorly applied technique.
- 2.80. Such a view would only hold true, however, if there were no other evidence of violence in the culture and practice of Brook House during the relevant period. Unfortunately, that is not the case.

⁵¹ [SER000038], §16.2.

⁵² [DL0000144], §52.

⁵³ Ibid, §52.

⁵⁴ [DL0000144].

- 2.81. As the Shaw Review set out in 2016⁵⁵, international evidence is quite clear: immigration detention adversely affects people's mental health; those who are vulnerable, like D1527, are most badly affected of all.
- 2.82. The negative impact on people's mental health, moreover, lasts well-beyond any period of detention. Witness statements, once again, are instructive.
- 2.83. In his statement to the Inquiry, for example, the man identified in the materials as D1851 reports that his time in Brook House "all led me to question my worth as a human being and changed me as a person."⁵⁶
- 2.84. D1527, D2033 and D1618 report suffering from flashbacks to their time in Brook House.⁵⁷
- 2.85. The man known as D668 reports that thinking about his time in Brook House "triggers my symptoms of post-traumatic stress disorder"⁵⁸;
- 2.86. Finally, the man known as D2033 states "When the Home Office took me to the detention centre from the reporting centre, this dealt me a mental shock" from which he has still not recovered.⁵⁹
- 2.87. While, post-Panorama, the Home Office and the private contractors have worked hard to develop better screening tools which are designed to ensure that people like D1527 are either screened out of detention by the Detention Gatekeeper or released from detention under the Adults at Risk policy, the IMB report on Brook House from 2020 shows continuing high levels of self-harm and suicidal intent among the detained population.⁶⁰
- 2.88. In that report, the IMB specifically relate the "significant increase in self-harm and suicide risk" to the "higher level of vulnerability" of the people detained in Brook House at the time, and "the intensive programme of Dublin Convention Charter flights".⁶¹
- 2.89. This finding, three years after the events screened on BBC Panorama, suggests that the system for screening out vulnerable people before and during their detention is not entirely successful. It also raises questions about the kind of care that can be provided to vulnerable people while they are detained.

⁵⁵ S Shaw (2016) *Review into the Welfare in Detention of Vulnerable Persons*. Cm 9186. London: HMSO.
[INQ000060]

⁵⁶ [DL0000143], p. 1

⁵⁷ [DL0000144], [DL0000149], §1; [INQ000055], §4.

⁵⁸ [DL0000153], §2.

⁵⁹ [DL0000149], §13.

⁶⁰ [INQ000107], Section 4.2, pp. 10 – 12.

⁶¹ *Ibid*, p. 11.

- 2.90. In their concerns about the treatment of people arriving on small boats across the channel, the IMB report offers an important reminder of the impact of the wider immigration control system on people's experiences of custody.
- 2.91. Such matters also affect staff as officers have to manage and support whoever arrives in Brook House.
- 2.92. Although beyond the scope of this Inquiry, the IMB report suggests that any lasting solution to staff culture and to the treatment of people in detention needs to engage with the system as a whole.⁶²

3. Staff Training and its impact on the culture of Brook House

- 3.1 I have been asked to comment on the impact of staff training and its adequacy in terms of staff culture and behaviour towards vulnerable detained persons. In addition, I have been asked to comment on how or whether the current arrangement in which the contracted provider for each IRC runs its own internal courses may affect staff competency and practices.
- 3.2. In the preliminary report, I examined the G4S training used during the relevant period. As I noted in that report, much of the material I examined emphasised security and risk management over other aspects of detention work including care. Many of the training materials, including those on safer custody, had been imported directly from the prison service.
- 3.3 I have been provided the internal SERCO statement on Management of Staff Training⁶³, along with up-to-date job descriptions for the DCO role⁶⁴ (albeit from Yarl's Wood, rather than Gatwick IRC), the Welfare Officer role⁶⁵ and the Custody Support Officer role.⁶⁶ I have also been provided with a variety of 'success profiles' for roles within the IRC, including the Assistant Director of Safeguarding⁶⁷, and the Gatwick IRCs and PDA Code of Conduct and Behaviour for staff.⁶⁸
- 3.4 Other than this SERCO material, I have been provided with no additional written material about staff training during the relevant period since my preliminary report, although in their evidence to the Inquiry, some of the former G4S custodial staff, like Mr Graham Matchett, refer in general terms to their ITC training or to refresher training, which they found to be adequate.⁶⁹ Mr Syred also refers briefly to a three day "ACDT assessor course"⁷⁰ he completed in 2010, and a "National Offender Management five-

⁶² Ibid., Section 3.1, p. 5

⁶³ [SER000034].

⁶⁴ [SER000114].

⁶⁵ [SER000113].

⁶⁶ [SER000093].

⁶⁷ [SER000073].

⁶⁸ [SER000033].

⁶⁹ See for example, [BDP000001], §3- 5.

⁷⁰ [INN000007], §54.

day residential course” he completed in 2017 to become “accredited as a safer custody trainer”.⁷¹

3.5 Healthcare staff who submitted statements were also asked about their view of their training. Most report that they believed it was adequate, although there was some variation in opinion.⁷²

3.6 As noted above Dr Hard’s report raised questions about the efficacy of training for GPs in identifying victims of torture.⁷³

3.7 Finally, Mr Anton Bole, from the Forward Trust, also describes the content of the training that members of his organisation received, and notes that the Forward Trust offered training to other staff to help them identify detained men who might benefit from support with drug and alcohol addictions.⁷⁴

3.8 Conclusions and Suggestions

3.9 My view of the training materials is limited to those I have been given for the purpose of the Inquiry. While I have not seen what the other providers used in 2017, I have had the opportunity to review some of the current SERCO training materials.

3.10 I have previously advocated that the training should both be publicly available and shared among the contractors so that ‘best practice’ could be disseminated and reinforced. Surveys of the quality of life in immigration removal centres identify differences among them,⁷⁵ and it is likely that some centres have strengths in certain areas that others do not.

3.11 I believe that sharing training material could also assist in creating a clearer sense of detention work as a professional activity.

3.12 In so doing, it could respond to former DCO Ioannis Pascali’s claim that “I have no professional qualifications and have never held a professional job.”⁷⁶

3.13 As I mention in §2.24 of the preliminary report, Stephen Shaw has called for a graduate entry programme to this line of work.⁷⁷ I note that Mr Owen Syred, a former DCO at

⁷¹ Ibid., §9.

⁷² Whereas Karen Churcher was broadly positive about the training she received, [DWF000003], §14 – 20, Donna Batchelor reported that she “didn’t feel prepared for my role at Brook House after completing the training provided” [DWF000014], §14.

⁷³ [INQ000075], §6.2.4.4.

⁷⁴ [FWT000001].

⁷⁵ M Bosworth and A Gerlach (2020) *Quality of Life in Detention: Results from MQLD questionnaire data collected in IRC Gatwick (Brook House and Tinsley House), IRC Heathrow (Colnbrook and Harmondsworth), Yarl’s Wood IRC, Morton Hall IRC, and Dungavel IRC: July 4 – September 20, 2019*. Oxford: Centre for Criminology.

⁷⁶ [IPA000001], §2.

⁷⁷ Shaw (2018) *Assessment of Government Progress in Implementing the Report on the Welfare in Detention of Vulnerable Persons: A Follow-Up Report to the Home Office by Stephen Shaw*. Cm 9661. London: HMSO.

Brook House who worked in the Welfare Department, also suggested a more modest version of this idea, which would be an NVQ in custodial settings.⁷⁸

- 3.14 The contracted-out nature of the immigration detention system currently offers a logistical barrier to such suggestions due to their cost and to concerns over corporate confidentiality.
- 3.15 One possible solution would be for the Home Office to run DCO training, working together with the contractors and other stakeholders, including HMIP, IMB and representatives from people in detention, to design an accredited course for all custodial staff.
- 3.16 A more ambitious solution would, as Mr Shaw suggests, require higher education qualifications for new recruits or relevant professional experience in addition to the new training.
- 3.17 In either approach it would be important to revisit the nature of the DCO role itself.
- 3.18 As the previous section on the treatment of vulnerable people reported, academic research suggests that custodial staff who view their job as one of care, may be better at helping people who attempt to take their own lives, than colleagues who perceive their roles primarily in terms of security.
- 3.19 One way to bring about that cultural change would be to change the nature of the job itself, to be a role that was centred on offering psycho-social support, rather than security.
- 3.20 The DCO role is modelled on a prison officer. However, as I have found in my own research, the two jobs are not really comparable not only because people in detention are not serving a criminal sentence, but also because the purpose of a period of immigration detention is not related to punishment or rehabilitation.
- 3.21 The legal complexity of the detained population and their known vulnerability add further distinctive qualities and challenges to the work of the custodial staff. This is a difficult job.
- 3.22 I note that the SERCO DCO job description starts with a requirement that the person appointed to the DCO role will “work with Residents in an empathetic manner, treating them as valued human beings during a difficult emotional time in their lives.”⁷⁹
- 3.23 This emphasis on empathy and humanity is a welcome addition to the language around this role, although I would suggest that it could be bolstered by additional statements about and greater training in the legal rights which detained people possess, access to which should not only be observed but facilitated by staff in their everyday work.

⁷⁸ [INN000007], §221.

⁷⁹ See, for example [SER000114], p. 1.

- 3.24 I would suggest that in any reorganisation of training and refresher courses that greater attention should be paid to the risks of secondary trauma for staff and more emphasis placed on the detained population's experiences of trauma.
- 3.25 In re-designing training courses around 'trauma-informed care and practice' the Home Office could be guided by work underway in prisons for women in England and Wales and in mental health settings.
- 3.26 I would further suggest that in any reorganisation of training that the voices and experiences and views of the detained population and advocacy groups should be included along with HMIP and the IMB to increase understanding of the lived experience of immigration detention and of the legal rights that people in detention retain.
- 3.27 Those who are detained will have a better sense of the pressures they face in these sites of custody and integrating them into the training process could also help tackle some of the unhelpful suspicions and stereotypes that were evident in the casual staff conversations that were caught on film by Mr Tulley and which were covered in some detail in my preliminary report.
- 3.28 Integrating advocacy groups, HMIP, and the IMB into training would further assist in shifting the balance in the training away from a focus on security towards one of care, dignity, and rights.
- 3.29 Notwithstanding these suggestions, however, I would like to sound a note of caution about whether the kinds of attitudes and actions caught on film in 2017 by Mr Tulley can be fully eradicated through training alone.
- 3.30 Academic and policy research with police and prison staff suggests that better training, whether that means more extensive study for a university degree or some other formal qualification, more regular refresher courses, perhaps delivered by a wider range of providers, or a greater focus in the coursework on matters of care and welfare, is unlikely without greater attention to existing workplace cultures and views, prevent the repetition of events that occurred at Brook House.
- 3.31 Once in the job, new recruits are far more likely to be influenced by colleagues than by what they learned in the classroom.⁸⁰ As Mr Stephen Shaw observed in 2005, in his report into *Allegations of Racism and Detainee Mistreatment at Oakington Immigration Reception Centre and While Under Escort*, in an environment like Brook House, which is designed to hold foreign nationals for the purpose of their removal,

⁸⁰ See, for example, B. Loftus. (2009), *Police Culture in a Changing World*. Oxford: Oxford University Press; Arnold, H. (2016) 'The prison officer', in: Y. Jewkes, B. Crewe and J. Bennett (Eds.), *Handbook on Prisons*, 2nd edn, Abingdon: Routledge; K. Morrison and M. Maycock. 'Becoming a Prison Officer: An Analysis of the Early Development of Prison Officer Cultures', *The Howard Journal of Crime and Justice*. 60(1): 3 – 24.

there will always be the danger of xenophobic and racist views such as those caught by Mr Tulley on camera.⁸¹

- 3.32 Challenging the logic of such views must, therefore, be at the heart of any staff training, and at the centre of staff relationships with their colleagues and with the detained population.

4 Staff relationships and their impact on the treatment of detained persons

- 4.1 I have been asked to comment on the relationships between healthcare and detention centre staff as well as on the relationships between the SMT, DCMs and DCOs and on the dynamics within the SMT staff group and the impact of any of these relationships on the treatment of detained men in Brook House. The former set of issues were examined in some detail in the preliminary report and I do not have much further to add to my findings in that report. I examine the Home Office staff in section 6 below.
- 4.2 The witness statements I have read from former G4S staff did not have much to say about their relationship with colleagues in Healthcare or the Home Office.
- 4.3 Healthcare staff by contrast, do mention their colleagues in other departments.
- 4.4 While they report little interaction with representatives from the Home Office, they are broadly positive about working together with custodial staff.
- 4.5 According to Ms Daliah Dowd, a registered mental health nurse, who was employed at Brook House in the relevant period, for example, “staff communicate well and work together to meet the needs of the resident.”⁸²
- 4.6 In terms of relationships within the Healthcare group, witness statements suggest some variation in views. Whereas most of the statements given appear to corroborate the view of Registered General Nurse Mr James Newlands that “the staff morale within the healthcare department was normal”⁸³, at least one member of staff refers to “bullying” within the Healthcare group.⁸⁴
- 4.7 There is also a variety of opinions about the adequacy of initial training and the induction process, with some Healthcare staff reporting that they were well-prepared for the challenges of their job, and others reporting that they were not.
- 4.8 Finally, there is some variation in the engagement Healthcare staff report with custodial staff. Those employed on the night shift, for example, do not seem to have had as much to do with DCOs as their colleagues who worked during the day.

⁸¹ [INQ000109], p. 3.

⁸² [DWF000010], §7.

⁸³ [DWF000012], §9.

⁸⁴ [DWF000014], §4.

- 4.9 On the whole, on the basis of the material I have seen to date, the Healthcare staff witness statements do not identify or acknowledge substantial difficulties in working at Brook House; this view of their work stands in some contrast to witness statements from some of the formerly detained men, and from members of GDWG, like Mr Jamie Macpherson who reports that “Healthcare, or the lack of access to Healthcare, is probably the most common complaint that you receive as a Volunteer Visitor from detained individuals.”⁸⁵ Mr Macpherson’s view resonates with academic literature and reports from civil society groups.⁸⁶
- 4.10 I have had the opportunity to read statements from eight former G4S staff who have provided their views of working in Brook House during the relevant period: Mr Nathan Ring⁸⁷, Mr Ioannis Pascali⁸⁸, Mr Graham Matchett⁸⁹, Mr Nathan Harris⁹⁰, Mr Kye Clark, Rev. Nathan Ward⁹¹, Mr Owen Syred⁹² and Mr Callum Tulley⁹³.
- 4.11 While Mr Owen Syred describes poor staff morale, high staff turn-over, inadequate support from managers⁹⁴ and a personal experience of bullying⁹⁵, Rev. Nathan Ward refers to “incompetence” in the SMT⁹⁶.
- 4.12 Mr Callum Tulley,⁹⁷ albeit in rather more measured terms, makes it clear too, that he encountered difficulties in some of his working relationships, particularly with DCMs.
- 4.13 Some of the other former staff rebut such suggestions.⁹⁸ However, they frequently refer to working in Brook House in very negative terms, characterising their work as stressful and upsetting.⁹⁹

4.14 Conclusions and Suggestions

- 4.15 The additional evidence that I have read confirms my findings in the preliminary report that there was dissatisfaction among the staff group. As in that report, the witness statements to the Inquiry suggest that there were also tensions among parts of the

⁸⁵ [INQ000027], §64.

⁸⁶ See for example, M Bosworth and A Gerlach (2020) *Quality of Life in Detention: Results from MQLD questionnaire data collected in IRC Gatwick (Brook House and Tinsley House), IRC Heathrow (Colnbrook and Harmondsworth), Yarl’s Wood IRC, Morton Hall IRC, and Dungavel IRC: July 4 – September 20, 2019*. Oxford: Centre for Criminology; Clinical Review for the purpose of an Independent Investigation of Gatwick Cluster IRC Carried out by Dr John Linsell. 22.03.19, [CJS007078].

⁸⁷ [MIL000001].

⁸⁸ [IPA000001], [IPA000002]

⁸⁹ [BDP000001].

⁹⁰ [SER000432].

⁹¹ [DL0000141], [DL0000154].

⁹² [INN000007], [INN000010].

⁹³ [INQ000052].

⁹⁴ [INN000007], §19, §26.

⁹⁵ [INN000010], §40.

⁹⁶ [DL0000141], §52.

⁹⁷ [INQ000052], §57 ; §74 - §75.

⁹⁸ [SER000432]. §15.

⁹⁹ [IPA000001], §7.

custodial staff group and that these conflicts likely affected the treatment of the detained men, both because staff felt undervalued by and suspicious of their peers and because the staff hierarchy and specific staff cliques and individuals discouraged them from calling out problematic behaviour by colleagues.

- 4.16 Thus, while Mr Tulley reports that “the majority of DCOs were not abusive. Many of them were hard working decent people, trying to do their best in a bleak, poorly staffed, highly charged and toxic environment,”¹⁰⁰ the evidence he captured on film which I covered in some detail in the preliminary report, shows far too many instances of inappropriate, undignified, disrespectful and at times dangerous, behaviour by staff towards the detained men in their care.
- 4.17 These kinds of behaviours were compounded by the problems of understaffing which put everyone under more pressure. They would also have been made worse by the low morale and low levels of trust in colleagues and senior staff mentioned by Mr Tulley¹⁰¹ and Mr Syred¹⁰² in their witness statements.
- 4.18 In their investigation, Ms Lampard and Mr Marsden spent some time trying to ascertain why staff levels were so often so low. In those interviews, representatives from G4S referred to the difficulties they faced in 2017 in recruiting locally, when, at the time, there were plenty of better-paying jobs available at Gatwick airport.¹⁰³
- 4.19 While, post-pandemic, the situation is quite different, and it may well be easier to recruit the appropriate numbers of staff to this work, I note that the most recent staffing data provided to the Inquiry shows significant staff turnover among DCOs in particular.¹⁰⁴
- 4.20 The current contract has a mandated number of staff who must be present, which is a welcome development.
- 4.21 However, the outsourced nature of Brook House (and all IRCs) mean that a financial incentive remains to keep salaries low.
- 4.22 The contract creates a significant pay gap between the small number of SMT staff and DCOs. This gap is compounded by differential arrangements around shift work, in which there are regular periods (e.g. during the evening and on weekends) when there are limited numbers of DCM or SMT staff physically present, although it is important to note that the new contract with SERCO also mandates a greater number of DCMs than were in post during the relevant period.

¹⁰⁰ [INQ000052], §74.

¹⁰¹ [INQ000108], lines 1- 9, p. 58.

¹⁰² [INN000007], §19, §20, §26.

¹⁰³ Independent Investigation into Brook House - Interview with Lee Hanford (Interim Director), dated 27/11/2017, [VER000266].

¹⁰⁴ [SER000158].

- 4.23 Even so, in a hierarchical institution like Brook House, in which jobs vary by shift patterns and pay, it is not unreasonable to assume that, at best, such matters mean that DCOs are unlikely to know their senior colleagues as well as they know people of the same rank whom they work alongside for 12-hour shifts. As I documented in the preliminary report, there is some evidence that these issues generated considerable resentment towards more senior, better paid, colleagues.¹⁰⁵
- 4.24 These staffing arrangements also make it difficult for senior staff to have a clear oversight of the actions and views of the majority of their employees. Instead, they rely on the DCMs to inform them of any issues that they need to manage.
- 4.25 It is then, of great concern that, according to the witness statements made by Mr Syred and Mr Tulley as well as the interviews conducted by Verita in 2018, that a small group of DCMs seem to have advocated aggressive practices and beliefs in Brook House in 2017 without challenge.
- 4.26 In the preliminary report, I offered some suggestions for ways to tackle these kinds of problems, including moving the SMT physically into the main building. I note that such suggestions have been made before,¹⁰⁶ and yet, to my knowledge, have not been adopted in any IRC.
- 4.27 In reviewing the new evidence on staff relationships during the relevant period, I am struck by the lack of interaction between the Home Office and any of the parties concerned in delivering the contract. As representatives of the Authority and also as the conduit of information between the detained population and their case workers, Home Office staff should be more visible within the IRC.
- 4.28 To that end I suggest that, like the SMT, their offices should be moved into parts of the building where they would be able to monitor interactions between custodial staff and the detained population, e.g. on the housing units.
- 4.29 Finally, I think the evidence suggests that staff relationships would benefit from more career development opportunities for all parties, including DCOs, alongside a more transparent system of reward and promotion. There must also be a clearer and more effective means for staff at any levels, detained men and representatives from other organisations of reporting concerns. It is to that issue that I now turn.

5. Whistleblowing and reporting concerns

- 5.1. In his live evidence, Mr Callum is asked why he did not report his concerns to G4S directly and why, instead, he chose to film for the BBC undercover.¹⁰⁷
- 5.2. Mr Tulley is quite clear in his evidence that he believed there to be significant barriers to whistleblowing from the start of his period of employment at Brook House, when,

¹⁰⁵ See for example §4.16 – 4.17 in that report.

¹⁰⁶ [INQ000109].

¹⁰⁷ [INQ00108]

during his initial training, an experienced member of staff referred casually to an episode of detainee abuse. Once in post, Mr Tulley reports, matters did not improve: "We had been told we could raise problems with DCMs in the first instance, but DCMs were involved in the behaviour I had witnessed."¹⁰⁸

5.3. Overall, according to Mr Tulley, "there was a visible hostility to raising concerns,"¹⁰⁹ in an institution in which, he believed, "there was a culture of abuse at Brook House among a significant minority of officers and managers."¹¹⁰

5.4. Mr Owen Syred offered a similar account, claiming that:

"The whistleblowing and reporting process at BH was not effective. I was bullied and harassed, and I had to take time off work with stress. I am not aware of any specific actions or initiatives in response to my treatment to seek to change the culture and to protect officers who were prepared to call out inappropriate behaviour."¹¹¹

5.5. Finally, in his evidence Rev. Nathan Ward claims that his attempts to raise concerns at Medway STC, when it was run by GSL, had failed.¹¹²

5.6. The witness statements from other former G4S employees do not mention such matters.

5.7. In any case, anyone can formally raise concerns and so it would be wrong to focus only on DCOs and other G4S staff. Here, again, the evidence suggests that practices and the institutional staff culture during the relevant period were unhelpful.

5.8. A number of the men who had been detained in Brook House in 2017 were asked why they had not officially complained about the treatment they received when it happened. Their answers are instructive.

5.9. According to the man known as D1527, for example:

"When these incidents happened, I didn't tell my lawyers because I thought this was normal in detention. When I complained in prison nothing happened, I was told the man who attacked me was just doing his job. Who could I complain to? The manager was friends with the staff, not with the detainees, he would do nothing if I said anything."

¹⁰⁸ [INQ000052], §59.

¹⁰⁹ *Ibid.*, §75.

¹¹⁰ [INQ000052], § 74.

¹¹¹ [INN000010], §40.

¹¹² [DL0000141].

- 5.10. The man known as D2033 states that he did not lodge a complaint about his medical care in Brook House because he “didn't think that there was anyone there to listen to my concerns.”¹¹³
- 5.11. According to Ms Anna Pincus and Mr Jamie Macpherson from GDWG, they were actively dissuaded from raising concerns about individual detained men to G4S by members of the SMT who threatened to reduce their organisation's access.¹¹⁴
- 5.12. According to Mr Jamie Macpherson, volunteer visitors at GDWG were further dissuaded from making complaints about the treatment of men they were supporting by the IMB, who insisted that complaints were lodged by the detained men themselves, rather than by a representative from GDWG.¹¹⁵
- 5.13. The Home Office testimonies simply set out the framework in place at the time; their role as potential whistle-blowers is not really addressed in the material I have examined.
- 5.14. **Conclusions and Suggestions**
- 5.15. Mr Tulley, Mr Syred and Rev. Ward all suggest in their statements to the Inquiry that whistleblowing would not have been taken seriously. Their views are important not only because of what they suggest about the work culture at the time, but also because the contract between G4S and the Home Office rested, in large part, on self-disclosure.
- 5.16. My understanding is that this aspect of the contract has changed and the apparent changes are underpinned by a section in the new contract on staff culture.
- 5.17. In the immediate aftermath of Panorama, G4S publicised far more widely within Brook House how staff could raise concerns. It is unclear to me whether this strategy elicited any further disclosure of concerns by staff or anyone else.
- 5.18. The IMB also appears, in its subsequent reports, to be taking matters of complaint very seriously.
- 5.19. GDWG are still active in the facility.
- 5.20. These are welcome developments. However, the issue of complaints and whistleblowing needs to be constantly under review to ensure that people actually are reporting concerns.
- 5.21. In this endeavour I suggest encouraging not only multiple mechanisms for reporting, but also greater transparency within the institution about the number and kind of reports being raised.

¹¹³ [DL000149], §59.

¹¹⁴ See for example [INQ000027] and [DPG000002].

¹¹⁵ [INQ000027] §11.

- 5.22. For example, it is a requirement for the company to log complaints forms, which are also reported to the IMB and to the Home Office. It would be helpful if that data could be shared more widely e.g. on housing units, to show the detained population that their concerns are taken seriously.
- 5.23. In 2016 and again in 2018, Mr Stephen Shaw in his review of the treatment of vulnerable people in detention advocated increased facilitation of independent academic research within IRCs, as an additional means of scrutiny and as a way to garner additional insights into the treatment and experiences of vulnerable people in detention.
- 5.24. There is of course, also the statutory role of HMIP and IMB, and in that, the greater focus by HMIP on staff views since Panorama is a welcome development. I am unsure what the IMB specifically does to elicit staff views, but that might be something they could also consider doing.
- 5.25. In all these examples, it would be best if a simplified complaints form could be made available to the detained population in multiple languages. Such a form, could, for example, be standardised, organised around common concerns, with closed ended questions and then an open-text section included at the end for greater detail.
- 5.26. If the complaints form were to be standardised, the language barrier would be less significant as its gist could be understood at a glance by the IMB and by the Home Office monitors. This technique is commonly used in surveys, including the *Measure of the Quality of Life in Detention*, to allow for machine reading of responses. It could be added to the kiosks which have been placed on the housing units.
- 5.27. The kinds of issues that could be included in a redesigned complaints form could include: lost property; staff language and behaviour; roommates; bullying; food; drugs; and information about the individual's immigration case.
- 5.28. I would suggest redesigning the form in consultation with the IMB, the Home Office, the private contractors and representatives from the detained population.
- 5.29. Finally, the role of the Home Office contract monitor in inviting and responding to whistleblowing needs further clarification.
- 5.30. Like the SMT, the Home Office staff are not as visible to DCOs or to the detained population as they could be in any IRC. As the representative of the 'Authority' in contractual terms, these members of staff offer an important and, I believe, currently under-utilized, resource for enhancing scrutiny.

6. The role of Home Office staff in Brook House and in monitoring the contract

- 6.1. In my preliminary report, I did not examine the role of the Home Office staff present in Brook House. Their role in Brook House during the relevant period is covered in more detail in the additional materials I have been provided for this report.

- 6.2. In a series of witness statements, Home Office staff report a good working relationship with one another and with G4S. They do not recall having concerns about staff culture in the IRC at the time. They do not report any complaints among their own staff complement.
- 6.3. According to Mr Paul Gasson, who was the Home Office Immigration Manager/Contract Monitor during the relevant period, "The engagement I witnessed between staff and those detained was always positive and professional."¹¹⁶
- 6.4. Likewise, Mr Alan Gibson, the Head of Operations in Detention and Escorting Services in the Home Office, "on my visits to Brook House I always found the attitude of G4S staff displayed to the people who were detained there to be professional. The attitude of the Home Office staff at Brook House was also professional."¹¹⁷
- 6.5. Mr Gibson goes on to state that "I do not recall having any particular concerns about how the values of G4S and or the Home Office or its culture impacted the general protection of those who were detained, the management of staff, or the protection of especially vulnerable detained persons."¹¹⁸
- 6.6. It is worth noting, that from a quite different perspective, Mr Jamie Macpherson, a Volunteer Visitor at GDWG, likewise reports that "Prior to the Panorama documentary being broadcast, it never occurred to me that physical mistreatment of detained persons at the hands of Brook House staff could be taking place."¹¹⁹
- 6.7. Unless we assume that all of these statements are made in bad faith, they all raise difficult questions not just about how the events of 2017 went undetected until they were broadcast by the BBC, but also about how they might convincingly be prevented from recurring in the future.
- 6.8. In their statements, the Home Office staff suggest that more attention should be given to the nature of the contract both in making sense of what happened, and in understanding why the Home Office staff were seemingly unaware of the problems Mr Tulley revealed.
- 6.9. While I deal with the contract separately below in section 7, it is worth noting here that the contract provides the primary mechanism through which Home Office staff view the actions of G4S staff. Monitoring it is also the primary way in which the Home Office obtains information about the operations of an IRC.
- 6.10. In her witness statements, Ms Clare Checksfield -- who was Head of Detention and Escorting Services at the Home Office in the relevant period -- notes that the contract

¹¹⁶ [HOM0332004], §29.

¹¹⁷ [HOM0331980], §43.

¹¹⁸ Ibid, §44.

¹¹⁹ [INQ000027], §58.

had “around 30 performance measures” for the Home Office to monitor and relied “heavily on self-reporting” by G4S.¹²⁰

6.11. Mr Ian Castle, who is now the Area Manager for Gatwick IRCs but was not in that role during the relevant period, states that: “I have no doubt that had G4S employed more staff, there would have been fewer incidents within the centre.”¹²¹ Given the acknowledged levels of under-staffing at the time, it is unclear whether Mr Castle’s statement pertains to the detail of the contract or to its delivery.

6.12. In either case, it is important to acknowledge that it was the Home Office itself which agreed the terms of the contract with G4S. It was also the Home Office’s role to monitor its delivery, no matter how many measurements were built into it.

6.13. **Conclusions and Suggestions**

6.14. Evidence submitted to the Inquiry suggests that more attention needs to be given to the role of the Home Office staff and to the contract in shaping the culture of immigration removal centres. There is very little evidence in the public domain about either factor.

6.15. In section 4 above, on staff relationships, I suggested that the location of Home Office staff may have made it more difficult for them to gauge what was happening more widely in Brook House, e.g. on the housing units. Located in offices in the administrative corridor, Home Office staff would have had few occasions to interact informally or otherwise with DCOs or DCMs.

6.16. They would have had more interaction with the detained population, however, as they meet regularly with individuals to update them on details about their immigration case. In those interactions, there should have been occasion to learn about concerns from the detained men about their treatment in Brook House.

6.17. While these Home Office staff would have witnessed some DCOs at work and might then have been reasonably expected to have taken a view on their attitudes and behaviour towards detained men, it is unlikely that they would have had more than passing interactions with G4S staff either in the legal corridor or the administration corridor.

6.18. As public sector employees, Home Office staff play an important symbolic and legal role in delivering safe and decent institutions. So far, their actions have largely been overlooked in academic inquiry or in reports by civil society actors. I suggest that more thought be given to enhancing their visibility and their role within the institution both in terms of their contract monitoring responsibilities and in terms of their interactions with the detained population.

¹²⁰ [HOM0331981], §13.

¹²¹ [INQ000056], §45.

7. The Contract

- 7.1 In my preliminary report I did not consider the role of the contract in shaping the culture of Brook House in the relevant period.
- 7.2 I have now had a chance to review the contract in place at the time.¹²² I have also considered Home Office and G4S witness statements which mention the contract.
- 7.3 There is very little information in the public arena about the contracts that the Home Office agrees to deliver immigration detention. The silence over their content, which is justified by the terms of 'corporate confidentiality', makes it difficult to draw firm conclusions.
- 7.4 While I have read the contract that was in place during the relevant period, I have no means of comparing it to equivalent ones used in other IRCs at the time.
- 7.5 In my view, in most respects, the contract sets out what appears to have been reasonable provision for a custodial institution; there are paragraphs devoted to safer custody, to activities for the detained population and to delivering services in languages people can understand. There is also repeated mention of the vulnerability of the detained population.
- 7.6 Three questions arise from this evidence
- (a) Did the events in Brook House stem from inadequacies in the contract (i.e. were there items that were not included which could be changed in future contracts)?
 - (b) Was the contract not adequately delivered in the terms it promised?
 - (c) Or is there an inherent risk in operating sites of custody through a contracted-out system?
- 7.7 To consider the detail of the contract is beyond the scope of this Inquiry, although I would suggest that this would be a useful exercise and one which, again, would best be conducted with a far greater level of transparency. While I appreciate that the *costs* of running any business would fall under the requirements of 'corporate confidentiality' it is unclear to me why the other details of all the contracts could not be made publicly available.
- 7.8 Were such matters to be more transparent, then there would be more opportunity to share best practice. It might also be easier to hold individuals and organisations to account in a timely fashion, rather than to seek to learn lessons five years later in a public inquiry.
- 7.9 In regards to the second question about the efficacy of contract delivery, it is somewhat difficult to come to a firm conclusion because of the manner in which the contract depended on self-reporting by G4S. However, the events of 2017 caught on film by Mr

¹²² [HOM000916].

Tulley suggest that, at a bare minimum, aspects of the contract concerning safety and the treatment of vulnerable people were not adequately delivered.

7.10 In their investigation, Verita sought to clarify whether the short-staffing at Brook House was a deliberate failure to meet the provisions in the contract.

7.11 While the interim Centre Director was adamant that it was not,¹²³ Rev. Nathan Ward asserts in his witness statement to the Inquiry that, “the Home Office went into the Brook House contract with their eyes wide open about the poor quality of GSL provisions and the potential effects this could have on detainees including for their safety and welfare.”¹²⁴

7.12 It is not possible to adjudicate such claims. However, both reveal that more attention needs to be given to the contracts which underpin these sites of custody. Witness statements to the Inquiry suggest that the contract with Serco differed substantially to the one with G4S. While I have read both contracts, it would be helpful to know more about decisions that were made to vary the terms between the one in force during the relevant period, and the one signed with Serco in 2020. It would also be helpful to know more about the changes made the G4S contract in 2019. I have not read that document.

7.13 Conclusions and Suggestions

7.14 As a contracted-out set of institutions, IRCs are always going to be vulnerable to cost-cutting measures since companies strive to deliver a profit to their shareholders.

7.15 This aspect of the contract can put all members of staff under pressure.

7.16 While considerations of the content of the contract are out of scope of this Inquiry, I suggest that greater attention be paid to the grounds on which contracts are selected and that lessons are learned from the events of 2017 in terms of staffing levels and the barriers to effective contract monitoring.

7.17 I further suggest that the Home Office maintains a public record of lessons learned pertaining to contractual provision, so that such matters can be more easily scrutinised.

8. Conclusion: Preventing harmful cultures within IRCs by encouraging greater transparency and bolstering rights

8.1 I would like to conclude this supplementary report by addressing two final areas that I have been asked to consider.

8.2 The first concerns Stephen Shaw’s 2005 report into Oakington Immigration reception centre, in particular, his 54 recommendations about which I have been asked to provide

¹²³ Independent Investigation into Brook House, transcript of second interview with Lee Hanford on 29/05/2018, [VER000239].

¹²⁴ [DL0000141], §100.

any comment on their potential efficacy in preventing or addressing harmful cultures within IRCs.

- 8.3 The second is to provide further comments or suggestions on the possible benefits of detained persons having greater awareness of their rights.
- 8.4 In his 2005 report into *Allegations of Racism and Detainee Mistreatment at Oakington Immigration Reception Centre and While Under Escort*, Stephen Shaw, then Prisons and Probation Ombudsman observed that the events he was exploring had occurred in an institution which had a high level of “independent scrutiny” and yet “harboured unseen a sub-culture of such nastiness”.¹²⁵
- 8.5 As I noted at the outside of this supplementary report, Mr Shaw suggested in 2005 that the problems he observed in Oakington sprang from “the very purpose of immigration detention”, which, he pointed out was “to exercise coercive power over foreigners prior to their removal from the country.”¹²⁶
- 8.6 Given this purpose, he went on, “It is perhaps not a surprise that this function, combined with the attitude towards asylum-seekers and other would-be immigrants of some sections of the media, can become a breeding ground for racist and abusive word and deed.”¹²⁷
- 8.7 As with this Inquiry, Shaw examined the role of management, the contract, the relationship between the private contractor (GSL, a precursor to G4S) and the Home Office, along with training, supervision, staff numbers and their deployment, living conditions in the detention centre, and the role of human rights monitors and NGOs.
- 8.8 Many of the practices and problems that he identified in Oakington are remarkably similar to those which were occurring in Brook House in 2017.
- 8.9 Oakington, like Brook House, appeared to have been operating with a particular group of staff (“the Green Shift”) who were known to abuse detainees.¹²⁸ Grievances had been “sky high” during the relevant period,¹²⁹ while whistleblowing was poorly understood and not encouraged.¹³⁰
- 8.10 In his report, Mr Shaw was particularly critical of the role of supervisors and managers “for allowing a sub-culture to develop where their juniors felt they could act or speak in the way they did with impunity.”¹³¹

¹²⁵ [INQ000109], p. 3.

¹²⁶ Ibid.

¹²⁷ Ibid.

¹²⁸ [INQ000109], p. 63 – 64.

¹²⁹ [INQ000109], p. 63.

¹³⁰ [INQ000109], p. 68.

¹³¹ [INQ000109], p. 35.

- 8.11 He was also concerned about the material conditions in Oakington and in short-term holding units where people were held before deportation.
- 8.12 He reported that the IMB were not as effective as they could be.
- 8.13 Mr Shaw's recommendations for how to solve some of these problems are also familiar. Some are the same as suggestions I made in the preliminary report. Others were made by Verita in their initial response to the events in Brook House.¹³² Shaw, thus, advocated enhanced resources to monitoring¹³³; moving the SMT offices into the "heart of the compound"¹³⁴; and better training in the ITC¹³⁵.
- 8.14 "Managers must constantly reinforce anti-racist messages," he concluded,
- "They must provide adequate training, effective supervision and regular feedback to staff. They should take steps to ensure that no swearing or 'off-colour' comments are tolerated and challenge every single instance of inappropriate language or behaviour. They must avoid complacency and constantly dig below the surface, questioning everything. They should take pains to address the needs of staff, to foster inclusiveness and encourage feedback from them, whatever its nature."¹³⁶
- 8.15 Only through such constant vigilance, he argued, could the "moral resilience" of staff be secured.
- 8.16 In his advocacy of 'moral resilience', and anti-racist practices, Mr Shaw emphasises the responsibilities and the role of staff in eradicating racism and violence from these sites.
- 8.17 While he is right to emphasise staff, and of course, staff are the focus of my work for this Inquiry, it seems to me important also to include the detained population in any discussion of how to prevent harmful cultures taking root in IRCs, not just as potential victims of racism or violence, but as rights-bearing people who deserve good treatment because they are fellow human beings and because they are entitled to it, under law.
- 8.18 In my preliminary report, I suggested that more effort should be made in IRCs to acknowledge and communicate to staff and to the detained population, the rights that detained people hold.

¹³² K Lampard and E Marsden (2018) *Independent investigation into concerns about Brook House immigration removal centre: A report for the divisional chief executive of G4S Care and Justice and the main board of G4S plc*. London: Verita, [CJS005923]

¹³³ [INQ000109], p. 99.

¹³⁴ [INQ000109], p. 69.

¹³⁵ [INQ000109], pp. 42, 103.

¹³⁶ [INQ000109], p. 105.

- 8.19 While greater acknowledgement of the legal frameworks within which IRCs sit should offer greater protections against the kinds of events of 2017, the language of rights and their content can be difficult to understand. In a custodial setting, rights can also be hard for people to access.
- 8.20 It is for that reason that it is very important to facilitate better access to legal advice for those who are detained. And yet, none of the documents I have read, nor the witness statements or video material that I have consulted have addressed that issue.
- 8.21 Currently, the detained men must rely on a limited number of organisations, like GDWG, or staff in the Welfare office like Mr Owen Syred, or their family members, to signpost them to legal advice.
- 8.22 This arrangement can be particularly different for vulnerable people and for those without family members in the UK.
- 8.23 To bolster and reinforce the rights of detained people, I recommend that the Home Office and the private contractors revisit legal provision and try to find ways of facilitating access to legal advice for all who need it.
- 8.24 In this report, I have sought to address rights in other ways too, through suggesting more transparency around specific issues, including complaints. I have also suggested greater integration of the detained population into policy design, including training and the complaints system.
- 8.25 People who are detained will have a specific set of knowledge and experiences which may help in devising alternative systems and responses.
- 8.26 There are examples already within IRCs of engagement with the detained population: each centre has a number of detainee 'Reps' and there are regular meetings which they are invited to attend.
- 8.27 SERCO, in its documents that it submitted to the Inquiry, included their policy around the 'Buddy' system, in which detained people are employed to offer formal support to their peers.¹³⁷ They also described a commitment to engaging formally and informally with the detained men in their care.
- 8.28 These kinds of practices could be expanded and formalised to actively seek out views from the detained population about IRCs and how they could be changed.

¹³⁷ [SER000193], § 14.0.

- 8.29 Elsewhere, and rather more ambitiously, the Howard League for Penal Reform designed a program called ‘UR Boss’ which involved young people in custody and in the community in a campaign for change in the criminal justice system.¹³⁸
- 8.30 A similar campaign could be run with people in detention, to identify what they believe are the most important issues that need changing.
- 8.31 I am aware that such suggestions are likely to be practically difficult; since the detained population are often transient and so it will be difficult to generate consistent interactions. Similarly, language barriers and vulnerabilities will be hard to overcome.
- 8.32 One response would be to work alongside and in partnership with advocacy organisations like GDWG, who have years of experience working with detained people and, therefore, will have a strong sense of their needs and views. Additional organisations in the community may also be potential resources.
- 8.33 There will be other problems too, as organisations and individuals may simply not wish to work together with the Home Office or the private contractors.
- 8.34 However, it seems to me that one of the key challenges that the evidence has brought to light is how to overcome what Mr Tulley refers to as an ‘us and them’ mentality.
- 8.35 It was this hostile view of the detained population which, in 2017, was so corrosive. It was that view too, Mr Shaw noted in 2005 that “can become a breeding ground for racist and abusive word and deed.”¹³⁹
- 8.36 Reading the Oakington report for the purpose of this supplementary report is instructive. Not only are there many similarities between the two sets of events but also, as with Shaw’s report, the response to the events in Brook House has, thus far, focused on matters relating to policy and practice and to staff culture.
- 8.37 Many of the recommendations made by Mr Shaw in 2005 continue to be relevant and insightful.
- 8.38 However, the similarities between the two events raise uncomfortable questions, not least of which is whether racism or violence can ever be fully eradicated from these kinds of institutions; and if not, whether these institutions can ever be completely safe or legitimate.
- 8.39 At the time of writing, I understand that Brook House is operating at around 25% of its capacity, but with a full staff complement.

¹³⁸ Jennie Fleming. *Use your situation to change your destination: Evaluation for the Howard League for Penal Reform’s UR Boss Summary*. Available at: <https://howardleague.org/wp-content/uploads/2016/03/URBoss-summary-final.pdf>. Accessed 19 January 2022.

¹³⁹ [INQ000109], p. 3.

- 8.40 The size and kind of the population detained at any one time is not decided by the private contractor; those decisions rest with the Home Office.
- 8.41 The situation at Brook House, were the numbers detained to rise again, is impossible to predict.
- 8.42 In any case, a small population can also be highly vulnerable, as the IMB detailed in their reports of 2019 and 2020.
- 8.43 Instead, and although I am conscious that I am veering outside the remit of this Inquiry and my instructions, I would like to end this supplementary report in response to the evidence I have consulted as I began, by urging a bold response to the events that occurred in Brook House during the relevant period.
- 8.44 The pandemic has radically changed the scale and nature of detention practices in the UK, yet the same buildings and security logic remain in place.
- 8.45 Rather than risk a return to the events that occurred in 2017 and before that in 2005 in Oakington, or indeed in 2004¹⁴⁰ and 2015¹⁴¹ in Yarl's Wood, the small numbers detained along with the close scrutiny of this Inquiry present an opportunity to work with stakeholders across the sector to develop a non-custodial mechanism for managing people whose immigration case has come to an end and who face removal or deportation from the UK.

¹⁴⁰ S. Shaw. (2004). *Investigation into Allegations of Racism, Abuse and Violence at Yarl's Wood Removal Centre*. London: Prisons and Probation Ombudsman. Available at: <https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkjhkjmngw/uploads/2015/11/special-yarls-wood-abuse-031.pdf>

¹⁴¹ K. Lampard and E. Marsden. (2016). *Independent investigation into concerns about Yarl's Wood immigration removal centre*. London: Verita. Available at: <https://www.verita.net/wp-content/uploads/2016/04/Independent-investigation-into-concerns-about-Yarls-Wood-immigration-removal-centre-Serco-plc-Kate-Lampard-Ed-Marsden-January-2016-1.pdf>