BROOK HOUSE INQUIRY

CLOSING SUBMISSIONS ON BEHALF OF
HER MAJESTY'S INSPECTORATE OF PRISONS (HMIP)

Introduction

1. The Inquiry has identified five central questions or issues for determination in order to fulfil its Terms of Reference.[1] The first is to establish the extent and severity of the mistreatment at Brook House Immigration Removal Centre (**IRC**) between April and August 2017 (the **Relevant Period**). Secondly, the Inquiry will examine the extent to which policies, practices, staffing and management arrangements at Brook House caused or contributed to any identified mistreatment. Thirdly, the Inquiry will assess the adequacy of the safeguards designed to detect mistreatment. This assessment includes an examination of the complaints system, and Home Office monitoring and oversight of Brook House, including the role of the Professional Standards Unit and the adequacy of the contractual framework. It will also include analysis of Her Majesty's Inspectorate of Prisons' (**HMIP**) inspection of Brook House (which took place between 31 October and 11 November 2016). Fourthly the Inquiry will examine what changes have been made in response to the Panorama documentary. Finally, the Inquiry will ascertain whether those changes were adequate or need to be improved upon.[2]

2. These Closing Submissions on behalf of HMIP will address the third, fourth and fifth issues, insofar as they relate to HMIP, and are arranged as follows:
    a. The role played by "inspection" generally as a safeguard to protect against mistreatment;
    b. The 2016 HMIP Inspection of Brook House in particular;

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[1] Brook House Scope Determination 6 January 2021, §2
[2] Ibid., §§3-4.

c. The changes in methodology that have been made following the Panorama programme; and

d. Potential further improvements which may be made in due course.

3. HMIP invites the Inquiry, having heard and considered the evidence, to draw the following conclusions:

a. **First:** Independent inspection is an essential and effective safeguard to detect abuse. In this case it was delivered by a professional inspectorate that is committed to and effective in improving outcomes for persons held in detention.

b. **Secondly**: In light of the sparsity of the evidence and also some significant differences between the conditions at Brook House in November 2016 and in the Relevant period, the Inquiry cannot safely find that HMIP 'missed' a culture or sub-culture of abuse or mistreatment as seen on Panorama during the 2016 inspection. For the same reasons, there is no proper basis to find that there was a failure in the adequacy of inspection as a mechanism to detect mistreatment in 2016.

c. **Thirdly:** There are important and relevant findings which were made by HMIP in the 2016 report which should have been properly considered and actioned by the establishment and the Home Office. Inadequacy in response or implementation – if found – is not a failing of HMIP or inspections more generally.

d. **Fourthly:** The Inquiry can confidently conclude that HMIP is a learning organisation, which is responsive and continues to proactively improve its processes, methodology and reporting. In the wake of the Panorama programme, HMIP reacted promptly to the possibility it might have missed important matters during the 2016 inspection and made sensible and meaningful enhancements to its methodology which have and will continue to enhance its abilities to detect concerns during inspections. HMIP is considering the evidence that the Inquiry has heard and will carefully consider the findings in due course with a view to whether any further changes may be made to enable it to further its aim of improving outcomes for detained persons.

Inspection: a safeguard to detect mistreatment

4. Her Majesty's Chief Inspector of Prisons (HMCIP) has duties and powers set down in statute to inspect various places of detention. These include the duties to inspect immigration removal centres, and to report to the Home Secretary on the treatment of detained persons and conditions in removal centres.[3]

5. Further, the United Kingdom is a signatory to the United Nations Optional Protocol to the Convention on Torture (OPCAT). The objective of OPCAT is to *"establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment".*[4]

6. OPCAT requires signatories to establish a "National Preventative Mechanism" (**NPM**) which is one of several visiting bodies for the prevention of torture and other cruel, inhuman or degrading treatment or punishment.[5] The UK NPM was established in March 2009 and currently comprises 21 members including HMIP. OPCAT also sets out a number of minimum powers and the unfettered access that visiting bodies must have.

7. Dr Hindpal Singh Bhui, in his live evidence, was asked what was the "purpose" of an inspection. He replied:

> *"I think it has multiple purposes. You know, one of the most important is to make sure that nothing is hidden; that what at goes on inside immigration detention is open to public scrutiny; and that the views of detainees, the experiences of people in detention are publicised. It is also about improvement. It is making sure that if centres aren't doing well enough in terms of keeping people safe, providing respectful conditions, providing enough activities and providing enough support for them, that those things are highlighted and they have an opportunity to improve on the areas where we think they are not doing well enough."* [6]

[3] Prison Act 1952 s.5A (2), (3), (5A) and (5B)
[4] Article 1
[5] Article 3
[6] Hindpal Singh Bhui 24 March 2022 108/2-14

8. It can readily be seen that these practical purposes tie in with the purpose of inspections as set down in OPCAT. That HMIP is independent of – separate to – those whom it inspects is of central importance.

9. "Inspection", and its place within the range of safeguards, must be properly understood. It follows from the detail of the Inquiry's 'third question' (explained above) that the Inquiry appreciates the distinction between the arrangements within Brook House, oversight by the Home Office, and the role of external oversight bodies. However, it is important and bears exposition.

10. The **first** stage of 'oversight' is local management – in this case by G4S and the Home Office. These bodies are responsible for the day to day running of the centre, including complying with – that is, meeting – individual Detention Centre Rules and procedures and policies within the centre. They are responsible for ensuring *compliance* in ways such as training, guidance, systems, management and supervision and so on (the adequacy and success of which, the Inquiry is investigating).

11. At the **second** stage of oversight, the Home Office and G4S are also responsible for *monitoring* that compliance, including but not limited to Home Office contractual monitoring. Again, the Inquiry is investigating the adequacy of this form of oversight, as part of its 'third question'.

12. The **third** stage is internal audit. This is the provision of *assurance*. The Inquiry will no doubt consider the extent to which this was being done and the effectiveness of governance structures within the Home Office and G4S.

13. HMIP's role sits beyond, outside, these three stages. It is wholly independent of the organisations it inspects and its function is not one of ensuring compliance with rules or regulations. Rather, HMIP undertakes regular inspections of immigration removal centres and reports on the treatment of detained persons and conditions in those centres as judged against its own human-rights-based Expectations of appropriate conditions for detained persons.[7]

[7] HMIP Expectations criteria (September 2012) – HMIP000644 00006 (see Introduction)

14. HMIP is not a substitute for the three stages of internal oversight – which are essential. It is not the role of HMIP (or other external oversight bodies) to do the job that should be done through the prior stages of compliance, monitoring and assurance set out above. In this regard the Inquiry may consider it significant that, in his live evidence, Peter Neden of G4S accepted that there was overreliance by G4S on external reports to keep people safe at Brook House.[8]

15. Although not a substitute for proper management and internal oversight and assurance, inspections by HMIP are an important part of the process of external oversight. As explained by Dr Bhui, HMIP's role, in essence:

> *"... is to do occasional deep dive inspections, to provide a good systemic analysis of what's happening in the institution, and then we pass that information over to others."*[9]

16. HMIP does this by bringing in an experienced and professional team of researchers and inspectors. They have a range of relevant specialisms and expertise and draw from their different, complementary backgrounds and experience.[10] They decide what they will look at, including the paperwork and procedures in the centre. They set out, in a number of ways, to hear the voice and find out the experiences of those held in detention centres. The inspectors have total access and considerable experience and know-how. If they pick up evidence of an issue or problem – e.g. from intelligence, or a disclosure in an anonymous survey or a confidential interview – they then follow it through.

17. HMIP's approach to the evidence, known as the triangulation method, is described in the 2016 report:

> *"Five key sources of evidence are used by inspectors: observation; detainee surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering*

[8] Peter Neden 22 March 2022 56/15-24
[9] Hindpal Singh Bhui 24 March 2022 120/18-21
[10] HMIP000685 0015-0018. An examination of those inspectors carrying out the 2016 Brook house Inspection shows the range of backgrounds – which, notably and meeting a concern raised by Professor Bosworth, are not all from a prison background: cf Professor Bosworth 29 March 2022 137/16-138/1; see also Hindpal Singh Bhui 24 March 2022 111/1-23

and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments."[11]

18. As Dr Bhui explained in his live evidence, this method – triangulation – does not simplistically mean that information is only accepted if it is verified by multiple sources and otherwise discarded or ignored. Rather, triangulation is about taking information received or obtained and seeing whether it is supported or verified by other sources, thereby strengthening the conclusion drawn from the information. As Dr Bhui put it: "*All 'triangulation methodology' really is, is making sure that you have looked for as much evidence as possible to back up a finding*".[12]

19. Aiming to verify information by multiple sources is a strength of the process. It gives HMIP's reports the rigour which means that they ought to be taken very seriously. Moreover, single voices are not ignored or discounted: they can still form the basis of a conclusion where appropriate and they prompt enquiry and follow up and contribute to the overall assessment even if a specific finding is not able to be made. They are included in the process of feeding back to managers throughout inspection and may appear in the final report.

20. For inspections to act as a safeguard, it is important that HMIP reaches robust, well evidenced conclusions. There are two core reasons:

    a. First, HMIP expects inspected establishments to act on its findings. The Inspectorate needs to be able to assure those inspected and the public that its conclusions are sound and solidly based, and therefore should be acted upon. To drive change, HMIP's reports must be seen as authoritative.
    b. Secondly, there is little value in a report which does nothing more than recount the various information it has obtained.[13] Without a systemic analysis of the evidence and clear findings, a report is less likely to be understandable by the public, less likely to be acted upon by institutions and ultimately, less likely to improve outcomes for detained persons.

[11] HMIP Report following 2016 inspection – CJS000761 0010 at para A8
[12] Hindpal Singh Bhui 24 March 2022 168/15-18
[13] Hindpal Singh Bhui 24 March 2022 169/6-8

21. Further, it is not a weakness that HMIP does not have enforcement powers. In his evidence, Dr Bhui explained that HMIP had been involved in the past in the enforcement of recommendations, but the consequence was lost independence.[14] Independence is essential for effective oversight. If HMIP is required to enforce its recommendations there is a real danger of the erosion of its independence from those inspected. A failure to provide for a system of independent inspection is also incompatible with the UK's responsibilities under OPCAT. Rather, if a concern is raised by the Inspectorate, the answer to it must come from those responsible for the management, running, compliance and oversight of the establishment. The inspection report provides a detailed analysis of the state of an IRC. It is then for the contractor and the Home Office to consider it and take any appropriate action.

22. In his live evidence, Steve Hewer of Serco stated that if concerns were raised by HMIP,

> *"We would, again, address the concerns ... we would take appropriate action to address any concerns that HMIP had within Brook House."*[15]

Leaving aside the application of this in practice, the Inquiry may consider that this is a description of how the system is supposed to work.

23. Therefore:
    a. It is not a weakness of inspection that inspectors strive to support findings with multiple sources. It is a strength. This method gives the reports authority and demands a proper response to the inspectorate's findings.
    b. It is not a weakness that inspections only occur periodically – the role is not one of day-to-day monitoring or oversight, but of deep and thorough inspection during a window by a wholly independent body. External day-to-day monitoring is also a valuable safeguard, but one which offers different insights. It is provided by other bodies.
    c. It is not a weakness that HMIP does not have enforcement powers. Rather, enforcement responsibility would interfere with HMIP's essential and fundamental independence from those inspected.

[14] Hindpal Singh Bhui 24 March 2022 184/13 to 185/1
[15] Steven Hewer 1 April 2022 139/22 to 140/6

24. In summary: the safeguard HMIP inspections provide is a strong and valuable one. Inspections are capable of driving real change and improvements in the circumstances of persons who are detained, but they must be used appropriately by contractors and the Home Office. It would be wrong to treat as 'limits', 'weaknesses' or 'flaws' of *inspection*, matters which are outside the inspection: that is, matters which are the responsibility of others.

25. This does not mean that HMIP does not find it frustrating if its recommendations are not meaningfully acted upon. Dr Bhui made that clear in his evidence. But this does not make HMIP recommendations "futile" or expose a "limitation" of inspections. It is a failure of *implementation*.[16] The inspection report provides a detailed analysis of the state of an IRC. It is then for the contractor and the Home Office to consider it and take any appropriate action.

26. Thankfully, in the usual case HMIP recommendations are *not* ignored. For the most part they are accepted and taken seriously by establishments and this leads to improvements. In addition, HMIP reports provide a rich source of information to the public and non-governmental organisations, who can themselves use the evidence in the reports and HMIP's recommendations to seek to bring about improvements.

27. These factors together demonstrate the value and importance of independent inspection as a safeguard against ill treatment.

HMIP 2016 inspection of Brook House

28. The Inquiry has indicated it intends to analyse the 2016 HMIP inspection of Brook House. HMIP welcomes this. Whilst the Inquiry will no doubt study the whole report, HMIP draws out the following significant features.

[16] This process was discussed in the live evidence of Philip Riley 4 April 88/2-17

Brook House in 2016

29. In approaching any question as to what HMIP should or should not have discovered in November 2016, it must be acknowledged that the inspection took place some 5 months before the beginning of the Relevant Period. Inspection, by its nature, provides an insight to a particular window of time. In this regard it is important to note there is at least one key difference between the conditions at Brook House in November 2016 and in the Relevant Period: staffing levels.

30. In the period from September 2016 to April 2017, staff from neighbouring Tinsley House were relocated to Brook House.[17] The Home Office witness Michelle Smith confirmed that there were **no** understaffing days as judged against the contract minimums in October and November 2016[18], and *"it was only on the re-opening of Tinsley House did the staffing hours become a problem."*[19] This was more than a matter of just meeting contracted levels: Steve Skitt of G4S confirmed that staffing in the 2016 window was: "*very high as you essentially had two centres worth of staff working at one centre*".[20] Callum Tulley's notebooks, whilst mentioning a feeling of hostility in the centre, acknowledged many of the consequences of understaffing were absent from the centre in the window running up to the inspection, recording on 10 October 2016 that this was *"somewhat softening the impact"* of the Brook House population increase.[21] In his live evidence in Phase 2, he confirmed that there was *"undoubtedly"* more staff on duty at Brook House whilst Tinsley House was closed.[22]

31. Dr Bhui was challenged by Counsel to the Inquiry as to why the report did not include a finding that there was a lack of staff. He did not agree that such a finding should have been made, explaining that, as to understaffing: "*I think almost certainly, in my view, it would*

[17] At this time Tinsley House was closed for refurbishment: see Tinsley House 2018 report – HMIP000686 0007
[18] Michelle Smith 23 March 2022 156/10-18
[19] Michelle Smith 23 March 2022 135/20-24
[20] SER000455 0013 at para 43 refers to the period Tinsley House was closed for refurbishment: "*During this time, the staffing levels at Brook House was very high.*"
[21] BBC000068 0003
[22] Callum Tulley 9 March 2022 148/23 to 149/5

have emerged quite strongly from other evidence if that was a big concern at the time we inspected".[23]

32. Understaffing *also* wasn't a feature of the window running *up to* the inspection: the relative high level of staff had been in place since the September. At the time of the HMIP inspection, the average length of detention in Brook House was 48 days and 78% of detainees had been in the centre for less than 2 months.[24] This means that the great majority of those detained in Brook House at the time of the HMIP inspection would have not known anything other than the higher, Tinsley House-supplemented staffing numbers. The 22% who had been in Brook House longer had still benefitted from higher staff levels and the advantages this brought for a number of weeks before inspectors arrived.

33. The difference in staffing levels is important. The Inquiry has heard evidence from numerous witnesses setting out in detail the consequences of understaffing: activities could not be opened, courtyards stayed shut, everyday queries and requests from detained persons – for cleaning products or paper or any other small thing – went unanswered.[25] This increased levels of tension amongst detained persons, which was itself capable of triggering incidents of aggravation or apparent aggression.[26] Such incidents drew staff time and attention and thereby exacerbated the cycle as staff numbers and time were yet further reduced. Staff too were caught in this cycle – the Inquiry heard a great deal of evidence about tiredness, frustration and short fuses amongst the staff consequential upon the understaffing situation.

34. As to this, Owen Syred stated in his written evidence that staff shortages left staff feeling *"overwhelmed"*, *"undervalued"* and *"absolutely worn out"* and it *"negatively impacted on the welfare of detainees, including the mental health of detainees, because of the lack of staff available to listen."*[27] In his live evidence, he stated that short staffing impacted

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[23] Hindpal Singh Bhui 24 March 2022 150/3-15. Notwithstanding the relatively high staff levels at the time of the Inspection, the report nonetheless mentions that staff were still "*under pressure*" and "*busy*": HMIP Report following 2016 inspection: CJS000761 0031 at para 2.5

[24] HMIP Report following 2016 inspection – CJS000761 0027 at para 1.68; see also 0067 (table of statistics concerning length of time at the centre)

[25] E.g. Daniel Small 28 February 2022 120/24 to 123/4; Edmund Fiddy 7 March 2022 158/15 to 160/12; Daniel Lake 1 March 2022 11/24 to 12/17

[26] E.g. Ryan Bromley 7 March 2022 89/2-7

[27] INN000007 0033 at paras 135-136

"[g]reatly" on the ability of staff to care for detained persons.[28] Further, Nathan Ward stated in live evidence that because two of the fears of staff are being alone or isolated, and being attacked, if staff find themselves in a centre with low staffing levels, they *"move very quickly into a "fight or flight" mode of working"*.[29]

35. As a result, whilst staffing levels are not the only important factor, the higher staffing levels at the time of the 2016 inspection in all likelihood contributed to the information which HMIP obtained, including during group interviews, at which detained persons described relationships with staff as a *strength* of the centre.[30] Likewise, 77% of detainees surveyed said that staff treated them with respect – increasing to 84% amongst those who did not speak English.[31]

36. Overall, therefore, there are good reasons to conclude that the higher staffing levels at the time of the 2016 inspection meant the centre was in a better state, affecting positively the data received by HMIP and the evidence accrued in respect of (most obviously) the safety of and respect for detained persons, as well as activities. This undermines the suggestion that HMIP 'missed' a sub-culture of abuse active in November 2016, or that inspection is (in conjunction with other safeguards) an inadequate safeguard to detect such abuse.

Understanding the report following the 2016 inspection

37. All HMIP reports include a summary of an establishment's performance against the model of a 'healthy establishment'. The four tests of a healthy establishment are:[32]

> *Safety: that detainees are held in safety and with due regard to the insecurity of their position;*
> *Respect: that detainees are treated with respect for their human dignity and the circumstances of their detention;*
> *Activities: that the centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees;*
> *Preparation for removal and release: that detainees are able to maintain contact with family, friends, support groups, legal representatives and advisers, access information*

[28] Owen Syred 7 December 2021 17/13-21
[29] Nathan Ward 7 December 2021 153/14 to 154/10
[30] HMIP Report following 2016 inspection – CJS000761 0015 at para S13 and 0031 at para 2.4
[31] HMIP Report following 2016 inspection – CJS000761 0057
[32] HMIP Report following 2016 inspection – CJS000761 0009 at para A3

about their country of origin and be prepared for their release, transfer or removals. Detainees are able to retain or recover their property.

38. Against each of these healthy establishment tests in 2016, Brook House received the assessment that "outcomes for detainees are reasonably good against this health establishment test". It is very important to understand what this means. This phrase does not mean "*the centre was reasonably good*". Rather, this assessment or score is defined in the report itself, as follows: "*There is evidence of adverse outcomes for detainees in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place*".[33]

39. The Inquiry may properly conclude that this description of the centre is justified by the evidence accrued by HMIP in 2016, and has not been undermined by the evidence before the Inquiry. The Inquiry will note that at the time HMIP declined to view the centre more favourably than could be supported by the evidence it had obtained.[34]

40. Attention has been given to the fact that the HMCIP at the time of the 2016 Inspection, Peter Clark, described the 2016 inspection as an 'encouraging' one. This comment should not be divorced from its context. This positive sentiment reflects the progress which Brook House had made since opening. In his written evidence, Owen Syred, who first worked at Brook House in 2009, stated that in 2010 Brook House was a *"dreadful place"* and he remembers that at that time HMIP inspectors did not feel safe.[35] Dr Bhui explains in his second written statement that in the 2010 inspection report, Brook House received the worst possible rating for safety ('poor') and was assessed as 'not sufficiently good' for all other tests. In the 2013 report the preparation for release test was assessed as 'not sufficiently good'.[36] This history makes clear that things were found to be better at the time of the inspection in 2016 compared to earlier inspections, and this is the context in which the phrase 'encouraging' is to be understood.

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[33] HMIP Report following 2016 inspection – CJS000761 0009 at para A4
[34] HMIP000148
[35] INN000007 00004 at para 15
[36] HMIP000697 0005-0006 at para 16; HMIP 2013 report – HMIP000311 0017 (at para S28); the 2010 report does not appear to be in the disclosure (though the conclusions from that report are partly but not fully included within the 2013 report at 0074 and 0075)

41. Within the report, the four sections dealing with each of the four healthy establishment tests contain "*a detailed account of our findings against our [Expectations]*"[37]. A proper reading of the report shows it to be packed with important detail and information. This should have been carefully considered, reviewed and actioned by the establishment and the Home Office. HMIP has therefore been disappointed to have heard witnesses for organisations with responsibility for compliance, monitoring or governance refer to HMIP as somehow having given Brook House a 'clean bill of health' following the 2016 inspection.[38] It should not have been possible to read the 2016 findings and conclude Brook House had no work to do.

Some key findings made in the report following the 2016 inspection

42. There are a number of key findings which were made by HMIP and set out in the report following the 2016 inspection which the Inquiry may consider are significant when evaluating the conditions at Brook House during the Relevant Period.

43. **Firstly**, the physical environment at Brook House. There has been considerable evidence from witnesses at all levels about the physical environment at Brook House. The Inquiry will no doubt consider whether and to what extent this environment was a relevant factor in respect of such mistreatment as it concludes has taken place. If the Inquiry finds that it is a relevant factor, it is important to note (particularly when assessing the effectiveness of inspection as a safeguard) that HMIP has consistently been highly critical of the physical environment at Brook House.

44. In the 2013 report, it was stated that: *"Despite efforts to soften the environment, the centre continued to look and feel like a prison"* [39] and a recommendation was made that *"[p]lans to soften the environment should be implemented across the centre"*.[40]

[37] HMIP Report following 2016 inspection – CJS000761 0011 at para A11
[38] E.g. Benjamin Saunders 22 March 2022 113/8-11 described it as *"a very positive report on the whole"*.
[39] HMIP000311 0014 at para S12; see also 0015 at para S14 and 0033 at para 2.1
[40] HMIP000311 0033 at para 2.8; see also 0058 at para 5.36

45. The introduction to the report following the 2016 inspection stated: *"The residential units very closely resembled the conditions found in prisons, and these were exacerbated by poor ventilation and unsatisfactory sanitary facilities"*.[41]

46. Further, within the key findings it was stated: *"The residential units remained stark and impersonal in design. Apart from paintings by detainees, the environment had not been softened. Many cells lacked curtains and many in-cell toilets were not curtained off. Many cells had ingrained dirt, especially in toilets, and those on C wing were in the worst condition. The lack of ventilation was the most common complaint, and many cells were too stuffy overnight."*[42] The condition of the residential units led to a concern and recommendation in the report.[43]

47. Dr Bhui underlined the significance of these recommendations in his evidence, explaining that Brook House: *"… is a centre which looks and feels like a prison, and it is designed like a prison. As we have said many times, that's inappropriate for a detainee population."*[44]

48. **Secondly**, the proposal to introduce 60 additional beds at Brook House. These 60 additional beds were in use at Brook House in the Relevant Period, and the Inquiry has heard evidence to the effect that the increase in the numbers of detained persons alongside the pressure on staffing was significant and causative of an array of problematic conditions within the centre in 2016. These beds were not in use in 2016 at the time of the HMIP report, although they had been fitted. The decision to approve their use would not be made until January 2017.[45]

49. HMCIP Peter Clark stated, in the introduction to the report following the 2016 inspection, that the proposal to bring third beds installed in two-person cells into use: *"has the potential to adversely affect the conditions in which some detainees are held"* and that inspectors

[41] HMIP Report following 2016 inspection – CJS000761 0005
[42] HMIP Report following 2016 inspection – CJS000761 0015 at S15
[43] HMIP Report following 2016 inspection – CJS000761 0018 at S36
[44] Hindpal Singh Bhui 24 March 2022 154/4-7
[45] As shown by CJS0074084 (signed Service Provider Change Request dated 25 January 2017); see also evidence of Jeremy Petherick 21 March 2022 67/21 to 68/11

shared the view of many staff and detainees that it would lead to a decline in living standards.[46]

50. As to this, Dr Bhui explained that a formal recommendation was not appropriate because the change had not happened:

> "*As third beds were installed but not yet being utilised, we had no evidence regarding the impact of a third bed on the experiences of detainees. No recommendation was made because inspections do not make recommendations about potential future outcomes, only about evidenced current outcomes.*"[47]

But this was a caution in stark terms. It is hard to see how, at that stage, HMIP could have put its concern about the prospect of bringing those additional beds into use more clearly or prominently.[48]

51. **Thirdly**, HMIP also reached important conclusions concerning the use of force. These were far from a 'clean bill of health'. A number of findings were made, including:

    a. Uses of force had increased in the 6 months up to the inspection window, as compared with the 6 months running up to the 2013 inspection;[49]
    b. Force was used proportionately and as a last resort in *"most"* (but not all) cases;[50]
    c. Echoing evidence given to the Inquiry by Jonathan Collier, HMIP inspectors found that video footage revealed mixed practice;[51]

[46] HMIP Report following 2016 inspection – CJS000761 0005
[47] HMIP000697 0006 at §18
[48] Hindpal Singh Bhui 24 March 2022 172/15-22; 173/6-10.
[49] HMIP Report following 2016 inspection – CJS000761 0025 at 1.52
[50] HMIP Report following 2016 inspection – CJS000761 0025 at 1.52
[51] It may also be significant that Prison Service Instruction 04/2017, concerning the use of body worn cameras, came into force on 20 March 2017 (after the 2016 inspection): see Jonathan Collier 30 March 2022 14/12-25. This means there may have been less video footage available to HMIP inspectors than was available to Mr Collier and the Inquiry more generally when investigating the Relevant Period. Moreover, it is noted that, in his first report, Mr Collier states that body-worn video cameras did not appear to be utilised during many incidents that he reviewed but that in circumstances where the policy was only introduced in 2017, it was *"acceptable"* that there was *"a degree of confusion as to their use"*. He recommends that a policy or operating procedure on this should be produced, or alternatively PSI 04-2017 should be enforced – see INQ000111 0151.

d. Some incidents took too long to resolve once force had been initiated. A description was given of an inappropriate use of force (the use of a shield to retrain a passive detainee);[52]

e. Video footage also revealed that waist restraint belts may not have been used as a last resort by Tascor;[53] and

f. A use of force observed during the inspection itself was described as "*chaotic*".[54]

52. These findings led to a recommendation by HMIP that "*all use of force should be necessary, proportionate and competently applied*".[55] This recommendation was made because it was the view of the inspectors that this was not always happening at Brook House in November 2016, as Dr Bhui confirmed in his live evidence.[56]

53. The report also noted as to governance that managers reviewed all incidents to learn and disseminate lessons,[57] which was described as "*very good*".[58] At this distance, little more detail is available within HMIP as to the exact systems which were in place at Brook House during the inspection period as opposed to the Relevant Period. However, the Inquiry has heard that improvement of use of force governance had been a focus for Lee Hanford during his period as director in 2016 (March to July)[59] and that use of force matters were often escalated to SMT and other specific leadership team meetings.[60] These matters may indicate that governance processes deteriorated subsequent to the HMIP inspection.

54. Dr Bhui was asked whether HMIP might have missed evidence of abuse in light of the contents of the anonymous detainee survey.[61] The survey in the report following the 2016

[52] HMIP Report following 2016 inspection – CJS000761 0026 at para 1.53
[53] HMIP Report following 2016 inspection – CJS000761 0026 at para 1.54
[54] HMIP Report following 2016 inspection – CJS000761 0026 at para 1.54
[55] HMIP Report following 2016 inspection – CJS000761 0026 at para 1.58
[56] Hindpal Singh Bhui 24 March 2022 133/15-19
[57] HMIP Report following 2016 inspection – CJS000761 0026 at para 1.52
[58] HMIP Report following 2016 inspection – CJS000761 0013 at para S1
[59] Lee Hanford 15 March 2022 106/3 to 107/12 (also described in his witness statement); see also CJS00495 – SMT minutes from 30 March 2016
[60] As evidenced in the following SMT meetings: CJS000462 (minutes from August 2016, querying a late use of force submissions); CJS000583 (minutes from October 2016, detailing a use of force review for Tinsley House); CJS000580 (minutes from December 2016, again querying missing use of force reports, and noting an increase in uses of force)
[61] Hindpal Singh Bhui 24 March 2022 186/18-188/7

inspection included the responses from four detained persons that they had been physically assaulted by a member of staff. This is a piece of information to be taken seriously. But that survey result is not sufficient to found a safe conclusion that there was a culture or sub-culture of abuse of the type seen on Panorama. In particular, some of those persons may be describing what were, in fact, lawful uses of force – the survey responses alone do not provide enough information for a firm conclusion. Rather, what these responses provide is an important prompt for further research and enquiry.

55. **Fourthly**, in relation to healthcare, the report following the 2016 inspection raised important concerns. First, Rule 35 reports *"... did not provide an adequate safeguard for detainees with post-traumatic stress disorder (PTSD)"* and it was recommended that *"[w]here a detainee claims they have been tortured, the Rule 35 report should include an assessment of PTSD ..."*.[62] This concern about Rule 35 reports was then followed up in the 2019 report, which also highlighted further concerns about the failure to complete Rule 35 reports.[63]

56. Further, the report also raised concerns and made recommendations about the need to carry out a health needs assessment and develop a centre health and well-being strategy;[64] the requirement for regular clinical audit;[65] about the healthcare complaints system compromising medical confidentiality[66] and in relation to the need for reasonable access to translated information about health services and health and well-being.[67]

57. It is a matter for the Inquiry to assess the adequacy of the response to these important concerns and whether these warnings were properly heeded, in light of its wider findings about healthcare during the Relevant Period.

58. Fifthly, the Inquiry has also heard considerable evidence of the problem of drug misuse at Brook House during the Relevant Period, particularly in relation to synthetic cannabinoids

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[62] HMIP Report following 2016 inspection – CJS00076 0028 at para 1.71 and 0029 at para 1.80 (see also 0013 at para S1)
[63] HMIP Report following 2019 inspection – HMIP000674 0014 see 1.19, 1.21, 2.65, S9 and S43
[64] HMIP Report following 2016 inspection – CJS000761 0036 at paras 2.27, 2.38 and 2.40
[65] HMIP Report following 2016 inspection – CJS000761 0036 at paras 2.35 and 2.41
[66] HMIP Report following 2016 inspection – CJS000761 0036 at paras 2.37 and 2.42
[67] HMIP Report following 2016 inspection – CJS000761 0036 at para 2.38 and 2.43

(e.g. 'spice'). Here too the report following the 2016 inspection raised relevant concerns, stating that the supply and misuse of drugs was *"the most significant threat to security, and there was evidence of the organized criminal supply of drugs"*. However, Brook House did not have a drug and alcohol strategy.[68] A specific recommendation was made in that regard.[69] A warning about drug use in these terms should have provided a clear warning to senior management of the extent and seriousness of the issue.

59. **Finally**, Dr Bhui was also asked about a small number of other areas where, candidly, he accepted that findings might have been more critical, or would now have been more critical. These were in respect of reporting detainee feedback more strongly in relation to healthcare and complaints,[70] whether the specific criticism which HMIP made in 2019 about the lack of Rule 35 (1) and (2) reports might also have been made in the report following the 2016 inspection ,[71] and whether it was too positive to describe half of the staff having received mental health training as "commendable".[72] He accepted these points. You may conclude that this is good evidence of HMIP's ongoing intention to improve. But these observations do not undermine the overall validity of the 2016 report.

Unannounced Inspection

60. The 2016 inspection of Brook House was unannounced, as the report itself makes clear.[73] However, Mr Tulley was understandably concerned that the centre may make improvements in the period between knowing of the inspection (i.e. its commencement in week one) and the full team arriving in week two. In this regard, Dr Bhui emphasised that the co-ordinating inspector arriving at the beginning of week one will look around the establishment immediately upon arrival, *"see it as it is"*, and take pictures, talk to staff, and

[68] HMIP Report following 2016 inspection – CJS000761 0025 at para 1.46 and 0039 at para 2.61
[69] HMIP Report following 2016 inspection – CJS000761 0039 at para 2.65
[70] Hindpal Singh Bhui 24 March 2022 169/24 to 170/17
[71] Hindpal Singh Bhui 24 March 2022 165/2 to 166/2
[72] Hindpal Singh Bhui 24 March 2022 166/3-19
[73] HMIP Report following 2019 inspection – HMIP000674 0001. It is noted that a question was raised by Callum Tulley concerning whether 2016 inspection was in fact "*unannounced*". It appears to HMIP that there has been a simple confusion arising from the fact that week one of an inspection involves an initial walk around inspection and is researcher-focused, whilst the 'full' inspection team arrived in week two, as explained by Dr Bhui in his evidence: Hindpal Singh Bhui 24 March 2022 116/22 to 117/3. It is of note that no other witness suggests there was any prior or unusual notice of the inspection. Moreover, Ben Saunders stated in live evidence that he had no experience of anyone knowing that HMIP would turn up before they first arrived: Ben Saunders 22 March 2022 113/19 to 114/16.

see detainees,[74] to be able to give the full team a good summary of the main concerns, and the emerging issues which would need to be looked at in more detail.[75]

61. Further, Dr Bhui explained that the experienced team of inspectors are used to seeing improvements made during the inspection, and it wouldn't cause any radical change to judgements. As he stated: "*there is a lot of wet paint around when we come back for our second week. And we just have to factor that into our assessments and make sure we don't give too much credit for something which has only happened in the last few days*".[76]

62. Moreover, the inspectors are mindful of the possibility of cover up. As Dr Bhui explained: "*... that's one of the reasons why we have a deep dive into records and into, you know, all of the available information that we can find, to see if things are being covered up or things are being presented as being more positive than they really are.*"[77]

63. HMIP's multi-source and triangulation method is a strength here: discrepancies between sources of information prompt investigation and enquiry. HMIP is not simply reliant on records, or what it is told by senior leadership, but follows leads and looks under the surface.

The changes made following the Panorama programme

64. As Dr Bhui explains in his first statement, following the programme HMIP reviewed its methodology with a view to whether it could increase the likelihood of identifying individual incidents of mistreatment and systemic risks in IRCs.[78] This led it to introduce its enhanced methodology to all inspections of IRCs. Detailed evidence concerning these changes and how they came about is set out in Dr Bhui's witness statement,[79] together with evidence concerning the careful review of their efficacy which followed.[80]

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[74] Hindpal Singh Bhui 24 March 2022 118/2-18
[75] Hindpal Singh Bhui 24 March 2022 110/22-25
[76] Hindpal Singh Bhui 24 March 2022 118/21 to 119/3
[77] Hindpal Singh Bhui 24 March 2022 120/2-11
[78] HMIP000685 0034 at para 97
[79] HMIP000685 0035-0040 at paras 98-101
[80] Hindpal Singh Bhui 24 March 2022 194/23 to 196/4; see also review documents HMIP000671 and HMIP000672

65. The enhancements to the methodology were designed to encourage greater engagement, and so obtain more information, from detained persons, staff and third-party organisations. There is now a greater opportunity for detained persons and members of staff to tell inspectors in confidence about concerns over safety or treatment.

66. **First**, every detained person is now offered an interview with an inspector, using interpretation where needed. This opportunity is also extended to persons who were recently detained at the centre in question.[81] As Dr Bhui explained in his live evidence: "*we offer every single detainee an interview … we have no systematic way of ensuring that every person who is vulnerable speaks to us. But … they have certainly got the opportunity to come forward. We identify people through other means as well. So, for example… the safeguarding inspector might identify someone through a rule 35, and we might make a point of going to speak to that person …* ".[82]

67. **Secondly**, all staff are now given the opportunity to respond to an anonymous survey that they can complete outside the establishment, and where staff identify themselves, follow up discussions and interviews may be arranged. This allows HMIP to better identify problems in leadership, staffing levels, morale and culture – which may affect outcomes for detained persons. In view of the evidence concerning the difficulty that staff faced in coming forward with concerns, the Inquiry may well consider the anonymous staff survey to be a valuable tool in assessing the state of affairs at an IRC.

68. **Thirdly**, NGOs are now proactively contacted by inspectors at the outset of inspections and expressly invited to contribute information and put detained and formerly detained persons with whom they are in contact in touch with HMIP inspectors. Systematic contact with NGOs strengthens flows of communication and intelligence, assists in giving leads to follow and further works to ensure that the voices of detained persons are heard by inspectors.

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[81] HMIP000685 0036 (stated that NGOs are contacted to request that formerly detained individuals with whom they are in contact speak to HMIP) and 0046 (stated that two ex-detainees were interviewed as part of the 2019 inspection)
[82] Hindpal Singh Bhui 24 March 2022 189/17 to 190/4

69. Overall, HMIP's enhanced methodology provides greater opportunities for inspectors to identify potential concerns. HMIP believes the enhancements improve its ability to detect any culture or sub-culture of abusive practice. These changes were designed and driven by HMIP and were already in place by mid-October 2017, and before HMIP was interviewed for the Verita Report. The Inquiry may consider that HMIP reacted commendably swiftly to Panorama. In his evidence in Phase 1, Nathan Ward stated that HMIP was *"the only organization, following Panorama, to actively want to learn … and sit down, which we did and we met following that Panorama"*.[83]

70. HMIP invites the Inquiry to conclude that these improvements, and its overall response to Panorama and this Inquiry are appropriate and sufficient. In addition, HMIP has continued to research and consult on methodological improvements across the body of its work.

71. A relevant and important example is the introduction by HMIP of a focus on leadership when undertaking inspections. In his witness statement, HMCIP Charlie Taylor stated that a change will be made to specifically consider this in view of the importance of good leadership of an IRC to outcomes for detained persons.[84] HMIP's increased focus on leadership since the inspection in 2016 was also discussed by Dr Bhui in his live evidence, who stated: *"we look in some detail at leadership and whether leaders are enabling staff to look after detainees properly, and that includes, of course, having enough experienced staff and people – and having enough people on the ground to do the job. So I think this would come out more now than it did in 2016 and I think, to that extent, that our methodology has developed since that time."*[85] The proposals for consultation are set out in a recent document in the documentary disclosure.[86]

72. Most recently, HMIP has consulted on changes to the ways in which it makes recommendations. The proposed change is explained in the relevant HMIP proposal paper in the documentary disclosure, and, in essence, the suggestion is to replace around 30 recommendations per inspection with a smaller number of "key concerns".[87] These concerns will still identify what must be resolved by the establishment and the Home

[83] Nathan Ward 7 December 2021 197/8-11
[84] HMIP000683 0005-0006 at para 14
[85] Hindpal Singh Bhui 24 March 2022 131/11-23
[86] HMIP000639
[87] Hindpal Singh Bhui 24 March 2022 206/6-9

Office, and an action plan will be required that sets out exactly how and when the identified problems will be remedied. As Dr Bhui explained in evidence, the idea is to reduce the scope for inspected establishments to claim success in responding to recommendations when they have just picked off 'low hanging fruit'.[88] The new "key concerns" would all be important matters, and demand action. But the body of the inspection report will still remain replete with other information which establishments will be expected to study carefully.

73. These recent changes demonstrate HMIP's commitment to improving its approach and continuing to build on its learning and expertise, wherever this is possible. It again supports a conclusion by this Inquiry that the improvements which have been made are appropriate and strengthen the effectiveness of its oversight.

Further improvements

74. HMIP has engaged fully with this Inquiry in the same productive and proactive way it responded to the Panorama broadcast. As explained by HMCIP in his written evidence, and demonstrated by the examples drawn out above, HMIP is a learning organisation which is committed to improvement wherever possible.[89] The evidence within the Inquiry provides four further examples which demonstrate HMIP's ongoing willingness to develop best practice.

75. **Firstly**, the receipt of intelligence. Under the enhanced methodology HMIP now proactively approaches NGOs and advocacy groups ahead of inspections to ask for information and to help make contact with those who may wish to speak to the Inspectorate. HMIP also makes clear that it is willing to receive intelligence and information outside of inspections. However, it is accepted that more could be done here to ensure HMIP more consistently receives information which might be relevant to (a) assessing when a further inspection is required of a particular place of detention, and (b) informing enquiries and findings during an inspection. As has been indicated already, HMIP will continue to reflect

[88] Hindpal Singh Bhui 24 March 206/17 to 207/9
[89] HMIP000683 0003-4, 0010 and 0012

on what information – and in what form – would be most useful to it to achieve those aims, and would of course be willing to engage with the Inquiry further on this point if required.

76. **Secondly**, the voice and reported experience of the detained person. The triangulation methodology and its value has been explained. But this does not mean that the voice of detained persons should not be clear from the report. Dr Bhui candidly expressed his view that there was value in giving more space to this within the healthcare sections of the report, stating in live evidence that *"in future, we are thinking of … making a change which has more … maybe rather than a line or two, maybe has a paragraph explaining exactly what detainees have told us, and then going on to explain why we either agree with those findings or why we can't find the evidence and what our overall conclusion is."*[90] The Inquiry can therefore be confident that work in this regard is already in hand.

77. **Thirdly**, Professor Bosworth has suggested that HMIP might have a role in the training of DCOs. Whilst it would not be appropriate for HMIP to be involved in management or oversight of DCO training (or have any involvement which might harm HMIP's independence), Dr Bhui confirmed that HMIP will reflect on whether DCO training can be considered as part of its thematic work, provided that it does not involve managerial-type oversight of training, as this would interfere with HMIP's independence.[91] This is a matter HMIP can take forward independently.

78. **Finally**, HMIP will consider whether the evidence presented during the inquiry can form useful training case studies for its own inspectors, particularly in relation to reviewing use of force incidents and assessing the effectiveness of Rule 35 reports.

79. **Overall**, therefore, well before the Inquiry commenced, HMIP responded swiftly and proactively to Panorama and made a number of sensible improvements to its methodology. These were designed, in particular, to examine the culture and sub-culture in a removal centres during inspections. The changes have already been the subject of internal review and HMIP continues actively, and of its own accord, to consider and make improvements to its methodology. Should the Inquiry consider more is needed, HMIP will listen carefully and engage actively.

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[90] Hindpal Singh Bhui 24 March 2022 169/24 to 170/17
[91] Hindpal Singh Bhui 24 March 2022 205/6-16

Conclusion

80. Independent inspection is an essential and effective safeguard to detect abuse. The inspection of Brook House IRC in October/November 2016 was delivered by a skilled and professional inspectorate, committed to and effective in improving outcomes for persons held in detention. HMIP made findings and recommendations which should have been acted on to make improvements. In the wake of Panorama, HMIP reacted promptly to the possibility it might have missed something during the 2016 inspection – making sensible and meaningful enhancements to its methodology. HMIP is considering the evidence that the Inquiry has heard and will carefully consider the findings in due course with view to whether any further changes may be made to enable it to further its aim of improving outcomes for detained persons.

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