BROOK HOUSE INQUIRY

CLOSING STATEMENT ON BEHALF OF THE INDEPENDENT MONITORING BOARD

Introduction

1. This Closing Statement is made on behalf of the Independent Monitoring Board ("IMB").

2. Over the course of eleven weeks, this Inquiry has exposed the shocking truth of life within the Brook House Immigration Removal Centre in April – August 2017. It has provided an important opportunity for formerly detained persons to speak openly about their experiences whilst at Brook House. In addition, the Inquiry has heard evidence from those who worked at or attended Brook House during the relevant period. The Inquiry has posed fundamental questions about how the immigration detention system operated in 2017 and continues to operate today.

3. This Inquiry offers an opportunity not only to cast light on the reasons for the appalling treatment in one immigration removal centre, but also to reshape the immigration detention system in a way which better promotes humane and decent treatment for those living within it.

4. The IMB has provided assistance to the Inquiry in the form of detailed witness statements, oral evidence from the immediate past chairs of the Brook House IMB, and a substantial amount of disclosure including rota reports from the regular visits conducted by IMB members, meeting minutes and annual reports. In addition, current and former IMB members have attended and have watched the evidence online throughout the public hearings. As explained below, in light of what emerged during the BBC's *Panorama* programme and the subsequent investigation by Kate Lampard and Ed Marsden, the IMB both at Brook House itself and at national level reflected on what had occurred and why the abuse and mistreatment which was revealed had not been identified. This resulted in action by the IMB at Brook House to re-focus the monitoring role, and at national level to provide additional support and training for members in the immigration detention estate. The IMB remains committed to learning from the events at Brook House and the conclusions of this Inquiry.

5. This Closing Statement is structured as follows:

    a. The IMBs' statutory basis, the National Chair and Management Board.
    b. The mistreatment and abuse which the Inquiry has revealed is reprehensible and inexcusable.
    c. The IMB was not unique in not identifying the abuse and mistreatment of the kind shown on *Panorama*.
    d. Mistreatment and abuse were hidden and not reported.
    e. There were barriers to reporting experienced by detained persons themselves.
    f. The role and function of the IMB.
    g. The 2017 annual report.
    h. The criticism that the IMB lacked independence is misplaced.

i. The present and future.
j. Recommendations.

The IMBs' statutory basis, the National Chair and Management Board

6. The Inquiry has previously received evidence from Dame Anne Owers as to the IMB's statutory basis and the relationship between the individual Boards appointed by the Secretary of State for each immigration removal centre and the national governance provided by the National Chair and Management Board (previously a President and National Council).[1]

7. As Dame Anne explained in her first statement, members of the Brook House IMB, like all members of the IMBs for immigration removal centres, are appointed by the Secretary of State pursuant to s.152 of the Immigration and Asylum Act 1999. That legislation refers to 'Visiting Committees.'

8. Board members are unpaid public appointees. They are appointed for three-year terms, renewable for a maximum of 15 years. Each Board elects a Chair and Vice Chair, who are approved by the Secretary of State. Each Board is a separate statutory entity, although in practice local Boards and their members are supported by the national Secretariat and guided by strategies and policies agreed in the national governance arrangements. However, those national arrangements do not at present have a statutory basis, and this has been acknowledged as necessary in order to effectively support the work of Boards and their members.

9. IMBs are members of the UK's National Preventative Mechanism ("NPM") under the United Nations' Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("OPCAT"). OPCAT recognises that people in detention are particularly vulnerable and requires States to set up a national level body that can support efforts to prevent their ill treatment. IMBs are one of the 21 organisations designated by the UK Government to be part of the UK's NPM.

10. During the relevant period, the Brook House IMB comprised nine members.[2]

The mistreatment and abuse which the Inquiry has revealed is reprehensible and inexcusable

11. As the Brook House IMB said in its 2017 annual report, it was horrified by the behaviour shown in *Panorama*. In the Executive Summary, the Board wrote:[3]

> "The IMB was horrified at the completely unacceptable behaviour of the small group of staff shown in the footage. We have never witnessed instances of ill-treatment of this kind, nor have we had any indications that it might be happening. If we had, we feel confident that we could have taken our concerns immediately to the top management of G4S and the Home Office at the Centre. The Board has regularly reported on, or discussed with management, the other issues focussed on in the programme."

[1] See Dame Anne Owers' first statement: IMB000199_0001-0013, §§2 and 5-37.
[2] See Dame Anne Owers' first statement: IMB000199_00038, §38.
[3] Brook House IMB 2017 annual report: VER000138_0004.

12. As the then chair of the Brook House IMB explained:[4] the members of the Brook House IMB had not observed mistreatment or abuse themselves, nor had they any indications that it might be happening. Centre staff did not report it to the IMB nor did detained people themselves (or other individuals or organisations which had contact with the detained population). If Board members had observed such mistreatment or received such reports, they would have reported it straight away and gone as high as necessary to ensure that appropriate action was taken.

13. However, it is now apparent that the mistreatment and abuse within Brook House was even more widespread than was shown on *Panorama*. The conduct which this Inquiry has revealed is reprehensible and inexcusable. That mistreatment and abuse includes:

    a. The physical abuse of detained persons through the inappropriate and unjustified use of force.
    b. The use of coarse and offensive language towards and about detained persons and staff.
    c. The use of racist and misogynistic language towards and about detained persons and staff.
    d. The apparent glorification of casual violence.

14. The Inquiry has uncovered a culture amongst Brook House staff and management that failed to secure the safety and basic dignity of detained persons. That culture went well beyond isolated incidents by a small number of staff.

15. The causes of this culture are complex. The Inquiry has received evidence on the issue from, amongst others, Professor Mary Bosworth. As stated below, since the broadcast of the *Panorama* programme, the IMB has monitored staff culture more closely.[5]

16. The IMB notes Counsel to the Inquiry's Note regarding the suggested approach to findings of fact under art.3 of the European Convention on Human Rights. The IMB does not make any submissions on the approach commended, save to repeat what was submitted during the IMB's oral closing statement: there can be no doubt that, in light of the evidence which the Inquiry has heard, at least some formerly detained persons were subjected to treatment that was inhuman and degrading. Some behaviour went well beyond even that.

17. The Inquiry has considered evidence as to the circumstances in which the men at Brook House were detained and whether those circumstances were abusive. The IMB endorses the approach adopted by Counsel to the Inquiry when questioning Callum Tulley.[6] During that evidence Mr Tulley agreed with Counsel to the Inquiry that mistreatment might be considered to arise in three ways:

    a. First: the deliberate acts of physical and verbal abuse of the kind shown on *Panorama*;
    b. Second: the harms caused by the nature of the immigration process, including the uncertain length of detention; and

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[4] See Jackie Colbran's statement: IMB000204_0002, §4.
[5] See Mary Molyneux's first statement: IMB000203_0053-0054, §§149-152 and Dame Anne Owers' first statement: IMB000199_00019, §59 and 0026, §§79-82.
[6] Callum Tulley 30 November 2021 56/16-57/1.

c. Third: the impact of the physical environment or conditions of detention.

18. The Inquiry Chair may also consider this to be a useful paradigm for the purposes of analysing what took place at Brook House.

19. In its 2016 and 2017 annual reports, the IMB reported on and raised concerns about the harms caused by the nature of the immigration process and the impact of the physical environment and conditions of detention. As discussed further below, whilst the IMB's 2016 and 2017 annual reports were broadly positive, it is wrong to read them as raising no issues about the safety of the Centre or the treatment of detained persons during those respective reporting years. In addition, IMB members raised concerns through their rota reports (which were sent to G4S and the Home Office) and monthly Board meetings (which were attended by senior managers from G4S and the Home Office).

20. However, it is now clearly apparent that the IMB – along with other oversight bodies and the on-site Home Office contract monitors – did not identify and prevent the abuse and mistreatment of the kind shown on *Panorama* and which the Inquiry has further exposed.

21. As Dame Anne Owers accepted in her first statement: it is entirely fair and understandable to question how the abuses uncovered during the *Panorama* programme were not identified by the IMB themselves.

22. In her first report, Professor Bosworth stated that, whilst "the sentiment" of what the IMB said in its 2017 Executive Summary was welcome and important, she considered it "does not address the lingering questions about why and how the committee were unaware of the issues occurring in the centre they visited so regularly."[7]

23. Professor Bosworth's criticisms of the IMB – in particular the contention that the Brook House IMB in 2017 "was not fully independent" – are addressed below. However, with respect to Professor Bosworth, it is overly simplistic to think that the reason why the IMB did not identify the abuse and mistreatment was because the Board had "a shared culture with officers" and was not "fully independent."[8] It is overly simplistic because:

    a. The IMB was not unique in not identifying the abuse and mistreatment by Centre staff of detained persons. The abuse and mistreatment was not identified by other individuals and organisations whose independence from G4S and the Home Office have never been questioned.
    b. It ignores the substantial evidence which the Inquiry has uncovered of Centre staff hiding and not reporting the abuse and mistreatment.
    c. It does not recognise the barriers which appear to have existed which resulted in detained persons themselves not reporting the abuse and mistreatment to the IMB.

[7] Professor Mary Bosworth's first report: INQ000064_0052, §10.33.
[8] Professor Mary Bosworth's first report: INQ000064_0052, §10.33.

The IMB was not unique in not identifying the abuse and mistreatment of the kind shown on *Panorama*

24. The Inquiry has received evidence from members of the G4S senior management team and the Home Office including its local contract monitors as to their knowledge of the abuse and mistreatment at Brook House. The IMB notes and endorses the point made on behalf of Her Majesty's Inspectorate of Prisons ("HMIP") during its oral closing statement as to the various stages of oversight, and the distinction between the arrangements within Brook House and the role of external oversight bodies. It was said:[9]

> "It follows from your approach that you appreciate the distinction between the arrangements within Brook House and the role of external oversight bodies but that distinction is important. The first stage…is local management, here by G4S and the Home Office. They are responsible for day-to-day running of the centre, including complying with individual Detention Centre Rules and processes and policies within the centre.
> They are responsible for ensuring compliance in familiar ways, the adequacy and success of which you are investigating, such as training, guidance, systems, management, supervision and so on. At the second stage, the Home Office and G4S are also responsible for monitoring that compliance, including Home Office contract monitoring and, again, chair, you are investigating the adequacy of that form of oversight. The third stage is internal audit. This is the provision of assurance. You will no doubt consider the extent to which this was being done and the effectiveness of governance structures within the Home Office and G4S.
> HMIP's role sits beyond 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. As you know, HMIP undertakes regular inspections of immigration removal centres and reports on the treatments of detained persons and conditions in those centres as judged against its own human-rights-driven expectations for appropriate conditions for detained persons."

25. The Inquiry has considered in some detail the 2017 report by HMIP following an unannounced inspection of Brook House in the autumn of 2016.[10] As Dr Hindpal Singh Bhui explained in his first statement:[11]

> "While there were some causes for concern in our 2016 survey and other findings, as recorded in the 2016 report, HMIP did not find evidence of the type of behaviour shown in the 2017 Panorama documentary."

26. It might be said that HMIP's inspection regime offers only a 'snapshot' of life within an immigration removal centre, and therefore that comparisons between HMIP and the IMB are misplaced. However, the Inquiry has heard from others who attended Brook House and / or had interactions with detained persons and they, like the IMB and HMIP, did not identify abuse and mistreatment of the kind shown on *Panorama* and further revealed

[9] Oral closing statement on behalf of HMIP 6 April 2022 13/11 – 14/16.
[10] Report of an unannounced inspection of Brook House Immigration Removal Centre 31 October – 11 November 2016: HMIP000613.
[11] Dr Hindpal Singh Bhui's first statement: HMIP000685_0034, §97.

during the Inquiry. Nor did they receive reports from detained persons that abuse and mistreatment had or was occurring. The following evidence is of significance:

a. Anton Bole of the Forward Trust:
   i. During the relevant period Mr Bole was the team leader of the substance misuse team (a separately contracted external organisation) within Brook House. He and his two colleagues delivered 1:1 sessions, group work, drop-ins and face to face inductions to all new arrivals.[12]
   ii. Mr Bole was not aware of physical or verbal abuse of the kind shown on *Panorama*.[13]
   iii. In his first statement, Mr Bole explained:[14]

> "85. I did not hear rumours of such incidents at the time.
> 86. I have been asked why I think that detained persons were not raising concerns with Forward Trust.
> 87. Such activities may have been hidden and done secretly. Officers are always polite. Abuse may have been happening behind closed doors when I was not present. The Substance Misuse Team does not attend operational incidents and this is usually when abuse happened. No reports of abuse by residents were made to me. I consider this was probably due to concerns about repercussions for those who made whistleblowing disclosures.
> 88. Additionally, it is possible that residents did not raise any issues with us as to achieve a level of trust in the short time working with us is hard and would put them in a vulnerable situation as well. Abuse could intensify even more if information was leaked and had come to the attention of abusive officers."

b. Dr Dominic Aitken:
   i. During the relevant period Dr Aitken was an academic who visited Brook House as part of his research for a DPhil. From 26 June to 27 July 2017, Dr Aitken spent 3-5 days per week in Brook House, typically from 9.30am to 5.30pm.[15]
   ii. Dr Aitken was "granted relatively unrestricted research access during my time in Brook House, especially when doing informal observations. I carried keys (but no radio), which permitted me to move around the centre freely… Considering that Brook House is a secure environment, I felt that I had been given a great deal of freedom as an external researcher."[16] He spoke informally with detained persons during his visits to residential units, courtyards etc.[17]
   iii. It is clear that Dr Aitken was shocked by the *Panorama* programme.[18]

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[12] See Anton Bole's first witness statement: FWT000001_0003, §§15 and 17.
[13] Anton Bole 8 December 2021 180/12 – 181/5.
[14] Anton Bole's first witness statement: FWT000001_0015-0017, §§85-88, 90 and 95.
[15] See Dr Dominic Aitken's first statement: INQ000094_0001, §5.
[16] See Dr Dominic Aitken's first statement: INQ000094_0002, §10.
[17] See Dr Dominic Aitken's first statement: INQ000094_0006, §28.
[18] See Dr Dominic Aitken's 2017 blog post *'From the Field': Thoughts on BBC Panorama and Brook House IRC*: INQ000007_0002.

iv. Dr Aitken discussed the types of complaint which were made by detained persons.[19]

c. Jamie MacPherson of the Gatwick Detainee Welfare Group ("GDWG"):

i. Mr MacPherson was a volunteer visitor with the GDWG. During the relevant period he was paired with four detained individuals and visited Brook House twelve times.[20]

ii. As Mr MacPherson put it in his statement to the Inquiry:[21]

> "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."

iii. It was only after *Panorama* had aired that D191 (one of the detained persons with whom Mr MacPherson was paired) explained that he had been subjected to physical mistreatment and had made a complaint to the Home Office's Professional Standards Unit.[22] At §62 of his statement, Mr MacPherson explained:

> "As regular visitors to Book House, Volunteer Visitors get a general feeling of the centre and are well placed to gauge the atmosphere within the Brook House Centre. I am therefore unsure why the issue of mistreatment by Brook House staff was not picked up by the Volunteer Visitor community. I can only guess that detained people, who are under intense pressure and often very vulnerable, were concerned that reporting mistreatment to a Volunteer Visitor might lead to more mistreatment by detention staff or might harm their immigration case."

27. Whilst recognising that all of the above individuals had varying degrees of access to the Centre and to the detained population and that they did not have the same role as the IMB, a consistent theme in the evidence which this Inquiry has heard is that there was a lack of awareness of the abuse and mistreatment shown on *Panorama*. All of the above individuals had direct contact with detained persons during the relevant period. These were people external to, and independent of, the Centre and Home Office. It cannot realistically be said that Mr Bole (employed by the Forward Trust), Dr Aitken (a visiting academic) or Mr MacPherson (a volunteer visitor with GDWG) were insufficiently independent of either G4S or the Home Office. Plainly, they were independent of the Centre and its staff. And yet, they – like the IMB – did not identify the physical and verbal abuse and mistreatment shown on *Panorama*. The fact that all of these people and organisations were unaware of what was revealed indicates that the reasons why this abuse remained hidden are complex and multifactorial.

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[19] See Dr Dominic Aitken's first statement: INQ000094_0006-0007, §§30-32.

[20] See Jamie MacPherson's first statement: INQ000027_0012, §48.

[21] Jamie MacPherson's first statement: INQ000027_0014, §58. See also Jamie MacPherson 8 December 2021 222/10 – 223/1.

[22] See Jamie MacPherson's first statement: INQ000027_0014-0015, §§59-61.

Mistreatment and abuse were hidden and not reported

28. The Inquiry has received a substantial quantity of evidence which shows that mistreatment and abuse was hidden and not reported by Centre staff. Self-evidently, this makes the task of monitoring such behaviour difficult if not impossible. As Dr Hindpal Singh Bhui agreed, it is difficult to uncover behaviour that is being deliberately concealed.[23]

29. The Inquiry Chair is invited to bear in mind the following in particular:

    a. Callum Tulley gave evidence that abuse frequently occurred out of the sight of CCTV:
        i. During his evidence on 29 November 2021 he stated:

> "Much of the abuse would happen inside cells in which there were no cameras. So how you would substantiate any of your complaints would be very difficult unless you had other officers who would co-operate with you. But my experience was most staff were too scared to raise concerns."[24]

        ii. During his evidence on 9 March 2022 Mr Tulley further explained:

> "Q. From your experience, did excessive use of force take place in cells or rooms because they were hidden from fixed cameras?
> A. Yes, sir."[25]

> "Q. Second, was it the case that officers -- already you have hinted this, but I want to be sure about what your evidence is. Was it the case that officers used excessive force inside cells to avoid fixed cameras?
> A. Yes, sir.
> Q. In other words to hide what was going on?
> A. No doubt about that, sir, yes."[26]

    b. Inappropriate language was not used – for obvious reasons – in front of IMB members:
        i. Mr Tulley was asked about this:

> "Q. You mentioned a little earlier, of course, about the kind of abuse that was common -- "cunts" and perhaps other language, some such language. On the occasions when the IMB visitors arrived, and I think you saw them from time to time, and I will ask you a bit about that later, was that language tailored? In other words, were people far more polite and more careful around them, or did they use that language in front of IMB visitors or perhaps when the inspectorate turned up, or not? It

[23] Dr Hindpal Singh Bhui 24 March 2022 119/13-23.
[24] Callum Tulley 29 November 2021 113/14-20.
[25] Callum Tulley 9 March 2022 113/3-6.
[26] Callum Tulley 9 March 2022 124/15-21.

may be an obvious question with an obvious answer, but help us.
A. I was never aware of any abusive language or treatment being demonstrated in front of the IMB."[27]

ii. This accords with Jackie Colbran's evidence: "I never heard abusive language used by officers towards detained persons and officers were very respectful in their use of language in front of me."[28]

c. Uses of force were not reported. Paperwork was not completed or was completed inaccurately: The Inquiry has uncovered multiple instances, but see, for example:
   i. Callum Tulley's evidence about his conversation with Yan Paschali following the use of force on D1527.[29]
   ii. Stephen Webb's evidence about failing to complete an injury to detained person form, despite D191 having received an injury to his head.[30]
   iii. Sean Sayers' evidence about incomplete and inaccurate records in respect of D313 and D390.[31]
   iv. Daniel Haughton's evidence about the completion of documentation following the incident on 13 May 2017 involving D687.[32]
   v. Jo Buss' evidence about the use of force on D1527.[33]

d. Accounts provided in debriefs were inaccurate: See, for example, Steven Dix's evidence about a control and restraint incident involving D1978.[34]

e. Body-worn video was not activated or was obstructed: See, for example:
   i. Jon Collier's evidence about the use of force against D52.[35]
   ii. Jon Collier's evidence that the "main culprits" of not turning on body-worn video recordings were DCMs.[36]
   iii. The evidence of the former DCM, Stephen Webb.[37]
   iv. Daniel Haughton's evidence in respect of the use of force on 13 May 2017 against D687.[38]

f. Use of force was wrongly characterised as 'unplanned' with the result that it was not filmed: See, for example, Sean Sayers' evidence.[39]

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[27] Callum Tulley 29 November 2021 106/1-13.
[28] See Jackie Colbran's statement: IMB000204_0060 §180.
[29] Callum Tulley 1 December 2021 109/25 – 110/16.
[30] Stephen Webb 8 March 2022 165/9 – 166/7.
[31] Sean Sayers 10 March 2022 142/3-6 and 168/24 – 169/8.
[32] Daniel Haughton 16 March 2022 106/24 – 107/15.
[33] Jo Buss 14 March 2022 148/13 – 150/22.
[34] Steven Dix 9 March 2022 71/18 – 74/7.
[35] Jon Collier 30 March 2022 165/25 – 166/19.
[36] Jon Collier 30 March 2022 157/19 – 158/2.
[37] Stephen Webb 8 March 2022 169/8-12.
[38] Daniel Haughton 16 March 2022 106/24 – 107/15.
[39] Sean Sayers 10 March 2022 133/4 – 134/21.

30. In addition to the fact that abuse and mistreatment was hidden, there is clear evidence that there was a culture amongst staff of not reporting concerns about their colleagues either internally to senior management or to the IMB and other external bodies. For example:

    a. Callum Tulley described a hostility to raising concerns amongst Centre staff. This included the defacing of 'speak out' posters and IMB members being described – behind their backs – as "snitches." In his first witness statement, Mr Tulley said:[40]

        > "There was a visible hostility to raising concerns. I remember clearly how the 'speak out' posters - which notified staff of a confidential whistleblowing line for if ever they wanted to raise concerns - had the words "snitches", "grass" and "don't be a rat" written across them. These were posted in the men's toilets opposite the detainee shop, which were accessible only to staff. The IMB were also routinely described as "snitches" by members of staff."

    b. As a result, Mr Tulley said that he "never seriously considered blowing the whistle internally within G4S… whenever I considered it I had no faith that doing so would be anything other than fruitless":[41]

        > "The Detainee Custody Managers who were responsible for residential areas included those who I identify in this statement as involved in misconduct, or were so closely connected to them that I felt it was inevitable that any concern I raised would get back to them, and that I would be bullied, marginalised or ignored as a result. I also did not feel I was able to take my concerns above DCM level to the Senior Management Team, because they had close relationships with those DCMs responsible for the abuse of detainees. For example, Jules Williams, the member of the Senior Management Team who was responsible for the residential units in my early days at Brook House, was close friends with Graham Panel [sic]. Graham Panel told me on number of occasions that they socialised outside of work. I had no confidence any complaint I raised would be treated seriously."

    c. Owen Syred gave powerful evidence as to the consequences of reporting poor behaviour: messages were left on his locker door describing him as a "N- lover" and a "Grass." Within the wing office on C wing, a poster bearing Mr Syred's face was defaced with the word "Grass."[42]

    d. Nathan Ward explained the consequences he felt of speaking out against his colleagues:[43]

        > "I would say that they were acutely aware that, if you wanted to speak out against your fellow members of staff, you were going out on a limb and you would be isolated. And I think it was very brave of those that did speak up, but the simple fact that the majority of staff didn't speak

[40] Callum Tulley's first statement: INQ000052_0018, §74.
[41] Callum Tulley's first statement: INQ000052_0018, §75.
[42] Owen Syred 7 December 2021 120/3 – 121/11.
[43] Rev Nathan Ward 7 December 2021 189/21 – 190/3.

up is both an atrocity in its own right but also evidence that they were silenced by their own peers."

31. It would appear that, to at least amongst some Centre staff, external bodies such as the IMB were viewed with suspicion and distrust. Dominic Aitken said this in evidence:[44]

> "Q. Do you remember if you spoke to any of the staff about the kind of monitoring or visiting bodies?
> …
> A. I think occasionally members of staff would mention oversight bodies and I think typically -- from recollection, when staff spoke about them, their impression was that oversight bodies were very sympathetic to detainees and were perhaps not very understanding of how difficult their working lives were. So that -- but that was fairly brief when I had conversations with staff about that.
> Q. Just to be clear, I think I ran the two together. You said the impression was, perhaps, from the few you spoke to, they were overly sympathetic to detainees. I had mentioned both the IMB and Gatwick Detainee Welfare Group. Do you remember which, if either of those two, you're referring to?
> A. It probably would have been the Gatwick Welfare Group but I think it's fair to say they might have been lumped together."

32. This hostile view of the IMB reflects Mr Tulley's evidence about some staff routinely describing the IMB as "snitches" (see above).

33. The Inquiry has revealed evidence that unacceptable conduct and attitudes had become normalised within the staff at Brook House and that others, such as Mr Syred and Mr Ward, were targeted when they attempted to speak out.

34. It is clear from the evidence that, whilst abuse and mistreatment of detained persons had become normalised amongst some staff, there were nevertheless steps taken to conceal it from, amongst others, the IMB. It is in that context that the IMB's actions should be considered: the IMB did not turn a blind eye to what was happening. Instead, those responsible for the abuse and mistreatment took steps to prevent their actions from becoming known.

There were barriers to reporting experienced by detained persons themselves

35. The Inquiry has also revealed evidence that, from the perspective of the detained population and those who worked with detained persons, there were significant barriers to complaining or reporting concerns to the IMB and others.[45] The causes of those barriers are complex and are informed at least in part by the life experiences of those who find themselves detained by the State.

36. At times during the Inquiry, the systems for making complaints or applications to the IMB and complaints to G4S and the Home Office have been conflated. Hence, the Inquiry has heard many witnesses express dissatisfaction with "the complaints process." In most

[44] Dr Dominic Aitken 8 December 2021 67/20 – 68/15.
[45] The fact that detained persons did not report abuse and mistreatment of the kind shown in *Panorama* to Anton Bole, Dr Dominic Aitken and Jamie MacPherson is discussed above.

instances, the witnesses have not distinguished between the different complaints processes operated by G4S, the Home Office, Healthcare or the IMB. Some evidence is of general relevance. Some concerned the IMB alone. Bearing that in mind, the Inquiry has heard evidence as to the following:

a. A concern that if a complaint were made it might prejudice a detained person's immigration status or that they would otherwise be subject to reprisals.
    i. D313 said:[46]

> "I was too frightened to say anything anyway. I knew exactly what could happen when you got on the wrong side of one of the officers and I was too scared. I retreated into myself after I was assaulted and I did not want to raise too much of a fuss. I would have been too scared to speak out."

    ii. D2158 did not know how to complain, but "even if I had known, I would not have done it. I was too scared of something being done to me if I complained."[47]
    iii. D393 stated that he felt "very scared to make any complaints whilst detained at Brook House. When you are detained there, you do not know what you are facing. If you made any complaints at all, you needed to be very careful of what kind of complaints these were. I was very careful not to make any type of complaints against the people making decisions about my immigration status. This is because we all feared repercussions, mainly from the Home Office staff who were deciding our immigration cases. We were also cautious of Brook House officers finding out we had complained about them and retaliating."[48] In respect of the IMB, D393 said:

> "The only complaint I felt comfortable making to the IMB was about my possessions which had gone missing, in particular all my clothes and my £450 Armani watch which had been a gift from my wife. I felt that the IMB did not take my complaint seriously, saying there was nothing they could do about it."

    iv. Anna Pincus of the Gatwick Detainee Welfare Group explained that many people simply would not feel safe enough to complain:[49]

> "So the most important thing to someone in detention is what's going to happen to them in the future: how long they are going to be detained; whether they will be returned to their family; whether they will be returned to another country where maybe they fear for their safety. The people who make the decisions about that are the Home Office. People learn from a young age to be acquiescent to the people making decisions about their future. It would be like a child challenging a teacher. The stakes were so high for people they would tolerate a great

[46] D313's statement: DL0000233_0019, §85.
[47] D2158's statement: BHM000029_0010, §38.
[48] D393's first statement: DPG000023_0011, §41.
[49] Anna Pincus 9 December 2021 51/7-23.

> deal before they would wish to bring something to the attention of the Home Office and risk putting their head above the parapet and any reprisals. And I'm not saying there would be reprisals, but that was a very real fear that people had."

v. In addition, Ms Pincus described Centre staff telling detained persons either not to complain or to withdraw their complaint.[50]
vi. Rev Nathan Ward explained:[51]

> "So there were things in place to make them aware of that system. There was posters placed on their units, and there was complaint forms, I believe, in the 12 most common languages. However, it was the experience that they were worried that, by complaining, they would hamper their case, their immigration case and, therefore, there is that first-line deterrent of not complaining. But there's a second issue of, all the time you're in that closed environment, surrounded by the staff who you may want to complain about, there is no element of safety for you to complain against them until you're removed from that environment, and, therefore, there's a profound issue within the system just on that point alone…there's no physical obstacle, in the sense that the complaint forms were on the wings, they were able to take one, fill one out and place it in the locked box on the wing, which would be collected by Home Office staff. But, actually, psychologically, I would say, there were many obstacles to making complaints. If staff were fearful of making complaints, and they could go home at night, then we can't even imagine what it must be like for detainees to make complaints, who are unable to go home."

b. A lack of awareness of the IMB or its role.
   i. D2158 explained that he did not know how to complain.[52]
   ii. D790 said that he did not know how to make a formal complaint. He said that he had not heard of the IMB.[53]

c. The misconception that the IMB was part of the Centre management or Home Office.
   i. D687 said:[54]

> "115. The complaints system at Brook House was a waste of time. I tried to use it but had absolutely no faith in it. I was scared that if I made a formal complaint about an officer, they would find out and I would then suffer reprisals.
> 116. Even the IMB who were meant to be independent, they just did whatever G4S or the Home Office told them to. It was obvious. If you made a complaint to them, within a few days

[50] Anna Pincus 9 December 2021 61/6-23.
[51] Rev Nathan Ward 7 December 2021 192/2 – 193/2.
[52] D2158's statement: BHM000029_0010, §38.
[53] D790's statement: DPG000022_0012, §44.
[54] D687's statement: DPG000021_0039, §§115-116.

> you would have a response repeating back exactly what officers had said. Their mentality was, if an officer said it, it must be true. They would never make their own findings. There was no point in complaining to them as the outcome was already obvious — whatever G4S said."

ii. The perception of independence was an issue the IMB were alive to (see paragraph 37 below). However, the problem is a broader one. James Wilson of GDWG explained that even NGOs such as GDWG were regarded with distrust:[55]

> "If I might just add, what I think was definitely the case was a more general, pervasive sense of distrust. I think it's -- you know, clients put in indefinite detention and increasingly at this point in crowded rooms in desperate situations, I think it's reasonably understandable that clients would be -- people detained would find it difficult to know who to trust, find it difficult to know how to distinguish between who is, you know, a G4S representative versus who is an NGO, where do those sit. I think a generalised sense of, nobody is helping me was understandable and probably common."

d. Barriers as a result of language: D2077 said that he was not aware of the complaints process in Brook House: "Nobody made me aware of the existence of any process in my own language that I can remember".[56]

37. Some of these barriers were known to the IMB before the relevant period and steps had been taken to attempt to mitigate them. In her first statement,[57] Ms Molyneux explained:

> "47. Having listened to the evidence adduced by the Inquiry during the first phase of its hearing, it is clear that some of the formerly detained men were not aware of the IMB or were not aware of what we did whilst at the Centre. Communicating the IMB's role to the detained men is an important and necessary part of our function. It is a topic in some of our ATPRs, but I think that is an area which needs regular work and is one which we can improve on.
> 48. I think for those detained persons who did engage with the IMB at Brook House, the IMB worked effectively for them. This is evidenced by the number of formal and informal applications referred to within our rota reports and records of applications received. For example, in 2017 we received 123 applications requiring follow up (see page 25 of the 2017 Annual Report [IMB000135_0025]). In 2018 the board received 142 applications (see page 23 of the 2018 Annual Report [IMB000156_0023]). However, I recognise there were and still are barriers to reaching detained men. language can be a barrier, although the use of Big Word and translation tablets assist with this (though Wi-Fi issues do prevent them from operating at times).
> 49. I think it is highly likely that there were detained men who might not approach us about mistreatment even if they were happy to seek help on things

[55] James Wilson 10 December 2021 72/24 – 73/10.
[56] D2077's statement: DL0000226_0039, §158.
[57] Mary Molyneux's first statement: IMB000203_0015-0017, §§47-51.

such as lost property, access to healthcare, or the IT facilities. When men express concerns about complaining about the Home Office, I always try to reassure them that it will not have a prejudicial effect on their immigration status, although I can understand why some detained persons may be reluctant to report mistreatment due to a perception that doing so could negatively impact on their immigration status. In fact, I did during the Relevant Period and still do actively encourage men to put in formal complaints to G4S/Serco, the Home Office, or Healthcare if they have an issue that I cannot resolve for them. It is part of holding those organisations to account.

50. However, I also recognise that many men do not have confidence in the G4S/Serco or Home Office complaints process. In our annual report for 2021 the IMB will review how the complaints process is working in practice at the Centre and make a recommendation that the Home Office review it too. Among other things, it can take a month to receive a response from G4S/Serco (in which time the detained person may have left the Centre or been transferred) and the burden is on the detained person to make their case, even though they may not have strong English and may not know (or have access to) all of the details. I explain to men that the IMB (through the Chair) sees copies of the complaints against G4S/Serco and the Home Office and the responses by G4S/Serco which shows how they have investigated the complaint. We do not see responses to complaints made against the Home Office. Nor do we see complaints made against Healthcare or responses to these due to data protection legislation and patient confidentiality. While it is possible for a detained man to give us a copy of the complaint and response himself, I cannot recall this happening in my time on the IMB.

51. I am aware that in paragraph 12 of his witness statement [INQ000027], Mr Macpherson of GDWG says that, for those detained at Brook House, the IMB were perceived as being "a branch of G4S." I do not recall ever hearing this view about the IMB and G4S from the detained men I spoke to, but I accept that the IMB have always needed to work to reach detained men and ensure that they understand that this is not the case. This is particularly true of men who have not had experience of the prison system or other detention centres. While we do not wear uniforms, we do carry notebooks and keys to get around the Centre and, in this sense, we could well look like another 'official.' We cannot do without the keys, but on a number of times over the years the board has had discussions about whether we should carry radios (for safety reasons rather than for communication). The collective decision has always been that we should not as it would make us look even more like staff. So, it is not surprising that those detained men without experience of UK detention institutions might be distrustful of the IMB and believe that we are part of G4S or the Home Office. Because of this, one of my first remarks whenever a man asks who I am or what I do is to explain that we are not related to either G4S (now Serco) or the Home Office, and that we are independent. However, this is something that we are conscious will always require ongoing work."

The role and function of the IMB

38. As set out above, the members of the Brook House IMB (of which there were nine during the relevant period) were appointed by the Secretary of State pursuant to s.152 of the Immigration and Asylum Act 1999. Their duties are set out within the 1999 Act and the Detention Centre Rules 2001.[58] These are summarised within Dame Anne Owers' first statement at paragraphs 5-11 and 38-49.[59]

39. As members of the local community, IMB members are the public's eyes and ears within places of detention. As the 2021 National Monitoring Framework explains at page 10:[60]

> "Boards' regular presence in an establishment gives them a unique insight into the day to day experience of prisoners and detainees."

40. IMB members, who are a regular albeit not permanent presence, bring their varied life experiences to bear on what they see and find, to record the actual outcomes for those in detention.

41. Their reports form a crucial part of the civic dialogue concerning detention and the experiences of those who are detained. The point is well illustrated by the use made by the Inquiry, witnesses and other core participants of more recent annual reports by the Gatwick IMB (the successor to the Brook House and Tinsley IMBs). By way of illustration: see paragraphs 2.30-2.33 and 2.87-2.92 of Professor Bosworth's supplementary report[61] and the evidence of Dr Rachel Bingham and Theresa Schleicher of Medical Justice.[62] Dr Hindpal Singh Bhui of HMIP described IMBs as "a very important source of information."[63]

42. The work of IMBs complements but does not replicate the work of other members of the NPM, such as HMIP (whose inspectors conduct periodic in-depth inspections). As Professor Bosworth explained in her evidence, there is great value in having transparent and reliable information of what happens within closed environments such as Brook House.[64]

43. IMB members are charged with satisfying themselves as to the conditions and treatment of detained persons. They must report to the Secretary of State annually, and immediately if they find abuse. To that end, they have free access to speak privately to all detained individuals and see all documents (except for healthcare records, staff personnel records and certain classified information) held in the detention centre. They also receive complaints and requests from detained individuals.

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[58] Detention Centre Rules 2001: CJS006120_0001-0020.
[59] Dame Anne Owers' first statement: IMB000199_0002-0004 and 0013-0016.
[60] National Monitoring Framework (February 2021): IMB000189_0010.
[61] Professor Bosworth's supplementary report: INQ000123_0008, §§2.30-2.33 and INQ000123_0014-0015, §§2.87-2.92.
[62] See, for example, §150 of Dr Rachel Bingham's first statement: BHM000033_0059 which notes that the Brook House IMB has repeatedly raised concerns over mental health training from 2017 onwards. In her second statement, Theresa Schleicher extensively refers to and relies upon IMB reports at, for example, §§109-113: BHM000031_0041-0042.
[63] Dr Hindpal Singh Bhui 24 March 2022 123/11-12.
[64] Professor Bosworth 29 March 2022 77/14-17.

44. The IMB notes and agrees with John Wadham's observations at paragraphs 14-15 of his supplemental statement:[65]

> "14. The external oversight as outlined, offered by national and international bodies cannot alone prevent all ill-treatment occurring in detention. As identified by leading academics: *'It is not realistic to presume that one institution, whether that be the SPT at the international level, or the NPM at the national level, will be able to achieve this single-handedly. It needs to be placed within the broader context of factors that play a part'*.
> 15. This view is shared by the SPT itself and international guidance. The SPT states that: *'the prevalence of torture and ill-treatment is influenced by a broad range of factors, including the general level of enjoyment of human rights and the rule of law, levels of poverty, social exclusion, corruption, discrimination. International guidance states that: 'Visits themselves are not enough to prevent torture and other ill-treatment... [this] requires a range of legislative, administrative, judicial and other measures.'* It goes on to highlight multiple areas where action is needed including changes to public policies, effective procedural safeguards, adequate training of all officials involved in deprivation of liberty, that breaches of the law must be appropriately sanctioned, and that effective complaints mechanisms and media reporting all play a part."

45. Reflecting the point made on behalf of HMIP (see paragraph 24 above): external oversight is not and should not be treated or regarded as a substitute for the proper management of an immigration removal centre by the Home Office and those to whom the Home Office contract-out their duties. As Dame Anne Owers explained in her first statement:[66]

> "It should be remembered that IMB members are unpaid volunteers, with no executive or regulatory authority, and that in a well-run institution they should not be the first line of defence against abuses. Nevertheless, the IMB needs to ensure that its monitoring practice is alert to the possibility of abuse and the hints and signs that it may exist."

46. Boards do not have a regulatory role: they can alert managers to problems and can offer advice and recommendations to the Centre management, the Home Office or the Minister. However, they are not responsible for the running of the Centre or the oversight of contractual responsibilities (indeed, they are not even privy to the contract). They can alert those who are responsible, the Minister and department, to any concerns. They do so weekly, through their rota reports; monthly, in meetings with Centre and Home Office managers; periodically, to senior Home Office officials or Ministers where there are issues of particular concern; and annually in their annual reports.

47. Before addressing the criticisms which have been made of the IMB in 2017, it is important to set out the role and purpose of the IMB. It is important to do so because the evidence from certain witnesses to the Inquiry has revealed a significant misunderstanding of the IMB's role and activities. For example: Nathan Ward in his first statement where he referred to being "aware that the Director Ben Saunders used to take them out for lunch

[65] John Wadham's supplemental statement: NPM000002_0010, §§14-15.
[66] Dame Anne Owers' first statement: IMB000199_0022, §64.

regularly, which I felt was inappropriate."[67] This was addressed within Ms Colbran's statement at paragraph 41:[68]

> "I am aware that Reverend Ward in his evidence has said that, as Director, Ben Saunders would take IMB members out to lunch regularly. The IMB were never taken out to lunch by Ben Saunders or G4S in my time on the board. In fact, when I was having an induction session in January 2014 with my predecessor as Chair, Bobby Fairclough, she informed me that during her time as Chair the board had decided that even accepting G4S hospitality at board meetings was inappropriate. As noted above, members therefore paid a levy of £5 each to Aramark for the provision of sandwiches at lunchtime and this was reclaimed as IMB expenses in the usual way."

48. By contrast, IMB members were encouraged to, and did, have lunch with the detained men as this enabled the Board members to sample the food which was being provided, increased the visibility of the IMB and was an opportunity to gain a better understanding of the experiences of those who were detained.[69]

49. It was unfortunate, therefore, that Rev Ward's perception was put to Ben Saunders when questioned by Counsel to the Inquiry on 22 March 2022 without noting Ms Colbran or Ms Molyneux's evidence on the point.[70] However, Mr Saunders was clear: he did not take the IMB out to lunch. Rev Ward's allegation was (adopting Counsel to the Inquiry's word) a fiction. Mr Saunders did not believe his relationship with the IMB was inappropriate or compromised.[71]

50. Further, in her fourth statement Anna Pincus made the following recommendation about the IMB:[72]

> "GDWG recommend that on receipt of an 'application', IMB's first check response is not with officers but with the detained person who has submitted the application since this is a first step in demonstrating the listening necessary for the IMB to demonstrate independence from those running the IRCs and from the Home Office."

51. The source of the perception that the IMB would first approach officers rather than the detained person who made an application, is unclear. If that were the IMB's approach it would raise legitimate questions as to why: it may suggest a lack of trust in the detained person. If this view was held it may well explain at least in part why GDWG have expressed concerns about the IMB. However, it is a misplaced view and concern. Mary Molyneux was asked about this during her oral evidence:[73]

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[67] Nathan Ward's first statement: DL0000141_0109, §317.
[68] Jackie Colbran's statement: IMB000204_0015-0016, §41. At §29 Ms Colbran explains that IMB members would have their lunch before their monthly Board meetings in the Centre but with just IMB members present: IMB000204_0011, §29. See also §37 of Ms Molyneux's first statement: IMB000203_0012.
[69] See Jackie Colbran's statement: IMB000204_0016, §43 and Mary Molyneux's first statement: IMB000203_0012, §37.
[70] Ben Saunders 22 March 2022 147/3 – 149/11.
[71] Ben Saunders 22 March 2022 147/3 – 149/11.
[72] Anna Pincus' fourth statement: GDW000012_0020, §68.
[73] Mary Molyneux 25 March 2022 119/1-13.

> "I was surprised at that because the first step the talking to the man who's written it. I think I say that in my thing. You just -- even if it is a detailed app, and most of them aren't, you really need to go to him and just understand what his issues are. So I agree with it and we are doing it, yes."

52. These misunderstandings appear to have informed the impression by some that the IMB was not sufficiently independent of the Centre management. However, those impressions are plainly inaccurate.

53. More generally, however, the IMB recognises that the misunderstanding as to its role is at least in part because of the way in which some Board members summarised their role when interviewed by Kate Lampard and Ed Marsden. Professor Bosworth was asked about the quoted comments that the IMB were "monitors, really, rather than the resolvers of problems."[74] As Professor Bosworth put it, such a description oversimplifies the IMB's role.[75] The IMB agrees: it does oversimplify the IMB's role.

54. Ms Colbran addressed this exact point in her statement at paragraph 188.[76] She explained that the way she expressed herself during the interview with Ms Lampard and Mr Marsden was demonstrably inaccurate: she and the Board spent a considerable amount of time in Brook House resolving problems for detained people. As she puts it: "We saw that as a major part of our role." The context for the statement quoted in the Verita report is of course that the IMB are not managers, with responsibility for fixing problems: rather they are independent monitors whose role is to point out those problems to managers and follow up any concerns. The extent and nature of that work is evident in the material before the Inquiry:

    a. As the 2017 annual report shows: in 2017 the IMB received 123 written applications.[77] During rota visits, Board members dealt with a much higher number of concerns raised with them orally.[78]
    b. In 2017 Board members made 205 visits to Brook House.[79]
    c. The IMB's application log book[80] illustrates the number and variety of applications made to the IMB during the relevant period and the many and varied ways in which members went about solving problems for detained persons.
    d. In addition, the Inquiry heard how referrals are made between organisations such as HMIP. By way of illustration, Ms Molyneux was asked about an email sent to her by Dr Singh Bhui on 4 May 2018. She has provided a statement addressing the significant steps which she and the IMB undertook in response to this email.[81]

55. Within the papers there are many instances of Board members seeking to resolve problems for detained persons. By way of illustration only:

    a. Food and fluid refusal: In the first week of April 2017, after a call from the Oscar 1, Joyce Turner visited a detained person (D2159) who was refusing food and fluid.

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[74] Verita interview with Jackie Colbran and Dick Weber: VER000229_0011.
[75] Professor Bosworth 29 March 2022 133/1-11.
[76] Jackie Colbran's statement: IMB000204_0063.
[77] Brook House IMB 2017 annual report: VER000138_0025.
[78] See Dame Anne Owers' first statement: IMB000199_0024, §73.
[79] See Jackie Colbran's statement: IMB000204_0006, §14 and the 2017 annual report: VER000138_0024.
[80] Complaints log book: IMB000150.
[81] Mary Molyneux's second statement: IMB000217.

Ms Turner noted the case in her rota report, explaining that she was very concerned about him.[82] Ms Molyneux followed-up on his case the week after, highlighting the need for clarity on his care and a multi-disciplinary approach between G4S, the Home Office and Healthcare. She attended his doctor's examination and ACDT review and noted that his case was discussed at the morning meeting and a healthcare meeting and was a focus of both healthcare and the senior management team. She recorded that he was subsequently taken to hospital for a full examination.[83]

b. Delays to D812's Rule 35 report: In the week commencing 22 May 2017 Ms Colbran visited D812 who was on constant watch and, after he told her he had been in detention for 19 months, she went to speak to the Home Office about his case.[84] D812's case was discussed again at the July Board Meeting where concerns were expressed that his Rule 35 report had taken 7 weeks to get a caseworker decision.[85] Ms Colbran then raised the case with Alan Gibson at the July IDE Chairs' Forum and reported back at the August Board Meeting.[86] D812 was recorded as being released on 3 August 2017.[87] At the September Board Meeting Mr Gasson accepted that this case should have been escalated more quickly.[88]

c. Assisting D2462 with his Rule 35 report: Ms Molyneux noted in her rota report for the week commencing 10 April 2017 that D2462's Rule 35 report appeared to have been returned due to typos and poor grammar despite serious delays in his case.[89] She raised this as an issue at the April Board Meeting[90] and ask Mr Jones (who was next on rota) to obtain an update. Mr Jones reported back in his rota report for the week commencing 19 April 2017 that he had done so and had obtained a copy of the Rule 35 report.[91] An addendum to the April meeting minutes suggests that an updated report was passed to the Home Office caseworker on 21 April 2017.[92] The matter was raised again with Mr Gasson in the May 2017 Board Meeting when he advised that he had looked into it and that the processes were working.[93] Fearing that this might be a more systematic problem, the Board also raised D2462's case with Alan Gibson at the IDE Chairs' Forum (as explained by Ms Molyneux in her first statement).[94]

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[82] See Joyce Turner's rota report of 3 April 2017: IMB000059_0002.
[83] Mary Molyneux's rota report of 10 April 2017: IMB000055_0001-0002. The IMB's involvement in D2159's case is also discussed at §§126-130 of Jackie Colbran's statement: IMB000204_0042-0044.
[84] See Jackie Colbran's rota report of 22 May 2017: IMB000036_0002.
[85] See the minutes of the July 2017 Board Meeting: IMB000014_0002.
[86] See the minutes of the August 2017 Board Meeting: IMB000003_0001.
[87] See Mary Molyneux's rota report of 21 August 2017: IMB000032_0003.
[88] See the minutes of the September 2017 Board Meeting: IMB000026_0001. The IMB's involvement in D821's case is also discussed at §§77-78 of Mary Molyneux's first statement: IMB000203_0025.
[89] See Mary Molyneux's rota report for 10 April 2017: IMB000055_0004.
[90] See the minutes of the April 2017 Board Meeting: IMB000005_0003.
[91] See Gareth Jones' rota report of 19 April 2017: IMB000040_0001.
[92] See the minutes of the April 2017 Board Meeting: IMB000005_0003.
[93] See the minutes of the May 2017 Board Meeting: IMB000030_0002.
[94] Mary Molyneux's first statement: IMB000203_0023-0025, §§72-76.

d. Taking on a referral from GDWG in respect of suspected minor: In her statement, Ms Colbran explained:[95]

> "161. The IMB never failed to follow up a case referred to us by GDWG. This includes the case of D852, who was a disputed minor. On 4 August 2017, GDWG contacted the IMB about this case. In my recollection, I had already come across D852 on a visit to E Wing where he was being kept in a safer and more controlled environment while the Home Office decided what to do. I recall that it was considered safer on E Wing than in other locations within the Centre where it was believed other detained persons were taking advantage of him. I went to the Home Office to ask for information and was told that there was documentary evidence that he was not as young as he claimed to be and his allegation was considered to be false. The IMB, of course, had no additional evidence it could bring to bear on the dispute between D862 and the Home Office and there was no reason from what I saw to think that the correct procedures were not being followed in this case.
> 162. We kept the situation under review and his solicitor eventually obtained a court order for his release into the care of Social Services for an age assessment outside the Centre (this was discussed in the May 2017 board meeting). It was a sensitive case and we certainly could not share information given in confidence to us by the Home Office with GDWG while the case was under review though we could reassure GDWG. In fact, I told GDWG that there was documentary evidence but that social services were investigating which was the correct procedure, alerted the rota member to keep an eye on the young man, and received a nice thank you from GDWG for letting them know. His case was also raised in the May Board Meeting with senior managers and it was noted that he had been transferred to Tinsley House and then released into the care of Sussex Social Services."

56. More generally:

a. The Board raised concerns about the failure to complete F213 (injury to detained persons) forms. The issue was raised during the July 2017 Board Meeting.[96] This problem persisted and the IMB raised the topic for discussion again during the August and September Board Meetings when Mr Skitt on behalf of G4S notified the IMB that he had raised the problem with DCMs and healthcare.[97] This issue is discussed in the statements of Ms Colbran[98] and Ms Molyneux.[99]

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[95] Jackie Colbran's statement: IMB000204_0055-0056, §§161-162.
[96] Minutes of the July 2017 Board Meeting: IMB000014_0002.
[97] Minutes of the August 2017 Board Meeting: IMB000003_0001. Minutes of the September 2017 Board Meeting: IMB000026_0001.
[98] Jackie Colbran's statement: IMB000204_0041, §123.
[99] Mary Molyneux's first statement: IMB000203_0032, §99.

b. Despite the lack of access, the IMB was consistently seeking ways to monitor Rule 35 reporting from December 2016 onwards, including by raising questions in rota reports and to the Home Office at Board meetings, asking for statistics and sharing both problems and case studies at the IDE Chairs' Forums.[100]

c. The IMB challenged inappropriate behaviour from healthcare staff where Board members encountered it. Examples were included within rota reports,[101] reported to senior G4S and Home Office staff in both the January[102] and March Board Meetings (in the March 2017 Board Meeting, Dick Weber raised concerns about a slow response from nurses called to attend on a detained person who had collapsed ("DW commented on a slow response from nurses called to the detainee's collapse, real or feigned.")).[103] In addition, Ms Colbran raised concerns at the April Healthcare Partnership meeting.[104]

d. Where detained persons expressed frustrations, the IMB would act as a liaison between them and the healthcare team. For example, where detained persons felt they were receiving insufficient medication.[105]

e. There are also numerous examples of IMB members checking up on individuals about whom they were concerned. For example:
   i. In the August 2017 Board Meeting Ms Gajdatsy raised the case of a man with reduced mobility being put on an upper bunk in a three-man room. She expressed concerns that neither healthcare nor the officers had noticed the problem and requested that he be moved.[106]
   ii. During a visit in August 2017, Ms Molyneux checked on D2951 who had previously been sectioned but had recently returned to Brook House: "Reviewed the ACDT and SLP files, and I spoke with D2951 who is on SLP and the Adults at Risk list on Detainees of Interest. He had been sectioned and was in Langley Green, but returned to Brook on 3rd August. I later spoke with Healthcare about him."[107]
   iii. In May 2017, Mr Weber went to discuss the case of D3309 (who was reporting that he was a minor) with the healthcare team.[108]

f. IMB members cannot ensure a change in situation even where they have concerns, however, they can monitor and challenge where appropriate:
   i. In April 2017, Ms Markwick called for staff to do more to identify and monitor Adults at Risk due to concerns about an increase in self-harm and bullying.[109]

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[100] See Jackie Colbran's statement: IMB000204_0031-0032, §§93-94.
[101] See Mary Molyneux's rota report of 27 August 2017: IMB000032_0003. See also Mary Molyneux's first statement: IMB000203_0026, §§80-81.
[102] See the minutes of the January 2017 Board Meeting: IMB000049_0003.
[103] See the minutes of the March 2017 Board Meeting: IMB000015_0003.
[104] See Jackie Colbran's statement: IMB000204_0026, §78.
[105] See Jackie Colbran's statement: IMB000204_0041-0042, §124.
[106] Minutes of the August 2017 Board Meeting: IMB000003_0002.
[107] See Mary Molyneux's rota report of 21 August 2017: IMB000032_0001.
[108] See Dick Weber's rota report of 8 May 2017: IMB000012_0003.
[109] See Elizabeth Markwick's rota report of 24 April 2017: IMB000051_0004.

ii. Ms Colbran recalled making notes within ACDT reports where they had not been completed in time ("I was under no illusions that there may be times when the IMB would need to report concerns about staff. Indeed, there were occasions when we did report concerns about staff. By way of example, I can recall making notes within ACDT documents where I had identified that the records had not been completed in a timely fashion.").[110]
iii. Ms Molyneux criticised the failure to document Supported Living Plans.[111]

g. Within the evidence there are many examples of IMB members raising concerns both in relation to individual cases where force was used and wider issues relating to the use of force. For example, Ms Molyneux noted on her 10 April 2017 visit that uses of force and handcuffs are up "significantly" from the month before.[112] This was raised for discussion with senior managers at the Home Office and G4S at the April Board Meeting on 19 April 2017.[113] At the July Board Meeting concerns were again raised that every person on a flight had been wearing waist restraints, suggesting no individual risk assessments had been undertaken.[114] This was raised for discussion again at the August Board Meeting.[115]

In terms of individual incidents, Ms Molyneux gave evidence as to the steps she took to raise concerns when she attended a use of force scrutiny meeting and reviewed camera footage of force used against a vulnerable man, D356, which appeared to be unduly prolonged. As she describes in her first statement, she spoke to the detained person to get his account, raised her concerns in her rota report and then with Lee Hanford and Paul Gasson. This resulted in Mr Hanford directing for a review of that use of force.[116]

h. IMB members monitored the use of Rules 40 and 42 through speaking to detained persons (such as D275 who was interviewed by Ms Colbran immediately after his forcible removal from the netting on 17 May 2017[117]), the notifications from the Centre management they received, the paperwork they examined and the statistics present in the Combined Reports prepared by the Home Office.[118] They raised concerns where there was increased use of these rules, such as in the February 2017 Board meeting.[119] They also raised concerns in relation to individual cases, such as at the September 2017 Board Meeting when Mr Weber raised concerns about the use of Rule 40 in respect of a detained person who was also on constant observations due to a risk of self-harm.[120] This is discussed by Ms Colbran in her statement at paragraphs 108-109.[121]

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[110] See Jackie Colbran's statement: IMB000204_00015, §40.
[111] See Mary Molyneux's first statement: IMB000203_0019, §58.
[112] Mary Molyneux's rota report of 10 April 2017: IMB000055_0006.
[113] Minutes of the April 2017 Board Meeting: IMB000005_0002.
[114] Minutes of the July 2017 Board Meeting: IMB000014_0001.
[115] Minutes of the August 2017 Board Meeting: IMB000003_0001.
[116] Mary Molyneux's first statement: IMB000203_0030-0031, §§92-96.
[117] See the Serious Incident Log Book: IMB000111_0016-0017 and Jackie Colbran's statement: IMB000204_0060, §§178-179.
[118] For example, see the April 2017 Combined Report: IMB000021.
[119] Minutes of the February 2017 Board Meeting: IMB000062_0002.
[120] Minutes of the September 2017 Board Meeting: IMB000026_0003.
[121] Jackie Colbran's statement: IMB000204_0036-0037, §§108-109.

i. To the extent that they were permitted to, IMB members did assist in immigration-related matters. For example:
    i. In the week commencing 12 June 2017, Ms Colbran received an application from D3425 who had only received his bail summary the day before the hearing leaving him unable to prepare. Ms Colbran spoke to the Home Office who could not explain why so she raised it with Paul Gasson.[122] She then raised it at the June Board Meeting.[123]
    ii. On his visit of 19 April 2017, D1199 made an application to Mr Jones complaining that he had finished his prison sentence but was being transferred back to prison. Mr Jones spoke to the Home Office and was able to provide D1199 with more information. Although it appeared to be a policy that Mr Jones could not prevent, he advised D1199 to speak to GDWG who may be able to assist by directing him to legal advice.[124] Mr Jones then raised D1199's case with Mr Gasson at the May Board Meeting.[125]

j. The issue of waits for legal aid and delayed access to justice was raised at Board meetings in January 2017,[126] February 2017,[127] March 2017,[128] April 2017,[129] and May 2017.[130] Ms Molyneux raised the issue of ongoing delay in her rota report of 10 April 2017.[131] In June 2017, Ms Molyneux noted that the delay was 7 days, which was less than it had been previously.[132] IMB members helped when they could, for example: on 13 February 2017, Ms Colbran helped a detained person with an application relating to legal aid: "Following up on an app about a detainee unhappy with his legal aid while at Harmondsworth, which he felt had lost him his chance of asylum I ended up in Welfare, where by great good fortune I met D4015 from Migrant Watch. He offered to see D3281 there and then and I was able to take him and leave him in much better hands."[133] Access to legal representation is discussed further within Ms Molyneux's first statement at paragraph 104-107[134] and within Ms Colbran's statement at paragraph 141.[135]

57. Where, in retrospect, the IMB could have done more, its members have been candid and have said so (see, for example, paragraphs 97-98 of Ms Molyneux's first statement).[136]

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[122] See Jackie Colbran's rota report for 12 June 2017: IMB000022_0001.
[123] Minutes of the June 2017 Board Meeting: IMB000043_0003.
[124] Gareth Jones' rota report of 19 April 2017 IMB000040_0002.
[125] Minutes of the May 2017 Board Meeting: IMB000030_0003.
[126] Minutes of the January Board Meeting: IMB000049_0003.
[127] Minutes of the February 2017 Board Meeting: IMB000062_0001.
[128] Minutes of the March 2017 Board Meeting: IMB000015_0001.
[129] Minutes of the April 2017 Board Meeting: IMB000005_0002-0003.
[130] Minutes of the May 2017 Board Meeting: IMB000030_0001.
[131] See Mary Molyneux's rota report of 10 April 2017: IMB000055_0005.
[132] See Mary Molyneux's rota report of 19 June 2017: IMB000046_0005.
[133] See Jackie Colbran's rota report of 13 February 2017: IMB000093_0004.
[134] Mary Molyneux's first statement: IMB000203_0034-0036.
[135] Jackie Colbran's statement: IMB000204_0048.
[136] Mary Molyneux's first statement: IMB000203_0031-0032.

58. This activity is also evident from the evidence of others within the Centre from whom the Inquiry has heard. For example:

a. Karen Churcher said in her first statement:[137]

> "The IMB were present around the wings and they took part in some of the review meetings. I was in regular contact with the IMB. They are completely independent and look out for the welfare of the detainees and make sure everything is being done properly and procedures are being followed. If they had any concerns regarding the welfare of detainees, they would raise it with members of staff."

b. Ms Churcher said in her second statement:[138]

> "18. … think the IMB had weekly meetings with Sandra and Michael. If they had any particular concerns regarding mental health then they would pop into healthcare and ask us.
> 19. As I was not present at the meetings with the IMB, I am unsure of their role.
> 20. I would not usually raise issues with the IMB, they would raise the issues with us. We once had a detainee who was seriously mentally ill and I was struggling to find him a bed anywhere. The IMB would regularly ask for updates and what steps I was taking to rectify this issue."

c. Christine Williams explained in her first statement:[139]

> "My understanding of the role of The Independent Monitoring Board was that they were there to ensure that the correct standards of care were upheld in relation to detainees. They would attend meetings in the centre and raise any concerns they had. They would come to healthcare if they had any queries. I had regular contact with them, as I would often answer their questions and provide any information they required."

d. Daniel Haughton explained in his first statement:[140]

> "The Independent Monitoring Board ("IMB") are present to monitor day-to-day life and ensure that proper standards of care and decency are in place. IMB acts as advocates for residents. I have regular contact and have a good working relationship with them. IMB felt comfortable challenging us on matters and I often sought and continue to seek their views if we are looking to change something within Brook House. Their input is valuable and they review matters from a different angle sometimes, which is helpful.
> …

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[137] Karen Churcher's first statement: DWF000003_0003, §13.
[138] Karen Churcher's second statement: DWF000022_0005, §§18-20.
[139] Christine Williams' first statement: DWF000020_0004, §15.
[140] Daniel Haughton's first statement: SER000453_0010, §37(a) and SER000453_0041, §186.

> Should a resident raise a complaint outside of this, then anyone could complete the complaint form on their behalf, or they would be encouraged to complete the form as there was then a record. Residents quite often raised complaints with IMB who would look into their concerns."

e. In answer to a question by the Inquiry Chair, Steve Skitt explained:[141]

> "I think with IMBs, I have always found through my career, you know, you have a professional positive relationship with the IMBs, and they will tend to talk to you when you're going around and raise any particular issues, if they feel it's appropriate. So sometimes, you know, you can deal with them straight away. But, you know, they do provide a -- their yearly report, which is obviously a number of recommendations if there are any that we will act on."

59. As the foregoing demonstrates, it is to misunderstand the IMB's role to suggest that members only concerned themselves with 'mundane' issues such as the heating, cleanliness and the absence of complaint forms. The evidence before the Inquiry clearly shows the IMB was engaged in much more beside this. IMB members were far more than passive observers within the Centre and regularly raised matters of concern with those responsible for the care of those detained.

The 2017 annual report

60. The IMB's 2017 annual report was published in May 2018.[142] As set out above, the Board recorded its horror at what was shown on *Panorama*. However, as the Inquiry has heard from the then chair of the Brook House IMB, she accepts that the 2017 annual report should have been more critical and challenging.[143]

61. The IMB accepts that, in light of what is now known, it was plainly wrong to say that the Centre kept detained persons as safe as it could, albeit this assessment was caveated within the report to make clear that the *Panorama* programme had uncovered instances of unacceptable treatment of detained persons.

62. The Inquiry has revealed significant problems with the way in which G4S and the Home Office reviewed complaints made to them by detained persons. Those problems – including a misplaced approach to the handling of multiple complaints against the same members of staff – were not known to the IMB at the time. Had they been known, the IMB would have placed considerably less reliance on the outcomes of G4S and PSU investigations of those complaints.

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[141] Steve Skitt 17 March 2022, 211/11-19. In his first statement, Mr Skitt described having "a good professional relationship with the IMB" (SER000455_0021).
[142] Brook House IMB 2017 annual report: VER000138.
[143] See Jackie Colbran's statement: IMB000204_0063, §186.

63. Whilst the IMB's 2016 and 2017 annual reports were broadly positive, it is wrong to read them as raising no issues about the safety of the Centre or the treatment of detained persons during those respective reporting years. To the contrary, in both annual reports, the IMB identified serious issues which required the attention of the Minister, the Home Office and the Centre.

64. In its 2016 annual report,[144] amongst others, the Brook House IMB:

    a. Identified as requiring a response concerns about:
        i. Night transfers of detained persons, because the Board did not believe that the impact on the care and welfare of individual detained men was being taken into account.
        ii. Delays in access to mental health treatment.
        iii. The need for a mechanism for detained persons to be able to raise concerns with Healthcare and for those concerns to be resolved at an early stage.
        iv. The desirability for social networking to allow detained persons to maintain contact with family and friends in the UK and abroad.

    b. Challenged the length of time people were detained at Brook House, saying:

        > "That any individual should spend one or two years in detention awaiting a Home Office decision as to their removal from the UK is to be deplored. There is a pilot project currently underway at Brook House but the Board strongly believes long term solutions are needed. Many are eventually released on bail by an immigration judge, calling into question the cost and effectiveness of extended detention".

    c. Recorded its concern about the preparations to add an additional 60 beds and require three men to share one room.[145] It raised similar concerns in its 2014 and 2015 annual reports. When giving evidence, Michelle Smith said that she could not recall the IMB raising concerns about the introduction of the 60 additional beds, however this is demonstrably incorrect.[146] The issue is discussed within Ms Colbran's statement[147] and she was questioned about this in her oral evidence.

    d. Highlighted that it was concerned by the handling of Rule 35 requests and reports, including the discrepancy between the number of self-harm incidents occurring and the number of Rule 35(1) and (2) reports being made.[148]

65. In its 2017 annual report,[149] the Board identified as areas for improvement:

    a. To increase staffing levels.
    b. To improve the operation of the adults at risk policy.
    c. To implement advanced mental health training for staff who interact with vulnerable detained persons.

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[144] Brook House IMB 2016 annual report: IMB000121.
[145] Brook House IMB 2016 annual report: IMB000121_0006-0007.
[146] Michelle Smith 23 March 2022 154/19-155/9.
[147] Jackie Colbran's statement: IMB000204_0022, §§64.
[148] Brook House IMB 2016 annual report: IMB000121_0008.
[149] Brook House IMB 2017 annual report: VER000138.

66. The Board recorded its concerns about the availability of drugs and alcohol within the Centre.

67. Even though it is clear that the Brook House IMB did raise concerns in its annual reports, at monthly Board meetings and in members' rota reports, the IMB has become increasingly concerned to hear the evidence in this Inquiry from some senior members of the Home Office and G4S as to the reliance placed upon both the IMB and HMIP to identify and report matters of concern up to and including abuse. To mention three examples:

    a. Michelle Smith:
        i. During the relevant period Ms Smith was a Service Delivery Manager within the Home Office and was responsible for overseeing performance under the contract at Brook House.
        ii. The contract appears to have required "the onsite team to carry out only seven hours' contract monitoring per week, that was the expectation, and an acceptance that, in the main, that didn't really stretch further than being able to have – attend meetings."[150] Ms Smith herself would typically have been on-site "a couple of days a week" but even then she did not go onto the residential wings to speak to detained persons: "that wasn't really part of my role."[151]
        iii. At various points in her evidence, Ms Smith appeared to suggest she allowed herself to become reliant on the IMB. In respect of the adequacy of activities, Ms Smith was asked and said (emphasis added):[152]

> "Q. In relation to activities, then, page 84:
> "The contractor shall encourage and provide a detainee with an opportunity to participate in activities which will be part of a regime designed to provide for their recreational and intellectual needs and the relief of boredom and which reflect the age, gender, cultural and ethnic needs of a diverse population."
> It goes on to provide:
> "The contractor shall ensure that:
> "A detainee will have access to activities, under proper supervision that ensures safety and good order."
> Then over the page, please:
> "There is a range of education, recreation and PE activities for detainees."
> How was that monitored?
> A. So as part of the monthly operational review meeting, there were aspects of the regime that were covered in the KPI. So there was a pack of information, a report, provided, produced by G4S and they would have reported, self-reported, against that. And then IMB would have checked our specs off that. And we, if we had any inkling, or anything coming out of the weekly IMB reports where they had any concerns, or any concerns that we'd identified in any of our ad hoc walk-

[150] Michelle Smith 23 March 2022 114/4-18.
[151] Michelle Smith 23 March 2022 101/21 – 102/4.
[152] Michelle Smith 23 March 2022 125/19 – 127/15.

arounds, then we would have followed that up with more systematic reviews over a period to satisfy ourselves that there was or wasn't an issue.

Q. The inquiry has heard some evidence that there were issues with the provision of activities related to understaffing, that there often weren't enough staff to provide activities during the relevant period. Were you aware of that at the time?

A. No, I wasn't, no.

Q. What's the explanation for that, given what you have just told me about monitoring?

A. That it either hadn't been identified by the Independent Monitoring Board or by our team, and certainly, in my experience walking around, from an education perspective, I saw the -- Sebastian, the educational lead, on a regular basis carrying out -- so from my own observation, I hadn't observed there being a problem. It hadn't come out through the detainee consultative meetings either, so there were various different methods of ensuring and gathering information, and, through that, those different methods, it hadn't arisen that there was a problem."

iv. It is not the role of the IMB to monitor the contract between the Home Office and its contractor. Still less is it the role of the IMB to 'check the specs' of a KPI under such a contract. Such an arrangement does not exist nationally or locally. The IMB had not even seen the contract between the Home Office and G4S.[153]

v. These comments also overlook the fact that the IMB had raised concerns about the activities and amenities available at Brook House. For example, in the 2016 annual report the Board raised the following in respect of amenities etc:

1. In respect of the provision and care for people with disabilities, it was noted that Brook House is not ideally suited to men with significant physical disabilities, for example, those requiring the use of a wheelchair, as there is no lift access for detainees."[154]
2. In respect of the lack of outside space and the closure of the courtyards:

> "One particular area of considerable frustration, especially in the summer months, was the partial closure of the four courtyards following the escape in March. Risk assessments were required and decisions as to how security could be improved, but the issue dragged on for what the Board judged an excessive length of time. Putting extra staff on courtyard duty at a time when staff numbers were low led to extra strains on operations. Cramming all those wanting fresh air, those wanting to play football and cricket or just have a cigarette on a warm day, into one or two yards led to

[153] See Mary Molyneux's first statement: IMB000203_0018, §54.

[154] Brook House IMB 2016 annual report: IMB000121_0010, §5.2.7.

stress and some incidents. It was a great relief when the IMB heard the work was to proceed, though it has taken most of 12 months to achieve."[155]

3. The lack of proper officer oversight at meal times leading to food running out at mealtimes.[156]
4. More generally, the impact of increasing the overall numbers of detained persons and the effect this would have on living conditions: "A frequent complaint to IMB members regards the lack of ventilation detainees experience in their rooms. This will not be improved by more individuals confined together. The Board is also concerned there should be consequential investment in other areas of the Centre to prepare for the increase and will be carefully monitoring the changes in 2017."[157]

vi. Putting to one side the fact that the IMB were raising these concerns (and raised many more through their rota reports and at their monthly Board meetings), it is of concern that the Home Office appears to have assumed that the IMB were undertaking a role which does not appear within the 1999 Act, the Detention Centre Rules 2001 or the Memorandum of Understanding between the Home Office and the Management Board of the IMBs.[158]

vii. The Inquiry Chair may think, having heard this evidence, that the Home Office had contracted out not just the running of the Centre, but also its contractual and managerial oversight. That is notwithstanding the fact that the IMB were not privy to the contract which the Home Office contract monitors were meant to be monitoring, nor were the IMB members a permanent presence on-site.

b. Peter Neden, Jerry Petherick and Gordon Brockington: All of whom sought to rely on parts of HMIP and IMB reports or, as Counsel to the Inquiry suggested to Mr Brockington, "seeking refuge" in Peter Clarke's finding that Brook House was "reasonably good."[159] Mr Neden accepted that G4S over-relied on the reports of external organisations.[160] The Inquiry Chair may wonder how it is that a company the size of G4S, employing as many people as they did, operating a contract valued in the millions, say they came to rely quite so heavily on occasional HMIP visits and the nine unpaid members of the IMB.
c. Philip Dove: Mr Dove sought to rely on the IMB, HMIP and the CQC to monitor healthcare provision at Brook House. Notwithstanding that the IMB does not have access to healthcare records, the IMB did raise concerns about healthcare provision, including about the application of Rule 35.[161]

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[155] Brook House IMB 2016 annual report: IMB000121_0017, §5.8.3. On the issue of the limited outside space at Brook House, see: (i) Jackie Colbran's statement: IMB000204_0046-0047, §§137-138; and (ii) Mary Molyneux's first statement: IMB000203_0033, §101.
[156] Brook House IMB 2016 annual report: IMB000121_0017-0018, §5.8.4.
[157] Brook House IMB 2016 annual report: IMB000121_0018, §5.8.6.
[158] Memorandum of Understanding on immigration detention between Home Office (Immigration Enforcement) and the Management Board of the Independent Monitoring Boards: IMB000187.
[159] Gordon Brockington 31 March 2022 43/16.
[160] Jerry Neden 22 March 2022 56/15-24.
[161] Philip Dove 31 March 2022 141/17-23.

The criticism that the IMB lacked independence is misplaced

68. In respect of the IMB, arguably the most serious criticisms are those which have questioned its independence. In summary, those criticisms are:

    a. At paragraph 14.33 of the Verita report, Kate Lampard and Ed Marsden said that they were "concern[ed] that the IMB have been over-empathetic to G4S and the Home Office."[162]
    b. At paragraph 10.33 of her first report, Professor Bosworth has said of the IMB: "the documents submitted to the Inquiry do point to a shared culture with officers among the committee at the time. The lack of trust of the detained men, the concerns about the work of GDWG, and the use of prison terminology all paint an organisation that was not fully independent and thus was not performing adequately as a safeguard for human rights."[163]

The Verita report

69. Before addressing the criticisms made within the Verita report, the Inquiry will note that Ms Lampard and Mr Marsden "do not suggest that either the IMB or HMIP should have uncovered or predicted behaviours of the type shown in the Panorama film, but we think that more focused questioning of staff and frontline managers might have more clearly identified some of these issues."[164] Further, Ms Lampard and Mr Marsden concluded that "The principle [sic] findings and recommendations in the latest IMB report largely coincide with our own."[165]

70. The criticism that the 2017 Board was 'over-empathetic' to G4S and the Home Office is one which the IMB took and continues to take seriously. Ms Molyneux addressed the Verita report and her reflections upon it within her first statement at paragraphs 170-179.[166] As Ms Molyneux explained at paragraph 173:[167]

> "I believe that perception is important in ensuring that people are confident in the independence of the IMB. Even a perceived lack of independence would be an issue of great concern, hence my introducing it as a discussion topic in the meetings which followed Panorama (I am recorded as asking whether either the Home Office or the IMB could be considered "too cosy" with G4S). The criticisms made in the Lampard Review questioning the independence of an 'independent' monitoring board are the most fundamental and deeply troubling that could be made of any IMB. I have remained conscious of them throughout my time as Chair and they have motivated and informed the approach I have taken throughout my time leading the board."

71. The criticism made by Ms Lampard and Mr Marsden appears to have been formed primarily on the basis of accounts of interactions between the IMB and GDWG, attendance at one Board meeting and comments within the Verita interviews which were themselves not reflective of the totality of the Board's role. The Inquiry Chair should

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[162] Verita report: CJS0073709_0240.
[163] Professor Mary Bosworth's first report: INQ000064_0052, §10.33.
[164] Verita report: CJS0073709_0030 §1.139 (repeated at CJS0073709_0233, §14.12).
[165] Verita report: CJS0073709_0030 §1.140 (repeated at CJS0073709_0234, §14.16).
[166] Mary Molyneux's first statement: IMB000203_0059—0062, §§170-179.
[167] Mary Molyneux's first statement: IMB000203_0060, §173.

approach with care the conclusions drawn by Ms Lampard and Mr Marsden. Neither have been called to provide evidence. During their interviews with numerous members of staff at Brook House, Ms Lampard and Mr Marsden sought to explore their contention that the IMB was not sufficiently challenging of G4S or the Home Office. From the transcripts of these interviews it is now apparent that it was frequently Ms Lampard and Mr Marsden who introduced these criticisms of the IMB to interviewees. In any event, the evidence before the Inquiry of the totality of the IMB's work, findings and concerns now provides a much fuller picture than was available to Ms Lampard and Mr Marsden.

72. More broadly, the Inquiry has heard evidence from G4S and Home Office staff about their perceptions of the IMB. These include:

    a. Michelle Smith: Ms Smith disagreed that Brook House IMB monthly meetings were "gossipy or cosy" rather they were "collaborative": she "never thought that the IMB had a tendency to overemphasise with G4S and the Home Office."[168]

    b. Jerry Petherick: In his first statement Mr Petherick described his impression of the IMB:[169]

> "32. I believe my relationship with the Brook House IMB was mutually respectful and professional. I would not describe it as being overly "close" in nature. When visiting Brook House, I would speak with any IMB member who was visiting. They struck me as a good, interested IMB who took an appropriately active interest in the people and events at the establishment.
> … from my interactions with Board members generally, I did not form an impression that they were "over-empathising" with either the G4S management team or the Home Office.
> 34. Reflecting on this through the prisms of my role with G4S (responsible for 6 establishments) as well as formerly an Area Manager (with HMPPS responsible for 13 prison establishments) and a Governor (within HMPPS), I consider the Brook House IMB had a professional interest in, and commitment to, the appropriate discharge of their responsibilities. Their approach compared favourably with other establishment IMBs.
> 35. I also believe that the IMB had sufficient independence from the G4S management team and the Home Office. I do not believe that it would be correct to view or interpret positive and appropriately professional relationships as being overly "soft" or compliant in

[168] Michelle Smith's second statement: HOM0332121_0024, §§73-74.
[169] Jerry Petherick's first statement: CJS0074047_0007, §§32-35. In his Verita interview, Mr Petherick described the Brook House IMB as being "an active IMB…They take a genuine interest." (VER000263_0025, §§440, 442). In his oral evidence, Mr Petherick referred to speaking with Dick Weber (a former colleague from when Mr Weber worked as a prison governor) and that Mr Weber's presence and experience gave him (Mr Petherick) "further assurance in relation to the Brook House's delivery" (Jerry Petherick 21 March 2022, 143/15-144/11). As addressed above, Mr Petherick along with others appears to have relied too heavily on the IMB to identify issues which G4S themselves should have identified. Insofar as Mr Petherick may have given the impression of having regular discussions with Mr Weber, this is incorrect. To the best of Mr Weber's recollection, he encountered Mr Petherick only once at Brook House where they had a brief discussion, with others present, which did not concern operational matters.

approach. In my experience, the IMB were able to raise issues and express opinions."

73. Whilst it is recognised that this evidence takes matters only so far, it is important evidence insofar as the counterparty to the alleged 'overly-empathetic' relationship does not recognise that description. The IMB was independent, however, as Ms Molyneux explained in her evidence, the perception that it was not independent is a matter of great concern and did prompt reflection and action (see below).[170]

Professor Mary Bosworth's reports

74. The IMB recognises that Professor Bosworth was appointed to assist the Inquiry in light of her experience and expertise. She is a respected academic and IMBs themselves have benefited from training she has provided. However, it is the Inquiry Chair who has read, seen and listened to all of the evidence in this Inquiry.

75. As set out above, at paragraph 10.33 of her first report Professor Bosworth identifies three reasons why she believes the IMB "was not fully independent and thus not performing adequately as a safeguard for human rights."[171] These are: (i) an apparent lack of trust of the detained men; (ii) concerns about the work of GDWG; and (iii) the use of prison terminology.

76. The IMB invites the Inquiry Chair to approach with caution Professor Bosworth's criticisms of the IMB in 2017 as set out within her report and her oral evidence.

    a. First, it is not clear that Professor Bosworth had read the three statements submitted to the Inquiry by Dame Anne Owers, Ms Colbran and Ms Molyneux. None of these statements are referred to within either of Professor Bosworth's reports.

    b. Second, in her oral evidence Professor Bosworth said that she had watched some of Ms Molyneux's oral evidence but none of Ms Colbran's.[172] It was Ms Colbran who was the chair during the relevant period.

    c. Third, as Professor Bosworth accepted when questioned by Counsel to the Inquiry, she was wrong about certain factual matters upon which she had relied in her statement.[173] Professor Bosworth explained that she was "trying to synthesise a huge amount of material."[174] However, the examples selected are partial and do not provide a complete or, as it transpires, accurate picture. In particular:
        i. Professor Bosworth incorrectly concluded that, by putting quotation marks around the word 'protest', Ms Molyneux had "[m]ore subtly…effectively [dismissed] the man's claims."[175] In fact, as Ms Molyneux explained in her statement:[176] (i) Ms Molyneux was quoting

[170] Mary Molyneux's first statement: IMB000203_0059—0062, §§170-179.
[171] Professor Mary Bosworth's first report: INQ000064_0052, §10.33.
[172] When giving evidence she set out the documents she had considered in addition to those referred to within her two reports (Professor Bosworth 29 March 2022 3/20 – 5/3).
[173] Professor Bosworth 29 March 2022 127/21 – 132/20.
[174] Professor Bosworth 29 March 2022 129/8-9.
[175] Professor Mary Bosworth's first report: INQ000064_0047, §10.13.
[176] Mary Molyneux's first statement: IMB000203_0041-0042, §§117-121.

information which had been provided to her about the c.40-50 detained persons; (ii) Ms Molyneux met with those who were moved to the CSU and spoke with them; (iii) the detained men offered a variety of explanations for their actions including that some were "protesting about food"; and (iv) when reporting that some were protesting about food, Ms Molyneux did not use quotation marks.

ii. In other rota reports where Professor Bosworth criticises the use of language the IMB member is in fact quoting what that member has been told (for example, a member was told that a particular detained person was "very lazy"). It is unfair to suggest that these are criticisms of detained persons by IMB members.

iii. Professor Bosworth accepted that she was wrong to say that IMB members "sat on a variety of centre committees."[177]

77. Those factual matters are important because they contributed to Professor Bosworth's conclusion in her first report that there was a "shared culture" between officers and the 2017 Board, that the Board had a "lack of trust of the detained men" and that the IMB "was not fully independent and thus was not performing adequately as a safeguard for human rights."

78. During her oral evidence, John Connolly's observation in respect of the IMB that "most of them were ex-prison officers"[178] was put to Professor Bosworth.[179] Putting to one side any reservations one may have about relying upon Mr Connolly as a reliable historian, this is plainly not correct. One of the then Board was a former prison governor. There were no ex-prison officers. There was, amongst others: a teacher, a lawyer and a nurse. Mr Connolly was wrong and it is regrettable his comment was put to Professor Bosworth, particularly as this was not explored either with Mr Connolly or the IMB's witnesses.

79. However, the IMB recognises that the use of language is important. It is accepted that, within the documents created by IMB members in 2017, there are instances where the language used was inappropriate. One such example was put to Ms Colbran during her evidence: she immediately accepted such language was not appropriate.[180]

80. As to the IMB's relationship with GDWG: it is now clear that both organisations were at the time unclear about each other's respective roles, objectives and working methods. In her first statement, Ms Molyneux explained: "In retrospect, I think both organisations were unclear of the work each other did and how they saw their roles."[181] This is partly because there was limited interaction between IMB members and GDWG (the latter were generally not permitted access to the Centre) and because the IMB was concerned about receiving urgent referrals when it (the IMB) was not best placed to take urgent safeguarding action (the Centre staff should have been better placed) and because the IMB was concerned about data protection and information security. The IMB did in fact receive referrals from GDWG and took action in light of them.

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[177] Professor Bosworth 29 March 2022 128/9-17.
[178] John Connolly's first statement: INQ000120_0005.
[179] Professor Bosworth 29 March 2022 138/11-15.
[180] Jackie Colbran 25 March 2022 86/7-10.
[181] Mary Molyneux's first statement: IMB000203_0043, §123. See also Jackie Colbran's statement: IMB000204_0050-0056, §§146-163.

81. The IMB's engagement with GDWG was well-intentioned but was open to misinterpretation and misunderstanding. This is particularly so where the IMB attempted to provide guidance to GDWG as to how its relationship with G4S and the Home Office might be improved.

82. The IMB has since been shocked to learn of the extent to which the relationship between GDWG and G4S and the Home Office had broken down. James Wilson's evidence about his treatment by G4S and Home Office managers is particularly troubling. This was not known to the IMB at the time. Further, as Ms Molyneux accepted in her first witness statement: the IMB was too affected by the criticisms made by the Centre and Home Office managers of GDWG. She has explained the steps which have been taken since to improve the two organisations' relations.[182] Ms Molyneux has explained that, during her time as chair, she worked to build a stronger relationship with GDWG. At paragraphs 131-132 of her first statement Ms Molyneux provided further information on the steps which she took to foster that relationship.[183] At paragraphs 133-134 she explained:[184]

> "133. I have found that the more we meet and talk, the better the relationship gets. I think that there is still some way to go for both of us to sort out what the best way of working together is although I certainly would not want the relationship to be restricted to some prescribed form. I do feel that there is now a two-way exchange of information and that both sides are beginning to have a better understanding of each other's work. As an example, I am not sure that GDWG had previously been aware of just how extensive the IMB's interaction with the detained men is when we are in the Centre, nor were they aware that we saw such things as use of force reports.
> 134. Generally, I would say that the relationship now has a good base to build on. Given the evidence we have seen from GDWG at the Inquiry, it is not surprising that considerable work needs to be done by us to build trust. However, it is absolutely clear to me that this is a relationship which the IMB must continue to invest in as we will be able to improve our own monitoring as a result. It is especially valuable as an opportunity for us to hear if GDWG are seeing particular concerns or themes emerging from their visits and dealings with men at Gatwick, including any relating to staff behaviour or staff culture."

83. The IMB invites the Inquiry Chair to reject the criticism that the IMB had a shared culture with officers and was not fully independent. As explained above, these are not the reasons why the IMB – along with many others – did not identify the abuse and mistreatment revealed by *Panorama*.

The present and future

84. The IMB has placed before the Inquiry evidence as to the current position both locally within the Gatwick IMB and nationally. The Inquiry Chair is invited to consider in particular: the first and second statements by Dame Anne Owers and the first statement of Mary Molyneux.

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[182] See Mary Molyneux's first statement: IMB000203_0043-0049, §§122-134.
[183] Mary Molyneux's first statement: IMB000203_0046-0048, §§131-132.
[184] Mary Molyneux's first statement: IMB000203_0048-0049, §§133-134.

85. Within this Closing Statement, we have addressed above some of the misconceptions about the role, work and findings of the Brook House IMB in the relevant period. That said, it is clear from evidence before the Inquiry that the events shown in *Panorama*, and the fact that this was unknown to either the IMB or other bodies, as well as the conclusions of the Verita report, prompted considerable reflection and subsequent action, both within the Brook House Board and in the then newly-created national structure.

86. The IMB has further reflected on the evidence which has emerged during this Inquiry.

87. The Brook House IMB has strengthened the focus on monitoring vulnerable detained persons, adults at risk and staff culture and behaviours. Ms Molyneux said the following in her first statement:[185]

> "175. The [Verita] report noted in paragraph 14.12: "[w]e do not suggest that either the IMB or HMIP should have uncovered or predicted behaviours of the type shown in the *Panorama* film" but added "we think that more focused questioning of staff and frontline managers might have more clearly identified some of these issues." For me, it is difficult to think what kinds of questions could have made a difference in 2017 given the extent to which the staff involved hid their behaviour in the presence of the IMB and other bodies. For those who were directly involved, I think it likely they would have continued to cover up their wrongdoing. For those who were aware but who may have felt unafraid or unable to speak up, I think it unlikely that further questioning would have encouraged them to 'break rank.' I, along with the Inquiry, have watched and reflected on the evidence given by Mr Tulley and Mr Syred on this issue.
> 176. However, looking at the position now with more awareness of the problems resulting from a poor staff culture and after seeing and hearing evidence of how ingrained and extensive this seems to have been, I agree that there are questions that should be asked regularly now which would more clearly identify some of the behaviours of the type shown in *Panorama*. This is why work we carried out to improve our monitoring of staff culture forms a central plank of the actions we took to build on our practices after *Panorama* as discussed above.
> 177. I have set out above the actions which the board took following the broadcast of *Panorama* and following the publication of the Lampard Review report. Each of these events had a fundamental impact on both the IMB and myself in my work as Chair from 2018. With *Panorama*, it raised serious questions about how we had failed to spot the abuse and mistreatment shown in Panorama, and how we needed to respond by developing a way to monitor staff culture and behaviour in particular, as well as sharpen our focus and develop further the work we were already doing in monitoring areas such as the actions of Home Office staff. For the board, the publication of the Lampard Review report reinforced the need for continued particular focus on some of the *Panorama* issues. Such as use of force and staff
> culture in particular.
> 178. With the Lampard Review, we were all troubled by the fundamental question of whether we as a board were sufficiently independent of the Home

[185] Mary Molyneux's first statement: IMB000203_0060-0062, §§173-178. See also §§149-169 of Ms Molyneux's first statement (IMB000203_0053-0059) and her oral evidence to the Inquiry.

> Office and G4S, and it raised questions about our approach to GDWG. After each of the *Panorama* broadcast and in the aftermath of the publication of the Lampard Review report both the board and I engaged in considerable review and reflection of our monitoring work and how we approach it, and also how we are seen to approach it. I was so troubled by the report and its criticism of the tone and approach in the board meeting the authors had observed and which I had chaired, that I considered resigning as Chair after its publication, and discussed this several times with the then Vice Chair Gareth Jones.
> 179. I would say that both *Panorama* and the Lampard Review have informed the board's monitoring work, with the Lampard Review in particular leading to the development of our work on monitoring staff culture and behaviour. For me personally, the implications of the Lampard Review's questioning of our independence informed and drove my behaviour in the time that I was Chair."

88. Similarly, there have been changes at national level, in order to support and train members within the immigration detention estate. There is now a much greater focus on training specific to immigration detention, including an emphasis placed on separation, adults at risk and mental health. That training, designed by a specialist trainer, draws on the expertise and experiences of those outside, as well as within, the IMB, including those with lived experience of immigration detention. In her second statement, Dame Anne Owers explained:[186]

> "8. I think the most significant change since 2017 is that there is now much more proactive support, training and guidance at the national level for IMBs within the immigration detention estate. For example, there is now a national policy and guidance on identifying and reporting allegations of abuse made by prisoners and detained persons [IMB000218]. This was the subject of national mandatory training in 2020-2021 [IMB000185_0005].
> 9. The assistance provided at a national level is complemented by the weekly Zoom calls between the IMB IRC chairs (see paragraph 153 of Ms Molyneux's statement) as well as the existing quarterly Chairs' Forums referred to in my first statement. As Ms Molyneux explains, these have proven to be an excellent opportunity to share experiences and learning amongst the chairs of the boards for immigration removal centres. This permits boards, through their chairs, to better contextualise their experiences and compare what they are observing against best practice and the practice in other establishments. The intention is for these meetings to continue."

89. In Professor Bosworth's first report, she recommended that the IMB "develops a rights-based approach and scrutiny document rather than one based on the layout of the centre."[187] The Inquiry has received evidence from Dame Anne Owers and Mary Molyneux as to the new template developed for both rota and annual reports.[188] This focuses on four areas, set out in the National Monitoring Framework, which reflect international and domestic human rights standards for the treatment of those in detention. The annual report template requires Boards to make judgements against each of these areas

[186] Dame Anne Owers' second statement: IMB000221_0002, §§8-9.
[187] Professor Mary Bosworth's first report: INQ000064_0052, §10.35.
[188] See: (i) Dame Anne Owers' first statement: IMB000199_0006-0008, §16 and 23; (ii) Mary Molyneux's first statement: IMB000203_0009, §30; (iii) the Gatwick IMB's statutory visit template: IMB000200; and (iv) Dame Anne Owers' second statement: IMB000221_0006-0007, §§19-22.

and the rota template means that members report their findings against each of these. This steers Boards towards placing their detailed findings within that human rights-based context.

90. Both before and since the relevant period, the Brook House IMB and the National Chair have reported on and made recommendations at Brook House and more widely. By way of example: the 2019 and 2020 Brook House annual reports,[189] criticised the pre-Brexit charter flights, failures in the Adults at Risk policy and Rule 35 policies and practices, Home Office DET staff not serving removal directions in person during the Covid-19 pandemic and delays relating to providing bail accommodation. As set out above, the IMB's reports have formed an important source of evidence within this Inquiry.

91. In addition, the Inquiry has heard how on 2 October 2020, the Chairs of the Brook House IMB and the Charter Flight Monitoring Team wrote to the Minister for Immigration Compliance and the Courts under Rules 61(3) and (5) to raise serious concerns about the inhumane treatment of detained persons.[190] In November 2020, Dame Anne Owers and Ms Molyneux (along with Dr Singh Bhui) gave evidence to the House of Commons Home Affairs Select Committee on Channel crossings, migration and asylum-seeking routes through the EU.

92. In her second statement, Dame Anne Owers discussed some examples of more recent activities by the IMBs:[191]

> "18. …We have been able to raise concerns arising out of monitoring, not just to Home Office Ministers and officials, but in Parliament and to the Tribunal. In addition to those which the Inquiry has already considered, I mention the following as examples:
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> a. In November 2021 I wrote to Home Office Ministers notifying them of the concerns of both the Dover and Heathrow IMBs about the conditions and treatment of those who had crossed the Channel in small boats, in particular their treatment at a facility at the Tug Haven. Subsequently, the IMBs and HMIP jointly press-released reports of their concerns. In January 2022 the Minister wrote to me confirming that the Tug Haven site would be decommissioned.
>
> b. For some time, IMBs in short term holding facilities (STHFs) have been signalling to the Home Office the risks to detained individuals due to the fact that they do not have access to their prescribed medication, or any alternative, in those facilities. As a consequence, arrangements are being made for pharmacy cover.
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> c. IMBs have raised concerns about the over-use of mechanical restraints, both on escorts and charter flights, and when detained persons are taken to external (for example hospital) appointments. The use of handcuffs on external appointments from Heathrow IRC significantly reduced, and Professor Mary Bosworth was asked to conduct a review of the use of restraints in general.

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[189] Brook House IMB 2019 annual report: IMB000201. Brook House IMB 2020 annual report: IMB000202.
[190] See: (i) letter to the Minister for Immigration Compliance and the Courts: DL0000140_0113; (ii) Mary Molyneux's first statement: IMB000203_0057, §163; and (iii) Mary Molyneux 25 March 2022 155/18 – 164/3 (during which Ms Molyneux gave evidence as to the sending of the letter and the response from the Home Office).
[191] Dame Anne Owers' second statement: IMB000221_0007-0009, §18.

> d. IMBs for many years have continued to raise concerns about the absence of a time limit for detention, the length of detention, and the consequences for individuals, particularly as a large proportion of those detained are subsequently released rather than removed. We provided both written and oral evidence to the Joint Parliamentary Committee on Human Rights on these and other human rights concerns. The Committee (and later the House of Commons Home Affairs Select Committee) then recommended a time limit on immigration detention, though this was rejected by the Home Office. Boards continue to flag up lengthy individual stays in detention, though they have also recorded fewer long stays.
> e. In June 2020, I wrote to the President of the Immigration Appeal Tribunal because of concerns raised by IMBs in relation to bail applications by those in detention. Because of the Covid-19 pandemic, it was extremely difficult to find suitable accommodation within the 21-day window before a bail application lapsed. The President issued new Directions to the Tribunal to avoid the need for a further application in such circumstances and in his response to me, copied to the Home Office, he reminded the Home Office that *'where accommodation is not found resulting in a delay in releasing the applicant this could give rise to 'unlawful detention' with a consequent claim for damages, and in the most serious of cases I might make use of the power to refer the matter to the Upper Tribunal under Rule 6(3) of the 2014 Procedure Rules'*."

93. All of this demonstrates that the IMB is committed to learning and of its own accord has continued to reflect and make changes to its own monitoring and training. It is also evidences that the IMB is prepared to speak out publicly on issues of concern arising out of its monitoring.

94. At the outset of this Inquiry, a core participant group questioned whether the IMB is fit for purpose. Whilst no organisation can afford to be complacent about the challenges which continue to be faced, particularly in the context of monitoring immigration detention, the Inquiry Chair can have confidence, given all the evidence presented to the Inquiry, that the IMB is able to fulfil its statutory and OPCAT obligations.

Recommendations

95. This Inquiry presents a unique opportunity to reshape and improve the immigration detention system. To that end, the Inquiry has heard a wide range of recommendations which the Inquiry Chair will consider with care.

96. On the issue of recruitment of IMB members and whether members should be paid (in addition to the expenses already provided), the Inquiry has received evidence from Dame Anne Owers (see paragraphs 24-31 of her second statement) and Ms Molyneux (see paragraph 169 of her first statement).[192]

[192] Dame Anne Owers' second statement: IMB000221_0007-0009. Mary Molyneux's first statement: IMB000203_0059.

97. The IMB endorses the recommendations made by Professor Bosworth as enumerated at the conclusion of her oral evidence.[193]

98. In addition, the IMB has previously identified three matters which should form the subject of recommendations arising from this Inquiry:

    a. First: it is imperative that the safeguards against the inappropriate use of detention which appear to have broken down at Brook House – the use of rules 34 and 35 and the Adults at Risk policy – must be strengthened with particular focus on the impact of detention on the mental health of all detained persons and especially those who are, or should be, identified as vulnerable adults at risk. IMBs have raised concerns or recommended changes in these areas in annual reports for a number of years. The IMB will, in any event, continue to focus carefully on how these operate in practice.
    b. Second: to ensure that detained people have access to meaningful support in dealing with those in the Home Office who are making decisions affecting their lives. Caseworkers should be on site and meeting with detained persons on at least a periodic basis. There should be meaningful access to legal advice, including significant improvements to mobile telephone reception, IT facilities and access to interpreters for legal appointments.
    c. Third: the IMB reiterates a recommendation made by it for many years: that, because of the profound impact which detention has on individuals, a time limit for immigration detention should be introduced.

99. The IMB would add that this Inquiry has confirmed the view held by the National Chair and Management Board that it is important that the IMB's national governance structures be placed on a statutory footing.[194]

29th April 2022

JONATHAN DIXEY
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[193] Professor Bosworth 29 March 2022 161/6 – 163/4.

[194] See Dame Anne Owers' first statement: IMB000199_0006, §17 and second statement: IMB000221_0009-0010. Within Dame Anne Owers' second statement she has addressed (at §§34-37: IMB000221_0010) the issue of whether there should be separate monitoring bodies for prisons and immigration removal centres. On this issue, see also Professor Bosworth 29 March 2022 163/12 – 164/25.