Introduction

Brook House is an immigration removal centre on the perimeter road of Gatwick Airport. It was last inspected in November 2016. It is operated by G4S, and holds adult male detainees. Since the last inspection the number of detainees held in the centre has reduced from nearly 400 to around 240.

About 10 months after the last inspection a BBC *Panorama* programme was broadcast which showed members of staff at Brook House acting in what seemed to be a violent and inappropriate manner towards detainees. A subsequent police enquiry submitted case papers to the Crown Prosecution Service, but no prosecutions were brought as a result of the criminal investigation. A further enquiry was carried out at the behest of G4S by Kate Lampard QC, and this found a number of failings in the culture and management of the establishment. At the time of this inspection a further enquiry had been commissioned by the Home Office, which is to be carried out by the Prisons and Probation Ombudsman, but at the time of writing it had been delayed pending the legal action.

Following the *Panorama* disclosures, we wanted to establish whether we had missed indications of abuse or poor behaviour during our inspection in 2016. There was no evidence that the inspection could or should have found anything similar to what was exposed by the programme; we nevertheless decided to implement what we have termed an 'enhanced methodology' at IRCs. This has involved deploying additional inspection staff to conduct extensive interviews with detainees and staff at the centre. Every detainee is now offered the opportunity to speak privately to an inspector, using interpretation where needed. With the help of community support groups, this offer is also extended to detainees who have left the centre. Inspectors undertake confidential interviews with a proportion of staff from all disciplines working in the centre, and issue a survey to all staff. This methodology provides multiple opportunities to identify potential concerns.

We found no evidence that the abusive culture shown by the *Panorama* programme was present among the current staff group at Brook House. On the contrary, our detainee survey and interviews found that most detainees were positive about the way they were treated by staff. We found improved training of staff employed in the centre, whistleblowing procedures that staff members had confidence in, and a much-improved ratio of staff numbers to detainees.

This inspection found that the judgements we made in each of the four healthy establishment tests were exactly the same as at the last inspection. We found that the appropriate assessment was of 'reasonably good' in all areas. However, the judgements themselves mask some distinct and positive developments, brought about by a determination to address the issues raised by the TV programme, to change and to improve. Nevertheless, the managers of the centre are very aware that there is still much to do.

In terms of safety, levels of violence were low. However, there was a need to understand why instances of self-harm had significantly increased and respond to our survey finding that 40% of detainees said they had felt suicidal at some point while in the centre. We also found that detainees spent too much time locked in their cells, and some aspects of security were unnecessarily stringent. The detainees who told us they did not feel safe tended to cite the uncertainty of their position and what the future held for them as the reason for this. At the last inspection we commented that the average length of detention had increased, and that not enough had been done to understand why. On this occasion we found that the average length of detention had markedly declined. However, as before, the precise reasons for this were far from clear, although where people were held for lengthy periods, our findings suggested this was due to delays in casework, as well as problems in finding suitable accommodation and in obtaining travel documents. We have commented before that when detainees have served a prison sentence before entering immigration detention, it would be beneficial if the removal process could be started in good time, while they were still serving their sentence. With nearly half of the detainees at Brook House having served prison sentences, the opportunities to speed up processes should be clear.

Safety

S4 *Arrival and early days arrangements were generally good, but initial risk assessment was not sufficiently thorough or confidential. Detainees reported good personal physical safety and there were few recorded assaults on detainees. Self-harm had increased significantly and ACDT procedures were not consistently applied. Some aspects of security were disproportionate and detainees spent long periods locked behind their doors. Procedural security was sound and anti-corruption measures were good. Rule 35 reports gave clear judgements but were not submitted for suicidal ideation. Whistleblowing procedures were understood by staff and they were willing to report concerns. Use of force was generally proportionate and governance was good. The use of separation was high but adequately justified in the cases we reviewed. The average length of detention had reduced markedly, but the lack of a detention time limit was often cited by detainees as affecting their feelings of wellbeing. There were enough legal advice surgeries and waiting times were short.* ***Outcomes for detainees were reasonably good against this healthy establishment test.***

S5 At the last inspection in 2016, we found that outcomes for detainees in Brook House IRC were reasonably good against this healthy establishment test. We made 20 recommendations about safety. At this follow-up inspection we found that four of the recommendations had been achieved, five had been partially achieved and 11 had not been achieved.

S6 Over a third of detainees continued to be transported to the centre overnight, many from other centres or after long waits in police stations. The reception environment and facilities were good. Most detainees spoke positively of their treatment on arrival. Detainee interviews were not conducted in private and did not cover enough areas of possible vulnerability and risk. There was not enough use by reception staff of professional interpreting. The induction unit was clean and in a good state of repair, with suitably equipped cells. The induction process was reasonably informative.

S7 At the start of our inspection, the centre held 46 adults at risk of harm: 30 at level two, 16 at level one and none at level three. Joint working between the Home Office, G4S and health care to identify vulnerable adults was good. Supported living plans used to care for the most vulnerable cases were good in theory but plans were not completed well enough to be a helpful tool for staff to care for detainees. Attendance at the weekly adults at risk meeting was reasonably good but only a few cases were discussed in detail.

S8 G4S whistleblowing procedures were promoted widely throughout the centre, and a reporting line had been used seven times in the previous six months. All staff in our survey said that they would report inappropriate behaviour, usually to managers, and most thought they would be taken seriously if they raised concerns. Security information reports showed that staff were alert to the potential for corruption and inappropriate behaviour by other staff.

S9 Rule 35 reports gave clear judgements but the reasoning behind the judgements was not always clear. Many commented on mental health issues in general but lacked specific consideration of post-traumatic stress disorder. Responses were largely timely. In the six months from October 2018 to March 2019, 14% of responses had led to release. In our sample, case owners often accepted the report as evidence of torture but maintained detention. Despite a higher level of self-harm than at the last inspection, and nearly a hundred constant watches in the previous six months, no Rule 35 reports had been completed on suicidal ideation.

S10 In our survey, 40% of detainees said they had felt suicidal while in the centre, reflecting a high level of distress among the population. The number of self-harm incidents had risen

substantially since the previous inspection. The quality of ACDT[3] documentation was not good enough. Assessments and reviews were timely but care maps frequently lacked detail, case reviews were not sufficiently multidisciplinary and some post-closure reviews were not completed. ACDT observations were regular but did not always demonstrate enough meaningful engagement. Not all key departments attended the safer community meetings and there was little evidence of actions being taken in response to the very useful data that were gathered and presented. Food refusal was common and was monitored well.

S11 In the previous six months, six detainees at Brook House had claimed to be children but none was subsequently found to be a child. Two detainees were held during our inspection following a Chief Immigration Officer age assessment. The centre correctly referred these detainees to social services, who confirmed the detainees to be adult. The G4S child protection training package was good. Arrangements to protect children in visits were sound.

S12 In our survey, a third of detainees said they felt unsafe, which was similar to the last inspection. In our confidential interviews, detainees who said they did not feel safe often cited concerns such as indefinite detention and anxiety about possible removal. No detainees said they had been assaulted by staff or other detainees. The level of detainee-on-detainee violence was low and no serious assaults had been recorded in the previous six months. The level of assaults on staff was much higher than in other immigration removal centres (IRCs). However, reported incidents were generally minor and none had resulted in serious injury. All incidents were investigated, but in some cases there was insufficient inquiry into the causes of violence. There was a good system for supporting perpetrators and victims of violence, but it was undermined by poor implementation.

S13 Some security arrangements remained disproportionate to the risks posed by the population: detainees were confined to cells overnight and for two roll counts a day. In the previous six months, 82% of detainees were handcuffed during escorts to external appointments, which was high. We did not find sufficient individual justification for handcuffing in several of the cases we reviewed. The volume, quality and analysis of security reports were good. There had been some good corruption prevention work. The number of strip-searches had reduced from the last inspection but was still high and some were not justified by the paperwork. There was some limited evidence of drug availability in the centre. There had been good work to interrupt the supply of drugs into the centre.

S14 The number of incidents involving force was high. There was nearly always good justification in the reviewed cases, and many incidents involved relatively little application of force. However, in a small number of cases more could have been done to resolve incidents before use of force. In our confidential interviews and survey, no staff said they had seen unjustified use of force. Records justifying force were generally completed to a good standard. Briefings before planned use of force were usually thorough and good attempts were made to de-escalate situations. All incidents were reviewed by a senior manager and there was evidence of them identifying and addressing deficiencies.

S15 There had been 130 instances of separation in the previous six months, which was similar to our last inspection but higher than in other IRCs. Separation paperwork was generally good and management reviews were thorough. Paperwork demonstrated a staged approach to testing compliance before reintegration. We saw very good efforts to engage with a particularly challenging man. Although detainees were assessed for access to the regime, there was little evidence in documentation of this happening. Conditions in the unit were reasonable.

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[3] Assessment, care in detention and teamwork case management of detainees at risk of suicide or self-harm.

Key concerns and recommendations

S42 Concern: Detainee interviews were not conducted in private and did not cover enough areas of possible vulnerability and risk. There was not enough use of professional interpreting by reception staff.

Recommendation: Reception interviews for new arrivals should be held in private using telephone interpreting wherever detainees are not fluent in English, and should consider a broad range of potential risks and vulnerabilities.

S43 Concern: During the previous six months, the centre doctors had not submitted any rule 35 reports notifying the Home Office that a detainee may be suffering suicidal ideation. Yet, in our survey 40% of detainees said they had felt suicidal at some time while in the centre. In the previous year almost 100 detainees had been on constant watch to prevent self-harm or suicide.

Recommendation: Doctors should submit a rule 35 report to the Home Office on any detainee they suspect of having suicidal ideation.

S44 Concern: The quality of ACDT documentation was not good enough. Assessments and reviews were timely but care maps frequently lacked detail, case reviews were not sufficiently multidisciplinary and some post-closure reviews were not completed. ACDT observations were regular but did not always demonstrate enough meaningful engagement.

Recommendation: Care maps should always be completed in detail and regularly updated. Case reviews, including those for post closure, should demonstrate multidisciplinary input and daily observations should be in depth and demonstrate engagement with detainees.

S45 Concern: Despite the reduction in the average length of detention, some detainees were held for prolonged periods. There was evidence that lengthy and indefinite detention affected feelings of safety and wellbeing. At the start of our inspection, 13 detainees had been held for more than six months, two of them for more than a year. The longest detention was for one year and eight months. Sluggish casework and delays in obtaining suitable accommodation and travel documents prolonged detention.

Recommendation: There should be a strict time limit on the length of detention and caseworkers should act with diligence and expedition throughout detention.

S46 Concern: Detainees were locked in their cells from 9pm to 8am and, during the day, for two half-hour periods for roll count. This was a disproportionate restriction for a detainee population.

Recommendation: Detainees should not be locked in cells and should be allowed free movement around the centre until later in the evening. (Repeated recommendation 1.49).

S47 Concern: There was a reasonable range of food choices, but we received many complaints about the food not meeting the diverse needs of the population, both in our detainee interviews and survey, where 68% of detainees said the food was quite or very bad. The centre was aware that some groups of detainees were dissatisfied with the food but had not succeeded in addressing these concerns.

Recommendation: Effective measures should be taken to ensure that a majority of detainees find the food to be of sufficient quality.

1.17 Adults at risk were discussed at a reasonably well attended multidisciplinary meeting. On-site Home Office, health services, G4S managers and, importantly, wing staff attended. We observed one meeting where the care of men on supported living plans was discussed in detail. Information sharing was good and the discussions contributed to their care. In one case the off-site Home Office case owner contributed via speaker phone. There was little discussion about the other adults at risk who did not have a supported living plan.

1.18 During the six months from October 2018 to March 2019, Brook House doctors had submitted 93 Rule 35 reports, 91 of which related to torture and two to the impact of detention on health. Fourteen per cent of the 91 reports had led to release.

1.19 We were concerned that doctors had not submitted any reports on suicidal intentions and thoughts (see paragraph 2.65 and key concern and recommendation S43). The level of self-harm was higher than at the last inspection. During the previous six months, centre staff had initiated suicide and self-harm prevention (ACDT) measures on 167 occasions and in the last year 95 detainees had been placed on constant watch. This was reflected in our survey, where 40% of detainees said they had felt suicidal while in the centre. The health services were aware of this and had recently created a pathway so that every detainee on an ACDT received a full mental health assessment by a registered mental health nurse within six days of the ACDT being opened. A doctor would then consider whether to submit a Rule 35 report. It was too early to judge the effectiveness of this initiative.

1.20 We reviewed 10 Rule 35 reports and their replies. All related to torture. One report had led to release and another detainee was released before the report was considered. In seven cases the reports were accepted as evidence of torture, but immigration factors were cited as reasons to maintain detention. In one case, the case worker did not dispute the events described by the detainee but concluded that they did not meet the definition of torture.

1.21 The reports that we reviewed all gave clear judgements but the reasoning behind the judgements was not always clear. Most reports commented on the state of the detainee's mental health but did not consider whether the detainee was suffering from post-traumatic stress disorder. All but one report contained body maps where relevant and all reports were legible.

1.22 Most replies were timely with the exception of two, one of which was delayed by more than a week. Some reports in our sample were considered, not by the case worker, but officers from a dedicated Home Office team. There was no discernible difference in the quality of responses from this team.

1.23 Staff submitted a large number of security information reports to prevent corruption. In the previous six months, 307 reports had been submitted, 107 by detainee custody managers and 200 by detainee custody officers (see paragraphs 1.49 and 1.52). Whistleblowing procedures were promoted widely in staff areas throughout the centre. G4S staff could report unlawful or inappropriate behaviour anonymously by telephone or online using the G4S Speak Out service. The service had been used seven times in the previous six months. All staff in our interviews said that they would report any inappropriate behaviour towards detainees, usually to managers; 12% did not believe that they would be taken seriously if they raised a concern.

Self-harm and suicide prevention

1.24 In our survey, 40% of detainees said they had felt suicidal while at the centre, reflecting a high level of distress. The number of self-harm incidents had risen significantly since the last inspection. During the previous six months, there had been 79 recorded incidents of self-

Safeguarding children

Expected outcomes:
The centre promotes the welfare of children and protects them from all kind of harm and neglect.

1.33 The centre had one comprehensive policy for safeguarding children and adults despite the distinct needs of these groups.

1.34 During the previous six months, six detainees had claimed to be children, but none was subsequently found to be a child. Shortly before our inspection and following a legal challenge, the Home Office had amended its policy to strengthen the test used by chief immigration officers (CIOs) to assess age. Two detainees were held who had been age assessed by a CIO before the policy change. We were pleased to see that the Home Office had referred both cases to West Sussex County Council. Social workers promptly attended the centre and confirmed that the detainees were adults. Links with the Council's children's services were sound.

1.35 The centre's age dispute policy had not been updated following the CIO age assessment test. It was otherwise a good policy which described the steps to be taken if a detainee claimed to be a child. The detainee would be consulted, a care plan opened and consideration given to relocating the detainee within Brook House or moving them to the more relaxed environment of Tinsley House IRC.

1.36 The G4S child protection training package for new staff was comprehensive, covering general child protection principles and the distinct protection issues arising in Brook House. Arrangements to protect children in visits were sound and visits staff were alerted to detainees who posed a risk to visiting children.

Personal safety

Expected outcomes:
Everyone is and feels safe. The centre promotes positive behaviour and protects detainees from bullying and victimisation. Security measures and the use of force are proportionate to the need to keep detainees safe.

1.37 In our survey, two-thirds of detainees said they felt unsafe. However, very few detainees in our confidential interviews told us they felt physically unsafe in the centre and none said that they had been assaulted by staff or other detainees. The detainees who said they did not feel safe cited concerns such as indefinite detention, anxiety about possible removal, the behaviour of other detainees or concerns about health care.

1.38 The level of detainee-on-detainee violence was low. In the previous six months, there had been 14 such assaults, which was similar to the level we see in other IRCs and at the last inspection. None of these assaults was classed as serious. There had been 12 fights in the same period.

1.39 However, the level of reported violence against staff had increased since the last inspection and was much higher than in other IRCs. There had been 51 assaults on staff. In the sample that we looked at, assaults were generally minor and none had resulted in serious injury. Managers attributed the high level of staff assaults to strict compliance with reporting requirements. Further investigation was needed to confirm this.

1.40 Systems and practices for identifying violence were good and records of incidents were examined to ensure they were logged and investigated. All cases were investigated, but in some there was not enough enquiry into the causes of violence. This weakness was reflected in data presented to the monthly safer communities meeting which was otherwise good. Managers suggested that frustration at the delays in Home Office casework was a significant factor, but this had not been established evidentially.

1.41 A violence reduction strategy and action plan were in place, but attendance at the safer communities meeting was generally poor. No discussion or actions were recorded arising from data on violence presented to the previous six meetings. A useful 'detainee of interest' meeting also took place each week (see paragraph 1.51).

1.42 In the past six months, 26 detainees had been formally monitored for bullying and violence, compared with 12 at the last inspection when the population was higher. However, at the time of the inspection, only one victim support document and one perpetrator document were open. Perpetrators and victims were managed through 'Monitor-Challenge-Support' books, which included provision for care planning, case reviews and monitoring. This was a good system, but it was undermined by poor implementation. In many cases, there was no record of whether care plan actions were completed and staff observations suggested some confusion about the purpose of the books. Some victims who were considered vulnerable were located on the quieter E wing. Otherwise, support books did not demonstrate adequate tailored provision for victims.

1.43 The centre no longer used the punitive incentives scheme that was in operation at our last inspection.

Recommendation

1.44 **Violence reduction processes should focus on identifying, quantifying and addressing the causes of violence.**

Security and freedom of movement

Expected outcomes:
Detainees feel secure. They have a relaxed regime with as much freedom of movement as is consistent with the need to maintain a safe and well-ordered community.

1.45 The physical security features of the centre resembled a category B prison and some security measures remained disproportionate to the risks posed by the population.

1.46 Freedom of movement was good during association, but detainees were locked in their cells from 9pm to 8am and for two half-hour periods during the day for roll count. In our survey, detainees commented on the adverse impact of this restriction. One said: 'The closed doors create a bad feeling in me and locking doors are also irritating and it hurts me emotionally ...' (see key concern and recommendation S46).

1.47 During the previous six months, 82% of detainees were handcuffed on hospital escorts, in some cases without sufficient justification. The number of strip-searches in the last six months had reduced from 52 at the last inspection to 27, but this was still high compared with other centres and the justification for some strip searches was still not recorded. Visits restrictions were, however, applied appropriately.

Use of force and single separation

Expected outcomes:
Force is only used as a last resort and for legitimate reasons. Detainees are placed in the separation unit on proper authority, for security and safety reasons only, and are held in the unit for the shortest possible period.

1.57 The number of incidents involving force was high. During the previous six months, staff had used force on 141 occasions compared with 80 at the last inspection. This was also more than we see at other IRCs, including those with a similar detainee profile.

1.58 There had been no clear analysis of the reasons for the increase, although managers told us that, in response to the Panorama investigation, there had been a drive to ensure strict compliance with reporting requirements. Paperwork had been routinely completed for very minor incidents and the documentation that we reviewed confirmed that many incidents involved relatively little application of force.

1.59 The use of force committee met monthly, but attendance was very variable. The meeting focused on practical matters such as training. Some useful data were presented but did not generate any discussion or actions. However, all incidents were reviewed by a senior manager and there was evidence that deficiencies were identified and addressed.

1.60 The inspection took place almost two years after BBC Panorama's September 2017 documentary which showed clear and very disturbing evidence of excessive use of force on detainees in Brook House. In addition to the incidents reported in the documentary, there was evidence of further abuse at around the time of the events shown. In a very concerning case, the Home Office Professional Standards Unit (PSU) found that an officer had assaulted a detainee on three occasions in June 2017. The same officer was shown in the Panorama documentary to have engaged in poor, unprofessional, insulting and possibly physically abusive behaviour.

1.61 The PSU also found that excessive force had been used against a detainee in October 2017 during the removal of his cell mate for a night time escort. It found that force was neither proportionate nor necessary, because staff had not spoken directly to him beforehand to explain what was happening and explore alternatives, such as moving him to another cell.

1.62 More recent records justifying force that we examined were completed to a good standard, although we saw a few staff reports which were not sufficiently detailed. Briefings before planned use of force were usually good and, in almost all cases that we reviewed, there were reasonable attempts at de-escalation and good justification of use.

1.63 However, in one case attempts to resolve an issue could have been made before planned use of force on a detainee who had self-harmed. It was particularly concerning that health care staff were not present from the outset of this planned intervention and were only summoned when a medical emergency was called (in the event, the detainee's injury was minor).

1.64 In our confidential interviews with detainees, none said they had been assaulted by staff. No staff said they had seen unjustified use of force in our survey or interviews. At the time of the inspection, no complaints about excessive use of force had been upheld by the PSU for incidents occurring after 2017, although other failings had been identified, such as a staff member swearing at a detainee. PSU investigations that we saw were thorough.

1.65 Conditions in the six-cell separation unit were reasonable. It was clean and reasonably bright and rooms were appropriately furnished. When in use, the ratio of staff to detainees was

Recommendation

2.14 Toilets and basins should be clean and unstained.

Good practice

2.15 *High standards of cleanliness were sustained through active management which included unlocking cleaners after lock-up at night to do a thorough clean of common areas; allocation of cleaners to specific tasks and careful management and monitoring of those tasks; use of high quality paint which could be kept clean; appointment of room orderlies to ensure that any vacated room was immediately cleaned and fully equipped; a cleanest wing competition with incentives; controlled and predictable provision of cleaning materials; and immediate removal of any graffiti.*

Detainee consultation, applications and redress

2.16 A detainee forum was held each Thursday morning. On the last Thursday of the month this took the form of a consultative council chaired by the director or centre manager. Notes were taken, but actions were not systematically tracked and many issues were repeated at consecutive meetings. There was good multidisciplinary attendance by staff at these meetings.

2.17 An average of 15 complaints were received each month, similar to the last inspection. Complaints were efficiently handled; forms were available in 21 languages on all residential units and the boxes were emptied every day by Home Office staff. A senior manager quality checked 10% of complaint responses each month. However, all the responses were lengthy and written in templates alongside standard material. The intention was positive but the templates made the responses difficult for many detainees to understand, especially those with little English. Most responses were defensive and focused on the precise wording of the complaint in a legalistic way.

2.18 In our interviews, 47% of detainees said they did not feel confident about making complaints, often because they had no faith in the effectiveness of the complaints system, particularly in resolving key concerns about immigration status.

2.19 Any complaints judged by the investigator to be upheld were sent for approval to the centre manager or director. A reluctance to uphold complaints had increased, with no explicit change in policy. During 2018, 8% had been fully substantiated. During the last six months, 95 complaints had been dealt with by G4S, only one of which (1%) had been substantiated. We saw evidence that some of the unsubstantiated complaints should have been upheld (see key concern and recommendation S48).

Recommendation

2.20 Decisions on actions should be made, and their implementation tracked, at detainee consultation meetings.

Residential services

2.21 The catering department had put considerable work into consulting detainees and introducing varied choices at each meal. Hot meals continued to be served at lunchtime and in the evening, and breakfast alternately included baked beans and boiled eggs. The portions

S46	Key concern: Detainees were locked in their cells from 9pm to 8am and, during the day, for two half-hour periods for roll count. This was a disproportionate restriction for a detainee population. **Recommendation: Detainees should not be locked in cells and should be allowed free movement around the centre until later in the evening**	Centre manager
S47	Key concern: There was a reasonable range of food choices, but we received many complaints about the food not meeting the diverse needs of the population, both in our detainee interviews and survey, where 68% of detainees said the food was quite or very bad. The centre was aware that some groups of detainees were dissatisfied with the food but had not succeeded in addressing these concerns. **Recommendation: Effective measures should be taken to ensure that a majority of detainees find the food to be of sufficient quality.**	Centre manager
S48	Key concern: The complaints system had several layers of quality checking. However, while courteous, replies often took an unhelpfully defensive and legalistic approach. Almost no complaints were upheld, and in some cases, that had clearly been the wrong decision. In both our survey and interviews, nearly half the detainees suggested that they did not have confidence in the complaints system. **Recommendation: Managers should investigate and address the reasons for detainees' low confidence in the complaints system.**	Centre manager
S49	Key concern: There was no systematic approach to the identification of individuals' protected characteristics. **Recommendation: Information about the protected characteristics of all detainees should be systematically collected on arrival, with support offered where necessary.**	Centre manager
S50	Key concern: The centre did not give detainees enough encouragement to participate in education and improve their skills. Managers had not developed policies to incentivise consistent attendance. The centre induction did not include advice or guidance to help and encourage detainees to choose a course. **Recommendation: Managers should significantly increase the number of detainees who benefit from the education provision, through better promotion, guidance and incentives to improve participation.**	Centre manager
S51	Key concern: Although access to fitness provision was reasonably good, there were not enough activities to promote wellbeing, relaxation or stress relief to help detainees who were often preoccupied by their cases. **Recommendation: Managers should introduce relaxation and stress-relief activities into the centre's activities programme.**	Centre manager

Section 6: Respectful detention

6.1 Please answer the following questions about the wing or residential unit you are currently living on:

	Yes	No	Don't know
Do you normally have enough clean, suitable clothes for the week?	79 (56%)	54 (38%)	9 (6%)
Can you shower every day?	135 (91%)	1 (1%)	12 (8%)
Do you have clean sheets every week?	71 (51%)	47 (34%)	20 (14%)
Do you get cleaning materials for your room every week?	71 (53%)	48 (36%)	14 (11%)
Is it normally quiet enough for you to sleep or relax at night?	64 (45%)	69 (48%)	10 (7%)
Can you get your property from the centre's property store when you need it?	74 (55%)	33 (25%)	27 (20%)

6.2 Normally, how clean or dirty are the communal/shared areas of your wing or unit (landings, stairs, showers etc.)?

Very clean	36 (24%)
Quite clean	73 (48%)
Quite dirty	27 (18%)
Very dirty	15 (10%)

6.3 What is the quality of food here?

Very good	15 (10%)
Quite good	34 (22%)
Quite bad	35 (23%)
Very bad	69 (45%)

6.4 Do you get enough to eat at meal times?

Always	45 (30%)
Most of the time	26 (18%)
Some of the time	47 (32%)
Never	30 (20%)

6.5 Does the centre's shop sell the things that you need?

Yes	67 (45%)
No	58 (39%)
Don't know	25 (17%)

6.6 Do you know how to make a complaint about your treatment in this centre?

Yes	62 (42%)
No	85 (58%)

6.7 In your experience, are complaints dealt with fairly?

Yes	14 (10%)
No	15 (10%)
Not made a complaint	116 (80%)

6.8 Have you ever been too afraid to make a complaint about your treatment in this centre?

Yes	49 (35%)
No	91 (65%)

9.2 Where have you felt unsafe? (Please tick all that apply.)

In your room	36 (29%)
On corridors	32 (26%)
In the dining hall	22 (18%)
At health care	18 (15%)
In association or shared areas (e.g. TV room)	19 (15%)
In activity areas (e.g. library, IT room, education, gym)	18 (15%)
In outside areas	26 (21%)
Anywhere else in this centre	20 (16%)
Never felt unsafe here	51 (41%)

9.3 Do you feel unsafe now?

Yes	48 (34%)
No	94 (66%)

9.4 Have you experienced any of the following forms of victimisation or bullying from other detainees here? (Please tick all that apply.)

Verbal abuse	22 (18%)
Threats or intimidation	24 (20%)
Sexual comments	6 (5%)
Sexual assault	1 (1%)
Physical assault	12 (10%)
Theft	11 (9%)
Other	7 (6%)
Not experienced any of these from detainees here	81 (66%)

9.5 If you were being bullied or victimised by other detainees here, would you report it?

Yes	95 (68%)
No	45 (32%)

9.6 Have you experienced any of the following forms of victimisation or bullying from staff here? (Please tick all that apply.)

Verbal abuse	15 (11%)
Threats or intimidation	11 (8%)
Sexual comments	2 (2%)
Sexual assault	1 (1%)
Physical assault	4 (3%)
Theft	2 (2%)
Other	10 (8%)
Not experienced any of these from staff here	106 (80%)

9.7 If you were being bullied or victimised by staff here, would you report it?

Yes	100 (75%)
No	33 (25%)

Section 10: Alcohol and drugs

10.1 While in this centre, have you developed any problems with:

	Yes	No
Illicit drugs	11 (9%)	108 (91%)
Medication not prescribed to you	30 (25%)	91 (75%)
Alcohol	8 (7%)	103 (93%)