Report on an unannounced inspection of

# Brook House Immigration Removal Centre

by HM Chief Inspector of Prisons

30 May – 16 June 2022

# Contents

# Introduction

Brook House Immigration Removal Centre (IRC) is located in the shadow of Gatwick airport. At the time of inspection there were 344 detainees, a population that had increased considerably in the last few weeks. While most detainees were held in the centre for just a few weeks, we came across five who had been locked in immigration detention for more than two-and-a-half years.

Increased numbers meant that the centre felt crowded – the prison-like wings were noisy and the sparse, small exercise yards meant there was limited outdoor space. The lack of mobile phone signal across the site meant that detainees struggled to make calls, adding to their sense of isolation and uncertainty. Off the wing there was an inadequate library that had been neglected, while the gym and the art room were not big enough for the population. While teachers were engaging and got on well with their students, there was insufficient oversight of education by leaders. This meant detainees were not being properly assessed, the suitability of the curriculum had not been tested, and there was no monitoring of progress or quality assurance of teaching.

The Home Office run Detention Engagement Team, which had largely vacated the site during the COVID-19 pandemic, had begun to provide better support to detainees, and there were also welcome plans in place to introduce more wing-based surgeries. Progress had been too slow and much of the frustration, anger and anxiety we found among detainees was due to delays in the Home Office processing cases and failing to provide sufficient information about progression or decisions. We were concerned that in our survey, 28% of detainees said they had felt suicidal at some time. To some extent, the uncertainty was mitigated by a well-staffed and committed welfare team that provided good support to detainees, giving them as much information as possible and answering questions when they arose. However, there was no psychological support for the high number of detainees with mental health needs, and it was worrying that the separation unit had been used to hold detainees with poor mental health.

Leaders were doing some promising work looking to assess and improve the staff culture, which was welcome because our survey found that morale among some staff was not good. In general, we were impressed with the staff, who had good relationships with detainees and engaged with them well. However, we also saw a reluctance to challenge some low-level poor behaviour such as smoking on the wings and pushing into queues. In our survey, it was telling that a third of detainees said they felt unsafe at the time of our inspection. The quality of detainee operational managers (DOMs) varied and there was more work for leaders to do to make sure that DOMs had sufficient training and support to perform this important role effectively.

Our visit coincided with the first attempt to remove detainees to Rwanda. There had not been enough information given to operational staff, meaning that they were unable to reassure the men or answer their queries, leading to increased levels of stress among detainees. There was no interpreter at the Home Office-

led briefing for detainees, meaning many did not understand what they were being told, and a leaflet they were given did not contain much useful information. The Home Office and the centre will need to work closely together and learn from the recent attempted removals to make sure that processes are better organised, and that staff and detainees are kept informed and given sufficient time to make preparations.

While the use of force remained relatively high, the centre had worked hard to make sure that the governance had improved. There was a review of each incident by senior managers and the use of body-worn cameras had improved. Staff members who had been repeatedly involved in use of force were given a formal review. In our confidential interviews, none of the detainees said they had been assaulted by staff members.

Leaders have worked to make sure that the general standards of care and accommodation at Brook House were reasonably good and the treatment by staff is mostly positive. The Home Office will need to be more active, processing cases more quickly, keeping detainees informed and where possible releasing them into the community. A reduction in the overall numbers of detainees would mean the centre would feel safer and quieter and there could be more activities on offer.

**Charlie Taylor**
HM Chief Inspector of Prisons
August 2022

# What needs to improve at Brook House Immigration Removal Centre

During this inspection we identified 15 key concerns, of which six should be treated as priorities. Priority concerns are those that are most important to improving outcomes for detainees. They require immediate attention by leaders and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

## Priority concerns

1. **Case progression was slow for many detainees and the length of detention remained unacceptably long in some cases**. The person detained the longest at Brook House had been there for 16 months and we found five cases where people had been held in different places of detention for over 1,000 days. Delays obtaining travel documents and a lack of bail accommodation contributed to lengthy detention.

2. **The centre did not provide an open or relaxed environment suitable for immigration detainees.** The centre was crowded and noisy, ventilation in cells was inadequate and the prison-like environment was one of the main reasons that detainees gave for feeling unsafe.

3. **The centre did not meet the needs of the high number of detainees with mental health problems.** The centre held many people with low-level mental health needs who could not access psychological interventions as all the psychology posts were vacant. Several detainees with poor mental health had been located in the separation unit, which was not a suitable place for them.

4. **The number of activity places and space in the centre as a whole were not sufficient for the current population.** Few detainees were in employment or attended education. There was little activity to promote well-being, relaxation and stress relief. The library service was very poor and the gym too small.

5. **Management oversight of the education provision was weak.** Teachers did not receive sufficient management support. They lacked supervision and guidance. There were no clear processes for curriculum planning or review, and no analysis of learners' achievements was undertaken. Teachers had not received any recent staff development.

6. **The mobile phone signal in the centre was poor.** This restricted detainees' ability to maintain contact with the outside world when they were locked in their cells.

## Key concerns

7. **The identification and management of risks on arrival was not good enough.** Not all detainees were offered a private interview on arrival and staff did not always spend enough time enquiring into detainees' risks. The standard of health screening was variable.

8. **The Rule 35 report process was not being used to its fullest extent to protect detainees who had conditions that might have been worsened by detention.** Nearly all reports related to potential victims of torture and very few were prepared for detainees with health problems or suicidal ideation.

9. **Assessment, care in detention and teamwork case management for detainees at risk of suicide or self-harm was not good enough.** Assessments were sometimes very brief and care maps lacked detail. Health care staff and Home Office attendance at reviews was poor, and interpretation was not consistently used.

10. **Detainees were inappropriately locked in cells overnight.** They could have been left unlocked if they had been given a key to their cell and if there had been sufficient staffing at night.

11. **Detainees who had been told they were to be removed to Rwanda found it difficult to access their legal rights and had been given inadequate information**. They had difficulties in responding to the notice of intent to remove them within the seven-day window and problems obtaining or communicating with legal representatives. The information provided to detainees who had been told they were to be removed to Rwanda was of little value.

12. **Too many staff did not supervise the units in a sufficiently professional or confident manner.** Minor misbehaviour that could escalate tension if unchallenged was not managed consistently. For example, detainees were observed smoking on the landing, pushing in food queues and playing very loud music. Operational leaders did not provide the high number of inexperienced staff with enough support in the units.

13. **Equality work was underdeveloped.** Data collection on equality and diversity was not systematic and there was a lack of investigation and action in areas where there might have been evidence of unfair outcomes.

14. **Governance of health services was not sufficiently robust.** The systems and processes for managing clinical audit and clinical incidents did not meet the standards for safe and effective practice.

**15. Emergency protocols were not consistent and not all staff used the centre's method of summoning emergency assistance.**

**Care Quality Commission regulatory requirement**

There were not always sufficient, qualified health care staff deployed in primary health care and to provide appropriate mental health and psychological support to detainees.

# About Brook House Immigration Removal Centre

**Task of the establishment**
The detention, care and welfare of adult detainees subject to immigration control.

**Certified normal accommodation and operational capacity (see Glossary of terms)**
Detainees held at the time of inspection: 344
Baseline certified normal capacity: 450
In-use certified normal capacity: 450
Operational capacity: 450

**Population of the centre**
- 77% of the population had been held for less than one month, although five detainees had been held for longer than six months.
- 37% of the population arrived at the centre from prison.
- 36% of the centre's population were Albanian nationals.
- At the time of our inspection, 68 detainees had been given 'notices of intention' (see Glossary of terms) informing them that they were eligible for removal to Rwanda.

**Name of contractor**
Serco

**Escort provider: Mitie**
Health service commissioner and providers: Practice Plus Group
Learning and skills providers: Serco

**Location**
Gatwick Airport

**Brief history**
Brook House opened in March 2009 and is a purpose-built immigration removal centre with a prison design. It holds a mix of detainees, including a number who are regarded as too challenging or difficult to manage in less secure centres and those waiting to be removed from the UK on organised charter flights. In May 2020, the contract for managing the centre passed from G4S to Serco.

**Short description of residential units**
The centre has four main wings (A, B, C and D). Three wings have three landings and the fourth, the induction wing, has two landings. The ground floor of the induction wing is a discrete unit (E wing) used to manage detainees with complex needs and those who are separated from the rest of the population.

**Name of centre manager and date in post**
Steve Hewer, May 2020

**Leadership changes since the last inspection**
Phil Wragg, in post until May 2020

**Independent Monitoring Board chair**
Neil Beers

**Date of last inspection**
20 May – 7 June 2019

# Section 1 Summary of key findings

1.1 We last inspected Brook House in 2019 and made 34 recommendations, 12 of which were about areas of key concern. The immigration removal centre (IRC) fully accepted 26 of the recommendations and partially (or subject to resources) accepted seven. It rejected one of the recommendations.

1.2 Section 8 contains a full list of recommendations made at the last full inspection and the progress against them.

## Progress on key concerns and recommendations

1.3 Our last inspection of Brook House took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for detainees at the time. Although we recognise that the challenges of keeping detainees safe during COVID-19 will have changed the focus for many IRC leaders, we believe that it is important to report on progress in areas of key concern to help leaders to continue to drive improvement.

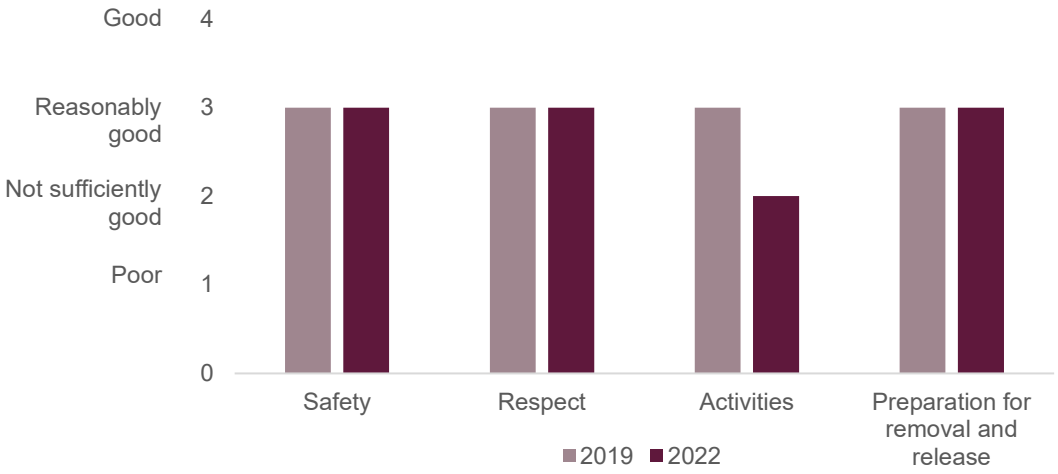
1.4 At our last full inspection, we made 12 recommendations about key concerns. At this inspection we found that one of those recommendations had been achieved, three had been partially achieved and eight had not been achieved. At this inspection we found that one recommendation made in safety had been partially achieved and four had not been achieved. In the area of respect one recommendation had been achieved and two had not. Neither of the recommendations made in the area of activities had been achieved, and in preparation for removal and release both recommendations had been partially achieved. For a full summary of the recommendations achieved, partially achieved and not achieved, please see Section 8.

## Outcomes for detainees

1.5 We assess outcomes for detainees against four healthy establishment tests (see Appendix I for more information about the tests). At this inspection of Brook House, we found that outcomes for detainees had stayed the same in three healthy establishment areas and declined in one.

1.6 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account the IRC's recovery from COVID-19.

**Figure 1: Brook House Immigration Removal Centre healthy establishment outcomes 2019 and 2022**




## Safety

At the last inspection of Brook House in 2019 we found that outcomes for detainees were reasonably good against this healthy establishment test.

At this inspection we found that outcomes for detainees remained reasonably good.

1.7 About 20% of detainees arrived at the centre overnight and not all were offered a private reception interview. Reception staff were welcoming and prioritised those identified as vulnerable, but first night safety procedures were not always followed. Detainees received a good one-to-one induction.

1.8 More than a third of detainees were classed by the Home Office as being at risk of harm, including three who were at the highest level of risk. Nearly all Rule 35 reports (see Glossary of terms) concerned claims of torture. Detention was maintained in most of these cases, including where the Home Office accepted that a detainee had experienced torture. Centre staff generally provided a good level of care for vulnerable detainees. There were various ways of reporting concerns about the treatment of detainees, although in our staff survey a minority said either that they would not raise concerns if they had them or that they were not sure if they would.

1.9 In our survey, 28% of detainees said they had felt suicidal at the centre. There had been 33 recorded self-harm incidents in the last six months, which was lower than at the previous inspection and no incidents had resulted in serious injury. There had been no deaths in Brook House since the last inspection, but during the inspection a detainee died shortly after his release on bail. Although detainees subject to assessment, care in detention and teamwork (ACDT) case management for detainees at risk of suicide or self-harm told us they

felt well cared for by staff, most ACDT documentation did not assure us that risk management was effective, and health care staff and Home Office attendance at case reviews was poor.

1.10 Five detainees had been subject to age dispute procedures in the previous six months, and all had individual care plans suggesting that they had been appropriately safeguarded and had received care in the centre. Links with local social services were good, but in one case a child was held for 16 days before the local authority took him into their care. There had been no reviews so lessons could be learned.

1.11 In our survey, 33% of detainees told us they felt unsafe in the centre at the time of the inspection. Our interviews suggested that this was mainly due to uncertainty over their immigration case, the prison-like environment and conflict between frustrated detainees. There was little recorded violence, but two assaults in the previous six months had been classed as serious. No detainees reported that staff had physically mistreated them.

1.12 Security was well managed, and staff submitted a good amount of security information. Detainees now had more time out of their cells than at the last inspection, but they should not have been locked up at all. In other respects, security measures were proportionate.

1.13 The number of incidents in which force was used was high, but most cases involved a minimal level of force and there had been no serious injuries. Management oversight of use of force was good. Senior managers reviewed all incidents within 24 hours and officers who had repeatedly used force had a formal review. Body-worn cameras were well used and usually showed that incidents were handled effectively. We examined in detail one use of force case raised by some detainees who had not witnessed the incident themselves. We concluded that the action taken in this case was proportionate. Separation was used less frequently than at the previous inspection and most paperwork we reviewed showed reasonable grounds for its use. However, we looked at two cases where the justification for separation was poor, both involving the segregation of the victim of an assault. It was a concern that the unit had held a number of detainees with poor mental health, including at least one who was considered unfit fit for detention.

1.14 While most detainees were held in the centre for no more than a few weeks, five had been held for over six months. Home Office data also showed that five current detainees had been in different centres and prisons for over 1000 days, which was unacceptably long. Slow case progression, delays in obtaining travel documents, and a lack of suitable bail accommodation contributed to lengthy detention.

1.15 Detainees could access half an hour of free legal advice through weekly surgeries. The Home Office's detention engagement team was now routinely speaking to detainees face-to-face, but many detainees complained about a lack of meaningful new information in case updates and difficulties in obtaining answers to their ad hoc queries. The planned return of unit surgeries was a welcome step that could

help address these issues. Detainees who were due to be relocated to Rwanda could not easily obtain legal representation, communicate with their representatives or gain a sufficient understanding of the process in the seven-day window provided to reply to the notice of intent (see Glossary of terms).

## Respect

At the last inspection Brook House in 2019 we found that outcomes for detainees were reasonably good against this healthy establishment test.

At this inspection we found that outcomes for detainees remained reasonably good.

1.16 In our survey and interviews, the vast majority of detainees said staff treated them with respect. However, staff did not always challenge low-level behaviour, such as smoking in units or pushing in food queues. A large number were inexperienced and operational leaders did not provide them with enough support in the units. Serco leaders had commissioned some promising work to help better understand staff culture and areas of concern, but it was still in its early stages of implementation.

1.17 The centre was clean, cells were in reasonable condition and detainees could obtain cleaning materials. Laundry arrangements were adequate, and showers and toilets were now reasonably well screened. However, the centre was crowded and noisy, ventilation in cells was inadequate and the prison-like design remained inappropriate for a detainee population.

1.18 There were few formal complaints. More were upheld than at the last inspection and most of those who made a complaint said they had been dealt with fairly. Unit forums were held every week but were not always well attended, nor was interpretation used. The quality and quantity of food was not always sufficient, although more detainees than at the previous inspection said the food was good. The cultural kitchen was under-used.

1.19 There had been little recent focus on equality work, but a new action plan was being implemented and there were early signs of progress. Telephone interpretation was used reasonably well.

1.20 There was a visible and accessible team of chaplains who offered structured religious activities on most days. Detainees had free access to recently improved faith rooms during association periods.

1.21 In our survey, detainees reported a better experience of health care than at the previous inspection. Significant staffing vacancies meant health provision was precarious, but care was being delivered diligently. Health screening was not always being completed adequately and there was still no confidential health care complaints system. There were short waiting times for GP and nurse appointments

and medicines management arrangements were safe and effective. However, there were several areas of weakness. Custody staff still did not use the correct method for summoning emergency medical assistance, which could cause confusion and delays. The large number of detainees with lower-level mental health needs were being seen by nurses but could not access psychological interventions.

### Activities

At the last inspection of Brook House in 2019 we found that outcomes for detainees were reasonably good against this healthy establishment test.

At this inspection we found that outcomes for detainees were now not sufficiently good.

1.22 There was a reasonable range of activities but still not enough provision to promote well-being, relaxation and stress relief. The number of activity places and space in the centre were not sufficient for the current population. A recent rise in detainee numbers had exposed the limitations of the centre's infrastructure.

1.23 Management oversight of the education provision was not sufficient. Teachers were left to do as they thought best, without supervision, guidance, support, or development opportunities. There was a limited range of taught classes, although detainees could study accredited short courses, such as customer service. The art room provided opportunities for creative expression and was popular but too small. Teachers were enthusiastic and developed a good rapport with detainees, and those who attended regularly made reasonable progress. There was insufficient paid work, and few detainees were in employment. None of the jobs offered training.

1.24 The library was poorly stocked and managed, and little used by detainees. The gym was popular but far too small for the population and several machines were out of order. Yards were used for some sports but were too small. There were no links to the health care department.

### Preparation for removal and release

At the last inspection of Brook House in 2019 we found that outcomes for detainees were reasonably good against this healthy establishment test.

At this inspection we found that outcomes for detainees remained reasonably good.

1.25 The welfare team had been expanded and was very active. Staff now interviewed every new arrival within 48 hours and followed up any identified needs. The welfare office was easily accessible and some of the team were trained to provide basic immigration advice and

assistance. The Gatwick Detainee Welfare Group contributed well to welfare work in the centre.

1.26 There were enough visiting slots for detainees, and staff were reasonably welcoming. The visitors' centre and the visits hall provided a fairly comfortable environment, but both areas were in need of refurbishment. The children's play area in the visits hall was inadequate.

1.27 The mobile phone signal in the centre was poor and plans to resolve the problem had not yet been implemented. Access to and take-up of Skype was good, and it was positive that each unit had a room for this facility, but the provision was inadequately managed. Internet access was good, but detainees still could not use social networks.

1.28 About half of detainees leaving the centre were released into the community after a potentially damaging period of detention. Many detainees who were granted bail continued to be detained for lengthy periods because of a lack of bail accommodation. Staff had not been adequately briefed on the operation to remove detainees to Rwanda, which left them poorly placed to support detainees who were affected. Group sessions to advise detainees on their removal to Rwanda were poorly organised and written information on the country was of little practical value and had only been translated shortly before the planned flight.

## Notable positive practice

1.29 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

1.30 Inspectors found three examples of notable positive practice during this inspection.

1.31 Newly arrived detainees who were identified as vulnerable were seen first by reception staff, which minimised the time they had to spend in reception before going to their living accommodation. (See paragraph 2.3.)

1.32 The expanded welfare team provided detainees with very good support. Team members now interviewed every new arrival within 48 hours, recording salient information about the individual and following up on any identified needs. Their office was freely accessible, they were knowledgeable and made good use of interpretation. (See paragraph 2.5.)

1.33 Serco leaders had taken action to improve staff culture. Some early-stages but promising work had been undertaken to help leaders identify

areas of strength and weakness, and it was being used to inform strategic planning priorities. (See paragraph 3.4.)

# Section 2 Safety

**Detainees are held in safety and with due regard to the insecurity of their position.**

## Arrival and early days in detention

Expected outcomes: Detainees travelling to and arriving at the centre are treated with respect and care. Risks are identified and acted on. Detainees are supported on their first night. Induction is comprehensive.

2.1 Some detainees told us they were held for several hours in reporting centres before being escorted to Brook House. One detainee was detained at 10am and entered his cell at Brook House over 12 hours later, having spent the intervening time in a short-term holding facility, travelling or waiting in escort vehicles. Too many detainees continued to be escorted at night, with over 20% arriving in Brook House between midnight and 4am.

2.2 In our survey, 77% of detainees said escort staff treated them well or quite well during their journey to the centre. Vehicles that we examined were clean, in good condition and stocked with snacks and water.

2.3 The centre generally received advance notice of detainees' arrival. However, information about their medical needs, vulnerabilities and disabilities was not always provided in the movement documentation, particularly when detainees had arrived on small boats. Detainees who were identified as being vulnerable were appropriately dealt with first (see paragraph 1.30). Otherwise, they could spend over three hours in reception.

2.4 The reception area was spacious and well-furnished. Reception staff were relaxed and welcoming and made good attempts to put detainees at ease. In our survey, 90% of detainees said they were treated well or quite well in reception.

2.5 Not all detainees were offered a private interview and staff did not always spend enough time enquiring into detainees' risks. A member of the health care team saw detainees for a confidential medical interview, but the interviews were of variable quality (see paragraph 3.37). Some detainees told us that interpreters were not used when they were needed during the reception process. However, welfare staff now interviewed detainees in private on reception, which offset some of these weaknesses. Welfare staff helped to identify detainees' needs before they left the centre and addressed their immediate concerns (1.31).

2.6 The first night unit staff were warm and welcoming, and the unit was reasonably clean. However, the handovers we observed between day

and night staff were poor and, in some cases, they did not happen at all. This meant important information about detainees in the care of staff might not have been communicated. First night checks were not always carried out.

2.7 In our survey, 75% of detainees said they had received information in a language they understood about daily life in the centre. Induction was comprehensive and largely conducted through one-to-one sessions with welfare and induction unit staff. Each detainee had an induction booklet, containing checklists to make sure that relevant information was documented and shared, and that all elements of the induction were completed.

## Safeguarding

Expected outcomes: The centre promotes the welfare of all detainees and protects them from all kinds of harm and neglect. The centre provides a safe environment which reduces the risk of self-harm and suicide. Detainees at risk of self-harm or suicide are identified at an early stage and given the necessary care and support.

### Safeguarding of vulnerable adults

2.8 At the outset of our inspection, 128 detainees held at Brook House were classed as being at risk of harm in detention, including three who had been assessed as level 3 adults at risk under Home Office policy (where there was professional evidence demonstrating that ongoing detention was likely to cause the detainee harm). One was released during the inspection, but the other two continued to be held in the centre, despite the Home Office recognising that they were highly vulnerable. One of the latter had been granted bail in principle in March 2022, but a lack of accommodation meant he had been held in the centre for almost three months after being bailed. He had a child who was being looked after by social services, and his mental health had declined significantly since being detained. While he was receiving good care, the delay in the Home Office finding him suitable accommodation risked exacerbating his vulnerabilities.

2.9 Data sharing between the Home Office and Serco on adults at risk was generally sound and was consolidated every week to make sure that records were consistent. However, we found one case where the Home Office had not informed centre staff for several months about a detainee being assessed as a level 3 adult at risk, which meant he may not have received the support he required. In another case, a detainee was recorded as being a level 3 adult at risk in Serco records while the Home Office continued to record him at level 2 (where there is professional evidence that a detainee is particularly vulnerable to harm in detention, for example due to a history of torture, trafficking or mental illness).

2.10 The centre had started using vulnerable adult care plans (VACP) in April 2022, and 22 had been opened. VACPs were being used well to support detainees and were established for a range of reasons beyond health concerns. For example, one detainee who could not speak the same language as anyone else in the centre was being monitored to make sure he was not isolated. The quality of the VACPs we reviewed was good – care plans were completed, and observations indicated that interactions with detainees were productive.

2.11 There was good management oversight of vulnerable detainees through the weekly multidisciplinary vulnerable residents meeting. Participants discussed adults at risk as well as detainees subject to assessment, care in detention and teamwork (ACDT) case management for detainees at risk of suicide or self-harm and VACPs, and those on constant watches. Information-sharing and care planning during the meeting were good, and Home Office caseworkers usually participated via conference call.

2.12 At our previous inspection, E wing accommodated only detainees who were considered vulnerable, but it now had a more mixed population. Staff on the wing provided good care, but vulnerable men were often located alongside disruptive detainees or those who were about to be removed, which posed a risk to their well-being.

2.13 In the six months leading to our inspection, 179 Rule 35 reports (see Glossary of terms) had been submitted in the centre. Of these, 170 concerned torture claims, five were related to health issues and just one referred to suicidal ideation, despite 60 detainees being subject to a constant watch because of concerns about self-harm in the same period. Detention was maintained in 60% of cases, which was lower than at our last inspection.

2.14 We reviewed a sample of 15 Rule 35 reports, all of which related to torture. The reports were variable – some failed to assess the impact of continued detention and others that discussed physical injuries did not contain body maps. Home Office responses were timely and judgements were clear. In our sample, torture was accepted in 12 cases, but detention was maintained for six of these detainees, despite the acknowledgement that they were at risk of harm. In three cases, detainees were released for other reasons before the Rule 35 process had been concluded. (See also paragraph 3.43.)

2.15 Centre leaders considered any allegations of staff impropriety at a meeting held every two weeks. The meeting had monitored investigations into 85 members of staff for a variety of reasons, including poor conduct towards detainees, since Serco took over the contract for the centre in 2020. Leaders had implemented various ways for staff to report concerns about the treatment of detainees. A staff whistleblowing policy was in place – it had been used 23 times since it had been established in 2020. There was also a more widely used confidential security incident report (SIR) process through which staff could report any concerns. It had been used 134 times in the six months before the inspection, but managers were unable to tell us how

many of the reports were about staff conduct. Despite these measures, a sizeable minority of respondents to our staff survey said they would either not raise concerns about detainee welfare if they had them or were not sure if they would.

**Self-harm and suicide prevention**

2.16 There had been no deaths in Brook House since 2010. However, during the inspection, we were notified that a detainee had died shortly after his release on bail and the death was under investigation. In our survey, 28% of detainees said they had felt suicidal in the centre, and detainees had been placed on constant supervision 60 times in the previous six months because of concerns about the risk of self-harm or suicide.

2.17 There had been 33 recorded self-harm incidents in the previous six months, lower than at the last inspection. None of the incidents were serious. There were plans to introduce a new process under which all self-harm incidents would be formally investigated.

2.18 In the previous six months, 117 ACDT documents had been opened, similar to the level at our last inspection. They were usually opened because of detainees' concerns about their detention, removal and related immigration matters, such as delays in the provision of bail accommodation.

2.19 Although detainees we spoke to felt staff cared for them well, most ACDT documentation did not reflect a good standard of care. Assessments were sometimes very brief and care maps lacked detail. Health care staff were not routinely told when ACDT reviews were taking place and their attendance was poor. Despite immigration concerns being a factor in most cases, Home Office staff seldom attended case reviews. We saw little evidence of staff using interpreters consistently in assessments or case reviews.

2.20 Sixty-six detainees had refused food in the six months up to 31 May, fewer than at the last inspection. Health care staff appropriately monitored food and fluid refusal.

2.21 Attendance at monthly safer community meetings was reasonable. Useful data were presented to the meeting, although little action was taken in response. There was now some discussion of individual cases of most concern, for example detainees who had been placed on constant supervision. The weekly vulnerable residents meeting focused well on detainees on an ACDT.

2.22 In our survey, 80% of detainees said they had felt depressed at Brook House. However, there was no capacity to offer psychological interventions to the large number of detainees with lower-level mental health needs, and there was no befrienders scheme to support them (see also paragraph 3.47).

## Safeguarding children

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

2.23 The centre had a good safeguarding children policy. It was combined with the policy for safeguarding adults, but the distinct needs of children were fully addressed. There was also comprehensive guidance for staff on dealing with age dispute cases. Staff at Brook House were not routinely trained in child safeguarding, but trained staff from nearby Tinsley House could be deployed to supervise children if necessary.

2.24 There had been five age disputes in the centre in the six months to the end of the inspection. In each case, the detainees involved were found to be children. Social workers removed three of the five promptly, but the other two cases were a concern.

2.25 In the first, a non-verbal child with learning disabilities had gone missing from hospital, was arrested by police and then held in the centre for two days before being taken back to hospital when his true identity was discovered. The child had indefinite leave to remain in the UK and should not have been subject to immigration enforcement. The Home Office were conducting a review into the case to learn lessons. In the second case, a 17-year-old boy who had served a six-month sentence in adult prisons was only identified as a child after arriving at Brook House. He was held in the centre for 16 days before social workers took him into the care of the local authority. No review was conducted. In both cases the centre provided good care, but neither child should ever have been detained there.

2.26 Detainees subject to age disputes were monitored through comprehensive and individual care plans. Staff individually assessed each case to establish where best to locate the detainees and how they could most effectively provide suitable support and access to the regime.

## 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.

2.27 In our survey, 33% of detainees said that they felt unsafe in the centre. Our detainee interviews suggested that this was due mainly to the prison-like environment of the centre and anxiety about their immigration cases and possible removal – for more detail, see Appendix V.

2.28 Centre managers undertook regular surveys, which allowed them to assess perceptions of safety and detainees' experiences of violence in the centre, but they led to little analysis or action. Detainees were also invited to complete weekly 'candour logs' using the wing kiosk systems where they could report any concerns about other detainees or staff. Staff followed up reports, but records showed that most detainees did not want to pursue issues further.

2.29 The level of violence in the centre was low. In the six months leading to our inspection there had been 30 assaults that detainees had carried out (14 of which were against staff) and eight fights. Two of the incidents were serious. In our confidential survey and interviews, no detainees reported being physical assaulted by other detainees or staff.

2.30 When violent incidents occurred, they were generally managed well, and we observed staff de-escalating conflicts effectively. However, there were some flashpoints for aggressive behaviour – such as food queues – that were less well managed. Violent incidents were investigated and appropriate action was taken against the detainees involved, but few investigations identified lessons that could be learned.

2.31 The monthly safer communities meeting reviewed all violent incidents and the detainees involved, but there was little documented analysis of trends. A violence reduction policy was in place, but there was no strategy to address violence that was specific to Brook House. At the time of our inspection, leaders were developing a data-driven model to help monitor and analyse violent incidents, which was promising.

2.32 In the past six months, 26 detainees had been on tackling antisocial behaviour (TAB) documents, which were used to monitor perpetrators and support victims of violence and antisocial behaviour. They were poorly implemented. TAB documents demonstrated very little investigation into the circumstances around incidents and did not set out targets or plans for addressing behaviour or providing support.

2.33 The centre did not use a punitive incentives scheme against detainees. Those who were involved in violent incidents could lose access to paid work, but this sanction was used infrequently and not at all in the months leading to the inspection.

## 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.

2.34 Detainees were locked in their cells for two hours less than at the last inspection – from 10pm to 7am. However, they should not have been locked up at all and a more open regime could have been arranged by offering detainees keys to their cells and providing sufficient night-time staff. (See also paragraph 3.8).

2.35 Otherwise, security measures were proportionate – good, balanced risk assessments led to fewer than a quarter of those taken to hospital being handcuffed (four out of 19 in the previous month). Three strip-searches had taken place in the previous six months, all for justifiable reasons relating to safety and security. Only one detainee had been placed on closed visits in the six months before the inspection, and in this case, there was evidence of a risk of drugs being brought in.

2.36 The security operation was confidently led, with a well-organised monthly cycle of monitoring, planning and communication. A monthly well-attended security meeting provided effective oversight. The amount of security information submitted by staff remained at a good level that was proportionate to the population. In the previous six months, 1,114 security information reports had been submitted and the number was rising following the recent relaxation of COVID-19 restrictions.

2.37 There was some misuse of drugs, but there was no evidence of a high prevalence. Suitable measures were taken, such as mail testing. Regular drug and alcohol testing was carried out on a random sample of staff.

2.38 Corruption prevention work continued to be prioritised, and, as before, all new officers received training on how to resist, detect and respond to the possibility of corruption or conditioning.

## 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.

2.39 In the last six months, staff had used force on 105 occasions. Its use was still high and proportionately similar to the last inspection. Detainees' poor mental health was a factor in a number of incidents. In at least one case, force was used against a detainee who was not fit to be detained.

2.40 Managers told us that most cases involved the minimal application of force, but the level of force used was not monitored, which meant it was difficult for them to substantiate the claim. However, our sample of use of force paperwork suggested that most force used consisted of pushes, blocks and guiding holds. Seven detainees had been injured following incidents involving force, but none of the injuries were serious.

2.41 In our confidential interviews with detainees, none said they had seen staff using excessive force. Six complaints of excessive use of force had been referred to the Home Office's professional standards unit in the last year. Investigations were completed in five cases and none of the complaints had been upheld. We reviewed in detail one case raised

by some detainees who had not witnessed the incident and found the action taken to have been proportionate (see also Appendix V).

2.42 In our review of footage, incidents were usually handled and de-escalated effectively. However, in one case force was initiated without sufficient de-escalation, and an inexperienced team repeatedly failed to gain control of the detainee. In another, a risk assessment for the planned use of force on a man with health care issues was not sufficiently well documented, although the incident was generally handled well.

2.43 Oversight of the use of force was good. Reasonable use was made of body-worn cameras, and senior managers from Serco and the Home Office reviewed all incidents within 24 hours. In addition, one to two incidents were reviewed at the reasonably well-attended monthly use of force committee. Incidents involving officers who had used force three times in the previous three months also had a formal review. The use of force committee was presented with some data, but it did not generate any action, and themes in the use of force were not monitored.

2.44 Paperwork was generally completed well and usually explained the reasons for force being used. However, in some cases, there was insufficient detail to provide full assurances.

2.45 The six-cell separation unit was reasonably clean and bright, and cells were suitably furnished. There had been 71 instances of separation in the previous six months, which was lower than at the last inspection. The average length of separation was 25 hours, but this average had been inflated by some particularly long stays. It was a concern that the unit had held a number of detainees with poor mental health, including at least one who was considered unfit for detention.

2.46 Most paperwork we reviewed showed reasonable grounds for separation and reviews were thorough. However, we looked at two cases where the justification for separation was weak – both cases involved segregating the victims of an assault.

2.47 In the last six months, 13 detainees had been held in the care and separation unit while they were on an ACDT. It was not always clear from the paperwork if the separation of detainees on an ACDT was justified.

2.48 Paperwork demonstrated a staged approach to reintegration for the minority of detainees who were held longer term. Subject to a risk assessment, detainees were offered some access to the regime, such as gym sessions.

2.49 There was little oversight of segregation, with no regular meetings or analysis of data to look into its use.

## Legal rights

Expected outcomes: Detainees are fully aware of and understand their detention, following their arrival at the centre and on release. Detainees are supported by the centre staff to freely exercise their legal rights.

2.50 At the start of our inspection, 79% of detainees had been held in the centre for less than a month, but five had been held for more than six months. The longest period of detention at Brook House was over 16 months, which was unacceptably long. Forty-seven per cent of the population had formerly been in prison as had all five of the longest held cases.

2.51 More detainees were held in the centre (344) than at the last full inspection in 2019 (239) and the population of the centre had risen rapidly in the weeks before the visit. The average continuous time spent in detention – including time in other centres – was 72 days. Available Home Office data showed that, at the time of our inspection, five detainees at Brook House had spent over 1000 consecutive days in detention, including at other centres or prisons.

2.52 We examined 10 detainees' cases, four involving detention periods of more than six months, and six that were covered by the adults at risk policy. Four of the detainees had been held under immigration powers on more than one occasion. As at the previous inspection, slow case progression, delays in obtaining emergency travel documents (ETDs) and a lack of suitable bail accommodation contributed to lengthy detention.

2.53 Six of the cases we examined involved those who had been in prison, and in only two of these were the deportation orders served and travel documentation organised before the end of the detainee's custodial sentence. In other cases, the Home Office had taken too long to begin and progress deportation. The Home Office also sometimes took too long to consider detained asylum claims (claims that are made by individuals held in detention). In one case, it took almost a year to resolve a claim for a man held in detention, and in another it took over a month for a detainee to have an initial screening interview after making an asylum claim.

2.54 Long waits for ETDs also prolonged periods of detention. In one instance, there was no recorded progress on obtaining travel documents for 11 months, and the detainee involved had been held in a prison for this duration. The detainee who had been held for 16 months continued to be detained despite the Home Office having failed to secure an agreement from his home country to remove him.

2.55 At the time of our inspection, 22 detainees had been granted 'bail in principle' but had not been released because of a lack of suitable accommodation. Some of the detainees who were waiting for accommodation were considered by the Home Office to be vulnerable,

including one who had been assessed as a level 3 adult at risk. The longest wait for release accommodation at the time of our inspection was five months.

2.56 The Home Office detention engagement team (DET) had resumed face-to-face contact with detainees in the centre in the weeks leading up to our inspection, and the DET was now conducting between 100 and 200 in-person engagements a week. The DET also saw each detainee during their induction. Despite this, in our survey, only 37% of detainees said that the Home Office was keeping them up to date with their cases. Many told us this was because the DET was unable to offer them meaningful updates. Others said that, while Home Office staff routinely provided them with monthly detention updates, these were often unhelpful, and it was difficult to obtain answers to ad hoc queries. The planned return of DET wing surgeries was welcome and had the potential to help address these issues.

2.57 Detainees could access half an hour of publicly funded legal advice through the Detained Duty Advice Scheme. Surgeries took place five days a week, and about 70 sessions were offered every week. Waiting times were not excessive, and additional sessions had been provided after the Home Office had given a number of detainees removal directions to Rwanda. However, until May 2022 all surgeries had occurred remotely. Some detainees told us that, while they could access this scheme, they had to speak to several solicitors before finding one who agreed to take on their case. Arrangements for legal representatives to visit the centre were sound, and there were enough rooms for in-person visits or video conferences.

2.58 The centre library contained some legal material, although not all of it was up to date. The welfare office provided a good range of material, including application forms, and information about bail and removal. It was available in a range of languages. Detainees could also visit the relevant websites of organisations such as Bail for Immigration Detainees and Asylum Aid in the centre's IT rooms.

**Case study – legal rights for the planned removal to Rwanda**

At the time of our inspection, 68 detainees in Brook House had been told that the Home Office was considering their removal to Rwanda. Nineteen had been served with removal directions for a flight scheduled during the inspection. Removal directions were deferred before the flight in all cases except one, and in the end the flight did not depart.

We looked at a sample of five cases. Two detainees had extended family in the UK and two had young children in their home countries. The Home Office had not considered the welfare of the children in these cases. We could not find any evidence showing that the Home Office had assessed whether family reunification in Rwanda was possible and an assessment of Rwanda's capacity to accommodate children was yet to be undertaken.

Initial asylum screening interviews were too brief and none of the records we examined showed that detainees had an opportunity to disclose their sexual orientation or gender identity, nor was there a prompt for this issue during the DET induction, despite the Home Office guidance on Rwanda describing reports of human rights violations against LGBT individuals.

Rule 35 reports had been submitted in three cases, two of which related to torture and one to medical grounds. All three detainees were classed as either level 2 or 3 adults at risk, but detention was maintained in each case. All three detainees were or had been on an ACDT.

Notices of intent (see Glossary of terms) to remove detainees were given to detainees at least three weeks before the scheduled flight and removal directions at least five business days before the flight, but there was no record of interpretation being used and all documents were in English.

Detainees due to be removed to Rwanda were anxious for more information. The Home Office held two poorly organised surgeries, where no interpreters were used. Translated versions of two information leaflets were not sent to detainees until after their removal directions had been issued. Both leaflets provided little useful information about the removal process and what to expect on arrival. The Home Office was not aware of a detainee who said that he could not read in any language and had not understood the documents he received.

Detainees were largely reliant on centre welfare staff to find legal representation and faced challenges in communicating with legal representatives (see paragraphs 2.57, 2.58 and 5.9). One detainee told us he did not know that he might be sent to Rwanda until he spoke to a lawyer. Another understood that he needed to reply to the notice of intent within seven days but described his escalating panic as he could not speak to a lawyer as the window drew to a close. In another case, a detainee only obtained a lawyer to represent him on day six of the seven-day window. In the cases we looked at, no detainees had replied to the notice within the seven-day window or before the decision to issue removal directions.

# Section 3 Respect

**Detainees are treated with respect for their human dignity and the circumstances of their detention.**

## Staff-detainee relationships

Expected outcomes: Detainees are treated with respect by all staff, with proper regard for the uncertainty of their situation and their cultural backgrounds.

3.1 In our survey, 84% of detainees said staff treated them with respect all or most of the time and most detainees we interviewed were also positive about relationships with staff, who were variously described as friendly, helpful and reassuring.

3.2 Care officers held meetings with detainees twice in their first month of arrival and then monthly to check on how they were feeling and whether there were any problems they wanted to discuss. The reviews we observed were brief, lacked confidentiality and added little value. However, 79% of detainees said they had a member of staff they could turn to for help if they had a problem.

3.3 During our inspection it was not uncommon to see detainees smoking on the landings. Staff often failed to challenge this and other minor misbehaviour, such as detainees pushing in food queues and playing loud music. A large number of staff were inexperienced, and many reported low morale and a lack of support from operational leaders.

3.4 Serco leaders had commissioned an external service to help better understand staff culture and areas of concern to inform strategic planning priorities. The initiative had begun following the new contract two years earlier but had been affected by the pandemic – only a limited amount of work had been undertaken during COVID-19 restrictions. The initiative included a strong focus on detainee and staff perspectives and looked promising, but it was too early to see any outcomes. (See paragraph 1.32.)

## Daily life

Expected outcomes: Detainees live in a clean and decent environment suitable for immigration detainees. Detainees are aware of the rules and routines of the centre. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair. Food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations.

## Living conditions

3.5 The centre remained prison-like and unsuitable for holding immigration detainees. Efforts had been made to make the environment more welcoming, for example through some new wall art, but this did little to improve detainees' view of the centre as being similar to a prison. The standard of cleanliness in the communal areas was good and detainees could obtain cleaning materials. Cells were in a reasonable condition, but some of the toilets remained heavily stained. Toilets were now reasonably well screened, as were the showers in the units, which had privacy curtains and stable doors.

**A wing landing (above), D wing toilet (below left) and C wing (below right)**

3.6 The recent rise in detainee numbers (see paragraph 2.51) had highlighted the limitations of the centre's infrastructure. The exercise yards were cramped and while D wing yard remained popular for its seating facilities, there was not enough space. The other exercise yards provided limited facilities for outdoor sports, such as football and volleyball nets. All were covered with netting and they were not always kept clean.

**Exercise yard**

3.7 The wings often echoed with noise. In our survey, only 42% of detainees said it was quiet enough to sleep at night. Detainees using the Skype rooms had to contend with the loud noise of the units (see paragraph 5.10) and the noise in the activities corridor affected health services (see paragraph 3.34).

3.8 Detainees frequently complained about poor ventilation. Windows in the cells could not be opened and although there was an air-conditioning system, some of the air vents were dirty and in poor repair. It was especially hot when detainees were locked in their cells at night (see paragraph 2.34).

3.9 Detainees were issued with clean duvets and pillows on arrival and the laundry areas were adequate and well maintained. There was a good stock of clothing in the centre if detainees required it.

## Detainee consultation, applications and redress

3.10 Wing forums were held every week and detainees in each unit had the opportunity to provide feedback on topics such as food, accommodation, complaints, and staff-detainee relationships. However, they were not always well attended, and interpretation was not used for those who needed it. Minutes of the meetings that were displayed were not always up to date. Monthly resident consultative committees were held and chaired by the deputy director of the centre, which was good, but the number attending varied.

3.11 There were fewer complaints during the last six months than at the previous inspection and of the small number who made a complaint, 74% said they had been dealt with fairly. Serco had dealt with 58 complaints, 10% of which had been upheld, which was an increase since our last inspection, where the figure was only 1%. Any complaints that were substantiated or involved staff members were sent to the deputy director to review, but no other quality assurance process for complaints was in place. The last three months had seen a decrease in the number of complaints. They were not discussed in detail at any meetings to identify patterns or emerging trends.

## Residential services

3.12 In our survey, 50% of detainees said the food was very or quite good, which was better than at the last inspection. Hot meals were served at lunch and in the evening and there was a variety of options to choose from. The catering department was now run in-house by Serco staff, and catering staff attended weekly wing forums and consultative committees to address any concerns. Detainees could eat in the communal dining areas, which were well used.

3.13 However, we received many complaints about the food, and we observed some poor quality dishes being served, including salad boxes where the portion sizes were inadequate. During our inspection, over a third of the population were given the vegetarian default meal option and during the evening meal we observed detainees becoming frustrated as a result, causing tension at the serveries. While this appeared to be because detainees were not completing menu sheets, there had been no investigation into the root cause of this problem.

3.14 There were limited options for detainees to cook for themselves and although microwaves were provided in the units, there were too few for the population. The cultural kitchen could only cater for three detainees in each session and, during our inspection, it was not always open and was greatly underused (see paragraph 4.7). The catering department supported the provision by providing a range of cooking ingredients.

3.15 The centre's shop had a variety of products and a good stock. Stock levels had been adjusted to meet the needs of the bigger population. When detainees were not on association, staff were seen buying products from the shop to take back to the units for detainees.

## Equality, diversity and faith

Expected outcomes: There is a clear approach to promoting equality and diversity, underpinned by processes to identify and address any inequality or discrimination. The distinct needs of detainees with protected and any other minority characteristics (see Glossary of terms) are recognised and addressed. Detainees are able to practise their religion. The multi-faith team plays a full part in centre life and contributes to detainees' overall care and support.

### Strategic management

3.16 The promotion of equality had fallen behind during COVID-19, but there was a new policy and action plan, and senior managers took the lead at the monthly meetings. Data were collected and analysed each month on a few key areas, such as use of force, security reports and those on tackling antisocial behaviour (TAB) documents (see paragraph 2.32), but coordination was poor and little action resulted from the findings. The centre did not have a systematic approach to addressing disproportionality in all aspects of life at the establishment.

3.17 Welfare staff now collected information on protected characteristics in their induction interviews, which they shared with the diversity and inclusion (D & I) team.

3.18 Two D & I coordinators were being appointed to replace a temporary one who was in post, and plans were underway to appoint a diversity orderly and introduce a regular cycle of activity to support and celebrate diversity and inclusion. Only eight complaints involving allegations of discrimination had been submitted in the last year – they were all referred to the D & I manager and, in the cases we reviewed, properly investigated.

### Protected characteristics (see Glossary of terms)

3.19 Telephone interpretation was used with reasonable frequency – about 510 times in the last month – but there was evidence showing it was still not used enough. For example, in our survey, 63% of those with no understanding of English said that interpretation was used during health care assessments and there had been limited interpretation during a recent removal operation (see Case study in the legal rights section, page 25).

3.20 The number of those disclosing that they were gay, bisexual or other sexual orientation had grown and the diversity coordinator provided them with one-to-one support. It was encouraging that more people felt able to seek affirmation and support, but far more detainees responding to our survey disclosed being gay, bisexual or another orientation than were known to the centre.

3.21 There was some provision for detainees living with a disability, including four adapted cells, and individual support was provided in

some cases. However, our survey showed this group was less positive about their experiences, especially in relation to safety.

### Faith and religion

3.22 In our survey, 90% of detainees said that they had a religion, 84% said their religious beliefs were respected, 63% that they could speak to a chaplain of their faith in private. Chaplains were very visible and supportive of detainees. There was now a full-time religious affairs manager for the Gatwick Immigration Removal Centre (which consists of Brook House and Tinsley House), and almost a full team of religious ministers. Interviews for two vacancies were to take place imminently.

3.23 In addition to weekly communal worship, which had been restored promptly after COVID-19 restrictions had been relaxed, there were now prayer events and classes on an almost daily basis, as well as drop-in sessions every day. Detainees had free access to all the faith rooms during association periods.

3.24 Some improvements had been made to the facilities, such as a new carpet and chairs in the chapel. The team worked well with equality and catering staff to promote celebrations of festivals and supported events relating to diversity and inclusion.

## Health services

Expected outcomes: Health services assess and meet detainees' health needs while in detention and promote continuity of health and social care on release. Health services recognise the specific needs of detainees as displaced persons who may have experienced trauma. The standard of health service provided is equivalent to that which people expect to receive elsewhere in the community.

3.25 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) (see Glossary of terms) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC issued a 'requirement to improve' notice following the inspection (see Appendix II: Further resources).

### Governance arrangements

3.26 In our survey, 68% of detainees said that health services were good, compared with 44% at the last inspection. In our interviews, some detainees were very positive about the healthcare they received, but others reported long waits for health care appointments (see Appendix V).

3.27 Regular, well-attended partnership board and local delivery board meetings made sure oversight of services was good, and there was strong partnership working between the centre, provider and commissioners.

3.28 Health services' management of several COVID-19 outbreaks at the centre had been commended by the UK Health Security Agency (UKHSA) as being exemplary.

3.29 Clinical governance arrangements were not sufficiently robust. Incidents were usually reported and investigated, but we saw a medication-related incident that had not been reported or investigated adequately. Clinical audits were being undertaken, but action and review dates were not always recorded, and we found instances where clinical emergency equipment was not subject to regular safety checks.

3.30 Complaints were still not confidential. There were no health care complaint forms on any of the wings, so patients submitted complaints via the Home Office, which sent them to the health care department.

3.31 There were significant staffing vacancies across most services, mainly covered by bank, overtime and agency staff and clinical leaders stepping in. We considered the staffing situation to be precarious and services were stretched. The provider was working creatively to recruit clinical staff and we were informed of a number of new recruits going through the lengthy vetting process.

3.32 The service delivered 24-hour cover and there were adequate on-call arrangements. It was well-led by an experienced clinical leadership team. We observed a caring, knowledgeable, and diligent team, who knew their patients well, providing a good standard of care.

3.33 Clinical and managerial supervision arrangements were being embedded and recorded, and health staff we spoke to felt health care leaders supported them well. Mandatory training requirements were being completed, except for intermediate life support, which the provider had taken steps to address.

3.34 Patient satisfaction surveys were being undertaken, and the newly appointed patient engagement lead staff member had begun to organise wing-based patient feedback sessions and produce a patient newsletter.

3.35 Health care facilities were cramped and there were not enough private consultation areas to deliver care effectively. Health care suffered negatively from severe noise pollution from the gym and one of the wings (see also paragraph 3.7). Services were fragmented and mental health and substance misuse services were on opposite sides of the centre (see paragraph 3.50). The standard of cleaning was not always acceptable and some clinical equipment was not fit for use, for example the examination couch in the treatment room.

3.36 Officers on the wings and in the control room told us that emergency codes were still not being used to summon medical assistance in an emergency. We observed staff requesting health care attendance to establish a detainee's fitness to be transferred. However, a miscommunication led to a full medical emergency response being mobilised.

3.37 There was a good range of health and well-being information displayed around the health care department and the centre, and it was available in numerous languages. Staff were working creatively to promote health and well-being, with a good emphasis on men's health. Detainees could access disease prevention and screening programmes, treatment for blood-borne viruses and travel vaccinations if required. Smoking cessation support was available despite the low uptake. Health care staff provided condoms on request and local sexual health providers offered appointments as necessary.

**Primary care and inpatient services**

3.38 Nursing staff and health care assistants completed a health care screening of detainees when they first arrived at the centre, but it was not carried out consistently well. All detainees were booked an appointment with the GP for the day after their arrival and referrals were made to other health services from reception, such as mental health. Secondary health screenings were not carried out and there was the risk that detainees' health conditions might not have been identified.

3.39 The service's 24-hour staffing cover was provided by two nurses and a health care assistant who were meant to work overnight. This level of cover could not always be achieved, which put pressure on other staff to work into the night when there were late arrivals. During the day, there was one nurse, one paramedic and one health care assistant – rotas from recent weeks showed that this level of staffing had not always been achieved. The primary care clinical lead staff member also helped provide patient care when staffing was stretched.

3.40 Detainees could request health appointments through paper application forms, which were collected from the wings twice a day. The forms were only available in English. Walk-in appointments were available for the nurse clinic and the provider planned to introduce a pictorial application form.

3.41 Waiting times for primary care services were short – GP appointments were available within 24 to 48 hours and appointments for the nurse clinic were available either the same day or on the next day. Nurses and health care assistants saw patients with minor ailments, offered vaccinations and took blood. Those with more complex needs, such as an unstable long-term condition, received support from GPs. More routine support for patients with long-term conditions was limited, but there were plans to reintroduce a weekly clinic. Staff put in place basic care plans and made sure patients had access to any medicines required.

3.42 Primary care services included an optician, physiotherapist and a podiatrist. Some detainees said they found some health staff rude, although interactions inspectors observed were caring and professional.

3.43 There was a wait of between two and three weeks for a Rule 35 assessment (see Glossary of terms). GPs undertook Rule 35 assessments face-to-face (see paragraph 2.14). A workshop had been held before the inspection to offer further development to GPs and centre staff in better identifying potential Rule 35 cases and supporting detainees who were making a disclosure. The Home Office did not always inform the health care department of the outcome of Rule 35 submissions.

3.44 Detainees received medication to take with them on their release or transfer. The centre's discharge process had been amended so that detainees did not leave before seeing a member of health staff. However, this still occasionally happened if there was minimal notice of removal or release. (See also paragraph 5.14.)

3.45 Secondary care appointments were managed well, and few were cancelled because not enough officer escorts were available. Administrative staff regularly liaised with hospital departments to follow up on appointments if they had not been received.

**Mental health**

3.46 In our confidential interviews with detainees, many reported stress, symptoms of trauma and other mental health concerns (see Appendix V). Approximately 70% of the mental health team's posts were vacant at the time of the inspection, with significant shortfalls being covered by overtime and agency staff. There were times when there was only one nurse for the day.

3.47 All the psychology posts were vacant and were not being covered. There was no counsellor in post. As a result, patients with conditions, such as depression and anxiety, where the evidence called for psychologically informed treatment, were not having their needs met. Similarly, patients with post-traumatic stress disorder, which was often complex, could not access the evidence-based treatment a psychologist would deliver. Given the needs of the population, this was of great concern.

3.48 At the time of the inspection, 46 patients were receiving support from the mental health team, and of those, 10 had severe and enduring mental health problems. Nurses told us of their frustration at not being able to offer psychological interventions.

3.49 Despite the pressure on the team, we found that most patients had good access to the service, with appropriate clinical triaging taking place, which meant patients were seen in a timely manner. There was a clear referral pathway in place, and clinical records we sampled were good. All patients whose cases we looked at had a care plan and risk assessment. Clinical staff attended all assessment, care in detention and teamwork (ACDT) case management reviews for detainees at risk of suicide or self-harm, and a locum psychiatrist attended the centre every week.

3.50 The mental health team had no dedicated space where they could see patients. Leaders made us aware of plans for a consultation room in the centre and to co-locate mental health services with substance misuse services.

3.51 One transfer to hospital under the Mental Health Act had taken place in the previous 12 months – the patient had been moved within time guidelines.

3.52 Mental health staff co-ordinated follow-up care arrangements for patients in their care who were being released from the centre. This included directing patients to psychological services in the community.

**Substance misuse treatment**

3.53 There was now a drug strategy in place that focused on supply reduction and involved health care services.

3.54 All new arrivals received an assessment of their substance misuse needs and those who required treatment received it promptly. Treatment decisions were guided by a range of appropriate clinical rating scales and those who needed detoxification were monitored during the day and overnight. The demand for clinical substance use treatment was low, with only two patients receiving opiate substitution therapy (OST) at the time of the inspection. Clinical prescribers had received further specialist training.

3.55 A small team of non-clinical substance misuse practitioners delivered a suitable range of interventions from Monday to Friday, and the information they provided was available in a number of different languages. All new arrivals to the centre were seen in person, and detainees who were referred were seen within five days. The service was in the process of recruiting additional staff to provide a seven-day service. Group sessions and peer workers were no longer available because of pandemic restrictions, but there were plans to reinstate them imminently.

3.56 Non-clinical services operated an open-door policy, which meant detainees could drop in freely, which was good. Naloxone (a drug to manage a substance misuse overdose) was not given to detainees on release from the centre.

**Medicines optimisation and pharmacy services**

3.57 Medicines from a pharmacy based at Gatwick Airport were dispensed to the centre every day, seven days a week. If any items were required urgently, staff took a prescription to the pharmacy and collected the medicines in person. The pharmacy was contracted to oversee medicines management and a pharmacist attended the centre every Wednesday, also providing a weekly medicine use review clinic for patients. The senior pharmacy technician and pharmacist provided strong oversight.

3.58 The pharmacy room was well organised, and medicines were clearly labelled. Storage temperatures were checked every day and there were robust stock control procedures.

3.59 The senior pharmacy technician and nurses undertook medicines administration three times a day, which included a period for providing controlled drugs. Health staff followed up any patients who had not collected their medication. During our observations of medicines administration, a detention officer was in the health care waiting area to manage detainees who were queueing.

3.60 Medicines information was only provided in English. If anyone did not understand the instructions for taking medicines, they were directed to the nurse clinic, where an interpreter could be arranged.

3.61 A suitable range of medicines was available on site in the out-of-hours cupboard if a detainee required medication urgently. Detainees could be provided with a range of over-the-counter medicines, which included pain relief, without a prescription. Discussions were ongoing with the centre to have paracetamol added to the shop list so detainees could also buy their own supply.

3.62 Medicines reconciliation was not always completed within 72 hours for new arrivals, but all detainees had access to a GP appointment before then, and medicines were prescribed as necessary. The senior pharmacy technician completed a risk assessment for all detainees to determine whether they could keep their medicines in-possession safely. A local formulary was in place, which outlined medicines that could not be given in possession.

3.63 A medicines optimisation group had recently commenced and had sufficient data to allow for the monitoring of prescribing patterns. The group had identified an increase in prescribing of an anti-depressant, which has a sedative effect, and discussions were held with the lead GP to find out the reasons behind the rise.

**Oral health**

3.64 There still was no dental suite at the centre, which meant that the dentist was unable to provide dental treatment. Commissioners and centre managers were in the process of arranging for a contractor to carry out the necessary work, having identified a suitably sized room.

3.65 The dentist attended once a week and offered advice and triage and could also prescribe antibiotics and pain relief to patients. Patients were seen within a week and the GP could also prescribe antibiotics for dental infections if a detainee could not wait for the dentist. Where somebody needed dental treatment, such as a filling, they were referred to the local emergency dental service. However, it had proved difficult to obtain these appointments as they were in high demand.

3.66 Dental staff received a package of training and regular supervision and support. Single use dental equipment was supplied, which the dentist stored on site.

# Section 4 Activities

**The centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees.**

**Access to activities**

4.1 There was a reasonable range of activities, but the number of places was not sufficient to occupy the population of the centre, and facilities such as classrooms, the gym, and the cultural kitchen were too small. In our survey, only 37% of detainees said there was enough to do to fill their time.

4.2 COVID-19 restrictions meant that for one session every day, access to off-wing activities was reserved for those who had just arrived at the centre, but most of the time detainees could move freely around the centre. Activities were available during morning, afternoon, and evening sessions every day. Detainees could attend any activity, including the gym, as long as there was space, and they could use the outside yards nearly all day.

4.3 Recreation facilities in the units were reasonably good. Each unit had table tennis and pool tables, a big-screen TV, and computer games. There was also a stock of board games. Officers organised a daily programme of activities on each wing, such as sports competitions, bingo sessions and film shows.

4.4 Education and art classes were provided all day and in the evening, seven days a week. Teachers were promoting activities more actively to encourage attendance. The centre induction included a visit to classrooms where detainees were told about the programmes on offer and encouraged to attend. Classes were advertised on posters throughout the centre, and in a monthly magazine, which was circulated in the units.

4.5 Despite these efforts, participation remained low. In our survey 21% said they were taking part in education, and only 16% of under-25s were involved. During May 2022, 160 detainees attended education and art classes about four times each on average. Detainees were free to come and go as they wished.

4.6 There were sufficient computers to meet the needs of the population and internet access was good. The network's home page had a useful range of links to organisations providing detainees with information and assistance (see paragraph 5.10).

4.7 Detainees particularly valued the opportunity to prepare their own meals in the cultural kitchen. However, the kitchen was small, and sessions were overseen by an activities officer rather than a qualified caterer. There was a waiting list and operational problems meant it was often closed. (See also paragraph 3.14.)

## Education and work

4.8 There was insufficient management oversight of the education provision, and little development since the last inspection. There were five teachers in general education and three in art, who provided classes every day and in the evening. Teachers worked independently, developing their own resources, and keeping their own record of the work they had done with detainees. Managers did not monitor the content or quality of the education provided. Teachers did not routinely meet to discuss the curriculum or the outcomes achieved by detainees, and they had not received any recent staff development. Teachers were left to do as they thought best, without supervision, guidance, or support.

4.9 Two classrooms were in use – one for general education and the other for art and crafts – with a total capacity of about 20 learners at a time. The education classroom was equipped with an electronic whiteboard and two computers. Teachers offered instruction in English and Spanish and had some resources for detainees who wanted to improve their mathematics. No accreditation was offered in these subjects.

4.10 Detainees could use the classroom computers to study online short courses, such as customer service, positive thinking, and mental health awareness. The courses were only available in English. Thirty-four certificates had been awarded to detainees in the six months before the inspection.

4.11 Teachers were welcoming and developed a good rapport with detainees. They recognised the stress detainees were under and used a good range of activities and resources to help them relax and participate in class activities. Detainees were very appreciative of the approach taken by teachers, and in our survey 100% of those who attended education said it was helpful.

4.12 Teachers had developed strategies to cope with learners with widely different levels of attainment in the same class. They recorded detainees' work on individual learning plans, so other teachers could continue with activities. However, most detainees attended only a few class sessions, and often for very short periods, so they made little progress. A small number attended regularly, enjoyed their studies and made reasonable progress, despite distractions caused by detainees arriving and leaving during sessions.

4.13 The art room provided detainees with opportunities for creative expression and was popular. Teachers stimulated interest, using displays, portfolios of work and competitions to inspire learners. Detainees were absorbed in their activities – most painted pictures, while others made bead bracelets or painted designs on t-shirts. Detainees said they enjoyed the sessions and found them helpful in relieving stress. The art room needed refurbishment and was often overcrowded at busy times, which negatively affected detainees' experience.

4.14 There were only about 70 paid jobs, of which 62 were filled. In our survey, 22% of detainees said they had a job, fewer than at the last inspection (45%). Most were cleaner or servery worker roles, but there were six posts for buddies and three orderlies dealing with safety, equality and learning support. Detainees could also work as barbers and library orderlies.

4.15 Work opportunities were advertised on multi-lingual posters in the centre. Applications for work were dealt with promptly and waiting lists for jobs were short. The Home Office did not routinely review applications, but detainees could still be removed from work if they were considered not to be complying with the Home Office or refused to share a cell. However, no detainees were barred from work during our inspection. None of the jobs offered training, and detainees' work was not sufficiently well supervised.

**Library provision**

4.16 The library service was poor and little used by detainees. Although it was open every day, centre records showed that only 25 detainees had visited in the month before the inspection, and only 40 books had been borrowed over the previous six months.

4.17 The stock of books was poor – it included books in 32 languages, but many languages had only a small number of titles. There had been few recent acquisitions. Most of the books were old, and there was no attempt to display them attractively to prompt detainees' interest. Most of the officers who were deployed in the library had no expertise in library work. They did not have a good enough knowledge of what resources were available, so could not help detainees use them. No activities were organised in the library to promote reading, and the space was not used for other activities.

4.18 The library stock included DVD films, computer games and electronic book readers, but their availability was not well promoted, and few detainees took them up. There was a stock of legal textbooks, many of which were out of date. A good range of British daily newspapers was available, along with a small number of foreign language newspapers.

**Fitness provision**

4.19 The gym was popular, and it had a range of exercise machines. However, it was far too small, accommodating only about 20 detainees. In our survey, 64% said they could attend the gym as much as they wanted to, which was lower than at the last inspection (81%). Ventilation in the gym was poor and several machines were out of order. Managers planned to open an additional physical education facility soon.

4.20 Gym staff provided instructions in the use of the exercise equipment on request but did not offer all users an induction to the facility. At busy times, the gym was crowded, and staffing levels were not sufficient to make sure that all attendances were recorded. Staff had recently

started to offer cardiovascular fitness sessions, but only a small number of detainees could attend them.

4.21 Detainees could use the wing yards for sports, such as football and volleyball. However, the yards were too small and were often used by other detainees for outdoor association. The sports activities were not always supervised by qualified gym staff.

4.22 The services offered by gym staff were too limited. They were not qualified to provide personal exercise programmes to detainees. There were no links to the health care department and there was no support for detainees with specific needs, for example those recovering from injuries. Although many detainees reported feeling stressed, there was no provision specifically designed to help with relaxation or stress relief.

# Section 5 Preparation for removal and release

**Detainees are able to maintain contact with family, friends, support groups, legal representatives and advisers, access information about their destination country and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property.**

## Welfare

Expected outcomes: Detainees are supported by welfare services during their time in detention and prepared for release, transfer or removal before leaving detention.

5.1 The welfare team had been expanded and was very active. Members of the team now interviewed every new arrival within 48 hours, usually in reception, recording on the digital case management system salient information about the individual, including any protected characteristics, and following up identified needs. Pre-departure interviews were also carried out, although not in all cases, and they were not systematically recorded.

5.2 Detainees could and did drop in to the welfare office when they had access to the activity areas. The team had recorded 720 individual contacts during May. Members of the welfare team spoke many languages between them and drew on colleagues as well as telephone interpretation to make sure that all could receive a service. They also had many leaflets available in a variety of languages, including information about statutory immigration processes, forms to apply for help, leaflets on the Rwanda arrangements, advice on returning to specific countries, and details of organisations that could offer help, such as Bail for Immigration Detainees and the Gatwick Detainee Welfare Group.

5.3 Three of the team had been trained to level 1 of the qualification in basic immigration advice and assistance accredited by the Office of the Immigration Services Commissioner, and preparations were underway for the others to receive this training. The team often arranged appointments with solicitors on detainees' behalf, with their consent.

5.4 The Gatwick Detainee Welfare Group contributed well to welfare work in the centre, providing individual support and cooperating with centre staff to share information. There was scope for this partnership working to be strengthened, if a suitable memorandum of understanding could be agreed that would meet any legitimate concerns on confidentiality and use of information.

## Visits and family contact

Expected outcomes: Detainees can easily maintain contact with their families and the outside world. Visits take place in a clean, respectful and safe environment.

5.5 COVID-19 restrictions on visiting had been lifted and the availability of visits was good – there were daily sessions from 2pm to 5.30pm and 6.30pm to 9pm. Many families and friends lived far away, and, in our survey, only 24% of detainees said that they had received a visit. It was now no longer difficult to book visits by telephone as an alternative to email.

5.6 The visitors' centre and visits hall were adequate but unattractive. The furnishings and décor were worn, the environment was drab and refreshment facilities needed modernisation. The hot drinks machines were old, the cold drinks vending machine in the visits hall was out of action as was a vending machine in the visitors' centre, and only basic items, such as chocolate and crisps were available. There was no proper play area for children, just a very few books and other items for small children in one corner of the hall.

5.7 Staff were reasonably welcoming – in our survey, 75% said staff usually treated their visitors with respect, and there was an informal atmosphere. An experienced team of 30 volunteers from the Gatwick Detainee Welfare Group was available to visit those who could not receive visits from friends or family.

5.8 Two minibuses continued to provide free transport to and from the station at Gatwick Airport, although one was off the road at the time of the inspection.

## Communications

Expected outcomes: Detainees can maintain contact with the outside world regularly using a full range of communications media.

5.9 The mobile phone signal in the centre was poor and detainees often struggled to get a signal in their cells or in some areas of the units. This caused problems when detainees wanted to phone families, friends, or legal representatives while they were locked in their cells. The centre had recognised this problem but plans to resolve it had not been implemented.

5.10 Access to and take-up of Skype was good, and it was positive that each wing had a room dedicated to the facility. Most detainees we spoke to were positive about access to Skype and being able to maintain contact with families and friends through the provision. However, there was inadequate oversight and management of the facilities, and the rooms could be very noisy and not always clean (see

paragraph 3.7). We observed more than one detainee in the room at one time, which raised privacy concerns.

**A wing Skype room**

5.11 Detainees' access to the internet was good, and there were sufficient computers to meet the needs of the population. There were 29 machines in two rooms in the association area and at least one computer in each unit. The problem of legitimate websites being blocked had been successfully addressed since the last inspection: detainees who found access to a site was blocked could use a well-publicised and prompt review process. However, there was still no access to social networks, which was inappropriate in an immigration removal centre. (See also paragraph 4.6.)

5.12 Detainees had access to a fax machine in each unit, which was good. There was one printer and scanner in the IT room and although there were no restrictions on how much documentation they could print, they were unable to do this without having it seen and authorised by a staff member first, which compromised confidentiality.

5.13 Detainees could send one free personal letter a week and unlimited legal correspondence. Reception staff managed incoming mail, which detainees collected. However, during our inspection we saw some mail being distributed late because the mail of new arrivals and those being released was prioritised.

## Leaving the centre

Expected outcomes: Detainees leaving detention are prepared for their release, transfer or removal. Detainees are treated sensitively and humanely and are able to retain or recover their property.

5.14 In the six months before the inspection, 51% of detainees leaving the centre were released into the community after a potentially damaging period of detention. On release, detainees received a summary of their medical records and up to a month's supply of medication. The Home Office had convened few multidisciplinary meetings to plan for the release of more vulnerable detainees. However, some joint planning took place at the weekly vulnerable residents meetings and suitable health care plans were in place for the release of detainees with health needs. (See also paragraph 3.44.)

5.15 The continued lengthy detention of people granted bail because of a lack of accommodation was unacceptable. We saw records of detainees waiting for bail accommodation for up to five months after they were granted bail (see paragraph 2.55).

5.16 In the six months before the inspection, 438 detainees had been removed from the UK. An independent charity, Praxis, provided useful translated information sheets on support available in most destination countries, but not on northern Iraq or Rwanda, where detainees subject to recent charter removal operations were to be sent.

5.17 Serco operational staff were not adequately briefed on the operation to remove detainees to Rwanda, which left them poorly placed to support those who were affected. Welfare staff we spoke to knew little of what detainees could expect in Rwanda. During the removal process, centre staff were caring and supportive with the only detainee who was eventually taken from the centre to the airport, but not enough effort was made to obtain interpretation. Escort staff were largely respectful but crowded around the detainee unnecessarily. All paperwork and property was handed over as required, but the process was rushed (see Case study in the legal rights section, page 25).

5.18 Detainees were not routinely seen by the welfare team before leaving the centre, but this was offset by good early preparation for their departure.

# Section 6 Summary of priority and key concerns

The following is a list of the priority and key concerns in this report.

## Priority concerns

1. **Case progression was slow for many detainees and the length of detention remained unacceptably long in some cases.** The person detained the longest at Brook House had been there for 16 months and we found five cases where people had been held in different places of detention for over 1,000 days. Delays obtaining travel documents and a lack of bail accommodation contributed to lengthy detention.

2. **The centre did not provide an open or relaxed environment suitable for immigration detainees.** The centre was crowded and noisy, ventilation in cells was inadequate and the prison-like environment was one of the main reasons that detainees gave for feeling unsafe.

3. **The centre did not meet the needs of the high number of detainees with mental health problems.** The centre held many people with low-level mental health needs who could not access psychological interventions as all the psychology posts were vacant. Several detainees with poor mental health had been located in the separation unit, which was not a suitable place for them.

4. **The number of activity places and space in the centre were not sufficient for the current population.** Few detainees were in employment or attended education. There was little activity to promote well-being, relaxation and stress relief. The library service was very poor and the gym too small.

5. **Management oversight of the education provision was weak.** Teachers did not receive sufficient management support. They lacked supervision and guidance. There were no clear processes for curriculum planning or review, and no analysis of learners' achievements was undertaken. Teachers had not received any recent staff development.

6. **The mobile phone signal in the centre was poor.** This restricted detainees' ability to maintain contact with the outside world when they were locked in their cells.

## Key concerns

7. **The identification and management of risks on arrival was not good enough.** Not all detainees were offered a private interview on arrival and staff did not always spend enough time enquiring into detainees' risks. The standard of health screening was variable.

8. **The Rule 35 report process was not being used to its fullest extent to protect detainees who had conditions that might have been worsened by detention.** Nearly all reports related to potential victims of torture and very few were prepared for detainees with health problems or suicidal ideation.

9. **Assessment, care in detention and teamwork case management for detainees at risk of suicide or self-harm was not good enough.** Assessments were sometimes very brief and care maps lacked detail. Health care staff and Home Office attendance at reviews was poor, and interpretation was not consistently used.

10. **Detainees were inappropriately locked in cells overnight.** They could have been left unlocked if they had been given a key to their cell and if there had been sufficient staffing at night.

11. **Detainees who had been told they were to be removed to Rwanda found it difficult to access their legal rights and had been given inadequate information**. They had difficulties in responding to the notice of intent to remove them within the seven-day window and problems obtaining or communicating with legal representatives. The information provided to detainees who had been told they were to be removed to Rwanda was of little value.

12. **Too many staff did not supervise the units in a sufficiently professional or confident manner.** Minor misbehaviour that could escalate tension if unchallenged was not managed consistently. For example, detainees were observed smoking on the landing, pushing in food queues and playing very loud music. Operational leaders did not provide the high number of inexperienced staff with enough support in the units.

13. **Equality work was underdeveloped.** Data collection on equality and diversity was not systematic and there was a lack of investigation and action in areas where there might have been evidence of unfair outcomes.

14. **Governance of health services was not sufficiently robust.** The systems and processes for managing clinical audit and clinical incidents did not meet the standards for safe and effective practice.

15. **Emergency protocols were not consistent and not all staff used the centre's method of summoning emergency assistance.**

**Care Quality Commission regulatory requirement**

There were not always sufficient, qualified health care staff deployed in primary health care and to provide appropriate mental health and psychological support to detainees.

# Section 7 Progress on recommendations from the last full inspection report

## Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy establishment.

## Safety

### Detainees are held in safety and with due regard to the insecurity of their position.

At the last inspection, in 2019, 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.

#### Key recommendations

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.
**Not achieved**

Doctors should submit a rule 35 report to the Home Office on any detainee they suspect of having suicidal ideation.
**Not achieved**

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.
**Not achieved**

There should be a strict time limit on the length of detention and caseworkers should act with diligence and expedition throughout detention.
**Not achieved**

Detainees should not be locked in cells and should be allowed free movement around the centre until later in the evening.
**Partially achieved**

**Recommendations**

Detainees should not be subjected to exhausting overnight transfers when this could be avoided through more timely escorts.
**Not achieved**

Key departments should be consistently represented at monthly safer community meetings and the minutes should demonstrate discussions and actions based on the data presented.
**Partially achieved**

Violence reduction processes should focus on identifying, quantifying and addressing the causes of violence.
**Not achieved**

All security procedures should be proportionate to a detainee population and based on individual risk assessments.
**Achieved**

An in-depth review of use of force should be conducted to ensure that such incidents are minimised in line with the level used in other immigration removal centres.
**Not achieved**

Detainees in the segregation unit should be offered full access to the regime. Subject to individual risk assessments.
**Not achieved**

## Respect

**Detainees are treated with respect for their human dignity and the circumstances of their detention.**

At the last inspection, in 2019, detainees were generally positive about staff. Increased and consistent staffing and lower numbers of detainees had supported better relationships between detainees and staff. The living accommodation remained prison-like but was in good condition and clean. Equality and diversity work was underdeveloped. Faith provision was good. Replies to complaints were quick and courteous, but too defensive and almost none were upheld, even where justified. Most detainees were critical of the food. The cultural kitchen remained a very good resource but was small. Health care provision was reasonably good. Many detainees complained about the attitude of health care staff, and managers had been

working on improving communication with detainees. Outcomes for detainees were reasonably good against this healthy establishment test.

**Key recommendations**

Effective measures should be taken to ensure that a majority of detainees find the food to be of sufficient quality.
**Not achieved**

Managers should investigate and address the reasons for detainees' low confidence in the complaints system.
**Not achieved**

Information about the protected characteristics of all detainees should be systematically collected on arrival, with support offered where necessary.
**Achieved**

**Recommendations**

Toilets and basins should be clean and unstained.
**Not achieved**

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

All detainees who wish to take part in the cultural kitchen activity should be able to do so regularly and within a reasonable timescale.
**Not achieved**

Diversity monitoring should facilitate the identification and investigation of trends in detainee outcomes.
**Not achieved**

Detainee support forums should be provided for detainees with protected characteristics and different nationality groups.
**Not achieved**

Chaplains should be available for the drop-in service at specified times each day**.**
**Achieved**

The health care complaints system should be well advertised and ensure that medical confidentiality is maintained**.**
**Not achieved**

All health staff should receive regular, recorded managerial and clinical supervision.
**Achieved**

The centre should promote the emergency protocols to ensure that all custody staff are familiar with them and are confident to use them when needed to prevent confusion and potential risk.
**Not achieved**

A wide range of translated health information, including self-help guidance, should be easily accessible and clearly promoted.
**Achieved**

Formal monitoring should be introduced to ensure that all detainees leave the centre with their prescribed medication.
**Achieved**

## Activities

**The centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees.**

At the last inspection, in 2019, there was a reasonable range of activities and detainees had good access to them. There was enough work for the population. Education was valued and teaching was good, although outcomes were mixed. Only a third of detainees in our survey said they could fill their time and not enough was done to encourage participation. The library was poorly managed and did not meet the needs of most detainees. Fitness provision was reasonably good. Outcomes for detainees were reasonably good against this healthy establishment test.

### Key recommendations

Managers should significantly increase the number of detainees who benefit from the education provision, through better promotion, guidance and incentives to improve participation.
**Not achieved**

Managers should introduce relaxation and stress-relief activities into the centre's activities programme.
**Not achieved**

### Recommendations

Managers should implement the quality assurance framework to support teachers more effectively in improving the provision.
**Not achieved**

Managers should monitor use of the library to identify areas where the service can be improved, and use increased.
**Not achieved**

## Preparation for removal and release

**Detainees are able to maintain contact with family, friends, support groups, legal representatives and advisers, access information about their country of origin and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property.**

At the last inspection, in 2019, welfare support was good and we were pleased to see that staff had qualifications accredited by the Office of the Immigration Services Commissioner (OISC). The visits experience was well managed and had improved, but visitors found it difficult to book over the phone. Access to communications was generally good but the blocking of legitimate internet sites was a significant problem, which could have affected detainees' ability to prepare for their release or removal. Not all detainees leaving the centre were systematically seen by welfare staff. All currently had sufficient notice of removal. Outcomes for detainees were reasonably good against this healthy establishment test.

### Key recommendations

Detainees should have access to legitimate websites, including those facilitating legal assistance, Skype and social networking. There should be effective and prompt procedures for unblocking such sites.
**Partially achieved**

Detainees should be routinely seen on arrival and before discharge to ensure that welfare matters are identified and addressed.
**Partially achieved**

### Recommendations

Visitors should be able to book visits easily by telephone.
**Achieved**

Detainees should have access to video-calling and social networking sites unless an individual risk assessment determines that this is inappropriate.
**Partially achieved**

The Home Office should keep records of the numbers of detainees being released homeless.
**Achieved**

# Appendix I About our inspections and reports

Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners/detainees, based on the four tests of a healthy prison that were first introduced in this Inspectorate's thematic review Suicide is everyone's concern, published in 1999. For immigration removal centres the tests are:

**Safety**
Detainees are held in safety and with due regard to the insecurity of their position.

**Respect**
Detainees are treated with respect for their human dignity and the circumstances of their detention.

**Activities**
The centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees.

**Preparation for removal and release**
Detainees are able to maintain contact with family, friends, support groups, legal representatives and advisers, access information about their destination country and be prepared for their release, transfer or removal. Detainees are able to retain or recover their property.

Under each test, we make an assessment of outcomes for detainees and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the Home Office.

**Outcomes for detainees are good.**
There is no evidence that outcomes for detainees are being adversely affected in any significant areas.

**Outcomes for detainees are reasonably good.**
There is evidence of adverse outcomes for detainees in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

**Outcomes for detainees are not sufficiently good.**
There is evidence that outcomes for detainees are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of detainees. Problems/concerns, if left unattended, are likely to become areas of serious concern.

**Outcomes for detainees are poor.**
There is evidence that the outcomes for detainees are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for detainees. Immediate remedial action is required.

The tests for immigration detention facilities take into account the specific circumstances applying to detainees, and the fact that they are not being held for committing a criminal offence and their detention may not have been as a result of a judicial process. In addition to our own independent *Expectations*, the inspection was conducted against the background of the Detention Centre Rules 2001, the statutory instrument that applies to the running of immigration removal centres. Rule 3 sets out the purpose of centres (now immigration removal centres) as being to provide for the secure but humane accommodation of detainees: in a relaxed regime; with as much freedom of movement and association as possible consistent with maintaining a safe and secure environment; to encourage and assist detainees to make the most productive use of their time; and respecting in particular their dignity and the right to individual expression.

The statutory instrument also states that due recognition will be given at immigration removal centres to the need for awareness of the particular anxieties to which detainees may be subject, and the sensitivity that this will require, especially when handling issues of cultural diversity.

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for detainees. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Five key sources of evidence are used by inspectors: observation; detainee and staff surveys; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection.

All inspections of immigration removal centres in England are conducted jointly with the Care Quality Commission. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

## This report

This report provides a summary of our inspection findings against the four healthy establishment tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the conditions for and treatment of immigration detainees* (Version 4, 2018) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/immigration-detention-expectations/). Section 7 summarises the areas of concern from the inspection. Section 8 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of detainees and a detailed description of the survey methodology can be found on our website (see Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

### Inspection team

This inspection was carried out by:

| | |
|---|---|
| Charlie Taylor | Chief inspector |
| Hindpal Singh Bhui | Team leader |
| Jade Glenister | Inspector |
| Deri Hughes-Roberts | Inspector |
| Martin Kettle | Inspector |
| Rebecca Mavin | Inspector |
| Steve Oliver-Watts | Inspector |
| Chelsey Pattison | Inspector |
| Billie Powell | Inspector |
| Paul Tarbuck | Inspector |
| Charlotte Betts | Researcher |
| Rachel Duncan | Researcher |
| Rahul Jalil | Researcher |
| Alec Martin | Researcher |

| | |
|---|---|
| Shaun Thomson | Lead health and social care inspector |
| Matthew Tedstone | Care Quality Commission inspector |
| Joanne White | Care Quality Commission inspector |

# Appendix II Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

**Care Quality Commission (CQC)**
CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: http://www.cqc.org.uk

**Certified normal accommodation (CNA) and operational capacity**
Baseline CNA is the sum total of all certified accommodation in an establishment except rooms in segregation units, health care rooms or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged rooms, rooms affected by building works, and rooms taken out of use due to staff shortages. Operational capacity is the total number of detainees that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

**Notice of intent**
A notice of intent is a letter from the Home Office to someone who has claimed asylum, informing them that their asylum claim may be considered inadmissible and that they could be removed from the UK to a third country, including Rwanda, where applicable. Detainees are provided with seven days to reply to the letter to explain why they should not be removed.

**Protected characteristics**
The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

**Protection of adults at risk**
Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

**Rule 35**
Rule 35 of detention centre rules requires the Home Office to be notified if a detainee's health is likely to be injuriously affected by detention, including if they may have been the victim of torture.

# Appendix III  Care Quality Commission Requirement Notice

Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: http://www.cqc.org.uk

The inspection of health services at Brook House Immigration Removal Centre was jointly undertaken by the CQC and HMI Prisons under a memorandum of understanding agreement between the agencies (see https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/working-with-partners/). The Care Quality Commission issued a 'requirement to improve' notice following this inspection.

## Requirement Notices

### Provider

Practice Plus Group Health and Rehabilitation Services Limited

### Location

Gatwick IRC Cluster

### Location ID

1-11252188957

### Regulated activities

Treatment of disease, disorder or injury and Diagnostic and screening procedures.

### Action we have told the provider to take

The table below shows the regulations that were not being met. The provider must send CQC a report that says what action it is going to take to meet these regulations.

### Regulation 18 - Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

**How the regulation was not being met**

There were not always sufficient staff deployed due to the vacancy rate and recent difficulties in securing agency staff. The required daytime staffing levels at Brook House IRC were three healthcare practitioners, two mental health nurses and two healthcare assistants. However, the service tried to maintain staffing levels with two healthcare practitioners, two healthcare assistants and two mental health nurses during the day. The large number of patients arriving at Brook House IRC on a regular basis meant there was significant pressure on primary care nursing staff to complete reception screens and healthcare assistants were helping to complete reception screens.

There had been some occasions during the months before the inspection when the primary care staffing levels were lower than the required levels. Between 1 April 2022 and 14 June 2022 there were 25 days when there was one healthcare practitioner on duty during the day, eight days with one mental health nurse and 29 days with one healthcare assistant. In addition, there was one day when the primary care clinical lead was the only member of the primary care team on shift

There was often only one member of the mental health team on duty who had to triage new applications, attend ACDT reviews and also see patients on the team caseload. At the time of the inspection there was no psychology provision due to the provider being unable to recruit into these positions.

Despite efforts by the provider, at the time of the inspection, there was a 51% vacancy rate with staffing challenges evident across all services.

# Appendix IV  Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed reports distributed to the prison). For this report, these are:

## Detainee population profile

We request a population profile from each centre as part of the information we gather during our inspection. We have published this breakdown on our website.

## Detainee survey methodology and results

A representative survey of detainees is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

## Survey of centre staff

Staff from the centre are invited to complete a staff survey. The results are published alongside the report on our website.

# Appendix V Summary of detainee interviews

Every detainee at Brook House was offered a confidential individual interview with an inspector. A few had either left the centre or did not want to be interviewed when inspectors went to see them, and we eventually conducted 88 interviews, 36 with interpretation. We also invited, through various voluntary and community groups, recently released detainees to speak to us. One was referred to us and we interviewed him by phone. The interviews were semi-structured and were held on 30–31 May, 1 June and 6 June 2022. What follows is a brief summary of the key messages that emerged. The opinions of interviewers are not included, and this represents only the views of interviewees. These interviews were used as one source of evidence to inform the rounded judgements made by inspectors in the body of this report. The principal objectives were to identify concerns about safety and safeguarding of individual detainees, and to deepen inspectors' understanding of the culture in the centre. The detainees we spoke to were self-selecting and the findings below should be seen as supplementing our detainee survey findings (see Appendix IV). We followed up any allegations of concern and have reported on outcomes in the main body of the report where we were able to corroborate the allegations.

## Key themes from 89 detainee interviews

***Many detainees felt unsafe, usually because of the prison-like environment and their immigration case.***

A significant minority of detainees said they felt unsafe, commonly describing the psychological stress of being detained, not knowing what was happening with their immigration case and/or being in a place that looked and felt like a prison. Some detainees were anxious about having to share a cell with a stranger and many said they had felt intimidated being around ex-prisoners, at least until they got to know them. They also found it stressful being locked up at night in cells and being around so many other frustrated people on wings where there was often a lot of noise. A few detainees mentioned that they had seen fights. Most thought that staff generally responded to them quickly. Very few detainees had seen any use of drugs or alcohol.

Detainees were generally positive about how staff treated them. The detainees who were more negative mentioned a lack of interaction, particularly with those that did not speak English, and some rude or dismissive behaviour. None reported that they had been physically mistreated, but several detainees thought that a man had been mistreated by staff when being taken to the separation unit before a forced removal. They had heard rather than witnessed the incident. We identified this case and found no evidence of mistreatment. However, detainees were still disturbed by the incident. One said: 'I'm really worried this will happen to me'.

***A common source of frustration and anxiety for detainees was their immigration case and difficulties getting information.***

Many detainees commented that a lack of communication about their immigration cases and not knowing what was going to happen in the future, or how long it would take, was a major concern for them. Some detainees had little understanding of what was happening to them because of language difficulties. One said: 'I had some paperwork this morning but didn't understand what it was about. They just put it under my door'. Others commented that Home Office staff were not visible or communicative.

Those with more complex situations were often more frustrated – they included detainees with families in the UK and detainees who wanted to return voluntarily and could not understand why the process was taking so long. The detainees who had been told they would be taken to Rwanda were especially anxious and some presented serious mental health concerns.

A number of people we interviewed had been granted bail but were still detained because of a lack of accommodation. Some blamed Home Office staff for not explaining or helping them to resolve such issues. A detainee said: 'They don't respond to requests and can't tell me what is happening with my case. I only know I have bail and need accommodation. I have case owner's email, but they never respond.' One man who had been granted bail in principle said he was particularly frustrated because he could not start treatment for his diagnosed post-traumatic stress disorder (PSTD) until his release.

***The vast majority of detainees said they were treated well or reasonably well by detention staff.***

Virtually all detainees said staff at Brook House treated them well. Staff were variously described as friendly, helpful and reassuring. The main reported concerns about detention staff were that many were inexperienced, could not answer questions, could be dismissive or did not interact well with detainees, particularly those who spoke little English.

Three people said they had seen staff behave inappropriately; they talked about a lack of help from health care staff, a detention officer being rude and swearing, and the case of the man forcibly taken to the separation unit before removal.

***Many detainees reported mental health concerns and there were mixed reports about the support from health care staff.***

Many detainees reported stress and mental health issues, including typical symptoms of PTD. Some outlined self-harming behaviour and suicidal thoughts. Although some described the care they received very positively, others reported limited or no contact with mental health services.

While many detainees said their health care needs were met, a similar number said there were long waits for appointments, they did not feel they were taken seriously or that they were not being given the medication they needed. Several said that they had a poor experience of dentistry, and some mentioned a lack of appropriate dental equipment.

***A number of detainees described psychological problems resulting from their journeys to the UK and said these problems were exacerbated by detention and, for some, the prospect of being taken to Rwanda.***

Several detainees described being held captive and mistreated during sometimes traumatic journeys to the UK through Libya:

> *'Being here reminds me of being in prison in Libya. I feel a great burden on my chest. I have no idea what is going to happen to me. I don't know anything about anything. I am being treated like I am a dead person.'*

> *'Any place where the door is locked, I don't feel safe… I'm terrified of having the door locked'.*

Another man who had experienced a traumatic journey through Libya was known to be at risk of self-harm. He was due to be relocated to Rwanda and said he would not go. He said he had been kidnapped by a militia in Libya, assaulted and tortured, and only released when his family paid a ransom. He then made his way to the UK, arriving 14 months after he had left his home. He was awaiting treatment for some of the injuries that had been inflicted during the journey. He said: 'I will kill myself if they send me to Rwanda, my dream was to come here… I have two children in Egypt… I want to make money to send to them'.

Three other detainees reported being subjected to modern slavery in Libya:

> '*Conditions were very hard. I was hired to work on a building site. They gave us no wages or food. We were exploited. After, the employer sold us to a militia, and we were detained for three months. They asked for our family contact details and demanded a ransom for our release. We were beaten every day.'*

They had all been told that the Home Office intended to remove them to Rwanda and two said they were refusing food.

***A number of detainees did not have the confidence to complain.***

Most of those we spoke to were confident about making complaints, but a substantial number did not know how to make them or were not confident enough to complain; this was especially the case with people who did not speak fluent English. We heard many complaints about the quantity and quality of the food.

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

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