Independent investigation into concerns about Brook House immigration removal centre

A report for the divisional chief executive of G4S Care and Justice and the main board of G4S plc

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Executive summary

Background to the investigation

1.1 G4S plc (G4S) has managed Brook House, an immigration removal centre (IRC) near Gatwick Airport, since 2009 under a contract with the Home Office. The centre holds up to 508 adult male detainees.

1.2 In late August 2017 BBC Panorama informed G4S that it was preparing to broadcast a documentary about Brook House. The programme showed staff at Brook House making derogatory, offensive and insensitive remarks about detainees and incidents of verbal and physical abuse. It raised other concerns about the management of Brook House and the welfare of detainees held there.

1.3 With the support of the Home Office, Peter Neden, divisional chief executive of G4S Care and Justice and Søren Lundsberg-Nielsen, group general counsel, commissioned this investigation on behalf of the main G4S board into the issues raised by the Panorama programme.

1.4 We had unrestricted access to Brook House over more than five months starting in November 2017. We observed daily life in the centre and how staff and detainees interacted. We believe that our unrestricted access allowed us to form a realistic impression of Brook House and its culture.

1.5 Under a separate contract with the Home Office, G4S also manages Tinsley House, another IRC near Gatwick Airport, under the same senior management team as Brook House. Brook House and Tinsley House are known collectively as Gatwick IRCs. We visited Tinsley House, and also HMP Rye Hill, HMP Preston and Heathrow IRCs to compare aspects of Brook House with those institutions and to increase our understanding of the management and culture of Brook House.

Background information

1.6 The BBC Panorama documentary titled *'Undercover: Britain's Immigration Secrets'* was broadcast on 4 September 2017. The programme was the result of covert video recording by a G4S detainee custody officer (DCO) who had been working at Brook House for about a year. The footage is thought to have been captured between April and July 2017.

1.7 The programme highlighted a number of incidents and concerns which fall into the following broad themes:

- Inappropriate mixing of detainees/ suitability of detention
- Drug use
- Mental health
- Poor staff behaviours: use of force and unsympathetic culture
- Staffing levels
- Lack of adherence to policy

1.8 There were 21 members of Brook House staff involved in the allegations raised by Panorama. 11 of these were dismissed or left the organisation following the programme. Three staff involved in the allegations later resigned. One was dismissed after subsequent similar behaviours.

1.9 The centre director (referred to as 'the former director' in this report), who had been in post since 2012, left G4S after the Panorama broadcast. He was replaced by a senior manager from G4S Custodial and Detention Services (whom we refer to as 'the interim director').

1.10 Detainees at Brook House arrive by differing paths in the immigration and asylum system and are detained for differing reasons. Detainees fall into one of three categories: foreign national offenders who have served a prison sentence in the UK and are awaiting deportation (known as TSFNOs); those detained while their asylum application is considered; and others who are thought to have entered or stayed in the UK illegally (sometimes referred to as overstayers). Brook House principally accommodates TSFNOs and overstayers.

1.11 Detainees come from all parts of the world and some have little or no command of English. They have widely differing life experiences, expectations and concerns. Some

detainees have been victims of violence, torture and other traumatic events. Many detainees at Brook House have mental health issues.

1.12 Most detainees at Brook House have reached the end of their attempts to remain in the UK. They face enforced removal and are highly resistant to it.

1.13 Brook House provides the highest level of security in the IRC estate and is used to house some detainees whose behaviour is too challenging for other centres. The presence of disruptive and challenging detainees has a detrimental effect on the experience of other detainees and staff and undermines their sense of safety and security.

1.14 Unlike prisoners, detainees are not required to work or undertake education, nor can they be subjected to punitive sanctions. Where it is necessary in the interests of security or safety, a refractory or violent detainee may be confined temporarily in special accommodation or removed from association with other detainees. But in managing detainees, staff have to rely above all on constructive engagement.

Management at Brook House

1.15 Since Brook House opened in 2009, there has been a history of dysfunctional relationships and instability in the senior management team.

1.16 The former director told us that his role at Gatwick IRCs required him to manage multiple stakeholders as well as fulfilling internal reporting requirements, and he largely relied on the heads of Brook House and Tinsley House to deliver operational management of the centres.

1.17 We found some members of the senior management team at Brook House tended to adopt an abrupt, directive and authoritarian approach in dealing with staff at Brook House, rather than being consultative and developmental. Staff described their experiences of senior managers dealing with matters of individual poor performance in unnecessarily severe and heavy-handed ways.

1.18 Our interviews and conversations with staff and more junior managers suggested they did not see members of the senior management team out and about in Brook House

regularly. They told us that the only time they saw most members of the senior management team was when they were performing their rota duty as duty director. The only regular forum at which staff at Brook House might otherwise have encountered a senior manager was the staff briefing held for 10 to 15 minutes at the beginning of each working day. We visited Brook House on many occasions over a number of months and did not see senior managers in the centre for purposes other than accompanying official visitors or undertaking a specific duty.

1.19 Whatever senior managers at Brook House may have believed about their own level of engagement with staff, staff clearly did not perceive senior managers as being either visible or approachable. The principle effects of this were that frontline managers and staff tended to rely on colleagues, especially the more assertive of them, for leadership, guidance and support; and did not feel able to raise issues and matters of concern with senior managers.

1.20 Management arrangements at Brook House were at their weakest in relation to frontline management by detainee custody managers (DCMs). The weakness was apparent in both the number and the capability of the frontline managers. A number of DCMs told us how demanding they found their workloads. They told us how more pressing operational requirements of the centre meant they were often unable to give the required amount of attention to their own specific duties and responsibilities including the line management of detainee custody officers (DCOs). DCMs told us they had received no formal training for either the practical or managerial aspects of their role other than short periods shadowing existing DCMs. The interim manager had recently introduced a training programme for DCMs.

1.21 The lack of DCM capacity and capability contributed to the disaffection of staff at Brook House and undermined their work and the way they managed detainees. A number of DCOs said they wanted DCMs to be more proactive in their management and in ensuring that rules and procedures were more consistently applied. The failure of frontline managers to actively manage DCOs and their work on the wings led some DCOs to adopt a passive attitude to their work and to their failing to take ownership and responsibility for what went on in the centre. We met some enthusiastic and energetic DCOs and DCMs at Brook House who tried to enforce rules, dealt with detainees proactively and consistently and took ownership of their wings. But this was often not our experience of DCOs and DCMs at Brook House.

1.22 A DCO told us the lack of visible and capable frontline management made them feel unsupported. One DCO told us he sometimes did not raise concerns about how other officers behaved or carried out their duties because he felt that DCMs were too busy, there was nothing they could do, and they would not welcome being bothered. We also found weaknesses in staff welfare arrangements. And staff were not given formal opportunities to reflect on their practice and the lessons to be drawn from incidents.

1.23 The absence of frontline managers and/or their failure to tackle poor performance or poor behaviours by DCOs in a routine and appropriate fashion meant that issues were often not addressed until they had escalated and were dealt with formally by disciplinary or grievance processes.

1.24 We found a lack of visible and capable management and a sense among staff that managers were unapproachable, unsupportive and sometimes draconian. DCOs told us they did not feel managers valued them as colleagues or for their contribution to the work of the centre. This led to disaffection among staff and to their relying principally on each other for support and guidance. It had worked against the development of an open and learning culture. It had also presented opportunities for some stronger personalities to gain undue influence leading them sometimes to behave in inappropriate ways without being challenged, as the Panorama film showed.

Staffing arrangements

1.25 G4S contracted with the Home Office to provide 668 hours of DCO time a day. How these staff are rostered and where they are deployed in the centre is for G4S management to determine but the contract requires at least two DCOs on duty on each residential wing throughout the day.

1.26 We were told that the staffing plan in place before September 2017 (developed in discussion with the staff union and G4S senior management) did not provide for enough staff to ensure the smooth running of the centre and an adequate regime and activities programme for detainees. In any event problems with staff retention meant it had not been possible to meet the intended staffing plan.

1.27 In September 2017 the interim director reviewed the Brook House staffing arrangements. He set as a target for there to be three or four DCOs and one DCM on each residential wing. Staff told us in early 2018 that this level of staffing was being achieved for only about 60 per cent of the working day. They often found themselves working alongside only one colleague and were sometimes left on their own. On most days a single DCM managed two wings. Our visits confirmed what staff told us about staffing levels.

1.28 Records confirm a significant increase in the number of staff leaving employment at Gatwick IRCs during 2016 and that staff turnover has remained high.

1.29 A number of events in early 2017 undermined efforts to keep staff and stabilise the staffing levels at Gatwick IRCs. These were:

- a new staff contract requiring all staff to work a 46-hour week consisting of largely inflexible 13.5 hours shifts;
- the effect of the loss of additional staff support at Brook House following the refurbishment and reopening of Tinsley House;
- the introduction of 60 extra beds to increase the number of detainees who could be accommodated at Brook House;
- Gaps in staffing at Brook House being increasingly filled by Tinsley House staff who did not welcome having to work in the more challenging environment of Brook House.

1.30 In addition, a number of staff were dismissed as a result of the investigations into the behaviours of staff reported in the Panorama programme aired on 4 September 2017. As might be expected, the programme undermined staff morale and led to further staff losses. A manager described the staffing during September and October 2017 as *"dire"*.

1.31 Maintaining staffing levels continued to be a significant problem. An overtime scheme and recruitment plan to improve staffing levels had only limited effect as the attrition rate averaged 10 or 11 per month. Between September 2017 and May 2018, 112 DCOs were recruited to Gatwick IRCs but the centre lost 92.

1.32 Nearly all the staff and managers we interviewed said low staffing and the high staff turnover had adversely affected the experience of working at Brook House and undermined staff morale. Staff felt unsafe when manning wings with too few colleagues or even alone.

The number of new and inexperienced staff appeared to have had an effect on both more experienced staff, who talked about the added pressure of having to support new recruits, and on the newer staff who felt unsure about their role and responsibilities. They also felt unsupported and ill equipped to meet the demands of managing more challenging detainees. Many of the DCOs we interviewed said they were considering alternative employment.

1.33 A number of interviewees said the pay for DCOs was inadequate, especially given the many other employment opportunities on offer locally. The managing director of G4S Custodial and Detention Services acknowledged that the DCO salary at Gatwick IRCs was less likely to appeal to more experienced people. G4S does not offer a bonus for long service and has no arrangement for pay rises. Working at Brook House requires particular personal qualities and skills which are more likely to be developed over time and with experience. For this reason, we believe it is particularly important to retain experienced staff at Brook House.

1.34 We found that the lack of staff and the failure to retain staff had a profound and detrimental impact on many aspects of life at Brook House for detainees, managers and staff. The staffing problems compromised the care and management of detainees. Managers and staff told us about problems in managing their workload, in ensuring that procedures designed to ensure the wellbeing of detainees were consistently adhered to, and in delivering an appropriate regime. Detainees told us that staff shortages had adverse effects on their lives.

1.35 We believe there is a need for a comprehensive review of all the matters we refer to as affecting staff retention at Brook House, particularly remuneration, shift patterns and working hours. G4S needs to develop plans for addressing these matters.

Staff training

1.36 All new DCO recruits at Brook House undertake an eight-week initial training course (ITC). It begins with a six-week classroom-based course. DCOs who are assessed as having passed this phase of the ITC and who have Home Office security clearance to work as a DCO spend one week working in the IRC shadowing experienced members of staff. This is followed by one week working in the centre with support from a more experienced member of staff.

1.37 The Home Office prescribes some of the course content of the ITC. New recruits undertaking the ITC told us that instructors set homework and tested and assessed them as they went along. We heard of recruits who had not passed the ITC. This suggested some rigour in the training process.

1.38 However, we had cause to question the quality and content of some of the training offered to new recruits on the ITC and to staff as refresher training. We found that not all those delivering the ITC and refresher courses were appropriately qualified. The trainers who undertook a personal protection course that we attended were not always confident or comfortable in their understanding of the training material and at times they appeared dismissive of the rules that DCOs using physical force on detainees are expected to observe. In addition, the material that instructors use, and the instructors we observed, made frequent reference to prisons and prisoners. The ITC needs to better reflect the requirements of an IRC as opposed to a prison and to include specific IRC-based case studies. We learned that no quality assurance was undertaken in respect of the delivery of training sessions at Gatwick.

1.39 We heard about a personal protection training session which took place during the course of our investigation whose tone and content had given rise to serious concerns resulting in two control and restraint trainers being dismissed. This episode also raised questions about the attitudes and culture among some staff at Brook House.

1.40 Trainee staff at Gatwick IRCs, are currently not allowed access to the centre until after they have passed the six weeks classroom-based part of the ITC and have Home Office clearance. Staff told us that their training had been based on handouts and PowerPoint, which had not been engaging and had not prepared them well for situations they would encounter at Brook House. This contributed to many staff leaving soon after joining. This is a waste of the time and expense that recruits and G4S have invested in training. Staff and managers told us the only way new recruits could be made to appreciate the unique environment at Brook House was by experiencing it. We agree with this view.

1.41 Unlike staff working elsewhere in Brook House, potential recruits in healthcare see the centre as they arrive and leave so they are exposed to the 'vibe' of Brook House. The manager concerned said it was *"useful to have interviews in the centre"* and that potential future employees *"hear the noise and see the patients (detainees) wandering around the*

centre". He said that exposure to the environment allowed those interviewing to assess the likely suitability of a candidate.

1.42 Staff at Brook House should receive annual refresher training but owing to a lack of staff, including a lack of training staff, in January 2018 only 72 per cent of staff were up to date with their refresher training. Annual refresher training helps to ensure that staff are properly equipped to undertake their role. It also offers some assurance that staff will perform their role in accordance with policies and procedures.

1.43 The evidence suggested that Gatwick IRCs have more to do to better establish the training requirements of existing staff and what should be the subject of refresher training or further specialised training for individual staff or groups of staff.

1.44 The appraisal and development process for staff at Brook House was not effective. This contributed to staff feeling undervalued and unsupported. It may also have meant that disaffection or poor performance, and inappropriate behaviours and attitudes went unchecked.

Facilities

1.45 Brook House is built to the security standard of a category B prison. It comprises three separate buildings: a visitors' centre, a gatehouse and the main accommodation building. The main accommodation building has four small courtyards. One has been laid with artificial grass as a garden, while the others are hard-surfaced and used for sports and games.

1.46 Facilities for use by detainees include a chapel and a mosque, a multi-faith room and a quiet room. There is also an arts and crafts room, a music room, a classroom, two IT rooms, a library, a gym with 21 fixed pieces of equipment, a shop, a cinema room and a barber's room. Most of these facilities are housed in rooms that can comfortably accommodate no more than about 25 people. The only larger space that can be made accessible to detainees is the visits hall. There is no sports hall.

1.47 The lack of seating and tables in the communal areas on wings meant that most detainees ate in their rooms. Detainees often sat on the floor in corridors and other communal spaces.

1.48 Brook House was never at full capacity while we were there, but we nevertheless had an overwhelming impression of it as overcrowded and unsettled. The overcrowding and sense of tension is exacerbated by there being corridors, to which the detainees do not have access, across the main accommodation building on the ground and second floors. This obliges all detainees who want to get to the other side of the building to pass through the corridor and facilities on the first floor, which is a significant bottleneck.

1.49 Doors to wings were locked and only the residents on a wing were allowed access to it. We noticed that queues built up at the entrances to wings and detainees continually banged on wing doors and shouted in order to attract the attention of an officer. This noise could be heard throughout the residential wings and beyond.

Activities

1.50 The provision of activities and entertainment for detainees at Brook House was limited not only by the lack of space. It was under-resourced, poorly managed and further compromised by long-standing staffing problems. The activities team consisted of only four DCOs in late 2017 and early 2018, meaning only two were on duty most days. None of them had had specialist training for their role. Two more DCOs were assigned to the activities team in April 2018, but staff shortages elsewhere in the centre still meant there were often only two DCOs working in activities on a given day. G4S's contract with the Home Office requires daily opening of the IT rooms and the library. The activities DCOs were used to run these facilities and a DCO was rarely available to act as sports officer or to organise the sporting and other events.

1.51 A lack of staff available to man courtyards meant that there was only one courtyard open at a time. The courtyard was often overcrowded.

1.52 Detainees spoke to us about the fact that there was not enough to occupy their time. Detainees told us about two weeks in March 2018 when they did not even have an

unpunctured football to play with. On an unannounced visit to the centre at a weekend we found no organised activities for the detainees.

1.53 A lack of space and equipment meant that teachers struggled to deliver a worthwhile programme to detainees.

1.54 Detainees were not able to obtain qualifications from paid work undertaken at Brook House, and no certificates or other awards were made in recognition of their work.

1.55 We compared provision of activities and entertainments for detainees at Brook House with that at Colnbrook IRC near Heathrow Airport, which is managed by Mitie plc. Like Brook House, Colnbrook stands on a restricted site with outdoor space that is limited to small enclosed courtyards, however the building is more spacious than Brook House. It has two gyms and a sports hall. We acknowledge the space constraints at Brook House. Even so, the activities and entertainments programme and the resources devoted to them compared very poorly with those at Colnbrook.

1.56 Activities available to detainees at Brook House do not meet the standard prescribed by rule 17(1) of the Detention Centre Rules 2001. The lack of activities and opportunities for exercise present a risk to detainees' welfare and wellbeing and to the general safety and security of the centre.

1.57 The size and layout of Brook House, its lack of a sports hall and its limited outside space make it unsuitable to accommodate as many detainees as it does. It is also an unsuitable environment in which to hold detainees for more than a few weeks. Whatever the shortcomings in the physical space at Brook House, the current provision of education, activities and entertainments is inadequate.

Food

1.58 We asked detainees about the food at Brook House. Their comments were largely negative.

1.59 The onsite general manager for [redacted] Limited, the company which contracts with G4S for the supply of catering, cleaning and laundry services at Gatwick IRCs, told us of the

challenges in catering for detainees. He said that with as many as 70 different nationalities among the detainee population, tastes and requirements varied greatly.

1.60 The [redacted] general manager explained that [redacted] used to be paid on the basis of full occupancy of Brook House, but a new contract with G4S meant that from October 2017 [redacted] was paid on the basis of actual occupancy plus 75p per head for special meals for the main religious and cultural festivals. The [redacted] general manager was clear that this had reduced by nearly 10 per cent the amount he could spend on the provision of meals. The [redacted] general manager suggested that the reduction in the funding available for meals had led to a reduction in quality.

1.61 The [redacted] general manager, detainees and staff complained that inadequate supervision of meal service led to food being presented in an unappetising way, and to tensions and arguments between detainees at meal times.

Cleaning

1.62 The standard of cleaning at Brook House has been a problem for some time. The Home Office contract managers at Brook House confirmed that G4S had incurred significant financial penalties for the poor standard of cleaning.

1.63 We observed that the cleaning of wings, which is undertaken by detainee orderlies, was particularly poor.

1.64 Detainees complained to us that they found it difficult to clean the wings and their rooms properly because they did not have adequate cleaning products and cloths. [redacted] kept cleaning cupboards stocked with cleaning products for orderlies to use under supervision by DCOs. However, DCOs did not routinely supervise orderlies and detainees were only able to use the detergent and old cloths kept on the wings.

1.65 The standard of cleaning at Brook House was unacceptable. Managers need to resolve the issue either by agreeing with [redacted] that it will undertake the cleaning of wings or by ensuring that wing orderlies keep wings to an acceptable standard of cleanliness throughout the day, that they are properly supervised and allowed access to the necessary cleaning products and equipment. All wing staff need to be held to account for ensuring wings are

maintained at an acceptable standard. All detainees should have access to cleaning products to clean their own rooms, washbasins and toilets.

The care and welfare of detainees

1.66 A number of management committees at Brook House consider and oversee the practical implementation of care and welfare arrangements in relation to detainees, both individually and collectively. We attended meetings of some of these committees but with some difficulty because pressure on managers' time meant meetings were frequently cancelled, often at short notice.

1.67 Our observation of these management meetings gave us cause for concern about their effectiveness. We found that they were chaired poorly, sometimes by a last-minute substitute, and lacked focus.

1.68 We found that the Gatwick IRCs policies directly relevant to care and welfare were on the whole well written and comprehensive, but a significant number had not been reviewed within their due date. A number of staff and managers referred to the failure of staff to observe policy and correct procedures and how this affected the care and welfare of detainees.

1.69 The lack of staff and the pressures on their time undermined their ability to give as much attention as they and detainees would have liked to the emotional needs and concerns of detainees. Detainees who attended our focus groups with them told us that officers did not have time to address their needs.

1.70 Managers and staff told us how the reception at Brook House sometimes struggled to cope with the number of people being detained and removed from the centre. Each of these movements involves a relatively lengthy process. The arrival of large numbers of detainees at one time, places unnecessary strain on the reception process and the long waiting times involved add significant further stress to detainees' arrival at Brook House.

1.71 All newly arrived detainees undergo a room sharing risk assessment as part of the reception process. We found deficiencies and inconsistencies in the Detention Services Order and G4S's own policy for determining risk in respect of room sharing. But the staff we

observed at work in the reception at Brook House did take account of all available information to determine if a detainee was a high risk for room sharing purposes. However, they said they felt under pressure from the Home Office not to allocate detainees to single occupancy rooms and they had to refer to a manager all cases where they considered a detainee was a high risk.

1.72 Staff and managers working in reception told us that staff at Brook House cannot see electronic prison records of TSFNOs arriving at Brook House. They have to rely initially for information on the hard copy prisoner escort records (PERs) that are supposed to accompany TSFNOs. The prison service is meant to send full prison records to Gatwick IRCs. Complete records do not always arrive at the centres and some arrive sometime after the detainee they relate to. The lack of staff in the security team at Brook House caused considerable delay in staff being able to examine files for information about the risk profile of a TSFNO detainee.

1.73 The Gatwick IRCs induction policy requires new detainees to be accommodated on B wing. From about May 2017 until March 2018 this induction policy was largely disregarded, and most detainees were not subject to the required programme. This was partly a consequence of other detainees, apart from new arrivals, being accommodated on B wing. Some were disruptive detainees who could be better managed on a smaller wing. Many new arrivals were sent straight to other larger wings housing long-standing detainees.

1.74 Whatever the reason, it was entirely unsatisfactory and inappropriate for detainees not to have been given the support needed to enable them to cope during the initial stages of their time at Brook House. The failure to house detainees in an induction wing where they could be properly assessed and any concerns about them identified presented a risk to their welfare and wellbeing.

1.75 From March 2018 B wing was being managed once again as the induction wing. We saw that officers on the wing were maintaining records to identify which detainees had received the necessary induction interview and had completed the induction programme. Nevertheless, a few long-standing detainees were still being housed on the wing.

The welfare team

1.76 The welfare office is staffed by G4S officers and is open every day for a morning session and afternoon session. The DCOs who act as welfare officers told us that the most common problem they dealt with was detainees' lost property. They also help detainees resolve problems managing their lives at the centre. The welfare officers are not allowed to advise detainees about their immigration cases, but they tell them where they might get help.

1.77 The welfare team at Brook House consisted of four DCOs to allow for two officers to work in the office while it was open. From about October 2017 staff shortages at the centre meant welfare officers had frequently been assigned to other duties. Frequently only one officer had been available to staff the welfare office. Following a staff complaint, from mid-April 2018 there were fewer occasions when only one officer was on duty.

1.78 The welfare staff at Brook House would be better able to undertake their duties if they had training in immigration processes. We believe that this would ensure that welfare staff could then correctly identify and understand documents received by detainees and point them to help elsewhere. They could do this without becoming involved in discussions about the details or merits of individual cases.

1.79 Few if any contacts took place between the Brook House welfare team and charities and other organisations that offer networks and support with resettlement overseas. The welfare team should develop such contacts.

1.80 We saw that the Brook House welfare team fulfilled a necessary and valuable function. They were caring, sympathetic to detainees and their concerns, and helpful in trying to resolve problems. The welfare team should be adequately staffed and supported at all times.

Safer community arrangements

1.81 The ACDT process by which detainees at risk of harm are made subject to a care plan, including regular assessment and observation, is vital in ensuring the safety and wellbeing of detainees at risk. The requirements of the process must be closely adhered to.

Our conversations with staff and our examination of the ACDT paperwork in wing offices suggested that staff understood their obligations in respect of identifying, monitoring and documenting the progress of those thought to be at risk. However, we noticed that DCOs undertaking observations of a detainee did not as a matter of course engage with the detainee but often relied on visual observation alone. Entries in ACDTs and other assessment documents were minimal and not always informative. Staff involved in the ACDT process must be properly and regularly trained to ensure robust and effective case management.

1.82 Staffing and rostering difficulties at Brook House meant the DCMs in residential units with responsibility for doing ACDT case reviews were not necessarily available so the reviews were sometimes done by DCMs from other areas. In our view a detainee on ACDT should be reviewed by a DCM accompanied by a DCO acquainted with the detainee.

1.83 Healthcare managers said they often learned of ACDT case reviews only at the last minute, and that this meant they sometimes had difficulties in attending. Sometimes the healthcare team had to make their contribution by phone rather than face to face. We believe that healthcare staff should always be present at ACDT reviews to assist the assessor and the detainee in their decision making and planning.

1.84 Detainees with identified disabilities and chronic conditions are managed under the supported living plan (SLP) policy introduced in 2016. We learned of concerns about the level and quality of the observations undertaken by staff in relation to those on SLPs.

1.85 Few wheelchair users were sent to Brook House, but we did see detainees with mobility problems and learned that their presence was common. Owing to the layout and location of facilities in Brook House, opportunities for disabled detainees to access facilities and engage in the life of the centre are severely limited. We do not consider it appropriate for wheelchair users or those with limited mobility to be detained at Brook House.

1.86 The Panorama programme included the case of a detainee who claimed, and who appeared to be, under age for detention. The programme alleged that local social services might not have been told about his presence at Brook House. The programme also shows film of a DCO saying she would not raise the issue a detainee's age with managers or the Home Office. An internal investigation into the operational aspects of allegations in the Panorama film was carried out and found that managers did follow correct procedure in this case.

1.87 We were told that age dispute cases were infrequent with only four cases in the 18 months from January 2017.

1.88 Gatwick IRCs age dispute policy does not make it explicit that it is the duty of all staff members who for any reason have cause to believe that a detainee is under age to report it to a manager or ensure that it has been reported. The policy needs to be amended for this purpose. However, the staff we spoke to about underage detainees told us they understood that children should not be held in the centre and that if they suspected that a detainee was under age they would raise the matter with managers so that the detainee could be made the subject of a risk assessment.

1.89 The Gatwick IRCs safeguarding policy was amended in April 2017. It is set out in a series of documents. The scheme of the documents is confusing, but they cover the essential matters that G4S and managers must consider in ensuring appropriate safeguarding.

1.90 Most of the staff we spoke to seemed to understand safeguarding largely in terms of matters affecting detainees at Brook House and in particular the risks of suicide and self-harm. Staff did not appear to have much understanding of the need to be alert to and report concerns about matters affecting the lives of detainees and others outside the centre. The safeguarding policy does not make clear that staff have a duty to report any matter that comes to their attention which suggests that a child or vulnerable adult is at risk in the community for whatever the reason, and whether or not that risk is posed by a detainee.

Healthcare

1.91 NHS England Health and Justice commissions and funds the healthcare services at Brook House. The commissioning team is based in Kent and covers prisons and IRCs in the southeast. G4S Health Services Limited provide most of the health services at Brook House. Services provided at Brook House include primary care, mental health, substance misuse, dentistry (triage) and eye care.

1.92 The centre has 24-hour nursing staff cover. General practitioner cover is available seven days a week. A psychiatrist from a private provider visits the centre weekly. There

are no inpatient beds. Detainees with more serious health problems are cared for on E wing or moved to hospital.

1.93 The head of healthcare or one of her team attends the daily 8.30am operational centre management meeting. This allows the healthcare team to participate fully in the running of Brook House.

1.94 Healthcare staff attend first response incidents in the centre and visit detainees on their wings if they are unwell. They participate in ACDT reviews and the assessment of detainees held under rule 40 and rule 42. We saw examples of them undertaking these roles during our visits to the centre.

1.95 Nursing staff play an important role in planned use of force in the centre. They attend use of force incidents to ensure the safety and good health of detainees. However, we learned during our interviews that nursing staff have no formal training for their role and responsibilities in relation to the use of force.

1.96 Mental health care is provided by three psychiatric nurses, a visiting psychiatrist and psychologists. Mental health provision in the centre consists of drop-in groups, one-to-one work with the nurses and consultations with the visiting psychiatrist. Detainees who need a mental health assessment are seen within two days.

1.97 Those who are acutely mentally unwell are cared for on E wing and moved to a mental health facility as soon as a bed is available. This means that they might spend some weeks with detainees with other vulnerabilities or challenging behaviours. Nursing staff told us that officers *"are very good"* at dealing with detainees with mental health problems despite their limited training, but it would be helpful to have a small number of officers with more advanced knowledge.

1.98 Staff told us that the centre had to manage more detainees with drug and alcohol problems than they had in the past. This included people who were withdrawing and those who needed methadone. Detainees at Brook House can access help with substance misuse from both the Forward Trust and healthcare.

1.99 The deputy head of healthcare inspection at HMIP shared with us her insights into why detainees might misuse drugs, she suggested boredom was a significant trigger. We think this has relevance to Brook House where the activity programme has been so sporadic.

1.100 Detainees at Brook House have access to a good range of healthcare services. Long-standing issues to do with recruiting good quality healthcare have seen recent improvement. Access to a range of healthcare services is probably faster for most detainees than it would be if they were in the community. Overall, provision is good.

1.101 Detainees who attended our two focus group meetings expressed strong views about healthcare. Concerns ranged from access to services to the relationship between healthcare professionals and the Home Office immigration staff. The findings of our detainee focus groups suggest significant levels of distrust of healthcare staff. Healthcare is easily mistaken as part of the immigration enforcement system. This view of healthcare is reinforced by healthcare staff being identified as part of the management of the centre and by, for example, their necessary involvement in use of force and removals. Healthcare staff should be alert to the need to explain themselves to detainees and adopt a caring, open and independent-minded attitude. They need to make clear to detainees that their involvement with Home Office immigration enforcement is to provide an independent clinical opinion. This must be emphasised from reception onwards. Healthcare managers should reinforce regularly this message to healthcare staff.

Security and safety

1.102 The work of the management team responsible for security at Brook House has been hindered by lack of staff. The lack of staff meant they had not been able as a matter of course to process all the prison files of TSFNO detainees. This raised the possibility that important information about the risks posed by TSFNOs had been missed. The security team had also not had the resources to investigate all the security information reports (SIRs) giving information about potential risks to safety and security at Brook House. The security team could not undertake trend analysis and planning of mitigation strategies for security issues. The security team worked reactively.

1.103 A number of detainees spoke to us about having experienced violence and bullying from other detainees. Detainees at our focus groups told us that staff shortages meant that violence among detainees was not properly managed.

1.104 Lack of staff at Brook House may not account for or contribute to every incident of violence or assault at Brook House but many staff and detainees said it sometimes left them feeling insecure, unsafe and unsupported and that they perceived Brook House as unsafe.

1.105 Many officers told us that they had been threatened or assaulted by detainees. Most incidents of violence or assaults on staff were not serious, but we heard of many incidents that were more serious and some resulting in staff needing hospital treatment and significant time off work. They told us how frightening this was and how unsafe it had made them feel. The director of detention and escorting services Home Office Immigration and Enforcement said more assaults on staff took place at Brook House than at any other detention centre.

1.106 There was a rise in assaults and violence during 2017 and early 2018. TSFNOs were disproportionately the subject of reports of security incidents and incidents of violence or threatening behaviour. The interim director told us however that a few more disruptive TSFNOs were often responsible for a large number of incidents of violence and assault and other behavioural problems.

1.107 The presence of many inexperienced staff unable to deal with detainees' problems as they would like led on occasion to detainees becoming frustrated and aggressive. Some interviewees told us that low staff morale and lack of ownership of their responsibilities meant that staff were not prepared to challenge detainees, which encouraged detainees in further poor behaviour.

1.108 We believe the lack of activities, entertainments and other distractions available to detainees has played a significant part in some of the poor behaviours and violence at Brook House. Thought should be given to how activities and entertainments can incentivise and improve detainee behaviours as part of an improved programme.

1.109 The Gatwick IRCs anti-bullying policy provides that all complaints or reports of bullying must be investigated and that logs will be compiled of all incidents of bullying and of all perpetrators and victims. We found that many DCOs seemed to have little

understanding of the anti-bullying policy and little involvement with cases of bullying. We examined some of the monitoring-challenge-support books used to address bullying. They did not always set out coherent plans for managing an individual detainee's bullying behaviour. It was not clear that plans had resulted in proactive management of bullying behaviour or led to improvements in behaviour.

1.110 Lack of management capacity in the safeguarding team until at least early 2018 meant that cases of bullying and violence at the centre had not been routinely or promptly investigated. The violence reduction manager told us that incidents of bullying and violence had not been investigated properly since 2015.

1.111 The current version of the violence reduction strategy refers to an annual survey of all detainees at Gatwick IRCs about the types of bullying they experience. In the light of the issues in the Panorama programme, the survey should be widened to include staff and encompass all forms of violence, assaults and threats witnessed or experienced.

1.112 One of the more disturbing incidents in the Panorama programme involved the unauthorised, violent restraint of a detainee. The Panorama film showed a number of other officers present but doing nothing to prevent the mistreatment of the detainee. None of the officers who saw or were made aware of the incident reported it as required. The Panorama film shows officers on a number of other occasions referring to and bragging about their use of unauthorised restraint.

1.113 We were given further cause for concern about staff attitudes to the use of force on detainees and about the processes for managing and overseeing the use of force at Brook House.

1.114 Some DCOs told us about planned and unplanned use-of-force incidents they felt had been poorly planned or managed and had resulted in unnecessary staff injury.

1.115 Oversight of the use of force was supposed to be provided by scrutiny meetings, at which the control and restraint coordinator and trainers examine reports and film footage of each use of force incident, and a weekly use-of-force meeting, involving managers. These scheduled meetings were usually cancelled while we were at Brook House because of the lack of a use-of-force coordinator and C and R trainers. Formal use-of-force meetings had not taken place regularly since 2016. The interim director told us that any use-of-force

matters would be discussed *"at the back end of"* SMT meetings. Given the potential consequences for both detainees and staff of any unauthorised use of force or of any poorly planned or poorly managed use-of-force incident, it is essential that there is regular and rigorous review and oversight of all use of force at Brook House.

1.116 The fact that staff at Brook House did not wear body cameras was a further weakness in the management and oversight of the use of force. Body worn cameras were bought for all staff in 2017 but a lack of trainers delayed their introduction and staff showed a marked reluctance to wear them. This meant that filming of unplanned use-of-force incidents and the capacity to review such incidents relied on CCTV footage, which does not cover all areas at Brook House. Senior managers began to insist in March 2018 that staff use body cameras. We noticed most staff wearing them from that time.

1.117 The Panorama programme contained criticism of the availability of drugs in Brook House. Managers and staff told us that in recent years there had been a significant increase in drug use and drug finds in the centre. We were told that the experience of drug use at Brook House mirrored that at other IRCs and that there were greater difficulties in detecting the presence of drugs and drug use in IRCs compared to prisons.

1.118 The Brook House security team told us that apart from by mail, the other means by which drugs could enter the centre were via staff, detainees' visitors and detainees' property.

1.119 Before the Panorama programme broadcast in early September 2017 searches at Brook House had not been as consistent or thorough as they should have been. No staff searches were undertaken in three of the five months before the Panorama programme.

1.120 Searches increased significantly after the Panorama programme. In the eight months up to the end of April 2018, staff searches were undertaken each month and there was an increase in room searches.

1.121 The security staff we interviewed told us that much of their searching activity was based upon intelligence and had led to some significant finds. Search and detection arrangements at Brook House have improved in recent times but weaknesses remain. Managers should continue to question and tighten up arrangements where possible.

The culture of Brook House: relationships and behaviours

1.122 We asked detainees we met at our focus groups and more informally for their views on how staff treated them. Most said they had no cause to complain. Some were complimentary. Some said a few staff had attitudes they did not like. Detainees told us Brook House had too few staff. Many of their comments about the way staff treated them appeared to centre on staff being too busy to give them the attention they would have liked.

1.123 Some said they found their interactions with staff *"dehumanising"*. They said staff *"evidently lack training and experience"*. Detainees were particularly critical of the attitude of healthcare staff whom they described as *"uncaring"*, *"arrogant"* and *"unkind"*. Detainees made general complaints about the failure of staff to communicate. The detainees did not suggest that there were significant or widespread problems with poor or abusive behaviours by staff.

1.124 In a survey undertaken by Brook House managers in January 2018, about detainees' experience of violence and abuse, some mentioned being the victim of threats, violence or bullying by fellow detainees. None mentioned physical assault by staff but a few of the responses referred to staff being verbally abusive. Most responses suggested that detainees appreciated the work of staff.

1.125 We saw staff and detainees greeting each other in a friendly way and staff dealing with detainees in a cordial and appropriate fashion. Staff seemed mostly willing to help detainees with their inquiries and requests, but they were sometimes too busy and their interactions with detainees rushed and may have seemed brusque to a detainee.

1.126 We did not witness any member of staff behaving inappropriately or making inappropriate or disrespectful comments to detainees.

1.127 The Panorama programme featured evidence of staff being abusive, unduly aggressive and unsympathetic in their attitudes and behaviours. We asked staff and managers about their reaction to the incidents and behaviours featured in the Panorama programme. They told us they were shocked, surprised and upset. An experienced DCO told us that the dismissal of a number of DCOs and DCMs after the Panorama programme had

"cleared things out". A few DCOs and managers told us that Brook House still had officers who exhibited the wrong attitudes and behaviours.

1.128 The Panorama programme also featured instances where staff who had witnessed inappropriate and abusive behaviour had evidently not felt obliged or able to challenge or report their colleagues.

1.129 A few members of staff spoke to us about tight-knit groups of DCOs and DCMs from which they felt excluded and whose inappropriate behaviours could not be challenged without fear of repercussions or bullying. A DCO suggested that managers were not prepared to take responsibility for investigating and addressing bullying among staff and did not handle allegations of staff bullying with tact or discretion.

1.130 We were not able to examine and come to firm conclusions about the allegations of bullying made by these members of staff, but we were left with concerns that some staff and DCMs at Brook House might exert a malign and undue influence over colleagues and that their behaviours were not subject to appropriate challenge.

1.131 Our observations of and interactions with DCOs and DCMs led us to believe that there were a few high-profile DCMs and DCOs who demonstrated a particular degree of physical and social confidence and assertiveness. Their colleagues held them in high esteem, as did some members of the senior management who favoured a more disciplined and regimented approach to management. These DCOs and DCMs appeared to be valued for their operational competence and effectiveness, especially in dealing with challenging or threatening situations. At times, their behaviours and interactions could be characterised as 'laddish'. The dangers of an unchecked assertive, laddish culture were brought to life in some of the behaviours towards detainees shown in the Panorama film and by the testimony of one of the officers subject to disciplinary proceedings after the programme. He claimed that he had talked about assaulting a detainee in order to *"fit in"*.

1.132 DCOs and DCMs must be able to manage challenging detainees in sometimes threatening or violent situations. Physical and social assertiveness may sometimes be indispensable qualities. But DCOs and DCMs must always be empathetic and able to engage and sympathise with detainees and colleagues. Some DCOs and DCMs we interviewed and observed at work did not always appear to strike the right balance.

1.133 We are concerned that the absence of strong and visible management arrangements, ensuring the modelling and reinforcement of the behaviours expected of staff; the lack of staff and the inexperience of many; and the assertive laddish culture among some DCMs and DCOs heightens the risk of inappropriate behaviour by staff.

Raising concerns and whistleblowing

1.134 Following the Panorama broadcast large, eye-catching, posters were displayed in the gatehouse and other staff areas at Brook House to draw attention to the G4S whistleblowing process, known as Speak Out. The policy's many references to wrongdoing of a commercial nature or amongst senior staff makes it off-putting and undermines its relevance to ordinary staff at Brook House who may wish to raise issues relating to inappropriate behaviour by fellow DCOs and frontline managers. Brook House needs a more relevant local policy that refers explicitly to the need to report inappropriate conduct or abusive behaviours by fellow staff members or other serious concerns about them.

1.135 Staff at Brook House told us they were unwilling to report concerns about fellow staff and managers, were not confident that managers would handle such matters appropriately and did not have confidence in the Speak Out arrangements.

1.136 Detainees at Brook House can make a complaint about the care and services provided, including matters relating to mistreatment or misconduct by staff, using a DCF 9 form. The spreadsheet that records complaints of misconduct by staff does not include allegations that are not the subject of a formal complaint and are identified via the SIR process, use of force reports, HR reports or any other way. In order to give assurance that managers are able to identify those members of staff whose behaviour might be a cause for concern and are addressing any concerns, there should be a single spreadsheet in which all instances of alleged misconduct by staff, however they might have come to light, are logged, together with the action being taken in respect of such allegations.

Intelligence and information sharing

1.137 The Brook House Independent Monitoring Board (IMB) In their annual report for 2016 gave a largely positive assessment of it, but they mention a number of matters of concern.

Some of these featured in the Panorama programme. The change in the make-up of the detainee population was among the matters raised. The report also highlights the emerging problem of staffing numbers.

1.138 The HMIP report published in January 2017 after an unannounced inspection at the end of October 2016, was less generous than the IMB report in its praise of the management of Brook House and the treatment of detainees, but it was positive. The inspectors make a passing reference to staff being *"under pressure"*. The main concerns and recommendations in the report relate to the time detainees spent in detention and the prison-like living conditions.

1.139 It is not possible for us to judge the precise state of affairs in relation to the management and culture of Brook House and the care and treatment offered to detainees at the time that the IMB and HMIP produced their reports in early 2017. However, a number of issues which might adversely affect the treatment of detainees had begun to be evident from at least the middle of 2016. These included the lack of staff, the disaffection of staff, the inadequacies of management arrangements and behaviours, and the size and nature of the detainee population. We do not suggest that either the IMB or HMIP should have uncovered or predicted behaviours of the type shown in the Panorama film, but we think that more focused questioning of staff and frontline managers might have more clearly identified some of these issues. We welcome the fact that HMIP are now surveying and interviewing staff as part of their inspection process.

1.140 The most recent report published by the IMB at Brook House in May 2018 covers the year to the end of December 2017. The principle findings and recommendations in the latest IMB report largely coincide with our own. However, we are concerned that the report does not mention the weaknesses in the administration and governance arrangements at Brook House particularly in relation to the use of force.

1.141 The tone of the report is more accepting and not as critical and challenging as it might be. This is in keeping with the tone and substance of the IMB meeting we attended and of some of our interviews with members of the IMB. We were struck during the IMB meeting by the tendency on the part of IMB members to over-empathise with the G4S management team and the Home Office, rather than to hold them vigorously to account and press them on their plans for action to address concerns and make improvements at Brook House.

1.142 The Gatwick Detainees Welfare Group (GDWG), a charitable organisation based in Crawley, undertakes research and campaigns in relation to immigration policy. It also provides a support, befriending and visiting service for detainees at Brook House. GDWG is one of few independent organisations with direct contact with detainees at Brook House. GDWG managers told us that relations with centre managers and the Home Office had become strained in 2017 because of concerns that GDWG was over-identifying with detainees and was trying to advance their immigration cases or campaign on their behalf.

1.143 What we learned about the SMT's relationship with GDWG suggested to us that the SMT had been unnecessarily defensive and had possibly been over-identifying with the Home Office and its interests in relation to immigration casework. G4S managers should welcome the referral of matters that may need to be addressed. GDWG offers G4S a potential channel of information about the wider experiences of detainees and insights into the way the centre is run. We were pleased to learn from GDWG that their relationship with managers at Brook House appeared to have improved in recent months.

1.144 The Home Office on-site team enter the centre regularly and have regular contact with detainees, staff and managers. Home Office managers in the service delivery team explained that they gathered information about G4S's performance of the contract and held them to account in a number of ways. They told us that members of the team regularly observe and discuss performance of different aspects of the contract. A monthly contract meeting with the G4S senior management team is chaired by the Home Office. It focuses on overall contract performance largely in terms of the financial penalties G4S has incurred for failures in delivery under the contract and any possible mitigation.

1.145 We were told by both Brook House and Home Office managers that the primary concern of their meetings had been how G4S supported the immigration removal process to support the delivery of Home Office immigration objectives.

1.146 Home Office managers also acknowledged that the Home Office monitoring of the performance of the contract at Brook House tended to be based on consideration of the individual elements of contract performance and compliance and that they had not taken an approach that examined and questioned the wider concerns of the care and welfare of detainees, their quality of life and experience of being detained in Brook House.

1.147 We believe the Home Office should take greater responsibility than they appear to have done in the past for monitoring the overall experience of detainees at Brook House.

1.148 Senior managers in G4S's Custodial and Detention Services sub-division oversee and receive information about individual contracts principally via trading review meetings. The senior management team at each G4S-run prison or IRC makes a presentation on their performance against their key contractual performance indicators to senior managers of the sub-division. The managing director and chief operating officer of the sub-division have trading review meetings in turn with senior managers in the G4S Care and Custody division.

1.149 Each trading review meeting involves the IRC management team preparing more than 100 slides of information.

1.150 We have been left with the impression that the trading review arrangements are time-consuming and inefficient. They have not always been constructive and have not encouraged openness and transparency. They have not focused to the extent they should on risks to the delivery and quality of care offered to detainees.

1.151 The fact that senior managers in the G4S Custodial and Detention Services had not had time for regular visits to Brook House to question managers and staff and see for themselves how the centre was being run was a further weakness in G4S's information gathering and assurance processes, both before and after the Panorama programme.

1.152 We found no evidence that any agency, organisation, or individual senior manager knew of a significant problem with staff behaviour and treatment of detainees at Brook House before the airing of the Panorama film. Neither do we believe that the behaviours and treatment of detainees depicted in the Panorama film should have been predicted.

Overall conclusions

1.153 Brook House offers the highest level of security in the detention estate and houses some detainees whose behaviour is too challenging for other removal centres. Many of the detainees at Brook House are time-served foreign national offenders. Many have mental health issues. Most have reached the end of their attempts to stay in the UK. They face enforced removal and are highly resistant to it.

1.154 Inadequate facilities or accommodation suitable for the care of detainees with mental health problems and other vulnerabilities add to the difficulties of managing such a challenging detainee population. The physical constraints and the lack of facilities at Brook House make it unsuitable to house the number of detainees it does. They also make it unsuitable to hold any detainee for more than a few weeks.

1.155 A failure to retain staff and low levels of staffing have been a problem at Brook House since at least the second half of 2016. The lack of staff and the high turnover of staff has had a detrimental effect on many aspects of life at Brook House, both for detainees and staff. The activities and entertainments programme has been severely curtailed, and detainees have been under-occupied and bored. Many staff have become disaffected and disengaged and feel insecure and unsafe. Weak management has compounded the staffing problems.

1.156 Problems of staff retention and staffing levels need to be addressed as a priority to ensure that other concerns about the management of Brook House can be resolved.

1.157 We were concerned about the extent to which managers and staff appeared to value assertiveness and operational competence above empathy, emotional intelligence and care; and the tendency among some DCMs and DCOs towards a laddish culture. These cultural issues, together with an absence of strong visible management modelling and reinforcing the behaviours expected of staff; the pressures on staff and the inexperience of many; and the weakness or absence of effective oversight and assurance, especially in relation to the use of force, heightened the risk of incidents of inappropriate or abusive behaviour by staff at Brook House.

1.158 Staff at Brook House deal with some demanding and challenging detainees. We saw many staff dealing with detainees with tact, compassion and good humour. We did not see any member of staff behave inappropriately or make inappropriate or disrespectful comments. Detainees we talked to and other witnesses did not suggest a significant or widespread problem with poor or abusive behaviours by staff.

1.159 A number of the matters of concern relating to the management of Brook House that we refer to above have been apparent for some time. However, Home Office and G4S performance management and assurance arrangements have not focused on them to the

extent that they should have, nor on the risks these matters pose to the care and experience of detainees.

Recommendations

1.160 The following recommendations are developed from our findings and conclusions in this report.

1.161 We make recommendations under seven headings:

- Centre management
- Training
- Staffing
- Regime and detainee welfare
- Environment
- Learning from incidents
- Safety and security

1.162 Below we set our recommendations out thematically and with a priority categorisation attached to allow G4S to take appropriate action efficiently. Recommendations will appear in the main body of the report alongside the evidence and issues in support of them.

Centre management

R1 The SMT should be more present in the centre and should consider how they can better engage with staff. ***(To be completed as a matter of urgency)***

R32 G4S and the SMT should ensure that the welfare team has the technological and administrative support it needs. ***(To be completed within 6 months)***

R39 The SMT, in consultation with the local safeguarding boards, should review and redraft the safeguarding policy to ensure that it:

- has a clear and easy-to-follow scheme and does not contain errors in drafting and meaning;
- makes clear to staff their principle duties and responsibilities in relation to safeguarding, including their responsibility to share all relevant information about children and vulnerable adults in the community. ***(To be completed within 6 months)***

R45 G4S and the Home Office must ensure that robust, full-length electronic turnstiles are installed at the entrance to the residential wings as soon as possible. ***(To be completed within 3 months)***

R48 The safeguarding team should survey staff at Brook House regularly to ascertain their experience of and perspective on violence and bullying and its causes. ***(To be completed within 6 months)***

R51 The SMT and G4S managers should review the policy and arrangements for raising concerns and their own handling of such matters to ensure that they encourage and support staff to report wrongdoing or misconduct or inappropriate behaviour by colleagues and managers. ***(To be completed within 3 months)***

R52 The SMT should ensure that a single log is kept of all allegations or instances of misconduct by staff and the actions taken in respect of them. ***(To be completed within 3 months)***

Training

R2 The SMT must ensure that DCMs are given adequate training to fulfil the tasks and responsibilities of their role. ***(To be completed as a matter of urgency)***

R3 G4S managers should work with DCMs undertaking training to ensure a common understanding of requirements of that training and how much time DCMs will be given away from operational duties as study leave. ***(To be completed within 3 months)***

R8 The SMT must ensure that all trainers are appropriately trained in the subject on which they deliver training and in how to deliver training. ***(To be completed within 3 months)***

R9 The SMT and G4S managers should undertake regular and systematic evaluation and quality assurance of the training provided at Gatwick IRCs to ensure that staff receive training of a consistently high standard; that it meets the operational needs of the IRCs, trains and develops staff appropriately and promotes appropriate values. ***(To be completed within 3 months)***

R10 The SMT should undertake unannounced observation of training sessions as part of the evaluation and quality assurance of training. ***(To be completed within 3 months)***

R13 G4S and the SMT should ensure that all staff receive annual refresher training in a timely way. ***(To be completed within 3 months)***

R14 Managers at Gatwick IRCs should undertake a full review of the training needs of existing staff, including needs identified in individual EDRs, and should ensure that the annual refresher training programme and specialist further training meet those needs. ***(To be completed as a matter of urgency)***

R15 The SMT should ensure that staff dealing regularly with detainees with mental health problems or with drugs or other substance misuse issues receive specialist training. ***(To be completed within 3 months)***

R33 G4S and the SMT should consider with the Home Office the possibility of providing the welfare team with training in immigration processes. ***(To be completed within 6 months)***

R36 Residential DCMs responsible for ACDT case management should receive regular refresher training. ***(To be completed within 3 months)***

R38 The SMT must ensure that staff are trained in the management of age dispute cases. ***(To be completed within 3 months)***

R40 The SMT in consultation with the local safeguarding boards must ensure that all staff receive appropriate annual safeguarding refresher training. ***(To be completed within 3 months)***

R43 Healthcare and G4S management should ensure that nurses involved in control and restraint understand their role and responsibilities. This should be as part of their induction and refreshed yearly. ***(To be completed within 3 months)***

R49 The SMT with the violence reduction manager should undertake a development programme with staff to:

- develop their confidence and skills in dealing with disruptive detainees; and
- improve their awareness and understanding of the anti-disruption policy and how it should be implemented. ***(To be completed within 3 months)***

Staffing

R4 The SMT at Gatwick IRCs must review arrangements for providing care and support to staff and ensure that they have ready access to a care service they trust. ***(To be completed within 3 months)***

R6 The SMT should urgently ensure that Brook House is fully staffed. ***(To be completed as a matter of urgency)***

R7 G4S managers should undertake a comprehensive review of matters affecting staff retention at Brook House including remuneration, shift patterns and working hours and G4S needs to develop plans to address the matters arising from such a review. ***(To be completed as a matter of urgency)***

R11 G4S managers should agree with the Home Office ways that recruits in training can be given early and regular opportunities to experience the environment at times when the detainees are at large in Brook House. ***(To be completed within 3 months)***

R12 The SMT should consider giving trainees the opportunity to view body camera images of incidents recorded at Brook House. ***(To be completed within 6 months)***

R16 The SMT and DCMs at Brook House must ensure that all staff are subject to an effective annual appraisal process that results in identifying and addressing training and other developmental needs. ***(To be completed within 3 months)***

R42 G4S Health Services should develop a career pathway for nurses working in Care and Justice. This should be accompanied by the development of customised training materials. ***(To be completed within 3 months)***

Regime and detainee welfare

R17 The SMT must design and implement as a matter of urgency purposeful and better-resourced education, activities and entertainments programmes. ***(To be completed as a matter of urgency)***

R18 The SMT should ensure that teachers at Brook House, including the arts and crafts teachers, have ready access to the equipment and resources to provide worthwhile programmes for detainees. ***(To be completed within 3 months)***

R19 The SMT should reinstate the cultural kitchen. ***(To be completed as a matter of urgency)***

R20 The SMT should consider whether it is possible to provide detainees in paid work with opportunities to gain qualifications. ***(To be completed within 6 months)***

R22 The SMT and residential DCMs must ensure that adequate numbers of staff are on duty throughout the service of meals to ensure orderly queues and service of meals. ***(To be completed within 3 months)***

R30 The SMT and DCMs must ensure continued adherence to the induction policy. ***(To be completed as a matter of urgency)***

R31 G4S and the SMT should ensure that the welfare team is adequately staffed at all times. ***(To be completed within 3 months)***

R34 G4S and the SMT should ensure that the welfare staff at Brook House should develop links with charities and other organisations able to support detainees with resettlement overseas. ***(To be completed within 3 months)***

R44 G4S and the Home Office should discuss relocating the Forward Trust's office at Brook House so that detainees have ready access to it. ***(To be completed within 3 months)***

Environment

R21 The SMT and staff must enforce the ban on smoking inside Brook House. ***(To be completed within 3 months)***

R23 The SMT must resolve the issue of the inadequate cleaning of the wings either by agreeing with [redacted] that it will undertake the cleaning of wings or by ensuring that wing orderlies keep wings to an acceptable standard of cleanliness throughout the day, that they are properly supervised and allowed access to appropriate cleaning products and equipment. ***(To be completed as a matter of urgency)***

R24 Residential DCMs must hold staff to account for ensuring wings are maintained at an acceptable standard cleanliness. ***(To be completed within 3 months)***

R25 Residential DCMs and wing staff should ensure that all detainees have access to cleaning products to clean their rooms, including washbasins and toilets. ***(To be completed within 3 months)***

R26 G4S managers and the SMT should:

- improve the environment in the reception area at Brook House and make it more welcoming;
- consider how all new arrivals can be interviewed in privacy; and
- agree with the Home Office how they will provide showers for new arrivals. ***(To be completed within 3 months)***

R41 Healthcare should agree with [redacted] how cleaning must be improved and how these new standards are adopted and maintained. Healthcare facilities should be deep-cleaned at least twice yearly. ***(To be completed as a matter of urgency)***

Learning from incidents

R5 The SMT should ensure staff have time for debriefing and reflecting about serious incidents in which they have been involved and an opportunity to learn from them. ***(To be completed as a matter of urgency)***

R50 The SMT must ensure regular and timely review of all use-of-force incidents by appropriately trained staff and that regular meetings take place, involving the SMT, dedicated to considering matters arising from use-of-force incidents and to ensuring that any concerns are addressed. ***(To be completed as a matter of urgency)***

Safety and security

R27 G4S should amend its induction policy to make it clear that a detainee posing a risk of any significant violence to others will be justification for accommodating the detainee in a single occupancy room. ***(To be completed within 3 months)***

R28 G4S should work with the Home Office to ensure that all time-served foreign national offenders arriving at Brook House are accompanied by prison escort records that identify matters affecting their risk profile. ***(To be completed as a matter of urgency)***

R29 The SMT must ensure that all prison files of time-served foreign national offenders are examined for relevant security information, including risk profiles, in a timely fashion. ***(To be completed as a matter of urgency)***

R35 The residential DCMs should ensure that ACDT case reviews are conducted by DCMs accompanied by a DCO acquainted with the detainee whose case they are assessing. ***(To be completed within 3 months)***

R37 The age dispute policy should be amended to make explicit that it is the duty of staff members who have any cause to believe that a detainee is under age to report it to a manager or ensure that it has been reported. ***(To be completed within 3 months)***

R46 The SMT and safeguarding team should ensure that all incidents of violence and bullying at Brook House are investigated in a timely way. ***(To be completed as a matter of urgency)***

R47 The SMT should undertake a programme of awareness-raising among staff to improve their understanding and use of the anti-bullying policy. ***(To be completed within 3 months)***

2. Introduction

2.1 G4S plc (G4S) has managed Brook House, an immigration removal centre (IRC) near Gatwick Airport, since 2009 under a contract with the Home Office. In late August 2017 BBC Panorama informed G4S that it was preparing to broadcast a documentary about Brook House. The programme showed staff at Brook House making derogatory, offensive and insensitive remarks about detainees and incidents of physical abuse. It raised other concerns about the management of Brook House and the welfare of detainees held there. The programme attracted considerable publicity in national newspapers and the Home Affairs select committee opened an inquiry into the matter on 13 September 2017.

2.2 The Panorama programme was broadcast on Monday 4 September 2017.[1]

2.3 In response to the programme, G4S started its own investigations and drew up an action plan to address immediate concerns about the running of Brook House. With the support of the Home Office, G4S also announced an independent investigation. Its purpose was to give a full account of the circumstances surrounding the incidents and behaviour featured in the Panorama programme and to examine other issues relating to the management of Brook House.

2.4 We have previously undertaken an investigation into concerns about Yarl's Wood immigration detention centre. Our biographies are set out at appendix A. Nicola Salmon has provided administrative support.

Kate Lampard
Ed Marsden
Novemver 2018

[1] The programme can be viewed online at: https://www.bbc.co.uk/iplayer/episode/b094mhsn/sign/panorama-undercover-britains-immigration-secrets

3. Terms of reference

3.1 Peter Neden, divisional chief executive of G4S Care and Justice and Søren Lundsberg-Nielsen, group general counsel, commissioned this investigation on behalf of the main G4S board.

3.2 Brook House is an immigration removal centre (IRC) situated near Gatwick Airport. It holds up to 508 adult male detainees. Decisions about who should be detained in an IRC are taken by the Home Office who are also responsible for managing the immigration case of each detainee. G4S is responsible for housing and caring for the detainees in a secure environment on behalf of the Home Office.

3.3 The purpose of this independent investigation is to understand the extent and root causes of the matters highlighted in a Panorama programme, dealing with the treatment of detainees at Brook House, which was aired on 4 September 2017. The investigation will examine G4S's management, operational and staffing arrangements and the practices and behaviours of G4S's staff.

3.4 This independent investigation is commissioned by the group general counsel of G4S Plc on behalf of the CSR committee of the G4S board. A report of the investigation findings will be provided to the G4S CSR committee and board.

3.5 The independent investigation is asked to examine:

1. the adequacy and appropriateness of G4S's operational policies, management and practice for the care and welfare of detainees, including in relation to mental health issues and self-harm, violence prevention, the availability of drugs, the handling of age disputes. Such investigation to include management arrangements within the IRC and the G4S Custody and Detention Business Unit
2. the attitudes and behaviour of staff towards detainees, including in relation to their welfare and wellbeing, self-harm and violence prevention
3. the extent and causes of any mistreatment of detainees by staff and whether the incidents reported on in the Panorama programme were isolated or reflective of a wider improper or inappropriate culture at Brook House
4. whether the use of force on detainees is subject to appropriate and adequate reporting, governance, assurance and improvement arrangements

5. the reasons for failures by staff to use the whistleblowing procedures and to report their colleagues' inappropriate attitudes and behaviours towards detainees
6. the appropriateness of staffing arrangements, including all aspects of recruitment, selection, training, appraisal and development; staffing levels and the deployment of staff; oversight and support offered to staff
7. the use and deployment of technology (CCTV, body cameras, listening devices[1]) at Brook House and the efficacy of the same
8. whether the information and intelligence gathering and monitoring arrangements relied on by managers (locally and centrally) to assess the care and welfare of detainees are appropriate, robust and reliable.

3.6 The investigation will include the healthcare services provided by G4S at Brook House but will not include transport services and/or matters or other services where they are not provided by G4S staff and/or where G4S is not responsible for their provision but will look at the extent to which such services impact on G4S's ability to deliver their services and how they work in practice.

3.7 The investigation will not include matters of detention and Home Office policy or mandated procedure, but the investigation will consider how their application in practice affects the management, operation and culture of Brook House, and the welfare of detainees.

3.8 The investigation team will make recommendations based on the findings of their investigation and in particular will make recommendations for actions that G4S should take to address any material weaknesses or issues identified.

3.9 Full details of the terms of reference are given as appendix B.

[1] G4S have made it clear to us that there are no listening devices at Brook House IRC.

4. Approach and methodology

4.1 We began our investigation by examining an initial bundle of documents G4S provided. This included correspondence about the issues raised in the Panorama programme between G4S and the BBC, the Home Office and Sussex Police; transcripts of evidence given by G4S managers to the Home Affairs select committee in the aftermath of the broadcast of the programme; recent reports on Brook House by HM Inspectorate of Prisons for England and Wales (HMIP), and the Brook House Independent Monitoring Board (IMB); G4S internal reports on Brook House and a three-month action plan developed in response to the programme.

4.2 We arranged early meetings with a number of organisations and individuals we thought might be able to further our understanding of Brook House; the way it is managed; and any concerns about the care and treatment of detainees held there. Among those we met were relevant representatives of Brook House's most significant stakeholders, including the Home Office, HMIP, the IMB, and the MP for Crawley; representatives of charities working with detainees at Brook House, including Bail for Immigration Detainees (BID) and the Gatwick Detainees Welfare Group; the Prison Officers Association and Sussex Police. We met a member of a research team led by Mary Bosworth, professor of criminology at Oxford University, undertaking research into detention centres, who had spent a month in Brook House in June - July 2017, and the chair of the House of Commons Home Affairs select committee. We considered whether our terms of reference reflected the concerns raised by the Panorama programme and were sufficiently comprehensive. We made minor amendments to the draft terms of reference after these meetings.

4.3 We wrote to the producer of BBC Panorama and asked whether the programme makers would share their views about Brook House with us. He declined our invitation saying:

> *"As you will no doubt be aware, events that took place at Brook House which were uncovered by Panorama are now the subject of an active police investigation. The BBC is co-operating with that investigation. In the event that criminal charges are brought, I am most likely to be called as a witness. Accordingly, the approach that the BBC is taking in relation to the numerous requests for assistance/material/meetings is that whilst the police investigation is active, our assistance is limited (wherever possible) to co-operating with that investigation.*

"In any event, I am not sure it would be appropriate for there to be any perception that the BBC had been assisting with the terms of reference into an investigation, which has only come about as a result of the BBC having exposed the very practices which are the subject of the investigation. The BBC's role is to tell stories and make programmes in the public interest. On this occasion, we uncovered a number of matters of concern at Brook House which we brought to the public's attention. G4S were provided with the substance and detail of what Panorama had uncovered ahead of transmission. The areas of concern were spelt out for G4S and they were given an opportunity to respond. G4S have subsequently viewed the programme."

4.4 Our correspondence with the BBC is at appendix G.

Evidence gathering

Document review

4.5 We reviewed many documents relating to the operating and management procedures at Brook House. These included Home Office Detention Service Orders (DSOs), Gatwick IRCs policy and procedure documents, minutes of local management meetings and local management reporting data. A list of the principal documents reviewed is set out at appendix C.

Interviews

4.6 We started our structured interviews with the local senior management team (SMT) at Brook House. We later interviewed detainee custody managers (DCMs) and detainee custody officers (DCOs). We selected DCMs and DCOs for interview at random from staff lists provided to us. We interviewed others because they were in certain roles and we felt they would add to our understanding of the culture and management of Brook House, for example the manager of religious affairs, the violence reduction manager, and a member of the welfare team.

4.7 We interviewed staff providing healthcare and drug treatment to detainees at Brook House. We interviewed members of the G4S Care and Justice division management team and other G4S corporate managers. We also interviewed representatives of third-party organisations working within Gatwick IRCs, including the charity Gatwick Detainees Welfare Group and the local manager of [redacted] Limited, the provider of cleaning and catering services.

4.8 We met Stephen Shaw who was conducting a follow up to his review of the welfare in detention of vulnerable persons.

4.9 The centre director responsible for Brook House at the time of the making and broadcasting of the Panorama programme had left the employment of G4S by the time we started our work. He did however agree to be interviewed. Sussex Police asked us not to interview the former member of staff who had acted as an undercover reporter for BBC Panorama because he was a witness in a criminal investigation.

4.10 A notice was put up in staff areas at Brook House telling staff about the investigation and explaining that we would be visiting the centre regularly. It also explained that we would be writing to some staff to invite them for interview but would be happy to talk to other staff during our visits. A number of staff contacted us to say that they wanted to be interviewed and we arranged to speak to them.

4.11 We wrote to all interviewees setting out the basis on which the interviews would be conducted. We also sent them a guide to the process. A copy of the letter and guide is at appendix D. Interviewees were offered the opportunity to be accompanied at interview. Interviews were recorded and transcribed. We sent interviewees a copy of their transcript and asked them to approve it. We told them at interview that they might be quoted in this report. We have not shared transcripts with G4S and they remain confidential to the investigation team. The lines of investigation and the questions asked of witnesses have been entirely determined by ourselves.

4.12 We held meetings with two groups of detainees in the centre. We chose detainees at random from a representative sample that managers at Brook House gave us. We invited the detainees by letter. Our letter, which is at appendix E, explained the purpose and form of the group interview sessions. Some detainees asked to attend chose not to do so but

others who had not received the letter came to talk us. The second group was notably well attended.

4.13 We are grateful to all those we interviewed. A full list of interviewees is at appendix F.

Our access and visits to Brook House

4.14 We were given Home Office security clearance to draw keys. This allowed us unrestricted access to Brook House. We visited the centre on 30 occasions over more than five months starting in November 2017. Some of our visits were unannounced, including one at a weekend. We spent a full working week at Brook House in January 2018. We visited all parts of the centre on our visits. We conducted structured interviews and attended management meetings. We also spent time talking informally to many staff and detainees. We made it plain that they could talk to us unattributably. We watched staff at work. We observed daily life in the centre and how staff and detainees interacted. We believe that our unrestricted access allowed us to form a realistic impression of Brook House and its culture.

Visits

4.15 Tinsley House is another IRC near Gatwick Airport run by G4S under the same senior management team. They are known collectively as Gatwick IRCs. We visited Tinsley House to compare the centres.

4.16 We visited HMP Rye Hill, HMP Preston and Heathrow IRCs (Colnbrook and Harmondsworth) to compare aspects of Brook House with those institutions and to increase our understanding of the management and culture of Brook House. We visited HMP Rye Hill and HMP Preston because they are of the same security standard (Cat B) as Brook House; because some of their management arrangements were commended to us by HMIP; and, in the case of HMP Preston, because it occupies a restricted site. HMP Rye Hill, which is also run by G4S, is near Rugby. It has an operational capacity of 664 and houses sex offenders serving longer prison terms. HMP Preston, which is run by HM Prison Service, has operational capacity of 750 local adult male prisoners.

4.17 We had the opportunity in all these facilities to talk to senior managers and staff; we were given an extensive tour and talked informally to staff and detainees/prisoners.

4.18 We are grateful to the staff of the facilities we visited and to the Home Office for making it possible for us to undertake these visits.

The extent of our investigation

4.19 Our investigation was commissioned by G4S alone. Our terms of reference did not therefore allow us to investigate the transport service that takes detainees to and from Brook House. Tascor Limited managed the service under its own contract with the Home Office. The contract changed to another provider during the course of our work. Neither did we consider matters to do with Home Office policy nor the work of the Home Office team based at Brook House, other than where it was relevant to G4S's management of the centre.

4.20 Healthcare for detainees at Brook House is commissioned by NHS England and provided by G4S Health Services Limited, a separate company in the G4S group. Our terms of reference ask us to consider healthcare provision at the centre.

4.21 This report sets out the findings from our evidence gathering during the period November 2017 to April 2018.

Structure of this report

4.22 The report is formed of 15 chapters. The first chapter is an executive summary highlighting the key findings of this report. The following three chapters introduce and provide background and context to the investigation and this report.

4.23 The next chapter contains background information on Brook House and the allegations arising from the Panorama programme.

4.24 Chapter 6 details the detainee population at Brook House and some of the challenges it presents.

4.25 In chapter 7 we consider the management of Brook House. This includes the history, behaviours and management style of the senior management team. We also consider challenges detention custody managers (DCMs) in the centre face, alongside their capacity and capability to cope with them. We then explore the effects of management failings on more junior staff and the operation of the centre as a whole.

4.26 Chapter 8 explores staffing at Brook House focusing on long-term staff attrition, recruitment and retention and their effects on the centre. We then explore subjects underpinning staffing in more detail, e.g. training and staff development.

4.27 Chapter 9 describes the facilities at Brook House and explores the regime (activities programme, education, paid work) and the staffing of the same. We then consider catering.

4.28 Chapter 10 explores the care and welfare of detainees at Brook House. This includes governance, handling of detainee inductions, the role and functioning of the welfare team. We then explore the operation of the safeguarding/safer community team, including the management of self-harm and attempted suicide.

4.29 Chapter 11 concerns the provision of health services at Brook House. We consider the role and performance of healthcare in relation to the work of the centre.

4.30 Chapter 12 examines the governance and management of security and safety at Brook House. We consider the incidence of violence, assaults and bullying. We also explore the governance of the use of force by staff in Brook House. The chapter includes a section on the availability of drugs in the centre and methods deployed to disrupt their supply.

4.31 Chapter 13 looks at the culture of Brook House. We comment on relationships between staff and detainees, and relations ships and cultures amongst staff. We explore the culture at Brook House with regards to raising concerns, whistleblowing and complaints.

4.32 Chapter 14 examines the means and efficacy of intelligence gathering and reporting arrangements in relation to Brook House. This includes the role of the independent monitoring board (IMB), the Home Office, relations with other organisations that operate

within Brook House. We explore G4S's reporting and performance management arrangements.

4.33 The final chapter contains our overall conclusions arising from this investigation.

5. Background information

5.1 Brook House is a secure residential facility on the southern perimeter of the Gatwick Airport estate. It is built to a prison design and houses up to 508 male adults detained under United Kingdom nationality, immigration and asylum legislation. Decisions to detain people are made by officials of UK Visas and Immigration, a division of the Home Office. The judiciary does not sanction the decisions. Officials are required to follow the Home Office's Detention and Temporary Release guidance (formerly Chapter 55 Enforcement Instructions and Guidance (EIG)). It allows detention for three broad reasons: effecting removal; establishing an individual's identity or the basis of their asylum claim; and to prevent noncompliance with temporary release or admission to the UK.

5.2 Brook House opened in March 2009. G4S acquired the contract to manage it on behalf of the Home Office when it acquired the initial contractor GSL in May 2008. The acquisition of GSL also led to G4S taking on the contract to manage Tinsley House, an immigration removal centre (IRC) a few hundred metres east of Brook House on Gatwick Airport's southern perimeter. Tinsley House opened in 1996. Brook House and Tinsley House are the subject of separate contracts between G4S and the Home Office, but they are run together under one local senior management team and are known as Gatwick IRCs. Gatwick IRCs are managed by G4S Custody and Detention Services, a subdivision of its Care and Justice division.

5.3 The contract to manage Brook House expired in May 2018. The contract to manage Brook House and Tinsley House was put out to tender in late January 2017. G4S managers worked on the rebid for the contract from mid-January to the end of March 2017. On 4 May 2018 the Home Office announced an extension of the existing contract with G4S for two more years. The announcement said that this would allow for consideration of the findings in this report and of Stephen Shaw's report on progress in responding to his 2016 review of the welfare in detention of vulnerable persons.

The Panorama programme

5.4 A BBC Panorama documentary titled *Undercover: Britain's Immigration Secrets* was broadcast on 4 September 2017. The programme was the result of covert video recording by a G4S detainee custody officer (DCO) working at Brook House. Managers and staff at

Brook House believe the footage was captured between April and July 2017. The undercover reporter was a pre-existing member of staff, having worked at Brook House for a year. He had not reported any of the events depicted through G4S's internal processes.

5.5 We now describe the contents of the programme and some of the issues and implications it raised because these have contributed to the shape of our terms of reference and our investigations.

5.6 The programme shows a number of incidents and concerns. The bullets below summarise the themes:

- Inappropriate mixing of detainees/ suitability of detention
- Drug use
- Mental health
- Poor staff behaviours: use of force and unsympathetic culture
- Staffing levels
- Lack of adherence to policy

5.7 We summarise below the key incidents or allegations made in relation to each of these.

Inappropriate mix of detainees/suitability of detention

5.8 The programme makes the distinction between time-served foreign national offenders (TSFNOs) facing deportation at the end of a prison sentence, asylum seekers and detainees facing removal from the UK for immigration offences only. It stresses that the different categories of detainees are not segregated onto different wings and often share rooms. This means that vulnerable detainees are sometimes made to share a room with *"criminals"*. It claims that TSFNOs *"terrorise"* asylum seekers and suggests that asylum seekers should not be detained or should at least be separated from TSFNOs.

5.9 A group of detainees is filmed banging on the door of another detainee. The reporter suggests that the detainee inside is too intimidated to leave his room.

5.10 The reporter says the induction wing (B wing) is often used to accommodate detainees from other parts of the centre who are known to be involved with drug or gang culture. The implication is that the induction wing fails in its role of instilling good behaviour in new detainees and exposes them to prohibited behaviours from an early stage.

5.11 The programme comments on the indeterminate detention of detainees. Some are detained for years rather than the 72 hours that it is alleged the centre was designed to keep them for. It also comments on the numbers of failed removals, their effect on detainees and the frustration they cause staff. The reporter draws on expert opinion on this.

Drug use

5.12 The use of illegal drugs, particularly the synthetic drug 'spice' and cannabis by detainees is a key theme of the documentary. It shows detainees apparently under the influence of drugs, with some receiving medical treatment. Drugs in the centre are described as an "*epidemic*", and as being cheap and easy to access.

5.13 A few members of staff are filmed expressing concern that it will only be a matter of time before a detainee at Brook House dies from drug use.

5.14 One member of staff working in visits claims that 80 per cent of drugs come into the centre through visits. She also says staff do nothing to prevent drug passes. An inexperienced DCO appears to have been left in charge of visits even though it is his first time working in that area and he has not been trained in what to do in the event of a security incident such as a drug pass.

Mental health

5.15 The programme shows a number of detainees in distress. Some have pre-existing mental health conditions but for others the experience of detention has made them more vulnerable to mental health issues. There is footage of detainees protesting, self harming and attempting suicide as a result of learning of decisions relating to their immigration cases.

5.16 The reporter asks questions of an expert on the effect of detention on the mental health of detainees. The expert concludes from viewing footage that staff at Brook House misinterpret the signs of mental illness in a detainee as an attempt to be disruptive or annoy staff.

Poor staff behaviours: use of force and unsympathetic culture

5.17 Staff are seen to cause or talk about causing physical harm to detainees.

5.18 One example concerns a detainee who has been under constant watch by a DCO following an attempt to self-harm. The DCO is recorded bragging to other officers that he had banged the detainee's head, and bent his fingers back while no one else was watching. The DCO states that this was funny, and that the detainee was attention seeking. The DCO is shown repeating this story to another group of officers. One of the other officers says the best way to deal with vulnerable detainees is to *"turn away and hopefully, he's swinging"*. On neither occasion do other officers challenge the DCO's behaviour or attitudes.

5.19 The documentary shows a control and restraint (C and R) team preparing to engage with a detainee protesting on wing netting. The instructor advises the team to use racist language. He then encourages staff to attack the detainee in an area without CCTV surveillance if he does not comply with the team's efforts to remove him. He then suggests that they *"scrub"* the body worn camera footage to remove evidence. In this case the external national response team recovers the detainee, so the Brook House staff do not need to intervene.

5.20 A former senior manager at Brook House is interviewed. He says he raised concerns about the behaviour of some staff at Brook House towards detainees for the sort of *"rough"* language they used and their use of force.

5.21 Some staff attending to vulnerable or distressed detainees (some under the influence of drugs) are unsympathetic, taunting, mocking or insulting.

5.22 In one case a detainee who has taken the drug 'spice' is mocked by a detention custody manager (DCM). The DCM jokes to other members of staff, suggesting that they leave the detainee alone or pour a bucket of water over him to *"sort him out"*. A DCO

present says: *"I have no sympathy for them. If he dies, he dies"*. This is a medical incident, so the programme's allegation is that it should have been taken seriously. The reporter claims that the DCM in question often makes such situations worse by encouraging staff to laugh and joke at the expense of detainees.

5.23 We see a further example of the same DCM's attitude when he says *"we should plug him in like a Duracell bunny"* about a detainee who has threatened to commit suicide by putting a phone battery in his mouth. A nurse asked what is wrong with the detainee responds, *"he's an arse basically"*. The detainee then tries to strangle himself. In one of the more disturbing incidents featured, a DCO holds the same detainee's head, digging his fingers into his neck to restrain him. The detainee can be heard choking. Other officers present do not intervene. Some mock the detainee. None of the officers or medical staff who see or are made aware of the incident report it as G4S requires.

5.24 The DCO who choked the detainee later tells the reporter *"We don't cringe at breaking bones"* and says, *"If I killed a man, I wouldn't be bothered"*. Another DCO involved in the incident is asked later what to do about another distressed detainee. He appears to tell the reporter to repeat the actions of the DCO who had choked the detainee.

5.25 A member of staff is shown shouting at a detainee suffering from acute mental illness on E wing. He is heard telling the detainee to *"stop fucking about"* and *"I don't want to come back in this room again you'll be in trouble"*. The reporter says this detainee was sectioned and admitted to a psychiatric hospital two days later.

Staffing levels

5.26 The reporter claims that staff at Brook House seem overstretched. He claims that the centre is often staffed at minimum Home Office levels. He explains that often only two members of staff manage a wing of more than 100 detainees, creating poor staff morale, which negatively affects detainees.

5.27 As an example of this reference is made to roll counts being done incorrectly. There is a scene showing confusion among wing officers who appear not to know whether a roll count has been completed correctly. It is alleged that as a result, detainees were locked in their rooms for longer than necessary and became frustrated and hostile.

Lack of adherence to policy

5.28 The documentary shows a detainee suspected of being under 18. He is accommodated on E wing while the dispute about his age is investigated. A few members of staff say they think the detainee looks under 18 – some say as young as 14 or 15. One staff member says that even though she thinks the detainee looks young, she is not going to report it. This contravenes G4S and Home Office policy. The reporter claims that the detainee is released to the care of social services after two weeks in Brook House.

5.29 The programme also shows a DCM telling the reporter not to record a case of detainee food refusal. This contravenes policy.

The outcomes of the Panorama programme

5.30 In late August 2017, before the broadcast of the Panorama programme, the BBC sent letters to the divisional chief executive of G4S's Care and Justice division and 15 members of staff at Brook House outlining the plans for broadcast and the allegations against the staff. The letter gave them the opportunity for comment.

5.31 The BBC also informed the police about the contents of the programme. The police began an investigation into some of the issues raised and incidents featured.

5.32 The below table sets out the staff involved in the Panorama programme.

	DCM	**DCO**	**Nurse**	**SMT**	**Grand Total**
Identified by BBC (letter sent)	3	11	1	0	15
Identified by G4S	0	5	0	1	6
Total number of staff involved	**3**	**16**	**1**	**1**	**21**

5.33 Two members of staff had left G4S prior to the broadcast. G4S immediately dismissed a further two members of staff who featured in the programme and conducted internal

investigations in respect of 17 others. The table below shows the actions taken against the 21 members of staff involved in the allegations made in the programme.

	DCM	**DCO**	**Nurse**	**SMT**	**Grand Total**
Total number of staff involved	**3**	**16**	**1**	**1**	**21**
Left G4S before broadcast		[redacted]			[redacted]
Dismissed on basis of film, without G4S investigation	[redacted]	[redacted]			[redacted]
Investigated by G4S	2	13	1	1	17
Dismissed following investigation		[redacted]	[redacted]		[redacted]
Final written warning & accreditation later revoked by Home Office (dismissed)	[redacted]	[redacted]			[redacted]
Written warning		[redacted]			[redacted]
Advice and guidance	[redacted]				[redacted]
No further action		[redacted]		[redacted]	[redacted]

5.34 Three staff involved in the allegations later resigned. One was dismissed after subsequent similar behaviours.

5.35 The centre director (referred to as 'the former director' in this report), who had been in post since 2012, save for the period January to July 2016 when he was seconded to be the director of Medway Secure Training Centre, left G4S after the Panorama broadcast. He was replaced by a senior manager from G4S Custodial and Detention Services (who we refer to as 'the interim director'). The interim director had undertaken that role at Gatwick IRCs during the former director's secondment in 2016.

6. The detainee population at Brook House

6.1 Detainees arrive at Brook House by different paths in the immigration and asylum system. They are detained as a result of decisions by one of a number of Home Office bodies including the National Removals Command, the Third Country Unit, the Criminal Casework Directorate, the Detained Asylum Cases Team, Operation Nexus[1] and the Border Force. Detainees fall into one of three categories: foreign national offenders who have served a sentence in a UK prison and are awaiting deportation, known as time-served foreign national offenders (TSFNOs); those detained while their asylum application is considered; and others who are thought to have entered or remained in the UK illegally (sometimes referred to as overstayers). Brook House principally accommodates TSFNOs and overstayers. It accommodates some detainees regarded as too challenging or difficult to manage in a less secure centre and groups of detainees waiting to be removed from the UK on charter flights.

6.2 The following table is a snapshot of the length of stay of detainees at Brook House at intervals during 2017 according to the Home Office and G4S.

Length of stay	**Jan 2017**	**July 2017**	**Dec 2017**
Less than 1 week	95	108	24
1 week -1 month	138	181	119
1 – 2 months	68	74	64
2 – 6 months	70	83	70
6 – 12 months	21	12	9
1 – 2 years	7	5	2
Over 2 years	0	0	0
Average length of stay of detainees held at Brook House	54 days	44 days	49 days
Cumulative detention including other IRCs	93 days	78 days	99 days

6.3 Detainees at Brook House arrive with differing experiences of the immigration and asylum system and are detained for differing reasons. They come from all parts of the world

[1] A joint initiative by the Home Office and Metropolitan Police focusing on the identification of foreign nationals who break the law.

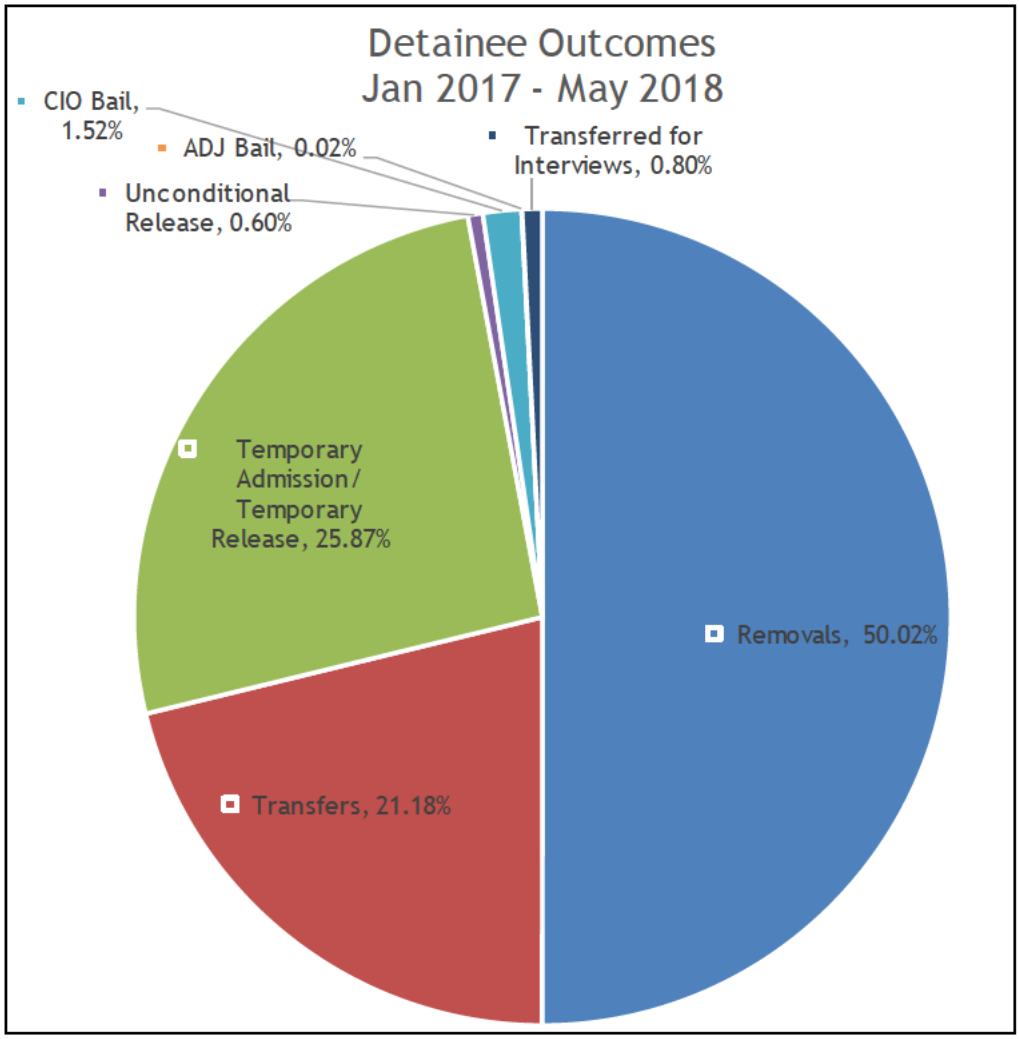
and some have little or no command of English. They have widely differing life experiences, expectations and concerns.

6.4 Some detainees have been victims of violence, torture and other traumatic events. Many detainees at Brook House have mental health issues.

6.5 Most detainees at Brook House have reached the end of their attempts to remain in the UK. They face enforced removal and are highly resistant to it. The former director described the desperation of many detainees and the difficulties of staff in managing them. He said:

> *"I was really struck by the desperation you could see in people sometimes, because whatever the situation, whatever the decision that has been made, some of them feel genuinely desperate about returning to their countries for whatever reason, and you see that on a daily basis. The staff are exposed to that on a daily basis, which makes it one of the most challenging jobs, I think, dealing with people who are that desperate and that challenging"*

6.6 The chart on the following page shows the outcomes for detainees between January 2017 and May 2018. About half of detainees left Brook House for removal from the UK and about 20 per cent were transferred to another institution (another IRC or prison).



6.7 In 2015, the Home Office introduced a system under which, instead of issuing removal directions specifying the precise date on which a detainee will be removed from the UK, some detainees are given notice of a three-month removal period during which they can be removed at any time subject to 72 hours' notice. Staff at Brook House told us that giving detainees such limited notice of their removal and not allowing them the opportunity to come to terms with this outcome and prepare properly for it had added to the detainees' anxieties.

6.8 Staff told us of a significant increase in the numbers of detainees who arrived with severe mental health problems. Two detainees were sectioned under section 48 of the Mental Health Act 1983 in 2016. That number rose to 12 in 2017. One of the reception managers at Brook House told us:

> *"Q. Have you ever had disabled people or people with mental health problems who you have just thought 'This person should not be here'?*

A. *Yes, lots and lots. I don't know how they decide that they end up here. I don't know if there is an assessment done before them coming here or not, I don't know but, yes, we've had people come here. We had one chap who was a Romanian chap, I can't remember his name, he had cerebral palsy or something and he was accepted somehow. I don't know how he was accepted, he might have been missed. Straightaway on E Wing he tried to bang his head, always trying to bang his head. ….. I can't remember exactly what happened to him, but he never should have been brought here in the first place and there are people who clearly have mental issues. They have been dropped off to us and then we have to deal with them.*

Q. *In your view do the Home Office act quickly enough to get those people out of here?*

A. *No, because they could be here for weeks and we have to deal with it until they've done something about it."*

6.9 The proportion of TSFNOs among the detainee population at Brook House averaged 22 per cent in the last four months of 2015. The TSFNO population at the centre increased significantly after that. In 2016 and 2017 they represented respectively 42 per cent and 36 per cent of the detainee population. In the first five months of 2018 they represented between 40 and 50 per cent.

6.10 The head of security and many of the staff we spoke to were clear that the increase in the numbers of TSFNOs had led to an increase in violence, indiscipline and other security problems. The head of security told us in November 2017 that 29 per cent of the TSFNOs detained at Brook House in the previous month had been involved in incidents involving drugs or violence and other security incidents, whereas only 6 per cent of the rest of the detainee population had been involved in such incidents. Figures compiled by the security team at Brook House show that TSFNOs were disproportionately the subject of reports of security incidents and incidents of violence or threatening behaviour.[1] The head of security told us however that TSFNOs held in the more attractive and less restricted environment of Tinsley House did not present the same degree of problematic behaviour as those at Brook House. She acknowledged that it was likely that the environment of Brook House affected the behaviour of detainees, a view shared by others we interviewed, including the inspection team leader at HMIP who led the unannounced inspection at Brook House in October and November 2016.

[1] See paragraph 12.21 below.

6.11 Brook House provides the highest level of security in the IRC estate and is used to house some detainees whose behaviour is too challenging for other centres. The interim director at Brook House and other interviewees commented on the effects of the mix of population at Brook House. They pointed out that a small number of challenging detainees had sometimes been extremely violent and disruptive and had had a significant impact on the sense of safety and security among staff and other detainees. The former vice chair of the IMB said:

> *"I think just as staff can be up and down, also detainees are up and down, and sometimes you just simply have three or four really difficult detainees who have an influence way beyond their numbers. If they are released, or they are sent back, or whatever, that can change the entire feeling within the establishment very, very quickly."*

6.12 The former director said:

> *"I'm sure there were people who weren't from a prison background, who came in here for just staying and not returning, and they found it very difficult with the population of 40 per cent foreign national offenders…and all the intimidating kind of behaviour that goes with that. I am sure there are some people who found that very difficult. We didn't have a choice about the people who came to stay with us. That wasn't our decision to determine"*

6.13 Unlike prisoners, detainees are not required to work or undertake education, nor can they be subjected to punitive sanctions. Subject to authorisation by the Home Secretary, a refractory or violent detainee may be confined temporarily in special accommodation or removed from association with other detainees[1] where it is necessary in the interests of security or safety.

6.14 Managing and caring for the diverse and demanding detainee population at Brook House presents a great challenge for staff. They rely above all on constructive engagement with detainees. The restricted site and limited facilities at Brook House make developing and maintaining that engagement difficult, as the interim director explained:

[1] The Detention Centre Rules 2001. Statutory Instrument 2001 No 238 Immigration. The Stationery Office, London

"The design of the building was all about short detention… The design doesn't allow for the length of stay that people are staying here for, I think that's the summary – if they were short term, it wouldn't create an issue."

"I think there's a big difference between the most difficult for a short duration and the most difficult for 12 months, 18 months, 24 months, because it can become a frustrating regime for 12, 18, 24 months. Even though there's a perception that it's more relaxed than a prison, of course it's more relaxed than a prison because they get unlocked during the day and the likes, we aren't able to provide that real engagement of activity that you can within a prison setting."

7. Management at Brook House

The senior management team

The history, culture and management style of the SMT

7.1 Since Brook House opened in 2009, there has been a history of dysfunctional relationships and instability in the senior management team. Prior to the appointment of the former director in 2012, the three most senior directors had all left at the same time. Three senior managers left in 2013, 2015 and 2016 after initiating formal grievance proceedings. The [redacted] left Gatwick IRCs by agreement at the end of 2016. The [redacted] told us:

> *"I found them to be quite a needy SMT. They needed a lot of support; they were quite sensitive. The dynamics needed to be managed quite well between them sometimes… They were quite a sensitive group…I have never known a place that uses grievances to air issues"*

7.2 [redacted]

[redacted]

7.3 G4S asked the [redacted] to investigate the grievances filed by senior managers in 2013 and 2015. He told us about what he described as the *"difficult dynamics"* between members of the senior management team at those times. He said [redacted] he found relationships were not *"quite right"* throughout the organisation. He believed the readiness of senior managers to deal with performance and relationship problems by formal investigation and grievance processes had had an adverse effect on the culture at Brook House and the behaviour of junior staff. He told us:

> *"It's never helpful, is it, if the top team can't get their act together. I think as a consequence of that, the number of grievances that are on there at the moment are quite toxic…*

"…I think [staff have] seen the top of the shop doing it, and found that that must be the way to [resolve things]"

7.4 The former director was in post between 2012 and September 2017, save for a five-month period from January 2016 to July 2016 when he was seconded to run Medway Secure Training Centre (STC) in the wake of allegations of the abuse of inmates by staff at the STC. The former director told us that his role at Gatwick IRCs required him to manage multiple stakeholders as well as fulfilling internal reporting requirements. He told us he had relied on his deputy, who was the head of Brook House, and the head of Tinsley House to fulfil their responsibilities for the operational management of the centres.

7.5 Interviewees told us the former director was a *"nice"* man. He told us he was *"people focussed"*. He has described his management style in the following terms:

"I held people accountable for their roles and areas of responsibility rather than providing instruction all the time. My approach was facilitative and collaborative believing that we were paying our SMT members a lot of money for their experience and skills and they should use them. I saw my role as partly escalation and oversight but also to provide support guidance and coaching, I could not run Gatwick IRCs as a one-man band operationally, manage stakeholders as well as growing the business for internal targets. Everybody should play their employed role as it is there for a reason."

7.6 [redacted]

7.7 [redacted]

[redacted]

7.8 [redacted]

[redacted]

[redacted]

7.9 [redacted]

[redacted]

7.10 Many interviewees told us that the former director had not been out and about and visible within Brook House. A senior manager told us:

> *"I would say probably once in three weeks or something [the former director] would be covering the duty director's role, so he would be there for the rule 40 round. Apart from that, I have never seen him on the floors."*

7.11 [redacted]

[redacted]

7.12 When we asked the former director whether he thought he had been too concerned with meeting the expectations of the Home Office and his managers at G4S and had not been as assertive or visible a manager and as focused on performance in the Gatwick IRCs as he should have been. He said:

> *"I saw my role as being one of customer-focused and managing external stakeholders. [The deputy director] did deal with the more operational day-to-day elements."*
>
> *"I would say that I would have liked to have been out and about more, and I would have liked to have been more visible. I am not sitting here saying that I was around all the time. I didn't go around every day, and I think with hindsight it would have been good for me to have done that a bit more."*
>
> *"… I think with hindsight I would carve out more time each day to go and have a presence around site and to ask questions. I think sometimes if you are really stretched you can't physically get out every day. You have to rely on a team to do that, and you have to set expectations of people being present. We did some of that, particularly around meal times and roll calls…"*

7.13 [redacted] A Home Office manager at the centre said:

> *"There is quite a lot of talk…of managers, senior managers' previous experiences in prison…Just for clarity, it is not just* [redacted] *comes from a prison background …..so there seems to be a lot of reference to how they deal with [things] in prisons, and I have said 'This isn't prison; this is a*

detention centre and things are different'; they don't seem able to take that on board."

7.14 Managers and staff described to us how the [redacted] tended to adopt an abrupt, directive and authoritarian approach in dealing with staff at Brook House, rather than being consultative and developmental.

7.15 Another Home Office manager said of the [redacted]:

"It is interesting, the disciplinary method approach. If I said, 'there were five or six people late yesterday bringing up for interview', the approach of [redacted] was very much, "right, who was down there? Get them up" rather than him saying 'what is the source? What is causing it?'.

Q. *It is very much focused on [whether] an individual has done something wrong rather than the system wasn't working?*

A. *From the little bits that I have seen, yes."*

7.16 One manager told us:

"Sometimes [redacted] can be quite abrupt in how he challenges things. Unless you tell [redacted], 'I don't think that's right', then he will keep on that course, whereas I understand that now, because I have tested the waters with him. I find that it works if you just tell him straight up what you think – he will listen. However, I don't think many staff quite get that."

7.17 [redacted]

[redacted]

7.18 The interim director said of [redacted]:

"…he's supportive, many of us have known him for many years. He was [redacted] he's always been there to support

people, and I think he has taken more of a robust style of management here, but I think that would have been my personal view, that he'd been driven a bit by [redacted] expectations of what he wanted from [redacted]."

7.19 The [redacted] told us that he had been the subject of a number of grievance claims, although none of these had been upheld. He told us the claims had been the response of staff he had tackled over poor performance or behaviour. He suggested his management style could be direct. He told us:

"Processes like Speak Out are there for a reason and they're there to be used, and if somebody was talking to me about concerns they had, certainly a number of routes and advice I would talk around how you could do that. But in my personal opinion it's used as a tool by people who are a bit upset or didn't like what they'd been told. I'm a straight-talking person and if somebody's not performing the way they should be, you need to have conversations with people and sometimes people don't like that. "

7.20 Interviewees told us that the [redacted] at Brook House had also tended to adopt a directive and authoritarian management style. The [redacted] said of him:

"… He would tend to be a bit critical and barky, rather than encouraging and nurturing would be my view of [the residential manager]. He cares a lot. He is a lot deeper than he shows in some ways, but he doesn't go around and give praise, or he can be, in my view, more critical than praising."

7.21 The [redacted] appeared to confirm what others said about his management style:

"I have been accused of being too direct myself in morning meetings because I go in and I say 'The wing is crap, it has not been cleaned. I have an inspection coming up. I have Home Office walking around', and I will have a go at them. Unfortunately, I am a bit old school, so I don't beat around the bush when it comes to wanting to say something. I have been brought up a few times myself in doing it like that, but then I think to myself if I don't actually tell them they are going to the wing feeling the wing is clean, when actually it is, excuse my language, a shithole."

7.22 A member of the chaplaincy team told us that in his view the problem with management at Brook House was its emphasis on ticking boxes rather than on modelling behaviours.

7.23 Staff at Brook House described their experiences of senior managers dealing with matters of individual poor performance in a heavy-handed way. They said managers were too ready to instigate formal disciplinary proceedings and to take punitive action rather than a more informal, developmental or supportive approach in dealing with performance issues, even when these were the result of innocent mistake. We heard about a new DCO who undertook roll call following the example set by officers he had shadowed. He was subjected to a formal disciplinary investigation for not having followed the correct procedure. Another staff member said that he had been subject as a new officer to an investigation after his first set of night shifts for mistakenly recording an incorrect time in a document. He was suspended and eventually reinstated. We learned of a senior manager who had sought to take disciplinary proceedings against a colleague who appeared to have fallen asleep in a management meeting.

7.24 One DCO told us:

> *"I was investigated for fact-finding… it was a detainee saying something, but I wasn't even in on that day, so I don't know how I was dragged into it… Before … there wasn't much suspension, do you know what I mean? If something happened you would be called upstairs and… you would probably get a bit of a bollocking 'Look, you shouldn't have done this, but sort it out', but nowadays it's probably like you would come upstairs and probably be suspended…*
>
> *"…The thing is working here you've already got enough stress as it is having to deal with loads of different people from different backgrounds, etc. You don't really need in the back of your mind another one thinking 'Oh, if I do this I could be suspended, if I do this', and it's like it's just one more stress that you don't need in your head, isn't it?"*

7.25 Staff complained to us about what they saw as the inappropriate use of formal disciplinary processes. They also complained that the processes took so long. One DCO told us he had been suspended for eight months while disciplinary proceedings were pursued against him.

7.26 A DCM said:

> *"I always say to a DCO if you've got a problem come and see your line manager, if you know who it is, on a wing. When it gets up to SMT, for some reason it takes forever. Someone could be suspended – we've had people up there after eight months, now they're back in working as if nothing's happened…"*

> *"…If something's gone wrong, you've made a mistake, you should be told about the mistake. Depending on the severity of the mistake, if you have to be off-site, which sometimes you have to be, depending on what it is, why does it take so long? When we were short-staffed, when we had people off suspended, you'd think the senior management team would want to get the staff back in. Some of them were very experienced staff, but how long does it take to do an investigation? Surely not eight months."*

7.27 Another DCM described the way senior managers dealt with staff performance issues as *"vile"*.

7.28 The [redacted] told us they had always taken HR advice and advice from senior G4S managers in relation to suspensions and dismissals. The [redacted] said:

> *"My view about disciplinaries was very much, and particularly dismissal, I would always look for the capacity to change because my view about disciplinary process is that it is about correction, not punishment".*

7.29 Nevertheless, the minutes of the senior management team meeting on [redacted] contain a record of the [redacted] report which says:

> *"Investigations- huge amount of investigations currently. There is a need to look at formal words of advice instead of conducting investigations"*

7.30 When we questioned the [redacted] about the evident preference of managers at Brook House to deal with even minor performance issues by suspension and formal investigation, he gave us contradictory answers. He said:

"I believe in total conversations. Call me old-fashioned, but I think a lot of things can be resolved by having a conversation with somebody and if something is clear you have done wrong you need to sit down and have a conversation with the person and talk about what happened, what we do to resolve it, and what you have done is perhaps not what we would expect. I believe there is a complete over-emphasis of commissioning investigations. I tried a couple of times to sit down with people….

"I… do believe that since Panorama there has been more of an emphasis that we need to get to the bottom of things and…
Q *It has gone back to investigating?*
A. *Yes…*

"I am a believer that if somebody has done something wrong or something has happened that you should have the confidence to sit in an office with somebody and talk through it, … because nine times out of ten people don't go out to do bad things."

"I think all the [formal investigations] that I have been involved in with suspensions, I believe, is the right choice."

7.31 The [redacted] told us he had been concerned by the tendency of the [redacted] to suspend staff and instigate formal investigations in respect of performance issues and described how he had had to stop some investigations and dismissals.

The visibility of senior managers and their engagement with staff

7.32 The [redacted] said his own practice was to walk about the centre every day he was on duty.

7.33 However, our interviews and conversations with staff and more junior managers suggested they did not see members of the senior management team out and about in Brook House regularly. They told us that the only time they saw most members of the senior management team was when they were performing their rota duty as duty director. The

interim director said that the administrative demands of his role meant he was not often able to be in the centre.

7.34 The former chair of the Brook House IMB, who stepped down at the beginning of 2018, gave us her views on the visibility of senior managers at Brook House:

> *"One [thing that staff complain about] is that they never see Management. We have actually raised that at a Board meeting with the Senior Management, and they have said, "it is not true, because Managers do go around", but that doesn't necessarily mean they are visible enough. I bumped into the* [redacted] *one Sunday when I was in for something, and he was saying how good it was to actually do the Duty Director role now and again to have a good feel. I rarely saw him round the centre."*

7.35 Another member of the IMB at Brook House, a retired prison governor, also talked to us about the extent to which senior managers were present in the centre:

> *"…you can't pick everything up and it is quite difficult sometimes to break out of the admin area and do the walkabout, which is really important, and that's where you pick things up. The pressure from G4S even above establishment level and from the Home Office is such that a lot of time is taken up with other things. It is in the bid process, for example. I think they are quite keen to have an objective eye on things and feeding that back into their management process."*

7.36 The Home Office area manager at Gatwick IRCs, who began working there in August 2017, told us he rarely saw members of the senior management team out and about in Brook House. We visited Brook House on many occasions over a number of months and did not see senior managers in the centre for purposes other than accompanying official visitors or undertaking a specific duty.

7.37 The managing director of G4S Custodial and Detention Services told us it was important that managers got out of their offices onto the wings of a prison or IRC and understood their staff. He said:

> *"As a… governor, I knew my time was best spent out of my office, walking the ground, and actually having that conversation, having that cup of coffee in the wing office, etc., at all kinds of different times of day, and so on, and so forth. That is*

what I expect, to be quite honest, because you can't say an officer on the ground will act in one way or the other."

7.38 The only regular forum at which staff at Brook House might otherwise have encountered a senior manager was the staff briefing held for 10 to 15 minutes at the beginning of each working day. A senior manager, usually the deputy director, updated staff with general information about detainees, including numbers and movements, and the number of detainees subject to the ACDT[1] process or refusing food and fluids. He also made general announcements about management issues. Managers told us that following the Panorama programme a monthly staff engagement forum was introduced. Staff we talked to were either not aware of the forum or told us that the operational needs of the centre and a lack of staff meant they had been unable to attend. We have subsequently been told by the interim director that recent forums have been well attended and the forum is now being used as the venue for presentation of employee of the month awards.

7.39 Whatever the senior managers at Brook House may have said about the time they spent walking about the centre and whatever they may have believed about their own level of engagement with staff, staff clearly did not perceive them as being either visible or approachable.

7.40 The principle effects of this were that frontline managers and staff tended to rely on colleagues, especially the more assertive of them, for leadership, guidance and support; and did not feel able to raise issues and matters of concern with senior managers.

7.41 We visited HMP Rye Hill near Rugby. We acknowledge that Rye Hill and the other custodial institutions that we visited operate in many respects under different circumstances to Gatwick IRCs. Nevertheless, we were struck by the fact that the governor and every member of the senior management team there spent time each day going about the prison and on to every wing, talking to staff and prisoners. Sometimes they undertook everyday duties alongside staff. The governor had, for instance, recently spent time working with staff who were helping with the administration of medicines from the on-site pharmacy. The governor of Rye Hill made clear to us the benefits of this level of engagement and visibility. He explained that it was easy for managers to busy themselves with management tasks and lose sight of what was really happening in their organisation and

[1] ACDT stands for 'assessment care in detention and teamwork'. It is the process by which detainees at risk of harm are made subject to a care plan, including regular assessments and observations.

what really needed to be the focus of their attention. He said that by wandering about the prison senior managers picked up matters that needed their attention from both prisoners and staff. It also provided senior managers with the opportunity to hand on and reinforce key messages.

7.42 It was evident from our meetings and discussions at Rye Hill that staff were familiar with members of the senior management team and found them approachable.

7.43 We learned during our visit to Heathrow IRCs that all members of the senior management team there also walked about the centre most days. They told us that in addition to making them visible and offering staff and detainees the chance to raise issues with them, it gave them the opportunity to model the behaviours they expected of staff.

7.44 At Rye Hill we were struck too by the extent of other efforts made by managers to engage with staff and to appreciate and celebrate their contribution to the work of the prison. In particular, we saw that gatehouse noticeboards, which were among the first things staff and visitors saw when entering the prison, were dominated by messages about and for the benefit of staff. There were photographs of awards ceremonies and other celebrations, posters exhorting staff and others to nominate their colleagues for employee of the month awards and notices about a forthcoming staff forum.

7.45 We understand that an employee of the month and team and employee of the year scheme had operated at Brook House, with an annual awards event at which certificates and bottles of wine had been handed out to winners and in recognition of long service. But staff told us the scheme had ended in July 2017. It returned in March 2018 and an awards ceremony took place in May 2018. Apart from the notice of the revived awards scheme put up in March 2018, notices in the gatehouse or on the staff notice board in the administration corridor were predominantly exhortations to conform to new rules or policies and informing staff of the consequences of failing to do so.

Recommendation

R1 The SMT should be more present in the centre and should consider how they can better engage with staff.

Management stretch

7.46 We became aware of continuing problems at Brook House resulting from a lack of senior management capacity and a lack of staff to support them in fulfilling their roles.

7.47 The loss of senior managers or their moves to other roles had led to some relatively long periods in which DCMs acted up into senior management roles. In particular, from the end of 2016 until June 2017 a DCM acted up as head of security and from June 2017 until December 2017 a DCM acted up as head of safeguarding until a new head was recruited from outside. The new head of safeguarding moved to a new role of head of residence after only a couple of months. His role was then filled by the former head of residence at Tinsley House.

7.48 The DCMs who acted up in the way we have described told us how challenging they had found it to fulfil their roles. They and other senior managers told us how further vacancies in the various management teams had hampered their ability to tackle workloads, with the result that important tasks had not been completed.

7.49 The DCM who acted up as head of safeguarding between June 2017 and December 2017 told us that while he was fulfilling that role he was also acting as the safer community DCM for both Brook House and Tinsley House and was undertaking the role of duty director on a rota with other senior managers. He told us that he had had discussions with senior managers at the time about the need to appoint a further DCM and an administrator to help the safeguarding team, but nothing had happened in respect of these appointments. We interviewed him in early December 2017 and asked what he thought were the major issues at Brook House that needed to be addressed. He told us:

> *"More management, who are trained to do what they need to do in order to give the staff the support they need, the training they need. We used to have a lot more senior management but, as I said, when the redundancies came in, they took away a couple of senior management. We used to have the Head of Safeguarding, who would just look at Safer Community and diversity, whereas now the Head of Safeguarding… does reception, the CSU, first night in detention, Safer Community, diversity – it is far too much for one person to do."*

7.50 Responsibility for the induction of detainees passed to the residential management team when the head of safeguarding was appointed in December 2018

7.51 The DCM who had acted up as head of safeguarding told us in December2017 that he had not been able to keep up with the requirement to investigate reports and incidents of bullying and violence and that only self-harm incidents up to October 2017 had been investigated. He had not had time or resources to consider the self-harm reports for any trends or wider implications for the management of detainees at Brook House. He said:

> *"For me, at the moment, it is far too much. Even when it was myself and [the head of security], I was just about keeping the lid on self-harm – looking at that and investigating it. However, to look into violence, I don't think it has been looked at since probably 2015, when it probably was looked at. It was looked at by [x] when he was here. He had bags of experience from working in prisons… Since then the level of self-harm and the level of violence has increased so much."*

> *"I am [keeping up with self-harm] but I am doing three jobs at the moment and it is very difficult. I haven't looked at self-harm at Tinsley House since July. I have just about caught up on October but I haven't looked at November for Brook House at all."*

7.52 The interim director and other senior managers told us that the DCM could not be expected to fulfil his workload. One said:

> *"I suppose if you put it into context, the safer community team should have two DCMs - one at Brook, one at Tinsley - and also has… the diversity manager, so you have three DCMs there looking after safer community and diversity… one of the safer community DCMs [is on a career break] and has had a prolonged period of absence, so she hasn't really been in the business for quite some time, just leaving [the DCM acting as head of safeguarding]. Then [the DCM] has been made into the head of safeguarding, and there's no-one doing [his] work as a DCM, so [he] is the head of safeguarding and also doing two DCMs' jobs"*

7.53 The security DCM who acted up as head of security from the end of 2016 until June 2017 told us that she, another DCM and a DCO had covered the work of the security team which should have comprised seven people (four collators of information, two DCMs and a

senior manager). She said the lack of staff had meant the team had not been able to process the prison files of TSFNO detainees and she acknowledged that as a result risks relating to them and their behaviours might have been missed. The security team had not been able to investigate all the security information reports (SIRs) giving information about risks to safety and security at Brook House. The head of security appointed in June 2017 told us:

> *"The [security] staff… have been unloved in my opinion. There has been no Head of Security, so in terms of day-to-day engagement it has not been there…I think they were overwhelmed. I really felt for them, they really struggled."*

7.54 We spoke to one of the security DCMs in January 2018. She told us that the security team was still under significant pressure. Security information reporting rose by 30 per cent after the Panorama programme but the team still lacked a collator. The security DCM said the team was only working reactively because of this pressure and did not have time to undertake trend analysis or identify any wider implications of individual security issues or devise mitigation strategies. She told us:

> *"…we are playing catch-up from Panorama. We don't have the time to go back. We are literally churning through them to just cover ourselves and get actions in place. We are not being proactive at all, we are just being reactive."*

7.55 As at June 2018, the security team had a vacancy for a collator and the safeguarding team had a vacancy for an Oscar 2 DCM.

DCM capacity and capability

7.56 Management arrangements at Brook House were at their weakest in relation to frontline management by DCMs. The weakness was apparent in both the number and the capability of the frontline managers.

7.57 The lack of operational DCMs had been a problem for some time. A single DCM had been assigned during the day to oversee two residential wings. Staff on the wings told us how the requirement for residential DCMs to undertake duties away from the wing, such as managing removals to the care and separation unit or other incidents, had meant that on some shifts they saw a DCM for only a short time. The interim director told us he was trying

to ensure a designated DCM was on duty each day on each wing, but this was not always achieved.

7.58 The interim director identified the lack of DCMs at Brook House as an issue and in December 2018 appointed nine further DCMs, eight of whom were internal promotions. He explained that the new DCMs would only be able to take up their new roles when the recruitment of further DCOs allowed them to be released from their existing roles. Five of the new DCMs were assigned to Brook House one as the paid work DCM, one as the activities DCM, one as safer community DCM and two as residential DCMs. The interim director told us four more residential DCMs were needed to ensure that his plan for a DCM on duty on each residential wing throughout most of the day could be fulfilled. He told us this was subject to negotiation with the Home Office.

7.59 A number of DCMs told us how demanding they found their workloads. They told us how more pressing operational requirements of the centre, or the need to stand in for colleagues meant they were often unable to give the required amount of attention to their own duties and responsibilities.

7.60 One DCM told us:

> *"Some days I come in and I can spend all day doing [my role], which is fantastic, because I can get it done correctly. Other days you come in and you are pulled away to do this. Can you make sure this is done, then you have to do something else, and before you know it you have done nothing… You are not left to get on with specifically what your job role is. However, it does state in the contract that you may be provided to fill other job roles, but sometimes it is ridiculous, it really is. to the point of frustration. That's my job. Let me do it. I am good at it. Just allow me to do it, and I will do it well." …*
>
> *"Everything is just difficult. Everything seems to be passed on, and what should be SMT work is just passed on to DCMs so that your workload is ridiculous."*

7.61 Another DCM said:

> *"I think that the general feeling, from the managers' side, is that there aren't enough. Christmas Day just gone, there were three of us in. There was me as Oscar*

1, an Oscar 2, and a DCO residential manager, running five wings, reception, the visitor centre, the outside area. I was running three wings and our Oscar 1"

7.62 The former director described the lack of capability among DCMs to manage staff. He said:

"…first line managers were generally good doing the core business of running the day. However, I wanted to improve how they managed people, and I think there was certainly room for improvement that we identified in that group to improve their management of their direct reports, and what I mean by that is not just in terms of giving critical feedback but also giving positive feedback. Being present and forming much more meaningful relationships with direct reports, so that they felt they would want to come and talk to them about issues, where I think some of that wasn't the case."

7.63 A number of factors added to the problems of DCMs in fulfilling line management responsibilities. DCMs told us they had limited time to line manage DCOs and to conduct their development reviews. DCMs were in some cases assigned to different rostering lines and therefore worked different shifts to the DCOs they managed. Some DCOs said they had not been assigned a line manager to replace the DCMs dismissed as a result of the incidents featured in the Panorama programme. Managers told us there were some unresolved issues in relation to which areas of the Brook House operations DCMs were to have responsibility for. This had led to uncertainty about which DCMs should line manage which DCOs.

7.64 A DCM said:

"You go and ask half the DCOs, they won't know their line managers. Obviously the [residential] ones do." …

"Some of them don't know who their line manager is, which is terrible. I don't know who I'm line managing, and if I don't know who I'm line managing, how are they going to know? I've got four or five ACOs."

"You have two sides to shifts, one's on, one's off, as a rule. Normally DCOs overlap but as DCMs you're totally opposite, so if you're on, you're off, if you're off, you're on, so you have your own group. Whoever used to roll it out… they used to give you

your set of papers, and I said why are you giving me these people because half of them are on the other shift… In the end, I sat down with [a detail manager] for half-an-hour and wrote it all out and gave it to them: this is how it should be because I'd see these people and they'd see those people. 'Oh yes, we'll go with that', and that took half-an-hour, and this was going on for months. It's so frustrating."
"How can I do an EDR[1] on someone that I don't see? … You can only manage and develop someone that you see, that you work with, not someone I probably see two or three times a month, which is what was happening."

7.65 We encountered a number of DCOs who told us that they had either not had an EDR or that they did not know who their line manager was or both.

The training of DCMs

7.66 DCMs, both long-standing and newly appointed, told us they had received no formal training for their role. They said that the only preparation they had for becoming a DCM were short periods shadowing an existing DCM. One DCM recently appointed to the Oscar 1 role in which he has responsibility for the daily running and management across the whole of Brook House, told us:

"In that period of starting, I was given four days of shadowing. I was writing down everything that I saw. I had bits and pieces of training but nothing substantial."

7.67 Another DCM responsible for managing detainee reception at Brook House told us his training had been *"a couple of days shadowing"*.

"I had a couple of days of shadowing another DCM who did my current role and then after that I was not left on my own as such, but then it was down to me to pick up whatever I could learn on the job."

7.68 The training needs analysis undertaken by G4S's UK and Ireland division central learning and development team in October 2017 found *"currently no management development or leadership skills and behaviour development in place"* at Gatwick IRCs. The analysis recommended the introduction of an apprenticeship programme for frontline and

[1] EDR stands for 'employee development review'. This is the staff appraisal process at Gatwick IRCs.

middle managers to *"strengthen right leadership behaviours and skills"*. In answer to this development need, the head of learning and development for G4S's Care and Justice services and the interim director introduced an apprenticeship programme, funded by the government's apprenticeship levy scheme and delivered by a company called Corndel.

7.69 The head of learning and development for G4S's Care and Justice Services explained what she saw as the learning needs of frontline managers and the purpose of the apprenticeship programme:

> *"It is a good way of making it live and getting them to understand what impact they have, not only on their people, but those that they care for as well at the same time…*
>
> *"…so strategic leadership is equally as important about getting the behaviours right and the values right. You might not manage a team of people, but you might manage the suicide and self-harm strategy, for example, and you need to negotiate, and you need to get by and you need to get people to understand the impact that they have."*
>
> *"I would argue we are not training… Because it is an apprenticeship scheme they get the opportunity for a one-to-one professional coaching conversation every two weeks for the next 12 to 18 months, so it is absolutely about development; this is not about training. The reason I say that is when I first joined G4S it is about the fact that they did do management intervention training, which is how to hold a difficult conversation, how to address sickness, absence, and those training courses still go on, but they are short term intervention, and it is about training in tools and techniques; it is not about the behaviours, the culture and the values, which is what the apprenticeships gives us the opportunity to do."*

7.70 We acknowledge that DCMs do need to be given the confidence and skills to lead and manage others, or in the words of the training needs analysis, *"leave the team to lead the team"*. New DCMs made clear however that they also needed better training in the more practical aspects of the roles and functions they were required to perform. For instance, the new activities DCM, who told us his only training for the role had been *"sitting down with the head of residence and the deputy director"*, said the security team had taken him

to task for not producing an inventory of the activities equipment. He said he had not known that this was part of his duties.

7.71 The training needs analysis identifies as an action point:

> *"establish a training forum at Gatwick IRCs to review the emerging manager needs from review of use of force, use of grievance, simple investigations and target learning interventions to meet needs".*

7.72 The forum was to be established by November 2017 and was to be used to develop a new training plan for introduction in 2018. The analysis recommended that managers be given HR training *"mini-modules"* on absence management, grievance procedures, simple investigations and performance management. The head of support services at Brook House told us the HR team would deliver these modules to DCMs during 2018.

7.73 The Corndel apprenticeship programme for DCMs lasts 13 months and consists of what Corndel describes as weekly *"micro-learning"* in the form of viewing two five-minute podcasts or YouTube videos or reading two chapters of a text book; writing a daily 100 words on a learning topic; and a fortnightly 60-minute one-to-one session with a professional development coach. DCMs said G4S were supposed to allow them to use 20 per cent of their working time to meet the learning commitments but lack of staff and the consequent operational demands on them meant this had not happened. They told us that they were struggling to find the time to devote to the apprenticeship. One DCM said:

> *"I am completely struggling with it. I do not have time. I genuinely do not have time – we are all the same."*

> *"I am inundated with work… if I take two hours out to go and do work, that means I have to claw back the two hours. There is nobody to fill in the gaps."*

7.74 Another DCM said:

> *"The main issue is getting time to do it. When we signed up to it, we signed part of it which said we would get 20per cent of our working hours a week dedicated to it. For me, I do 42 hours a week, so 8.4 hours, I only do 10.5-hour shift – out of four days realistically I am not going to do a whole shift a week…*

"Operationally it can't happen. There is no way you can have two hours a day. You can't say…. here are two hours where you are not going to have [me] on shift because somebody else will pick that up."

7.75 The interim director said DCMs had not been offered the apprenticeship course on the basis of being allowed 20 per cent of their working time off to do it. He said DCMs were meant to make arrangements with colleagues to release time during the working day for study, but they were also expected to do some course work in their own time, and to use daily work experience as part of the course work. Whatever they were or were not told, it was clear that DCMs believed they should be able to take 20 per cent of their working time as study leave.

Recommendations

R2 The SMT must ensure that DCMs are given adequate training to fulfil the tasks and responsibilities of their role.

R3 G4S managers should work with DCMs undertaking training to ensure a common understanding of requirements of that training and how much time DCMs will be given away from operational duties as study leave.

7.76 We found that DCMs did not have enough time and had not been given appropriate training to fulfil their roles. As we explain below and in chapter 8, the lack of DCM capacity and capability contributed to the disaffection of staff at Brook House and undermined their work and the way they managed detainees.

Failings in management and their effects

The lack of consistent and active management

7.77 DCOs commonly complained to us that poor management by frontline managers or DCMs meant that staff were not taken to task for being lazy or failing to fulfil their responsibilities and that rules and procedures were not consistently adhered to.

7.78 One DCO gave us an example of the importance of having DCOs enforce the rules of the centre. He told us about a DCO who had not challenged a group of detainees who had barged into a residential wing where they were not allowed and seriously assaulted another detainee there. The DCO told us:

> *"I always say to people, before that even happened, 'if you let people on the wing that aren't supposed to be on the wing I think you should get disciplined, I think you should get told off, slap on the wrist, not literally but -'. You should get a slap on the wrist, written warning because if someone actually went on the wing, shall we say they made an improvised weapon.*
>
> *"If they [the detainees] actually did some serious damage to someone, they're obviously going to go down the block, down to CSU, Care and Separation Unit but what is happening to the officers? No management, senior management team, are going 'right, we need to pull this chap in, it's on CCTV seeing you letting that guy in'; nothing is getting done about it."*

7.79 A DCM spoke to us about inconsistency in the way the centre was run. He said:

> *"One of the biggest issues here it is the consistency, I think it is a key word, I know other people have used it, but I have always used it. When you have consistent staff on a wing, consistent in the area, it does help the detainees. Yes, you may say it may open up to manipulation, if you like; however, if you utilise it in the right way, you will get a good regime/organisation running that also the detainees will trust the people that they are working with as well. It does benefit because what we are seeing at the moment is we are not having a regular, consistent team on the wings, the wings are quite vital, and you will see there is a lot of experience that moved out of the wings…"*

7.80 DCOs told us that the failure of managers to ensure that policies were adhered to meant detainees were sometimes treated inconsistently. This made detainees feel aggrieved and they would then become aggressive and difficult to manage.

7.81 We often found no DCM on a wing but when they were present, we did not see or otherwise get the impression that they were actively managing DCOs and directing their

work. We found staff and DCMs mostly spent their time in the office rather than walking about the wing engaging with detainees. Some staff clearly needed to be in the office to complete paperwork and to hand out supplies such a toilet rolls and toiletries or to make appointments and answer the needs and queries of detainees who came into the office. But even when there were more staff available than were needed in the office we did not see them routinely going out into wings and on to wing landings and DCMs did not appear to expect this of them or set an example by doing so themselves.

7.82 A member of the IMB, who is also a former prison governor, shared our view about the fact that staff did not get out into the wings enough:

> *"Certainly, one of the things that I have noticed and said is that when I do a rota visit,…..I go right up to the top of the wing, I will walk all the way around the top floor, drop down and walk all the way around the next one, and then I will drop down again. Unless I happen to be there when they are locking up immediately prior to lunch… I can't recall seeing a member of staff up on the upper landings. It was exactly the same when I was in the Prison Service. It was very difficult to make officers regularly patrol the higher landings, because they felt safer if there were two of them or more, and they felt safer being on, in Prison Service terms, the ground floor is the ones in the Prison Services. It is the ground floor here.*
>
> *"I think that there is an issue, not just about Management being more visible in this place, but also staff being more visible on the upper landings. I intend no disrespect or criticism of G4S, because I think if you went into a Public Service prison, or immigration detention centre you would probably find exactly the same"*

7.83 The failure of frontline managers actively to manage DCOs and their work on the wings led some DCOs to adopt a passive attitude to their work and to their failing to take ownership and responsibility for what went on. For example, some officers appeared to allow wings they worked on to be dirty, with drinks cans, bottles, cigarette butts and other litter strewn about the floors and with the main sink by the servery blocked with the remains of meals. On one occasion just before lunch we found tables piled up with bits of boiled eggs and other remains of breakfast. We pointed out the mess to a duty DCO. He appeared not to have noticed it and then told us that it would not be cleared up until the paid cleaning orderlies dealt with it that evening.

7.84 The lack of ownership of responsibilities by staff appeared to have been compounded by the fact that as a result of the staffing problems staff did not work together in particular areas of the centre on a regular basis. This meant they did not work as teams and lacked support and encouragement in undertaking their duties.

7.85 Management meeting minutes suggested that senior managers had identified some time ago the lack of ownership of responsibilities by DCMs and DCOs. The minutes of the Gatwick IRCs' security meeting on 22 September 2017 state under the heading of the Brook House residential report:

> *"DCMs are so busy managing detainees that they are not managing staff which was mentioned in the recent staff forum. Staff need to deal with issues instead of telling detainees to see a white shirt[DCM]. DCOs are not taking responsibility for managing simple things like running out of soap powder and not contacting stores".*

7.86 The Home Office compliance manager at Gatwick IRCs, who is based at Brook House, agreed with our concerns about the lack of ownership and responsibility by some staff and managers. He said:

> *"There's no ownership of any area, it's almost like a numbers game to fill cracks, and because you don't have that consistency, rapport can't be built with detainees, and nor can disciplining, in a way."*
>
> *"It is, and it's probably learned behaviour for the new staff, that it's someone else's responsibility."*

7.87 We met some enthusiastic and energetic DCOs and DCMs at Brook House who tried to enforce rules, dealt with detainees proactively and consistently and took ownership of their wings, ensuring that they were clean and well ordered. But this was often not our experience of DCOs and DCMs at Brook House.

7.88 A number of DCOs said they wanted DCMs to be more proactive in their management and ensuring that the centre ran according to rules and procedures.

7.89 A DCO said:

"there is no staff management – I wouldn't say there is none, but staff management is a bit poor, and then those staff, if you manage them properly will stop doing things they shouldn't. They will stop disappearing [from the wing]. They will start working how they are meant to work. They will enforce the rules they are meant to enforce."

7.90 A DCM said:

"DCMs coming onto the wing didn't exist when I was a DCO. It just didn't happen, but now that people are in place it is still not happening, and I am left questioning why? What is going on?"

The failure to support and engage with staff

7.91 DCOs told us the lack of visible and capable frontline management affected the way they worked and made them feel unsupported. One DCO said he sometimes did not raise concerns about how other officers behaved or carried out their duties because he felt that DCMs were too busy, there was nothing they could do, and they would not welcome being bothered by him:

"You feel like sometimes that you can't ask for help from certain people or if you do ask for help then it's going to be, "Oh, no -"

***Q**: What sort of help do you think you might be asking for?*
***A**. Just getting managers to the wing to deal with problems that we're not able to deal with, or [detainees] want to see a manager and you feel like you have to try and rectify it yourself…….*

… I just feel that I've heard DCMs talking in passing, "Oh, they can't even sort out a problem." Do you know what I mean? "They're always calling us all the time." That's in the back of your mind and you think to yourself I don't really want them to be talking to me, or talking about me, like that."

7.92 Another DCO told us:

"if you couldn't deal with problems yourself then you were weak."

"[A DCM] said he doesn't mind dealing with detainees' problems but it's officers, he doesn't want to deal with officers and their problems. If you are the sort of person who calls because you need assistance, you need a manager to attend to re-confirm something with a detainee, he doesn't want to attend, you're a problem if you keep calling for him."

7.93 We also learned of weaknesses in the official staff welfare arrangements. A staff care team at Gatwick IRCs was made up of other members of staff and managed by the manager of religious affairs. However, a number of DCOs told us they had little understanding of the care team or its work. One DCO told us he did not trust the members of the team and implied he did not think they would be discreet. A member of the care team told us that staff shortages meant that colleagues were not always able to make time to meet with those in need of support. One DCO said:

"It's not fit for purpose… Nothing against the individuals on it but in the structure and process in however it is meant to work…and it comes back to the same old thing here, and it's not happened to me but I know it's happened to others, in that they may want to speak to someone on that Staff Care Team after an incident. That person can't get relieved because they're on the wing and there's not enough staff."

7.94 Gatwick IRCs suicide prevention and self-harm management policy says:

"Dealing with suicide attempts, or other serious incidents of self-harm, can be as stressful as dealing with a death. The Safer Custody Team and Care Team will work closely to support staff and detainees following a death in detention, and also following an incident of serious self-harm, particularly those resulting in a life-threatening injury where the person required hospitalisation and it is likely that they will sustain permanent injuries as a result of the self-harm incident.

"Support for staff involved in an incident of serious self-harm will be offered in every case by the Gatwick Staff Care Team."

"…Any member of staff involved in …an incident [of self-harm or suicide] will automatically be contacted by the local Care Team and be offered support and care…"

7.95 The policy also says:

"The Safer Custody Team will organise regular (at least annual) consultation with staff working in areas of high self-harm, to identify their support needs and implement appropriate action. The Local Care Team will be involved in this consultation process."

7.96 No one we spoke to could recall a consultation with staff working in areas of high self-harm to identify their support needs. A DCO who had witnessed an incident of self-harm told us she had not received any support after the event. She said:

"When I started here after the first self-harm incident, somebody is supposed to call you. I am still waiting for that phone call today".

7.97 In our view staff who witness acts of self-harm should always be proactively offered support.

Recommendation

R4 The SMT at Gatwick IRCs must review arrangements for providing care and support to staff and ensure that they have ready access to a care service they trust.

7.98 A further failing was the fact that staff were not given opportunities to reflect on their practice and it was not customary for managers to debrief staff about the handling of difficult or challenging incidents, such as those involving self-harm or use of force, and the lessons to be learned from such incidents.

7.99 The former director told us:

"I have experience of hot and cold debriefs at Brook House. My experience is incidents I have been involved in, or involved in managing, and they have been more serious. However, I would be less confident about low level incidents."

7.100 The former director has told us that a few years ago DCMs were given incident management training which included an element on the importance of critical debriefing and identifying lessons and staff welfare. However, staff we spoke to said that while they sometimes discussed the handling of an incident informally among themselves or with a DCM, there was no formal process and no expectation of either hot or cold debriefing. They said they had no formal opportunities to reflect on their practice more generally.

7.101 Managers and staff told us that even after the airing of the Panorama film staff had no organised opportunity for discussion and reflection on the incidents shown in the film and the lessons to be drawn from it.

Recommendation

R5 The SMT should ensure staff have time for debriefing and reflecting about serious incidents in which they have been involved and an opportunity to learn from them.

7.102 Many of the people we spoke to said lack of support from managers for new staff coming to grips with their role was why a lot of DCOs left after a short time at Brook House.

7.103 One DCO told us new staff left Brook House:

"because they don't get the support which I personally had when I came here. I had the older staff still." …

"Personally, because they don't have the support and they don't have the standards of the old staff, or anyone there to support anybody, I think it will be hard to keep the new staff…."

7.104 A DCM said:

"When people first start they become used to the departments and then the people they're working with but at the moment on the wings that's not happening because the turnover is high, new people are learning off new people and then they are not really getting support or training, because the person that is showing them the job is new to the job himself. That's what's causing this, it's a knock-on effect.

Then that's where it starts from that, 'Oh, I don't want to work on this wing, I want to go and work there', or 'I'm not getting along with this person', probably because that person is new as well and the issues that happen are because they don't really know the job. Then maybe they are not working off the same page because they are new and inexperienced. That's where it can start."

7.105 DCOs told us they did not feel managers engaged with them in a more general sense. They did not feel managers valued them as colleagues and for their contribution to the work of the centre. The way staff, and front-line managers, felt about whether they were valued was summed up by a DCM who said:

"They should treat officers like officers and not like a number, basically - blue shirt, white shirt, regardless. It is hard to put your finger on a specific idea as to what they could do, but something needs to change. Much of the time, that is why people are leaving. They think, 'What's the point? You don't care so why should I care?' Every now and again, you get people going off to see officers who have been injured, and they are reasonably good at that. I was off for three months, but I never had a home visit - I had a couple of phone calls, but that was it, and that was what was needed to be done to fill a page out and I was off because of this role."

7.106 We asked DCOs whether managers ever thanked staff or recognised their efforts. One said:

"It's more on the lines that we thank each other"..

7.107 Another said:

"I don't remember. I think [the head of residence] said something to me the other day. I said hello to a guy in Somali and he said 'do you know Somali', and I said 'well

I can say that', 'that's good', but apart from that you don't really get anyone saying well done"

The mishandling of performance issues

7.108 The absence of frontline managers and/or their failure to tackle poor performance or poor behaviours in a routine and appropriate fashion meant that such issues were often not addressed until they had escalated and were dealt with formally by disciplinary or grievance processes. We heard of a number of instances of DCOs, often young and inexperienced, failing to carry out tasks properly or making innocent mistakes that resulted in formal investigations rather than a quiet word from a frontline manager. As we have already discussed, we found some members of the senior management team appeared to have favoured and encouraged this more severe and disciplinary approach.

7.109 One DCO told us:

"I was investigated for fact-finding but that was nothing because that person, or it was a detainee saying something, but I wasn't even in on that day so I don't know how I was dragged into it.

Q. *How long did that hang over you?*

A. *For me I did receive a letter about a couple of weeks beforehand that said 'You are going to be investigated this time.' … 'Come here and have a word with an independent group of people'. I came down and showed them my diary and I was like 'Look, I wasn't even in on that day…'"*

7.110 Another DCO told us:

"I'd rather they challenged for it and just [said] 'look, don't do that again because that's a stupid move but everybody forgets things sometimes, just make sure you're on the ball and lock it next time'. However, for example, when I did my shadowing I got taught by a DCO how to do roll count and I got a letter through the door saying 'you're under investigation'. For what? Apparently, I did the roll count wrong but obviously I was a newbie and I was looking at an officer. I was like 'how you do the

roll count?' and he said you do this and that. I said 'right, okay, brilliant, that's nice and easy'.

Q. *You adopted it?*

A. *Took it under my wing and just said 'right, okay, I'll do roll count', and for the whole week I was doing roll count how I got taught how to do it, and then I was under investigation and they said you've been doing wrong. I said 'how am I supposed to know that if no one tells me, apart from another DCO, how to do roll count properly'?"*

7.111 We asked a DCM whether senior managers could be more sympathetic and less heavy-handed:

"Yes, sadly yes. Sometimes there just needs to be just a bit more common sense with some things."

Management issues: conclusion

7.112 We found a lack of visible and capable management and a sense among staff that managers were unapproachable, unsupportive and sometimes draconian. This led to disaffection among staff and to their relying principally on each other for support and guidance. It had worked against the development of an open and learning culture. It had also presented opportunities for some stronger personalities to gain undue influence leading them sometimes to behave in inappropriate ways without being challenged, as the Panorama film showed. We discuss these matters further in chapter 13 on the culture of Brook House.

8. Staffing arrangements and issues

The history of staffing problems at Brook House

8.1 G4S contracted with the Home Office to provide 668 hours of DCO time a day. How these staff are rostered and where they are deployed in the centre is for G4S management to determine but the contract requires at least two DCOs on duty on each residential wing throughout the day.

8.2 The behaviour of detainees shortly after Brook House opened had been particularly disruptive and challenging. This undermined staff morale and had an adverse effect on staff turnover and staffing levels. But we understand that matters improved under new managers and staff numbers and turnover were relatively stable for some time. However, retention and turnover have been a significant problem at Brook House over the last few years.

8.3 The staffing plan in place before September 2017, which we understand was developed in discussion with the staff union and approved by G4S management, provided, (in addition to the staff required for reception, the gatehouse and patrols), for a daily staffing complement of four DCOs on the larger residential wings A and C, three on B and E wings, four to staff the official visits corridor and the visits hall, three to manage activities and one to work in the welfare office. The plan was for one DCM to manage two residential wings during the day.

8.4 The central detail manager, the interim director and other managers and staff told us this plan was not enough to ensure the smooth running of the centre and a proper regime and activities programme for detainees. In particular, it did not provide capacity to cover staff breaks, constant watches on at-risk detainees, the inevitable need for staff to leave the centre on escort duties, and the requirement, after an escape in March 2016 and an escape attempt in June 2017, for the courtyards to be staffed whenever open. The contract requires the IT room and library to be staffed at all times, so the plan meant only one DCO was available to take responsibility for delivering a sports and activities programme for more than 500 detainees. In any event, problems with retaining staff meant that it had not been possible to meet the intended staffing plan.

8.5 The interim director took up post in September 2017 and reviewed staffing for Brook House. He set a target for a daily DCO staff complement of at least 36 which he told us

should allow for three or four DCOs on each wing; the manning of the cultural kitchen; two DCOs in the welfare office; an additional patrolling officer; and an extra officer in the visits areas. He also set a target of a DCM on each residential wing. The interim director appointed another eight DCMs In December 2017. He told us that as part of any re-provision of the Gatwick IRCs contract by G4S there would need to be:

- four further DCMs appointed to work on the residential wings
- a dedicated operations manager for physical education, sport and activities
- two further DCOs dedicated to delivering the sports and fitness and activities programme at Brook House.

8.6 The minutes of the meetings of the centre's senior management team suggest that concerns about recruitment, retention and staffing increased during 2016.[1] The following comments appear in the minutes:

3/3/16:
"there is no consistency in Security as staff are being taken away from their jobs to cover other areas"

20/6/16:

"concerns around 2.5 vacancies on the activities lines"

"pressure on to recruit new staff. 30 leavers- 16 from BH and 14 from TH. Another 5 will leave TH during June. ITC [initial training course] will commence in August"

"Not enough staff to do full searches"

23/8/2016:

"[The former director] updated that financial cost of penalty points for 2016 is £101k compared to 57k in 2014 and £44k in 2015. Performance is being measured well and declaring transparently. Coping with staffing below contract and the Home Office are being tolerant"

[1] We were shown minutes of senior management team meetings for the period 26 January 2016 to 29 June 2017. We were told that subsequent SMT meetings had not been minuted.

"[HR report]: "MF updated that there had been little change from last month- busy with recruiting. Gave an update on DCO recruitment. Existing ITC to finish on 23 September. New ITC to start on 7th October"

25/10/16:

"[HR report]: "In HR this last month our main focus has been on DCO recruitment and ensuring all vetting for Oct ITC and Nov ITC. We have Assessment Day- 26 Oct for our Jan ITC. Retention is being looked at by [the former director] and [another manager]. Nov has 22 DCO staff on it as 1 lost due to not gaining [security clearance]".

8.7 Longer serving staff recalled staffing levels being a problem during 2016. One told us:

"…there were virtually two of us to a wing a day…I would write down the time [when my colleague had to leave the wing] and then whenever he got back write the time when he got back, because I was on my own for that time. These wouldn't come to minutes, these would come to hours, of being on your own,"

8.8 The on-site HR team records for those leaving employment at Brook House appear below. They confirm a significant increase in the number of staff leaving the Gatwick IRCs during 2016 and that staff turnover has remained high.

Year	Brook House	Tinsley House
2014	35 average 2.9 per month	12 average 1 per month
2015	43 average 3.5 per month	14 average 1.1 per month
2016	81 average 6.75 per month	41 average 3.4 per month
2017	75 average 6.25 per month	25 average 2 per month
2018 to end June 2018	50 average 8.3 per month	21 average 3.5 per month

8.9 The senior management team told us a number of events in early 2017 undermined efforts to keep staff and stabilise the staffing levels at Gatwick IRCs.

8.10 A new employment contract, developed in discussion with the staff union as part of a pay negotiation process, and signed off by G4S managers, came into effect at the beginning of 2017. It was a standard contract for all staff at Brook House and Tinsley House, apart from a few long-standing Tinsley House staff. Staff were assigned to work principally at either Tinsley House or Brook House, but they could be required to work at the other site if necessary. All staff were required to work a 46-hour week from 2 January 2017. This was a reduction of hours for the staff at Brook House but an increase for those contracted to work at Tinsley House. Shifts are 13.5 hours and staff work three days on, four days off, then four days on, three off. Once every eight weeks, they work seven nights on followed by seven days off.

8.11 Some staff said 13.5-hour shifts suited them because it allowed them to have more days' leave and working fewer longer days minimised their time and expense in getting to and from work. A DCM told us:

> *"They used to do shifts here and they did seven o'clock finishes and all that, … if I'm driving all this way, it suits me staying here as long as I can instead of coming in on more days. To me it used to be pointless coming in early and going home at lunchtime, so these shifts suit me from a personal point of view."*

8.12 Some staff told us how demanding and exhausting they found working such long shifts in such a challenging environment. Some said they did not think they were able to work as effectively and vigorously as they should towards the end of four consecutive days at work.

8.13 One DCO said:

> *"…if somebody worked 13 hours for four days, I would not expect that person to have the same energy on his or her fourth day of work."*

8.14 We asked staff what they thought of the 13.5-hour shift pattern. One DCO told us:

> *"I would have said that probably 60, 70 or even 80 per cent of the staff would prefer a shorter shift."*

8.15 Another said:

"…it would favour me to be here for longer, but it's sometimes not liveable, just the fatigue that you can have."

8.16 The former director explained the reason for the shift pattern:

"…we looked at shift patterns to look at whether there was anything we could do and we talked with the POA about what kind of shift patterns we could have, and the vast majority chose to remain with longer shifts."

"I think the difficulty around breaks comes with long shifts because if you have people working seven-and-a-half-hour or eight-hour shifts they don't have the same kind of need for a break within their shift, and you wouldn't need to incorporate that into your daily workings."

8.17 The length of shift was frequently mentioned as a reason for an employee's departure in the summaries of exit interviews. The former director confirmed this:

"Typically, it was shift work, the shifts issues that a rota pattern would throw up."

8.18 G4S senior managers told us that penalties for understaffing under the Brook House contract were higher than under the Tinsley House contract. This incentivised the staffing of Brook House which is the more challenging of the two centres and poses greater operational risk. Tinsley House staff were increasingly used to fill gaps in shifts at Brook House as staffing became more of a problem there.

8.19 Tinsley House staff did not welcome having to work in the more challenging, less settled and more daunting physical environment of Brook House and the increasing requirement for them to do so was a factor in further staff losses at Gatwick IRCs.

8.20 As the central detail manager put it:

"People got poisoned by other people if you like and said, 'well I don't have to go down there [Brook House]', and others would follow suit so there was a bit of an

uproar about that coming up to Brook House because Tinsley House is more laid back. People who want to stay there really the same money for lighter work…Less stressful job. So, trying to pull them up here was where the stress was coming from."

8.21 Towards the end of 2016 Tinsley House was refurbished and fewer staff were required to work there. This released more staff to work at Brook House for five to six months. The effect on Brook House of staff returning to work at Tinsley House was anticipated in a discussion at the senior management team meeting on 13 April 2017. The minutes record:

"[the former director] updated from the Trading Review the previous day about staffing levels whilst [Tinsley House] is shut. There is a need to manage staff expectations regarding staffing levels as staff will need to understand that it is not going to be understaffed on the wings but the normal level. Residential DCMs will need to prepare staff in advance. MB said that Residential need to be supported and supporting staff numbers on the wings. Suggested that some staff get taken off the wings in the afternoon so that staff get used to the impact of less staff."

8.22 Tinsley House fully reopened towards the end of April 2017 and staff at Brook House felt the effect of having fewer staff on their shifts. Managers told us this added to staff disaffection.

8.23 The head of Tinsley House told us:

"The numbers were low, but you had the buffer of the Tinsley staff, and for much longer than originally predicted, because the Tinsley refurbishment was meant to run from the August until just before Christmas and ended up going on until May. Therefore, for a much longer period staffing levels were, in the eyes of the staff, comfortable. They had people around them, they felt safe, and then we took the Tinsley staff away and mobilised the additional beds. We didn't even start the extra beds while the Tinsley staff were there, it came later."

8.24 The extra beds referred to were introduced in May 2017 after a request from the Home Office to increase by 60 the number of detainees who could be accommodated at Brook House. This was achieved by putting bunk beds in 60 rooms on the ground floors of

the wings. The central detail manager said the Home Office had agreed to pay for 17 extra members of staff to manage the extra detainees. The central detail manager told us:

> *"…when we expanded this place here the pro rata of or ration of detainees to staff should have gone up and it did by 17 people… We were getting paid for that and we were never filling it, never, never been filled."*

8.25 The central detail manager told us that G4S accountants had asked him whether money could be saved on the arrangements for the extra 60 detainees. He took this as a request to see if it would be possible to manage the centre with fewer than the agreed number of 17 extra staff.

8.26 The former director said he had not sought to save money by not recruiting the extra staff agreed as part of the terms of the increase in detainee numbers:

> *"Our aspiration was absolutely to fill those vacancies. There was never any instruction from me about holding posts. We were very clear about that."*

> *"There was an absolute determination to fill the posts. We weren't looking to hold any, but you know through the course of the year the ebb and flow of staff you will end up making a bit of money out of staff vacancies"*

8.27 Staff told us that having 60 more detainees in the centre made the place feel significantly more crowded and restless and made their work more demanding. A DCO, asked about the staff response to the additional beds, said:

> *"Negative. A hundred per cent negative. I think it's been proven correct."*
> *"… I mean, to go straight to the point from my view, is that the contractual requirement I don't think meets what's required to meet safety in the centre at Brook House."*

8.28 Minutes of the senior management team meetings up to the end of June 2017 reflect a continuing problem with retaining staff and the need for continuing large-scale recruitment:

9/02/17:

"5.5 leavers in January- some ITC leavers were due to shift patterns"

"[The former director] updates about staff engagement and staff retention -need to organize focus groups and ways to support staff"

"Vision - [The former director] asked for feedback on the new poster. DH said that 'a great place to work' might not resonate with staff and [the head of security] said it was a vison not where we are at the moment"

"[HR report]: Updated on recent assessment day-13 people. Running a further one in a couple of weeks. 5.5 leavers in January- some ITC leavers were due to shift patterns"

"ITC currently running and the next one will commence on 22/02/17. Anticipating 30-40 for the ITC commencing on 03/04/17"

13/4/17

"focus has been on recruitment during March"

"Next ITC commences on 05/06/17

03/05/17:

"[HR report]: "focus has been on recruitment during April

31/05/17;

"[HR report]: Focus has been on recruitment. ..23 to start the ITC commencing 5th June. 70 more applications to sift through and 50 will be invited to the assessment day in June".

8.29 We examined the shift detail records for Brook House during 2017. These show that daily staffing levels during the first half of 2017 were in the region of 32 DCOs but fewer staff were sometimes on duty. The former director told us:

> *"I would always expect that there would be a minimum of two people on a wing. I would not expect there to be any less than that, to have two. But I would expect there to be three, and at times four, depending on what's going on, what time of day it was… There would typically be one [DCM] for two wings.*
>
> *"…I wouldn't say that we settled for two on the wing. That was our minimum, and it would sometimes be as tight as that but it wasn't always."*
>
> *"I accept that staffing levels weren't always brilliant and at times were very tight. We were aware of that. We were not holding off on recruitment. We were trying to recruit as many people as we could so that we could get the numbers, but it is a complex situation to manage."*

8.30 Seven DCOs and three DCMs were dismissed as a result of the investigations into the behaviours of staff reported in the Panorama programme aired on 4 September 2017. As might be expected, the programmed undermined staff morale and led to further staff losses. The average daily number of DCOs on duty at Brook House appear from the records kept by the central detail team to have been in the region of 26 to 29 in the months after the Panorama programme. On some occasions there were only 24 DCOs in the centre. A manager described the staffing during September and October 2017 as *"dire"*.

8.31 From November 2017 to early January 2018, residential wings were closed on a rotating basis to allow for their refurbishment and for the fitting of inundation points. This meant a reduction in the detainee population. G4S senior management have told us that this also meant that under the terms of the contract with the Home Office, the daily staffing level was reduced during this period to 32 DCOs. Nevertheless, maintaining staffing levels continued to be a significant problem.

8.32 The central detail manager told us at the end of February 2018 he had been able to support Brook House staffing numbers with overtime from Tinsley House DCOs from November 2017. The records show that this alleviated pressures a little but average daily DCO numbers did not always reach 32.

8.33 More newly trained staff started work at the beginning of 2018 but staffing levels continued to fall because many people left. The spreadsheets the central detail managers maintained show the average daily figure for the number of Brook House staff deployed on each day shift during the early part of 2018 as follows:

- *"January 2018: 27.6*
- *February 2018: 25.39*
- *March 2018: 28"*

8.34 The central detail managers explained that these figures were supplemented by overtime work by Tinsley House staff. They also pointed out that Brook House was in quarantine for much of February 2018 because of a flu outbreak. The outbreak reduced the numbers of staff, but it also led to detainee numbers falling at one point to a little over 200.

8.35 As the interim director identified there needed to be at least three DCOs and one DCM on each of the main residential wings for most of the day to provide the care and security required. Staff told us in early 2018 that this level of staffing was being achieved for only about 60 per cent of the working day. They often found themselves working alongside only one colleague and sometimes they were on their own. On most days a single DCM managed two wings and was invariably called away to undertake duties elsewhere. Staff told us that a single DCO often had to manage two wings on their own during the night.

8.36 The G4S HR business partner at Gatwick IRCs told us on 13 March 2018 that the total complement of DCOs at Brook House should be 132 but resignations, suspensions, training and sickness meant that only 90 *"effective officers"* were available for deployment.

8.37 During our visits to Brook House, we usually found that three and sometimes four DCOs were rostered on each wing but escort duties, the need to staff open courtyards and other responsibilities, as well as last-minute staff sickness, meant that a wing sometimes had only two members of staff. One DCM was often covering two wings.

Recruitment and retention

8.38 In response to the continuing loss of staff and the need to maintain staffing levels, in November 2017 the interim director introduced a new overtime scheme. The scheme was designed to run until April 2018. Staff were offered the opportunity to commit to undertaking a weekly average of four, six, or eight hours of overtime. A bonus of £500, £1000, or £1500 was payable for reaching the levels of overtime committed to. We discussed the scheme with the central detail manager and the interim director. They said it had helped to alleviate some staffing difficulties. Ninety staff took part in the scheme and it delivered over 8000 staff hours. The scheme's one significant flaw was that it allowed staff to choose when they would work their overtime, so it did not address the problem of staffing Brook House at unsocial and unpopular times, especially weekends. The central detail manager tried to address this by limiting the overtime shifts made available to staff in order to encourage them into unsocial and weekend working but this had only limited effect.

8.39 The interim director devised a recruitment plan that provided for six initial training courses between 23 October 2017 and 15 June 2018 for 80 new recruits for Brook House (140 new recruits for Gatwick IRCs as a whole). The plan envisaged having enough new staff by mid-April 2018 and for all new recruits to become operational and available to meet the profiled requirements of Brook House and Tinsley House by 18 June 2018. The plan was based on an assumption of an average continuing loss of about six staff a month from Brook House and eight across the Gatwick IRCs. In the event however, the attrition rate was higher than this. It averaged 10 or 11 per month between November 2017 and March 2018. The interim director told us at the end of May 2018 that 112 DCOs had been recruited to Gatwick IRCs between September 2017 and May 2018 but the centre had lost 92. (Eighty-four had resigned and eight had been promoted).

The reasons for staff resignations

8.40 Nearly all the staff and managers we interviewed said low staffing had adversely affected the experience of working at Brook House and undermined staff morale, leading in turn to increases in sickness absence, problems with staff retention and further staffing difficulties.

8.41 DCOs said:

"If you have fewer staff in the wings then every single member of staff feels the hardness of the shift."

"There is not enough staff, the wrong staff in wrong places."

"I think they are slightly short of staff. They certainly have too many untrained or inexperienced staff in here, and they don't have enough experienced staff. They are still mixing people into different areas that they are not used to."

"The job's hard enough as it is and especially when you're short-staffed, you're expected to do two people's work and you're still expected to deal with everything else and some days it's just not physically possible."

"[the staffing level is] is the worst it has ever been. It is the worst I have seen it in the two-year period"

8.42 A manager told us:

"Until [the interim director] came here when we all agreed that 32 [DCOs on shift] was a bit low and people were getting left on wings on their own, there wasn't enough people to go round to give them their breaks and our TOIL [time off in lieu] forms were mounting up so high which reflected that…. They don't get their break they have to submit a signed form by their manager…because they are not getting what they are entitled."

8.43 Many of the DCOs we interviewed said the lack of staff and its effects on their experience of working at Brook House made them consider alternative employment.

8.44 Staff told us about the more obvious effects of not having adequate numbers of staff on duty, such as an increased and stressful workload and no opportunity to take breaks. Staff and managers referred to other issues, some interlinked, that contributed to the high attrition rate. Among these was the fact that they felt unsafe when manning wings with too few colleagues or even alone.

8.45 We asked a DCO how safe he thought Brook House was:

*"**A**. It's more unsafe, significantly, now, for most of it. Right now, it's the most unsafe it's ever been.*

***Q**. If one was safe and ten was …*

***A**. I can only imagine it's got to be a seven and an eight in terms of being unsafe, if ten was the most, I would say, at the moment. It's most unsafe by miles since I've been here. I was in here [in] the first six months or a year, because I was waiting for clearance, I wasn't a contact for my first six months here, and I know speaking to people at the time it was very challenging then as well. Very challenging. But I don't think it was as fundamentally unsafe. "*

8.46 Another DCO said:

"I don't feel safe working here anymore."

8.47 An experienced DCM said:

"Personally, I never felt unsafe. However, I could hear concerns and I could see why people were concerned. I had raised my concerns in meetings. I was at a different level at that point, so I had access and I had the ability to have a voice that could be heard, I raised concerns about what was going to happen when Tinsley did open and we had this loss of staff, but it almost seemed like 'We'll worry about that tomorrow'. It almost seemed that there always seemed to be something more important at that time."

8.48 Managers and staff suggested that the unease and insecurity some staff in Brook House felt was intensified by the high proportion of new and inexperienced staff being employed.

8.49 A DCO said:

"From Panorama, or just before Panorama, in the last nine months, you have lost about 200 to 300 years of experience from officers."

8.50 Another said:

"One of the problems is that you have new people, training new people".

8.51 We asked a DCO about the interim director's plans for improved staffing levels by April 2018:

"He was optimistic…. because they don't have the support and they don't have the standards of the old staff, or anyone there to support anybody, I think it will be hard to keep the new staff as well".

8.52 We asked the head of Tinsley House if she thought having new, younger staff affected the quality of work at Brook House:

"Yes, it does. It does, undoubtedly. You want a mix of staff. You want people with some life experience."

8.53 She explained:

"It can be very difficult. There are not the same control mechanisms within the immigration detention that there are in prisons, so you very much have to manage detainees with relationships and respect, and if you are going to do something for someone, actually doing it. I think some of that comes with experience. When you have new staff teaching new staff they don't have that experience, and I think sometimes I can totally understand why detainees become frustrated. If there is one thing I have learnt over the 14 years that I have worked in this field is to be completely honest with people. They might not like what you are telling them, but they will respect the fact that you are being honest."

"I think the way detainees can present at times, a lot of the time it is through frustration. Sometimes it is to deliberately try and intimidate, and I find that despite the fact that I am in civilian clothing, detainees quickly realise that I know what I am talking about. I think that is just because I am firm with them and I will say to them, "yes, the fax machine is broken, but that doesn't mean that you can go onto the wing next door. We need to resolve this issue. Can you step away from me, please, and keep your voice down. I am not shouting at you. I expect the same respect back from you." I think it is about challenging detainees, but in a way that

you would challenge anybody in the street who was shouting and hollering at you and getting too close."

8.54 The number of new and inexperienced staff appeared to have had an effect on both the more experienced staff, who talked about the added pressures of having to support new recruits, and on the newer staff who felt unsure about their role and responsibilities. They also felt unsupported and ill equipped to meet the demands of managing more challenging detainees.

8.55 A DCO said:

"…they have all new people, but for me personally, I am sorry that they are underaged. I think there should be a minimum age, because they don't have the life experience they need for [the] job… [new people are leaving] because they don't get the support which I personally had when I came here. I had older staff still…"

8.56 A DCM said:

"… we are replacing experienced officers with inexperienced officers – guys who have just come along, working in Tesco's for two years. They are young kids, somebody's son. I go on the wings now and I am looking at some of the officers and I am introducing myself and I don't know all of these people, and it is a wing full of new officers, and they are training, and I wonder, what's going on here?"

8.57 Another DCM said:

"you just get an influx of new staff coming in, put them onto the wings, challenging roles, and then they haven't got experienced people to show them how they're doing, so basically they're teaching themselves. You've got wing staff, wing managers there but you can't be here, there and everywhere at once."

8.58 Another DCM said:

"Recently we had a lot of experienced staff leave and we have a lot of new starters in at the moment. The problem we've had is that you've got some quite new officers teaching our new officers, which is a bit of a problem……"

8.59 Detainees told us they too had felt the effect of so many new and inexperienced staff. Detainees told us during one focus group that staff evidently lacked training and experience. One detainee said:

> *"…most DCOs are kids, younger than us…"*

8.60 He said he had had to tell a new DCO where to find the store for footballs and activities equipment. Other detainees told us that new DCOs did not follow correct search procedures and that detainees had to explain the rules. Detainees told us that DCOs lacked the people skills, the communication skills and the patience that were essential for the environment they worked in.

8.61 A number of interviewees said the pay for DCOs (£25,500 a year) for a challenging, sometimes highly stressful and occasionally physically dangerous job was inadequate, especially given the many other employment opportunities on offer locally, including at Gatwick Airport. The minutes of the senior management team meetings show that In June 2017 the SMT discussed the fact that new recruits were being sought for HM Prisons at a starting salary of £30,000.

8.62 The managing director of G4S Custodial and Detention Services acknowledged that the DCO salary at Gatwick IRCs was less likely to appeal to more experienced people. Younger staff who came to work there were likely to be more mobile and less inclined to stay for long:

> *"…we are seeing a younger staff group with very different standards of approach to employment, to be absolutely honest about it…*
>
> *"This group of people have mortgages less than we used to in the past, and, therefore, they are more transient because they are paying rent and not mortgages."*

8.63 G4S does not offer a bonus for long service and has no arrangement for pay rises. One member of staff said he had been given only a pen after five years of service. He ruefully remarked:

"It's blue so you can't even use it at work because it's black pens in here…..It was just a basic pen that said 'G4S' on it"

8.64 Another long-serving DCO said:

"I've been here a while and the incentive for you to stay is the fact that you enjoy your job, that's my perks basically. Your pay is the same as someone who has just started on day one. Your experience counts for nothing, but it counts for a lot of the work if they need something."

8.65 The head of Tinsley House said working at Brook House, with the need to manage and sometimes challenge the behaviours of the more difficult detainees requires particular personal qualities and skills, including resilience and confidence. These qualities are more likely to be developed over time and with experience. For this reason, we believe it is particularly important to retain experienced staff at Brook House. We believe G4S must ensure that the remuneration and rewards offered to DCOs incentivises experienced staff to stay.

8.66 We have already noted that many staff who left Brook House cited the long shifts and shift patterns as their reason. The current 13.5-hour shift pattern, and the requirement to work night shifts, may be popular with many staff because they allow staff to minimise their travel time and expense and allow for longer periods off work, but they are likely to be unattractive to many potential employees, especially those with family and caring responsibilities. The shift pattern also adds inflexibility to the way Brook House is run. It does not allow for extra staff to be in the centre when it is particularly busy.

8.67 The interim director told us he too thought that staff pay and shift patterns at Gatwick needed to be reconsidered as part of the response to current staffing problems.

8.68 We found that that staff retention had been affected by new employees not being adequately prepared for working at Brook House. We deal with this from paragraph 8.92 below. We also found that staff satisfaction and staff retention had been eroded by weak management arrangements and practices resulting in staff feeling unsupported and unvalued. We dealt with these matters in chapter 7.

8.69 We believe there is a need for a comprehensive review of all the matters we have referred to affecting staff retention at Brook House, particularly remuneration, shift patterns and working hours. G4S needs to develop plans for addressing these matters.

8.70 One former employee summed up the feelings of many:

> *"…G4S is a service-based business, so it's the employees who make a difference… therefore, more investment in people would serve G4S better if it wanted to adopt a longer-term strategy for success."*

Recommendations

R6 The SMT should urgently ensure that Brook House is fully staffed.

R7 G4S managers should undertake a comprehensive review of matters affecting staff retention at Brook House including remuneration, shift patterns and working hours and G4S needs to develop plans to address the matters arising from such a review.

The effects of low staffing and the failure to retain staff

8.71 We found that the lack of staff and the failure to retain staff had a profound and detrimental impact on many aspects of life at Brook House for detainees, managers and staff. The staffing problems compromised the care and management of detainees. Managers and staff told us about problems in managing their workload, in ensuring that procedures designed to ensure the wellbeing of detainees were consistently adhered to and in delivering an appropriate regime. Detainees told us about the adverse effects of staff shortages on their lives. They gave examples: courtyards closed, limiting their access to fresh air; the limited activities available; the fact that officers were not able to react quickly to break up fights; and that officers did not have time to talk to them about their concerns, their mental health and other matters affecting their wellbeing. We deal in more detail in other sections of this report with the effects of staffing problems at Brook House.

Staff training

8.72 All new DCO recruits at Brook House undertake an eight-week initial training course (ITC). It begins with a six-week classroom-based course. DCOs who are assessed as having passed this phase of the ITC and who have Home Office security clearance to work as a DCO spend one week working in the IRC shadowing experienced members of staff. This is followed by one week working in the centre with support from a more experienced member of staff.

8.73 The Home Office prescribes some of the course content of the ITC. The course includes a day of training in safeguarding; half a day's training on mental health; a day of training on safer custody including the assessment, care in detention and teamwork (ACDT) process under which staff monitor and intervene to prevent suicide and self-harm by detainees; a week learning about the physical control and restraint of detainees; and two days security training.

8.74 The head of learning and development for G4S's Care and Justice Services said that she did some work when she took up her post in May 2017 to ensure greater consistency of training across the IRCs and the prisons managed by G4S and to ensure that the ITC incorporated elements that reflected G4S's own requirements and priorities. This led to an increase in training in inter-personal skills and how staff should interact with detainees. Training in these matters now accounts for three full days of the ITC.

8.75 Six ITC courses ran between September 2017 and April 2018 under the interim director's recruitment plan. The Gatwick IRCs' training manager told us that three ITC courses took place a year before September 2017. We interviewed the training manager in January 2018. He told us he had no staff to support him for seven months from April 2017 and it had been difficult to cope with his workload. However, a support officer and a training administrator were appointed in November 2017.

8.76 We spoke to new recruits undertaking the ITC. They told us that instructors were asking them questions and assessing them as they went along and that they were set homework on which they were tested. We heard of recruits who had not passed the ITC, suggesting some rigour in the training process. However, we had cause to question the quality and content of some of the training offered to new recruits on the ITC and to staff as refresher training.

The quality of training

8.77 Most training at Gatwick IRCs is undertaken by the training manager. He holds a 'train the trainer' qualification. Managers at Gatwick IRCs deliver other training. Not all those delivering the ITC and refresher courses were appropriately qualified. For example, the violence reduction manager who delivered the training in safeguarding, suicide and self-harm, violence and bullying reduction, and mental health told us that, while he is an accredited ACDT trainer, he had no specific safeguarding training (other, we assume, than that received on his own initial training course) and he had not had time to read the Gatwick IRCs current safeguarding policy. He also told us he had not had training in mental health. He had acted up as the head of safeguarding at Gatwick IRCs between June 2017 and December 2017.

8.78 Managers told us that there had been contact with the local safeguarding adults board with a view to the violence reduction manager and the equality and diversity manager, who also delivers safeguarding training, going on a safeguarding 'train the trainer' course.

8.79 The practice manager employed by G4S Health Services to manage healthcare at Gatwick IRCs told us he thought the fact that the mental health training of DCOs at Gatwick IRCs was undertaken by managers without specialist mental health training and without training qualifications was *"wholly inappropriate"*. We agree.

8.80 The head of support services at Gatwick IRCs told us however that, one-off mental health first-aid training would be given to all operational staff by an independent training company, starting with a course in March 2018.

8.81 Our own direct experience of training at Gatwick IRCs also caused us to question its quality. We undertook personal protection training as part of a group that included recruits on an ITC and Home Office staff working at Gatwick IRCs. Our training was part of the process under which we were authorised to draw keys and allowed to enter and move about Brook House unaccompanied. The training was delivered by a control and restraint (C and R) instructor employed at Gatwick IRCs and an instructor from a prison managed by G4S. The training session began with a PowerPoint presentation on the legal and other considerations that underpin the correct use of force in personal protection. The trainers

were not always confident or comfortable in their understanding of the material. On a number of occasions, they referred to material and put up slides containing information that they acknowledged was out of date. At times they appeared dismissive of the rules that those using physical force on others must observe. The materials, and the instructors, made frequent reference to prisons and prisoners.

8.82 We heard about another personal protection training session whose tone and content had given rise to serious concerns. It took place on 22 February 2018. One of the two trainers at the event had delivered our session. The other was a C and R instructor seconded from a G4S-managed prison. Attendees included Home Office staff and staff employed by Hibiscus, a charity that provides welfare services to women held in the pre-departure accommodation at Tinsley House. The Hibiscus staff compiled a report on their concerns about how the instructors had conducted themselves and the training session. They said instructors had frequently referred to detainees as prisoners and to Brook House as a prison; had dismissed officers' legal obligations to adhere to a duty of care when using physical force on detainees as being included in legislation to *"fluff it up"*; had encouraged the use of swearing, aggression and violence in dealing with detainees; and had suggested that de-escalation techniques were ineffective.

8.83 We interviewed the Hibiscus staff. They told us:

> *"They did say that it was the same training for a detention centre as a prison, but the way it had been worded, it said the word "prison" rather than "detention centre", so they said it would be the same, it just had the word "prison" in it; but they were dismissing chunks of it, saying, this is going to be changed anyway, so almost like, ignore that bit, this is all being changed."*
>
> *"I think they were confident in the sense that they didn't mind telling us bits of it weren't relevant, like the Duty of Care thing, that was there to "fluff it up" – … "[what] Most shocked me? Punching them one more time for luck, being told that, or that they would never actually do the punch that is in the syllabus, but they have to show us, and then them both agreeing that they would never actually do that punch, because it's not effective……*
>
> ***Q.*** *So, what would they suggest you do?*
>
> ***A*** *Punch in the face.*
>
> ***Q.*** *And did they suggest that that wasn't in anybody's syllabus?*

A Yes……"

"We did query one thing, when [the Brook House C and R instructor] was giving an example of when one of his female colleagues had had a detainee put his hand on her shoulder, and he told us the response that the woman gave the detainee, and it had lots of effing and blinding in it, and I said 'why could she not just say, please don't touch me, you're not allowed to touch me', in a polite way; and then the group sort of said 'but you can't talk to them like that, they're murderers, they're paedophiles'…. 'so, you can't talk to them normally'. There was agreement from that group as well."

8.84 An investigation by G4S of the complaints of the Hibiscus staff resulted in both trainers being dismissed. This episode also raises questions about the attitudes and culture among some staff at Brook House, which we discuss in chapter 13.

8.85 The training manager at Gatwick IRCs told us that no quality assurance was undertaken in respect of the delivery of training sessions at Gatwick. The head of learning and development G4S Care and Justice told us:

"We go through an annual BTEC audit on a yearly basis to make sure that not only the learner case work that is produced meets the standard, but also our content of the ITC meets the standard as well.

Q. But do you do things like actually sitting in on the training….
A. That is not part of my responsibility because I cover such a wide area. It is something that I have suggested in the past and it is something that I am suggesting as part of the Improvement Board.

Q. Whose responsibility would that be? Would that be with each of the managers?
A. The responsibility for Custody and Detention I would say would sit with ExCom to decide that is appropriate to do quality assurance of training facilitators, and the directors as well themselves to sit in on training, to make sure that it is fit and appropriate for their needs. I have suggested it needs to be co-ordinated and monitored independently of site level so that it gives complete impartial overview of training.

Q. I can see how you can remotely audit the paperwork that comes out, and what is in the standard packs, but the personal delivery is very important.

A. Yes, and there is absolutely a need for quality assurance to be in place, particularly when you look at the package and the style of how that is being delivered. There are locally facilitators that are facilitating packages as well. My recommendations in the past have been that we need to do something around making sure that we are quality assuring their facilitation, so something along the lines of train the trainer and also to make sure that behaviours, presentation and content is all measured as part of that.

Q. It hasn't been taken up yet?

A. It is being looked at as part of the ongoing ITC review that started in October, and that does cover all of the custodial and detention sites, but it is not something that is in place at the moment."

8.86 The deputy director at Brook House bought video recording equipment in response to what happened in the personal protection training session on 22 February 2018. He told us it would be used to record future personal protection and C and R training. The interim director suggested that all classroom teaching should be recorded in future.

8.87 We think regular and systematic evaluation and quality assurance of the training provided at Gatwick IRCs should take place to ensure that staff receive training of a consistently high standard, that it meets the operational needs of the IRCs, trains and develops staff appropriately and promotes appropriate values.

8.88 Recording training sessions may deter trainers from exhibiting inappropriate behaviours and attitudes but the assessment of the overall quality and efficacy of training demands a more comprehensive suite of tools, including face-to-face observation of training sessions, feedback in writing and in discussion with attendees.

Recommendations

R8 The SMT must ensure that all trainers are appropriately trained in the subject on which they deliver training and in how to deliver training.

R9 The SMT and G4S managers should undertake regular and systematic evaluation and quality assurance of the training provided at Gatwick IRCs to ensure that staff receive training of a consistently high standard; that it meets the operational needs of the IRCs, trains and develops staff appropriately and promotes appropriate values.

R10 The SMT should undertake unannounced observation of training sessions as part of the evaluation and quality assurance of training.

The content of the initial training course

8.89 The learning and development function for G4S Care and Justice undertook a training needs analysis at Gatwick IRCs as part of the action plan in response to the Panorama programme. It identified a need to review the content of the ITC. The head of learning and development G4S Care and Justice told us that the ITC needed to better reflect the requirements of an IRC as opposed to a prison and to include specific IRC-based case studies. She told us:

> *"The material is Crown owned, it is actually prison service material. What we have started to do as part of my role from May [2017] is that I appointed a Head of Capability, … and he also works across Care and Justice services, and I have tasked [him] with linking in with HMPPS in order to raise this issue with them about how we can change their materials to refer to detention and also to refer to secure training centres, because the material is not just delivered into G4S, it is also delivered into* [redacted] *and continues in the same theme. I have picked up exactly what you are saying that the language is inappropriate for use across all of our sites."*

8.90 We examined the training materials for the ITC delivered at Gatwick IRCs and the terms 'prison(s)' or 'prisoner(s)' occur 253 times.

8.91 Staff we interviewed agreed the ITC needed to better reflect the experience of working in an IRC and to include IRC scenario-based training. They told us that their training had been based on handouts and PowerPoint, which had not been engaging and had not prepared them well for situations they would encounter at Brook House.

8.92 The head of support services, responsible for staff training at Gatwick IRCs, told us that the ITC review was completed by the end of November 2017 and had led to the incorporation of more scenario-based training and a greater emphasis on the daily operations of the centres.

8.93 Brook House has a noisy, restless, and oppressive atmosphere, with large numbers of men, often in groups, wandering about in confined spaces. Staff and managers told us that new staff were ill prepared for this environment and that this led to many staff leaving soon after joining. Staff and managers told us the only way new recruits could be made to appreciate the unique environment at Brook House was by experiencing it. We agree with this view. The head of Tinsley House said:

> *"I think it is very difficult to prepare someone for the DCO role, particularly at Brook House. I always say to people that if you take a job as a waiter or a waitress in a restaurant you know what you are getting yourself into because you have been there as a customer. Immigration and detention is a very closed environment and you won't have experienced it unless you have worked in this field. We have talked about trying to get staff cleared earlier in the process so that day one can be a walk around the centres and get a feel for it, because Brook House is ostensibly a prison. It is built like a prison - it is prison wings. I think the whole environment that that brings, the acoustics, the noise, the numbers can be really overwhelming for people who haven't experienced it before.*
>
> *"I think they have a fairly comfortable training course where it is office hours and it's away from the detainees. It is in the classroom, or in the dōjō [gym] if they are doing control and restraint, and then off they go into the residential wings at Brook. I did 18 months on res at Colnbrook. It can be very difficult. There are not the same control mechanisms within the immigration detention that there are in prisons, so you very much have to manage detainees with relationships and respect, and if you are going to do something for someone, actually doing it. I think some of that comes with experience."*

8.94 A DCO said:

"We've got training in the ITC and the only frustrating part of it is because it involves seven of the eight weeks sitting in a classroom. You have no insight into what is going on, until you come over here. Two out of 20 might walk in straightaway on their first day, and you can hear them saying, 'Let's just go. We're not doing that.' It prepares you as much as it can, but you don't really know what will happen once you hit the other side."

8.95 Managers told us that some years ago the Home Office had allowed trainee staff at Gatwick IRCs, even before they had passed the six weeks classroom-based part of the ITC and had Home Office clearance, to spend time in the centres, but they no longer did. The head of learning and development G4S Care and Justice said she was concerned about the need to get new staff to understand the environment in an IRC at an earlier stage in their training. She said she had discussed the matter with centre directors but left it up to them to progress matters with the Home Office. We learned that at some point in 2015 or 2016 G4S managers considered providing staff with virtual film access to the centre but nothing came of this idea. It had also been suggested by managers at Gatwick IRCs that people on the ITC might spend time in the control room, but nothing came of that either. Staff told us that viewing the centre from the control room would not give a true impression of Brook House, not least because it did not pick up on the shouting, the noise and general sense of commotion.

8.96 The head of learning and development G4S Care and Justice said that G4S had made better progress with HM Prison Service on the access that new recruits were given to prisons. They can shadow throughout their initial training.

8.97 The Home Office area manager for Gatwick IRCs told us he supported the need for staff in training to be given access to Brook House and said he had suggested to the interim director that this was needed. But the interim director told us he had concerns that senior Home Office managers and legal advisers would not sanction visits by trainees without security clearance. We were told however that trainees at Heathrow IRCs are allowed to have one escorted visit into the centre which might occur even when detainees are not locked in their rooms.

8.98 Trainees at Heathrow IRCs are also shown footage of incidents filmed on body cameras. This gives them an insight into some of the more difficult incidents they might

have to manage. We believe that this ought to be introduced to the training programme at Gatwick IRCs.

8.99 The loss of staff early in their employment wastes the time and expense that they and G4S have invested in their training. It is also poor practice not to provide potential new staff with a full picture of the environment in which they will be required to work, the demands that will be made upon them and to give them the chance to assess their suitability for the work as early as possible.

8.100 We are concerned about the lack of clarity in the senior management team and G4S centrally about where responsibility for solving this problem lies and the lack of progress in respect of it.

8.101 G4S senior managers should take responsibility for discussing this further with the Home Office with a view to finding ways that recruits in training can be given early and regular opportunities to experience the environment at times when detainees are at large in Brook House.

Recommendations

R11 G4S managers should agree with the Home Office ways that recruits in training can be given early and regular opportunities to experience the environment at times when the detainees are at large in Brook House.

R12 The SMT should consider giving trainees the opportunity to view body camera images of incidents recorded at Brook House.

Refresher and further training

8.102 Staff at Brook House receive annual refresher training in safer community matters (suicide and self-harm prevention, violence reduction), security, fire, equality and diversity, control and restraint.

8.103 The training manager at Gatwick IRCs told us in January 2018 that only 72 per cent of staff were up to date with their refresher training; the remaining 28 per cent were overdue. The training manager said this was largely because of staff pressures which meant that staff could not be released from operational duties. He had also had difficulties in organising training because he had been working alone without support staff.

8.104 We heard from some staff that their refresher training was significantly out of date. Two DCOs told us that apart from C and R training they had not had refresher training in the past two years. One told us:

> *"We had the yearly staff refresher, but I don't think I've had one of those for two years… It's supposed to be a yearly staff refresher. It goes through diversity and things like that… I think the one that I was supposed to be on was cancelled due to staff shortages."*

8.105 All DCMs should receive annual refresher training in ACDT (the care of detainees at risk of harm) case management but the manager who delivered the training told us that only two DCMs had received it since the beginning of 2017.

8.106 Some staff told us they had been working in Brook House without the control and restraint refresher training that is a strict condition of Home Office DCO accreditation. The interim director acknowledged that between September and December 2017 staff pressures and the lack of C and R trainers had meant he had had to obtain the agreement of the Home Office manager at Gatwick IRCs for 20 staff, whose C and R training had lapsed, to operate as DCOs for periods of about a month. The interim director told us that senior central Home Office managers had later withdrawn this agreement.

8.107 Annual refresher training helps to ensure that staff are properly equipped and feel confident to undertake their role. It also offers some assurance that staff will perform their role in accordance with policies and procedures and that detainees will be properly cared for. It is important that all staff receive annual refresher training in a timely way.

Recommendation

R13 G4S and the SMT should ensure that all staff receive annual refresher training in a timely way.

8.108 Staff told us they felt they needed to be better trained in some subjects. Staff on E wing, which accommodates detainees with more challenging mental health issues and other vulnerabilities, spoke of their need for further, more specialised mental health training than that which they had received as part of the ITC. One DCO told us:

> *"For me, mental health is a big issue sometimes and I have raised it with my line manager as well. We receive all our mental health training in a day, but I don't think that covers it…It doesn't cover it, so they have another course starting now where we are trying to get more mental health training – especially working down on E wing. I think they need to go into the specifics a little more…*
>
> *We deal with the situation when they come to us but, sometimes, I think the mental health training should be more intense."*

8.109 The head of support services at Gatwick IRCs told us that mental health first-aid training would be given to those on ITCs and, on a one-off basis, to operational staff during 2018. The training would be delivered by an independent company. It is not clear to us that this training will be adequate for officers on E wing who regularly work with detainees with more challenging mental health problems. The senior nurse at Gatwick IRCs said that officers *"are very good"* at dealing with detainees with mental health problems despite their limited training but she thought having a small number of officers with more advanced knowledge would help.

8.110 Staff on E wing also spoke of the need for training on managing drugs and other substance misuse. One DCO said:

> *"Healthcare are not there on E wing 24/7 and so we have to deal with the situation. I don't know when someone is withdrawing, when the point is to call healthcare down. Yes, he starts shaking, but how much can he shake before he goes to the next*

steps? He might end up in shock, but I have no idea…I am first aid trained, yes, but do we really want to let it come to that?"

8.111 Staff complained that they had not been offered training identified as a need in their EDRs or that they had asked for.

8.112 One officer told us about a lack of instructors and the lack of staff to cover for those who were supposed to be undergoing training:

A. *At the moment, nobody really supports you. I need to do the C and R training, and they are trying to push me as hard as they can. I have an assessment day on the 27th, but nobody has given me the training because they couldn't facilitate training.*

Q. *Do you mean to be an instructor?*

A. *Yes. I have an assessment on 27th, but they have one C and R instructor who is now there Monday to Friday, so he won't be there every day when I am working. He doesn't have the time to sit down with me and go through things. I feel as though they are setting me up to fail because they are not giving me the time off the wing to do the training, but they expect me to do it and to sail through that."*

8.113 We were concerned to learn that staff did not receive safeguarding refresher training. The head of support services told us this would be addressed during 2018.

8.114 The training needs analysis undertaken after the Panorama programme by the G4S UK and Ireland division's learning and development team also identified the fact that training needs identified in individual EDRs were not being fed into the Gatwick IRCs training plan. It recommended:

"Training needs to be identified from other forums throughout the year and fed into a learning forum quarterly so that the centre training plan can be updated proactively to reflect priority training needs."

8.115 The training needs analysis also recommended that the centre *"produce a more proactive training plan incorporating new training needs rather than just focus on ITC and statutory and mandatory refresher training each year"* and that this was to be part of a new plan for 2018. The head of support services at Gatwick IRCs told us that a learning

forum in November 2017 had discussed the 2018 training plan and that it *"included some development training outside of statutory and mandatory training."*

8.116 The evidence suggests that Gatwick IRCs have more to do to better establish the training requirements of existing staff and what should be the subject of refresher training or further specialised training for individual staff or groups of staff.

Recommendations

R14 Managers at Gatwick IRCs should undertake a full review of the training needs of existing staff, including needs identified in individual EDRs, and should ensure that the annual refresher training programme and specialist further training meet those needs.

R15 The SMT should ensure that staff dealing regularly with detainees with mental health problems or with drugs or other substance misuse issues receive specialist training.

Appraisal and development

8.117 As we discuss in chapter 7, there has, for some time, been a lack of capable front-line management at Brook House. One consequence has been a failure to implement the agreed appraisal process. A number of staff told us that they had not had an EDR since 2016. Others had not had their end of probation review. Some staff did not know who their line manager was. A DCM told us:

> *"Some of them [DCOs] don't know who their line manager is, which is terrible. I don't know who I'm line managing, and if I don't know who I'm line managing, how are they going to know?"*

8.118 Staff who had had an EDR with their line manager often said that it had not been meaningful or productive. One member of staff told us his line manager worked on different shifts, that he rarely saw the manager and that the most recent EDR had taken place at a snatched and perfunctory meeting. DCMs told us that their workload meant they had had difficulty in finding time to undertake EDRs. We heard from two sources of the case of a more senior manager who was pressed by a member of staff he line managed for an EDR.

He cut and pasted the EDR form of another person he line managed but failed to change the name of the subject. This suggested that senior managers did not sufficiently champion or reinforce the EDR process.

8.119 One cause of complaint by staff about the EDR process was that training they wanted or needed and had agreed with their line managers had not been delivered. This accords with the training needs analysis referred to above which suggested the need for training needs identified in EDRs to be fed into Gatwick IRCs' training plan.

8.120 The appraisal and development process for staff at Brook House was not effective. This contributed to staff feeling undervalued and unsupported. It may also have meant that disaffection or poor performance, and inappropriate behaviours and attitudes went unchecked. The failings in the appraisal and development processes are matters that DCMs should be trained to address and held to account for.

Recommendation

R16 The SMT and DCMs at Brook House must ensure that all staff are subject to an effective annual appraisal process that results in identifying and addressing training and other developmental needs.

9. The environment, facilities, activities and food

Brook House and its facilities

9.1 Brook House is built to the security standard of a category B prison. It comprises three separate buildings. A visitors' centre, a gatehouse and the main accommodation building. The gatehouse includes the staff entrance, staff cloakroom and locker facilities, the control room, the main boardroom, staff training rooms and other administrative offices.

9.2 The main residential wings in the accommodation building are of traditional prison design with rooms opening onto landings accessed by central metal staircases. The four main residential wings are called Arun, Beck, Clyde and Dove but invariably referred to as A, B, C and D. A, C and D wings have three landings. B wing, designated as the induction wing, has two. Below B wing is a separate single storey wing, Eden or E wing, used to house more vulnerable, disturbed or challenging detainees and detainees with medical conditions or mobility problems. The care and separation unit (CSU) at the far end of E wing, beyond a locked door and gate, is used to house detainees subject to removal from association or temporary confinement.

9.3 On the ground floor of each wing are a wing office, a food servery, and seats and tables that are fixed to the floor. The upper floors of the main residential wings have rows of shower stalls. Each wing has a laundry room.

9.4 Main wings have a pool table and a table tennis table. Each wing has a microwave oven for use by detainees. Fridges had been bought some time ago for the use of detainees, but these had not been installed at the time of writing.

9.5 The main accommodation building has four small courtyards. One has been laid with artificial grass as a garden with benches. The other courtyards are hard-surfaced and used for sports and games.

9.6 The operational capacity of Brook House was 448 but in May 2017, after an agreement between G4S and Home Office Immigration and Enforcement (HOIE), the operational capacity increased by 60 to 508. This was achieved by replacing one of the two

single beds in 60 rooms with a bunk bed. All other rooms, apart from CSU rooms, which are single occupancy, have two beds.

9.7 Apart from the bunk beds mentioned above, beds are built into the rooms and have a lockable storage space underneath them. Rooms are fitted with a washbasin and a lavatory screened by a wall and a curtain. Other than in the CSU, rooms have a built-in desk and shelf unit, a wall mounted television and a kettle. Windows are designed to be sealed shut and there is a centrally controlled ventilation system.

9.8 A corridor block runs between the two parts of the main building that house the residential wings. It houses offices, the healthcare centre and detainee and staff facilities. Facilities for use by detainees include a chapel and a mosque, a multi-faith room and a quiet room. There is also an arts and crafts room, a music room, a class room, two IT rooms, a library, a gym with 21 fixed pieces of equipment, a shop, a cinema room and a barber's room.

9.9 Most of these facilities are housed in rooms that can comfortably accommodate no more than about 25 people. The only larger space that can be made accessible to detainees is the visits hall. There is no sports hall. Christian Sunday services and Muslim Friday prayers are held in the visits hall because the chapel and the mosque are not big enough to accommodate all who want to attend.

9.10 One of the arts and crafts teachers told us it was sometimes difficult to find room for all the detainees who wanted to use the arts and crafts room. It measures 8 metres by 6 metres, with a large painting table and storage taking up most of the space. The one classroom was crowded at times. The lack of seating and tables in the communal areas on wings meant that most detainees ate in their rooms. Detainees used the library to play board and card games because it has the only suitable large table. The lack of seating meant detainees often sat on the floor in corridors and other communal spaces.

9.11 Brook House was never at full capacity while we were there but we nevertheless had an overwhelming impression of it as overcrowded and unsettled. We saw large numbers of mostly young men roaming aimlessly about the centre, barging past each other in narrow corridors and staircases and jostling for space in cramped communal rooms and the small outside courtyards. The overcrowding and sense of tension created were exacerbated by there being corridors, to which detainees do not have access, across the main building on

the ground and second floors. This obliged detainees who wanted to get to the other side of the building to pass through the corridor and facilities on the first floor, which was a significant bottleneck.

9.12 Doors to wings were locked and only the residents on a wing were allowed access to it. Detainees had to show their ID card to the officer who unlocked the wing door. We noticed that queues built up at the entrances to wings and detainees continually banged on wing doors and shouted in order to attract the attention of an officer. This noise could be heard throughout the residential wings and beyond. In chapter 12, we consider further the problems associated with the locked wing doors.

Activities

Staffing

9.13 The provision of activities and entertainment for detainees at Brook House was limited not only by the lack of space. It was under-resourced, poorly managed and further compromised by long-standing staffing problems.

9.14 Many staff praised the enthusiasm of the [redacted] and the full activities and entertainments programme in place during his time at Brook House. A member of the senior management team told us:

> *"[redacted] was really passionate about it…*
>
> *"You can't buy that kind of enthusiasm… His staff really liked working for [him] as well. I wouldn't question his ability to put on activities and for staff to work with him."*

9.15 The [redacted] told us that initially he had had a team of five DCOs to help with activities and entertainments. They had all undertaken a YMCA gym instructor's course and an activities course.

9.16 The [redacted] and his team put on daily football, cricket or basketball games in a courtyard and regular wing-based table football and table tennis

competitions. There was a cookery prize based on the meals cooked in the cultural kitchen. Small cash prizes were awarded, and the competitions were popular. A regular programme of evening entertainments included quizzes, karaoke sessions and bingo. A wide range of religious and other cultural events, such as Black History month, were celebrated. Special events were put on. These included a 'Brook House Got Talent' event. There was a games room for chess and other board games. This later became the cinema room. The cultural kitchen was open every afternoon. Detainees could book a session to cook food to share with up to seven friends.

9.17 The [redacted] told us that from late 2016 the [redacted] began to remove members of staff from the activities team for other duties and began to question the expense of providing the activities and entertainments programme. The former director told us:

> *"I think activities are often the first thing to go sometimes. I think if you are short-staffed you are prioritising some of the core and the contract, and activities and regime would be something that would go sometimes…"*

9.18 [redacted]. The DCM who replaced [redacted] was in post for only a short time before he went on sick leave. Brook House effectively had no substantive activities manager between June 2017 and the end of January 2018.

9.19 The [redacted] told us he had no training for the role other than a chat with the deputy director and the residential manager. He told us:

> *"Yes, there was nobody to shadow. I did sit down with [the residential manager] and try to go through bits, and [the deputy director] I sat down with a bit, and he pretty much said "It's your thing to run with", try to get something going". I tried to implement things, but then I am finding out now that people are like "There are inventory checks" and stuff like that, and it is security is saying "Where are these checks? You should be doing these", whatever and I was like "Nobody ever told me that". I will do it…"*

9.20 We asked [redacted] whether he had had spoken with [redacted] about how he fulfilled the role:

"Briefly. I haven't really seen [redacted] *that much. I looked through, because a lot of the stuff is saved on the computer still, I went through that to get an idea and obviously [a DCO] is still in activities, she started it and she is still in activities. I sat down with her and had an idea of what we used to run."*

9.21 The activities team consisted of only four DCOs in late 2017 and early 2018, meaning two were on duty most days. None of them had any special training for their role. Two more DCOs were assigned to the activities team in April 2018 but staff shortages elsewhere in the centre meant there were often only two DCOs working in activities on a given day.

9.22 G4S's contract with the Home Office requires the daily opening of the IT rooms and the library. The activities DCOs were used to run these facilities and a DCO was rarely available to act as sports officer to organise and supervise sporting and other events.

9.23 The [redacted] told us:

"Because we need somebody to man the library and IT, it pretty much takes everyone away from doing any other activity. They have a sports officer as well, but at the start [of the day] you have a sports officer, but they get called to do other things, and that is a problem I have had with people covering activities who aren't used to covering activities." …

"Again, it is just having enough staff at the time. I have covered the library and IT, but it is difficult planning activities well in advance, because I don't know. I am not 100 per cent confident that if I put on activities, a couple a day, there is going to be staff to put it on…[if staff are required for other duties]… you tell people the activity is going on and it doesn't happen"

9.24 A member of the senior management team said:

"I think there's always been a culture that activity staff is the first to go. If there's an escort, you will take your activity staff, if something else needs covering, you dip out the activity support; that's fairly common here."

9.25 One of the activities DCOs told us:

"The problem in activities is more or less about maintaining the staff, maintaining the correct set of activities, so that you can say, 'Okay, these are the activities and they are not going to be moved anywhere. They are basically based there for activities.' I think that is the problem, because if that was happening then there would be consistency in activities."

The provision of activities

9.26 The [redacted] drew up a programme of activities he hoped to deliver. It included a daily game of football or cricket and an evening programme of bingo, a film or an X-Box session. He conceded that delivery of the programme was patchy because of the lack of staff. He told us that he had been thinking about a programme of competitions but had not wanted to begin it and ask for participants without being certain he would have the staff to deliver it. The [redacted] also complained that it took a long time to get new equipment because it had to be ordered through the finance team.

9.27 Detainees spoke to us about the fact that there was not enough to occupy their time:

"There are no activities at weekend so weekends are particularly boring"
"There are no real activities. Nothing gets done in activities"
"Most detainees' only entertainment is to watch TV in their room"
"Free weights have been taken away from the gym for health and safety reasons. Gym equipment takes too long to repair"
"There hasn't been any football in the centre for at least a week. All the balls are stuck in the wire fencing. Many [detainees have asked] that staff get a ladder and bring balls down but with no action"
"The library is not good- the books are too simple and they don't get extra things if you ask for them"
"Pool tables are broken and remain unfixed on wings".
"Activities have been cancelled because staff forgot their keys to open activity room doors"

9.28 Detainees told us about two weeks in March 2018 when they did not even have an unpunctured football to play with. Detainees also complained that the stock of films was

limited and repeated many times. The [redacted] agreed he needed to acquire more films.

9.29 The [redacted] suggested a lack of activities had an effect on attendances at the healthcare centre:

> *"If there are activities in the centre, we tend to be quieter, with not as many patients for triage. However, if it is a bit chilly outside and a bit damp, a bit wet, we tend to have more people coming through the door. I don't know whether that is because there isn't enough going on in the centre."*

9.30 The [redacted] was evidently distressed by what he saw as the decline in the activities provision at Brook House. He told us:

> *"There is nothing happening. Don't take my word, go and ask people up there; just go and see people up there. For a start, the pool tables are broken, the table tennis is not there, or maybe they are replacing a couple of them, but I was always there repairing."*

> *"It used to be better, but I don't know how now because I don't even bother to look around there, but it will be upsetting"*

> *"it is really bad – it is upsetting. There were 20 detainees who wanted to play football, they come and ask for a football and we haven't got a football. That is really bad. That is the reason why I don't want to come over here, because the way things are and the way they used to be, it upsets me."*

9.31 On an unannounced visit to the centre at a weekend we found no organised activities for the detainees.

9.32 We noticed broken activities equipment in the centre. A pool table on one of the wings remained broken for months. All four of the guitars in the music room had either broken strings or no strings at all.

9.33 The wing offices and the library had board games for detainees but many were broken or had pieces missing. Some detainees said they did not know they were available. They told us "*there is nowhere to play them anyway*".

9.34 After an attempted escape in 2017, G4S decided that courtyards would be staffed whenever they were open. The lack of staff available to do this meant that usually only one courtyard at a time was open. The courtyard was often crowded with many detainees having to stand round the edges in order to make way for a game of football.

Cultural kitchen

9.35 G4S contracts with [redacted] for it to provide the cleaning, catering, shop and laundry services at Gatwick IRCs. Its onsite general manager told us that one of its female catering assistants used to be on duty during cultural kitchen sessions to give advice on food preparation and hygiene but assistants were often subjected to threats and abuse, so the arrangement ended. The cultural kitchen had not opened since because of a lack of G4S staff. People we spoke to said it had not opened since early 2017 and it was not open during any of our visits.

Class based activities

9.36 One of the two part-time arts and crafts teachers told us the limited space in the arts and crafts room and the limited equipment made it difficult for her and her colleague to work and hampered efforts to provide a worthwhile programme. She told us there was no computer equipment, only one sewing machine and one pair of scissors that had been broken for some time. They were replaced some weeks after we spoke to her.

9.37 The arts and crafts teacher and a classroom teacher told us a camera kept in the arts and crafts room had been used to photograph detainees with their work and to make certificates for completing education courses and for winning competitions. It had also been used to photograph events put on for detainees and to produce a magazine called the Gazette to which detainees contributed. The magazine had been popular with detainees and we found a complimentary reference to it in minutes of an SMT meeting for October 2016. The teachers we spoke to told us that the camera had been removed by senior

managers at some time in 2017. They complained that the loss of the camera had detracted from their work with detainees.

9.38 The head of security confirmed that the camera had been removed to the security office in May 2017 following security concerns about its use. She said it was still available for use by the teaching staff, subject to unspecified *"control measures"*. However, it was clear to us that this had not been communicated to the teaching staff.

9.39 The arts and crafts teacher questioned whether managers understood the benefit to detainees derived of doing arts and crafts. She told us *"It allows them to get away from their problems, to let off steam and feel valued"*. She wondered whether some senior managers saw the value of arts and crafts or whether they saw them instead as *"a babyish waste of time"*. Detainees told us how much they enjoyed arts and crafts and how much it helped to distract them from their concerns and anxieties.

9.40 Managers need to come to an arrangement with the arts and crafts staff which allows them ready access to the equipment they need to provide a worthwhile arts and crafts programme, including access to a camera.

9.41 Brook House has two teachers and one classroom. Some lessons took place in the cinema room. Detainees could do courses in English, maths, Spanish and Italian. The teachers also ran several weeklong courses in subjects such as communication skills, stress management, customer service, and management and leadership skills. Detainees were not able to obtain qualifications, but they were given certificates by the Brook House teachers.

9.42 The teacher we spoke to complained about a lack of equipment and materials and said he had no budget to buy them. He said he needed more books and would like an electronic white board and audio learning equipment.

9.43 Some detainees complained that the education courses were too basic and had nothing to offer better-educated detainees.

9.44 G4S does not quality-assure the teaching provided to detainees but it is inspected by Ofsted.

Paid work

9.45 The DCM responsible for managing the detainee paid work scheme at Brook House told us that there were 116 paid work roles. These included wing orderlies, barbers, kitchen orderlies and posts in the laundry, the garden, the chaplaincy and the food serveries. Longer-term detainees had no opportunities to gain qualifications through their work and no certificates or other awards were made in recognition of their work.

Comparison with Colnbrook IRC

9.46 We compared provision of activities and entertainments for detainees at Brook House with that at Colnbrook IRC (Colnbrook) near Heathrow Airport. Colnbrook is managed by Mitie plc. It is built to the security standard of a category B prison and has capacity for up to 339 detainees. Like Brook House, Colnbrook stands on a restricted site with outdoor space that is limited to small enclosed courtyards. The building is more spacious than Brook House and it has two gyms, one used as a free weights room, as a well as a sports hall. Five PE instructors, seven activities DCOs, seven tutors and a further two external tutors make up the activities and education staff.

9.47 Staff at Colnbrook said all detainees who wanted to use the gym facilities were given an induction. They could free train in the gyms or undertake training with an instructor. Sports competitions took place every day, some between mixed teams of detainees and staff, which helped to foster good relations. The cultural kitchen at Colnbrook was open every day and we were impressed by the enthusiasm and encouragement its permanent manager offered detainees. Detainees are able to work towards qualifications either through their paid work roles or by choice in a variety of subjects including painting and decorating, food hygiene, floristry, ITC, barbering, and sports and nutrition.

9.48 The library at Colnbrook was furnished with sofas. We noticed that crosswords and other puzzles had been photocopied and made available to detainees. A music room was managed by a professional instructor who enabled detainees to record their own music. The arts and crafts room contained supplies of scissors and other equipment that detainees were loaned against the deposit of their ID cards. The centre's shop sold food and toiletries and the charity HisChurch ran a popular shop selling books, clothes, and games.

9.49 We acknowledge the space constraints at Brook House and the lack of a sports hall but the activities and entertainments programme and the resources devoted to them compared poorly with those at Colnbrook.

Overall conclusion on the facilities and activities at Brook House

9.50 Rule 17(1) of the Detention Centre Rules 2001 says:

> *"All detained persons shall be provided with an opportunity to participate in activities to meet, as far as possible, their recreational needs and the relief of boredom".*

9.51 Activities available to detainees at Brook House do not meet this standard. The lack of activities and opportunities for exercise present a risk to detainees' welfare and wellbeing and to the general safety and security of the centre. As detainees put it:

> *"Lack of activity leads to disruption in the centre. Detention is highly stressful …so detainees need activities for distraction".*

> *"Activities are essential to keep the mind active and avoid getting depressed. Inactivity leads to fights and trouble"*

9.52 We agree with them.

9.53 The interim director acknowledged the physical inadequacies of Brook House, particularly in relation to the provision of space for activities. He told us:

> *"there is not sufficient activity space here, for 448, let alone 508"*

9.54 He said he would like one of the courtyards used for building a separate facility to house a sports hall and further activity and education rooms. He added that under any new contract for the management of the centre he would like to employ a dedicated senior PE and activities manager and two further sports and fitness DCOs.

9.55 The size and layout of Brook House, its lack of a sports hall and its limited outside space make it unsuitable to accommodate as many detainees as it does. It is also an unsuitable environment in which to hold detainees for more than a few weeks.

9.56 Whatever the shortcomings in the physical space and facilities at Brook House, the current provision of education, activities and entertainments is in any event inadequate.

Recommendations

R17 The SMT must design and implement as a matter of urgency purposeful and better-resourced education, activities and entertainments programmes.

R18 The SMT should ensure that teachers at Brook House, including the arts and crafts teachers, have ready access to the equipment and resources needed to provide worthwhile programmes for detainees.

R19 The SMT should reinstate the cultural kitchen.

R20 The SMT should consider whether it is possible to provide detainees in paid work with opportunities to gain qualifications.

Smoking

9.57 Detainees used to be allowed to smoke in the courtyards and in any bedroom designated as a smoking room. From 1 April 2018 smoking was permitted only in courtyards. The interim director told us that Brook House would be fully non-smoking from September 2018.

9.58 The healthcare service at Brook House offers a smoking cessation service to detainees.

9.59 We often noticed detainees openly smoking in communal areas in the centre before April 2018, and especially in the stairwells. Some staff challenged detainees who smoked in places they were not supposed to but many, including DCMs, did not. Problems with smoking

in the centre were exacerbated by the lack of access to the courtyards. A number of detainees complained to us about detainees smoking inside and the failure of officers to enforce the rules about smoking in communal areas.

9.60 Some detainees continued to smoke in stairwells and even on the wings after the ban, but much less than before the ban. We consider elsewhere in this report the need for DCMs and staff to be more active in their management of the centre and to take greater responsibility for challenging the behaviours of detainees. This requires clear and consistent enforcement of rules, including the ban on smoking.

Recommendation

R21 The SMT and staff must enforce the ban on smoking inside Brook House.

Food

9.61 We asked detainees about the food at Brook House. Their comments were largely negative. Among their comments were:

"Food is rubbish"
"Too many carbohydrates- rice and potato every day"
"Little or no protein. Two to three small pieces of chicken in a Biryani"
"Carbs- rice, chips, pasta served everyday"
"Prison food is more nutritious"
"The food is not suitable for the diet needed by older men"
"Food is slop"
"Meals are inconsistent- sometimes lots of salad and vegetables, some days none at all"

9.62 The onsite general manager for [redacted] told us of the challenges in catering for detainees. He said that with as many as 70 different nationalities among the detainee population, tastes and requirements varied greatly. [redacted] is contractually required to provide three choices at each meal: two meat choices, one halal and a vegetarian option.

The general manager said that [redacted] offered two further choices, a vegan option and a lighter option such as a sandwich or a salad.

9.63 In October 2017 a new catering contract with [redacted] came into effect. G4S senior managers told us that under the new contract the sums payable to [redacted] were reduced because G4S assumed direct responsibility for the supply of linen, crockery and detainee paid work was used to provide catering at Gatwick IRCs. They told us that G4S had not reduced the amount payable for detainee food. The [redacted] general manager explained however that [redacted] used to be paid on the basis of full occupancy of Brook House, but the new contract meant that from October 2017 [redacted] was paid on the basis of actual occupancy plus 75p per head for special meals for the main religious and cultural festivals such as Christmas, Diwali, Ramadan and the Chinese New Year. The [redacted] general manager was clear that this had reduced by nearly 10 per cent the amount he could spend on the provision of meals.

9.64 We checked and tasted meals at Brook House. We found that, as detainees had said, meals featured a high proportion of carbohydrates and much less vegetable and protein. Lunch choices usually included a wrap, a rice-based dish and chips. Detainees were offered salads fairly often and could have vegetables and a piece of fruit.

9.65 The [redacted] general manager suggested that the reduction in the funding available for meals had led to a reduction in quality and agreed that detainees' meals included too many carbohydrates.

9.66 The [redacted] general manager told us:

> *"[Protein] will be [more expensive], yes, and Halal meat is normally more expensive than ordinary meat. Therefore, yes, unfortunately, to give variety [adding carbohydrates is] the sort of thing you have to do. There [are] only so many certain ways that you can put a chicken together."*

9.67 Detainees serve food and the service is managed by DCOs. The [redacted] general manager said that DCOs did not understand or manage the food service properly which led to a number of problems. Food was presented in an unappetising way. There were arguments and tensions when food choices ran out. The detainees gave larger portions to their friends or allowed detainees to take food they had not ordered. Officers sometimes failed to go to

the kitchen to collect more. Detainees and staff also talked to us about the tensions and arguments during meal service. Detainees said:

> *"There is no control on ordered food and sometimes there isn't enough left for [detainees] to get the choice they ordered"*
> *"Orders are not kept to"*

9.68 Officers took meal breaks during detainees' meal service, adding to the problems of managing the meal service.

9.69 An officer told us:

> *"All of a sudden, 12 o'clock comes, and, say, you have four officers on the wing, your first two officers will say "I am taking my break now." That leaves two officers on a wing to open the doors to potentially, let's say, A Wing, which is 140. You have two officers. One has his back to where everybody sits because he is doing the meal list. The other one is on the first landing or on the second landing, unlocking. God forbid anything should ever happen… When those two come back, the other two go on their break. Now you have two people, and obviously it's dinnertime, when there's food. People are hungry, and that's when aggression, etc. tends to flare up when it is dinnertime…"*

> *"…We need one person to stop anybody jumping the queue, one person to oversee and make sure no extra food is being handed out, because that's always the case and that causes friction and causes fights, one person to lock, and one person to stand and overview for the back of the wing. Therefore, they know if anything happens, bang, it's done, de-escalated"*

Recommendation

R22 The SMT and residential DCMs must ensure that adequate numbers of staff are on duty throughout the service of meals to ensure orderly queues and service of meals.

9.70 [redacted] runs a well-stocked shop at Brook House and it opens every day. It sells toiletries, games, stationery, sweets, juices, breads, milk, dry and tinned food. It also sells fresh fruit and vegetables. We saw mangoes, oranges, apples, bananas, cucumbers, peppers, tomatoes and onions on sale.

Cleaning

9.71 The standard of cleaning at Brook House has been a problem for some time. The minutes of the meetings of the senior management team held in February 2017 contain the following entries:

> *09/02/17:*
> *"Cleaning needs to improve to a consistent standard"*
>
> *28/02/17:*
> *"The Home Office have raised 9 days of penalties regarding cleaning some of which could be mitigated"*

9.72 The Home Office contract managers at Brook House told us they had constantly raised concerns about cleaning with senior managers. They confirmed that G4S had incurred significant financial penalties under its contract with HOIE for the poor standard of cleaning. One told us:

> *"The last time I raised it in a quarterly was in July, [2017] and that is when I said the year to date G4S have already paid, I think it was close to £5,000. If you break that down to a pound per hour for paid work it didn't make any logical sense to me that the place wasn't clean and spotless. I think it was the consistency of having detainees and staff working on the wings knowing that the paid cleaners were there. The paid activities, the people who had signed up to do paid activities their responsibility was the cleaning. Therefore, it wasn't so much always getting people out of the rooms to do the cleaning, it was then the quality checking of the person to sign off"*

9.73 The IMB report for Brook House for the year 2017 says:

"…over the past 12 months cleanliness of the wings has at times become more of an issue e.g. tables not wiped of food after meals, bins not emptied and stairways not swept properly."

9.74 We observed that the cleaning of wings was particularly poor. We often saw bags of rubbish piled up on wings, unemptied bins, and rubbish on the floors, which often included cigarettes ends. We also saw that showers were dirty and often had rubbish in them. On two occasions we went on to wings before lunch to find that tables still piled with the remains of breakfast, including bits of boiled egg. We asked DCOs on duty what was being done about cleaning the tables, they told us that they would be cleaned by the paid detainee cleaning orderlies after the evening lock-up.

9.75 The common parts of the centre appeared to be better cleaned except for the stairwells, where we often found rubbish and cigarette ends.

9.76 The [redacted], who is responsible for managing G4S's cleaning contract with [redacted] suggested that part of the problem was a failure by [redacted] to fulfil its cleaning obligations. But the [redacted] was adamant that the company was responsible for cleaning only the common parts of the centre and that wing cleaning was not covered by its contract with G4S:

"I don't deal with the wings, I don't clean the wings…"
"However, if they want us to go on and do something that is external to my contract terms it may, say, come at a cost. It may be a charge for the cleaning chemicals, etc."

"Therefore, a new contract was signed with [redacted]… which actually said, "this is what you are paying for and this is what you are going to get." Within the terms of the contract, declarations were made that we would clean central and communal areas, but not the wings."

9.77 The former Home Office contract manager at Gatwick IRCs told us:

"I don't know what contract they have with [redacted] Apparently, it has changed recently, but as far as [redacted] are concerned it is not their responsibility, it never has been, and we have been told that from day one."

"…I think the contract isn't very clear. When it was first set it up, if that was the case, then [redacted] would have been in there a long time ago."

9.78 Paid detainee orderlies cleaned the wings. The interim director told us that he was in discussions with [redacted] and the Home Office about the possibility of [redacted] taking responsibility for deep cleaning each detainee room on a monthly basis. This discussion was part of the negotiations for the extension of G4S's contract to run Brook House as it requires the closure of detainee rooms during cleaning. We understand cleaning of communal areas of the wings will continue to be undertaken by paid detainee orderlies.

9.79 The paid orderlies and other detainees complained to us that they found it difficult to clean things properly because they did not have adequate cleaning products and cloths.

9.80 The [redacted] general manager told us that [redacted] kept cleaning cupboards on the stairs outside the wings stocked with cleaning products, including chemicals, for orderlies to use under supervision by DCOs. But DCOs were not supervising so detainees could use only the detergent and old cloths kept on the wings. He said:

"We supply the chemicals and in the detainees' cleaning cupboard, as we call it, there is actually dousing gear, so all they have to do is fill up the bottles and it comes out already diluted, but it is actually somebody going in, not us, but somebody from G4S going in to fill up the bottles and make sure the wings have the right stuff in the right bottles. That doesn't seem to happen in my experience."

9.81 The standard of cleaning at Brook House was unacceptable. Managers need to resolve the issue either by agreeing with [redacted] that it will undertake the cleaning of wings or by ensuring that wing orderlies keep wings to an acceptable standard of cleanliness throughout the day, that they are properly supervised and allowed access to the cleaning products and equipment. All wing staff need to be held to account for ensuring wings are maintained at an acceptable standard. All detainees should have access to cleaning products to clean their rooms, washbasins and toilets.

Recommendations

R23 The SMT must resolve the issue of the inadequate cleaning of the wings either by agreeing with [redacted] that it will undertake the cleaning of wings or by ensuring that wing orderlies keep wings to an acceptable standard of cleanliness throughout the day, that they are properly supervised and allowed access to appropriate cleaning products and equipment.

R24 Residential DCMs must hold staff to account for ensuring wings are maintained at an acceptable standard of cleanliness.

R25 Residential DCMs and wing staff should ensure that all detainees have access to cleaning products to clean their rooms, including washbasins and toilets.

10. The care and welfare of detainees

10.1 In this chapter we consider a number of matters relating to the care and welfare of detainees. We consider elsewhere the specific matters of how detainees' healthcare needs are met (at chapter 11), and those more closely associated with security at the centre (at chapter 12).

The governance and management of care and welfare

10.2 Overall responsibility for oversight, governance and assurance relating to the care and welfare of detainees at Brook House lies with the safeguarding team who are accountable for the reception arrangements; safer community arrangements, including the ACDT process; bullying and violence reduction and matters relating to equality and diversity. They also have oversight of the welfare team at Brook House. The residential managers who run the residential wings, the activities programme, and since January 2018 have taken responsibility for the induction of detainees, have primary operational responsibility for the care and welfare of detainees. As already discussed in chapter 7, from June 2017 until December 2017 a DCM acted up as head of the safeguarding team. He told us that he had only one DCM working with him during that time and had been unable to keep abreast of the workload. A new head of safeguarding took up post in December 2017 and two more DCMs joined the safeguarding team soon after; one took responsibility for suicide and self-harm prevention and the ACDT process at Brook House and the other took responsibility for those matters at Tinsley House.

10.3 A number of management committees at Brook House consider and oversee the practical implementation of care and welfare arrangements in relation to detainees, both individually and collectively. These committees, whose membership is drawn from across the security, residential and safeguarding management teams, the healthcare team and the onsite Home Office team, are the adults at risk committee; the safer community and violence reduction committee; the disruptive behaviours committee; the security committee. We attended meetings of some of these committees but with some difficulty because pressure on managers' time meant meetings were frequently cancelled, often at short notice.

10.4 Our observation of these management meetings gave us cause for concern about their effectiveness. We found that they were chaired poorly, sometimes by a last-minute substitute, and lacked focus. Meetings included discussions about the behaviour of individual detainees or groups of detainees who were a cause of concern but little discussion or agreement on action points or plans for managing them. We saw no obvious consideration of emerging trends or wider implications for policy and procedures that needed to be addressed. In some cases, particularly the adults at risk meeting we attended, we wondered what the purpose of the meeting was.

10.5 We found that the Gatwick IRCs policies directly relevant to care and welfare were on the whole well written and comprehensive, but a significant number had not been reviewed within their due date. The [redacted] told us that he had not had time to review policies. We consider in sections below any specific shortcomings we identified in policies and procedures relating to individual aspects of the care and welfare of detainees.

10.6 A number of staff and managers referred to the failure of staff to observe policy and correct procedures and how this affected the care and welfare of detainees. The manager of religious affairs said:

> *"I have no phone calls when I am getting called to ACDT reviews. On the G4S policy or on the paperwork it says that when someone goes down on to CSU, the Segregation Unit, the Manager of Religious Affairs is informed, but it hardly ever happens, hardly ever happens. It is a Home Office contractual requirement that the Manager of Religious Affairs is informed when someone goes on to CSU or comes off CSU."*

10.7 He said there was a tendency among staff not to follow agreed policy and procedure.

10.8 We discuss below areas in which we found that failure to observe correct policy and procedure posed a risk to the care and welfare of detainees. The lack of staff and the weakness in management capacity we found at Brook House, and discuss elsewhere, obviously played a part in these failings, as did the fact that so many staff were new and inexperienced.

10.9 The lack of staff and the pressures on their time also undermined their ability to give as much attention as they and detainees would have liked to the emotional needs and concerns of detainees. A number of staff told us that they were often too busy undertaking practical tasks to talk to detainees about matters that were causing them distress or anxiety. One DCM told us:

> *"At the moment it's all chopping and changing, there's no continuity on the wings, I don't think really detainees are getting as much support as they could. Before it used to be on C Wing, you would have C Wing staff so everybody on C Wing would know their officers, so then they would know because you build up a rapport. You get to know them, that's how it is and then you would have less issues on the wings."*

10.10 Detainees who attended our focus groups also told us that officers did not have time to address their needs. They said:

> *"[officers do not] carry out their duty of care; they are not there when you need them";" and*
> *"[officers] do not have the time to talk to detainees about their mental health and wellbeing".*

Reception and induction

10.11 We noticed on our visits to the reception area at Brook House that it was often untidy and piled with baggage waiting to be processed. The main reception area was poorly lit. The waiting rooms were scruffy and contained broken furniture. We sometimes found that plates of leftover food were left for long periods in the area where detainees waited after they had been booked in and before going to a wing. Overall, it was an unattractive and unwelcoming environment. The Home Office area director told us that new furniture was being provided for the waiting areas after he had complained.

10.12 Many detainees arrive at Brook House after sometimes lengthy journeys in an escort van involving a number of pick-ups from widely dispersed locations. These journeys can last many hours. Detainees often arrive at Brook House late at night. They may then be kept waiting for several hours to be processed through Brook House reception. They are searched

and offered a meal prepared by the centre's kitchens and kept in a fridge behind a counter in the waiting area. The reception area has no showers. We believe there should be.

10.13 Detainees who have been through the reception process are held in a large waiting area off the main reception while they wait to be taken to a residential wing.

10.14 Desks in the main reception area are separated by panels, which offer little if any privacy. Staff said that they could have private discussions with detainees in the single, small interview room or in the waiting area if necessary. We inspected the small interview room and found it had one chair and a broken, unusable sofa. Staff conceded that when the reception was busy, as it often was, the waiting area was not free for private interviews. It was clear that staff did not conduct private interviews with new detainees as a matter of course. Staff undertaking reception procedures need to ask personal questions of detainees including about their mental state; they also undertake a risk assessment of a detainee's suitability to share a room. Current arrangements in the reception do not ensure adequate privacy for these discussions.

Recommendation

R26 G4S managers and the SMT should:

- improve the environment in the reception area at Brook House and make it more welcoming;
- consider how all new arrivals can be interviewed in privacy; and
- agree with the Home Office how they will provide showers for new arrivals

10.15 Managers and staff told us how the reception at Brook House sometimes struggled to cope with the number of people being detained and removed from the centre. Each of these movements involves a relatively lengthy process. Managers told us about one week, beginning 22 January 2018, when 229 new detainees arrived at the centre, and 160 left Brook House. On one day alone that week 37 detainees arrived and 54 left. This volume of movements was high but not exceptional.

10.16 Managers at Brook House complained about the failure of the Home Office and [redacted] (the former transport service provider) to plan arrivals so that the centre could manage them properly. We asked a DCM responsible for managing reception about the week beginning 22 January 2018 referred to above when a large number of detainees had arrived. He said:

> *"It's terrible, it was like carnage down there. You had to have seen it to believe how it is… There's that many people. There's a limit to how many people are allowed in a waiting room, so we don't go over that and we stop accepting them, but then they might be sitting out in the van area for an hour… We physically can't hold them in the waiting rooms because we are allowed 16 in one and I think it's 8 or 6 in the other one."*
>
> …
>
> *"They must have sat in the vans, they must have been out there for I would say it wouldn't have been over an hour, so potentially a maximum of an hour but in the waiting room, I don't know, three or four hours easily they would have been waiting in there. When you take them over to the wings as well, you can't take all of them together, you can only take a few at a time - you know, four or five at a time."*
>
> …
>
> *"The longest I think - for example, if someone came in at half seven, when there are that many people coming in, they probably would have got on the wing close to midnight, about five and a half hours."*

10.17 The arrival of large numbers of detainees at one time, places unnecessary strain on the reception process and the long waiting times involved add significant further stress to detainees' arrival at Brook House.

Risk assessment on arrival at Brook House

10.18 New detainees are questioned and screened during the reception process to see if they have any mental or physical health problems and to find out about their religious and welfare needs.

10.19 All newly arrived detainees also undergo a room sharing risk assessment as part of the reception process, as required by the Detention Services Order (DSO) 12/2012 which says:

Clause 4:

"The room sharing risk assessment (RSRA) is an essential tool in the identification of detainees who pose a risk to other detainees when locked in a shared area e.g. a room or corridor (where lock down is limited to the corridor). The RSRA is intended to:

- *Help staff with the assessment of risk…*
- *Draw together information and knowledge about the predictive risk factors regarding an individual*

  …
- *Support staff judgment about allocation to rooms and risk management*
- *Record additional operational precautionary measures for a detainee identified as a potential risk, where sharing is unavoidable*

  …
- *Enable early identification of violent detainees or detainees who may bully others, which may include bullying on grounds of race, religion, sexual orientation or disability"*

Clause 5:

"The RSRA process does not:
Rule out room sharing by detainees posing a risk"

Clause 8:

"There are detainees who may present a risk to other detainees, and detainees who may be at risk from other detainees (because of particular vulnerabilities or other issues that may place them at an increased risk in certain circumstances or from certain individuals/ groups). In respect of a room sharing risk assessment Centre suppliers can assess a detainee as one of two categories:

- *High Risk:*
  A high-risk detainee is one for whom there is a clear indication, based on evidence available, of a high level of risk that they may be violent to another detainee in a locked area or that another detainee may be violent to them, this *should include detainees who may be vulnerable to sexual assault or coercive sex*

- *Standard Risk:*
  A standard risk detainee is one for whom, based on evidence available, there is no immediate risk that they may be violent to a detainee or at risk of violence from another detainee"

Clause 17:

"Staff in reception will consider all evidence available at the time and assess whether the individual is a standard or high risk…if there is evidence or strong suspicion that any of the following risk factors exists the detainee must be assessed as mandatory High Risk" and located in a single room…."

10.20 The clause goes on to identify the high-risk factors:

*"Life threatening assault, murder or manslaughter of another prisoner/detainee or assisting a suicide while in custody"; a*nd

"Sexual assault with same sex adult victim either in the community or in prison/IRC"

10.21 In our view the clauses set out above suggest that only acts of violence in custody or a locked environment are to lead to the conclusion that a detainee is high risk and should be allocated a single room. This interpretation is supported by the distinction in clause 17 between assault, murder or manslaughter *"while in custody"* and sexual assault *"in the community"*.

10.22 G4S's induction policy offers different formulations and descriptions of the level of risk to be established to justify a detainee being categorised as high risk and requiring a single occupancy room.

10.23 Paragraph 2.1 says:

> *"The Room Sharing Risk Assessment process is designed to risk assess detainees for their potential to murder or violently assault a roommate when they share with other detainees. Historically within the Home Office detention estate the chance of a life-threatening assault or homicide is low."*

10.24 Paragraph 2.3 says:

> *"A HIGH-RISK detainee is one for whom there is clear indication ...of a high level of risk that they may be severely violent to a roommate or that a roommate may be severely violent to them……"*

10.25 Paragraph 2.8 says:

> *"Detainees who have severely assaulted roommates, and those who have committed sexual assault against a same sex victim must be categorized as mandatory high risk"*

10.26 Paragraph 5.16 deals with the need to review the room-sharing risk of a detainee who shares a room but whose behaviour changes. It sets out examples of the indicators to be considered. These include:

> *"Violence. Fighting or assaulting other detainees or staff, especially when more than two incidents are recorded. Only violence in detention is relevant but this includes secure homes, mental hospitals and secure training centres as well as previous prison custody."*

10.27 In our view the DSO is deficient in two respects. It fails to make explicit that centre staff may decide that detainees pose a degree of risk that makes them unsuitable to share a room even when they do not fall strictly within the DSO definition of mandatory high risk. In addition, the DSO suggests to the reader that (other than in cases of sexual assault) only violent behaviours in a locked or custodial setting are relevant in determining high risk for the purposes of room sharing. We do not believe that such a limited approach to identifying risk can be justified.

10.28 The G4S induction policy is confusing because it uses different formulations to describe the level of behaviours that justify a categorisation of a detainee as high risk. In using words like *"severely violent"* and *"severely assaulted"* the policy sets a higher bar for categorisation as high risk than that contained in clause 8 of the DSO. In our view the policy ought to make clear that a serious risk of any significant violence towards roommates should lead to a decision that a detainee is not fit to share with others.

10.29 The staff we observed at work in the reception at Brook House took account of all available information to determine if a detainee was a high risk for room sharing purposes. The evidence they relied on was not confined to behaviours in locked or custodial settings. However, they said they felt under pressure from the Home Office not to allocate detainees to single occupancy rooms and they had to refer to a manager all cases where they considered a detainee was a high risk.

10.30 We asked a reception DCM whether he ever felt under pressure to accept a detainee for whom there was no suitable accommodation at Brook House:

> *"Yes, all the time. If they do send someone in and I believe he shouldn't be in here, I will ring them up and say 'I don't think he's suitable, we don't have the room', they are kind of like 'We can't send him to Colnbrook, this and that, he's coming to you', but there's no like back-up plan to that"*

Recommendation

R27 G4S should amend its induction policy to make it clear that a detainee posing a risk of any significant violence to others will be justification for accommodating the detainee in a single occupancy room

10.31 Staff and managers working in reception told us that privately-run IRCs such as Gatwick do not have access to the prison service's p-NOMIS computer system. This means that staff at Brook House cannot see electronic prison records of TSFNOs arriving at Brook House. They have to rely for information on the hard copy prisoner escort records (PERs) that are supposed to accompany TSFNOs. Managers and staff told us that TSFNO detainees sometimes arrived with records incomplete or missing altogether. A reception DCM told us

that they could phone the Home Office for further information but the Home Office staff who could help were not on duty after 7.30pm. This caused problems in risk assessing the many detainees who arrived late at night.

10.32 The prison service is meant to send full prison records to Gatwick IRCs, but complete records do not always arrive at the centres and records can arrive after the detainee. The lack of staff in the security team at Brook House caused considerable delay in staff being able to examine files for information about the risk profile of a TSFNO detainee. A recent examination of a backlog of prison records revealed that a detainee who had been put to share with another detainee was a risk to others and should have been put in a single occupancy room.

Recommendations

R28 G4S should work with the Home Office to ensure that all time-served foreign national offenders arriving at Brook House are accompanied by prison escort records that identify matters affecting their risk profile.

R29 The SMT must ensure that all prison files of time-served foreign national offenders are examined for relevant security information, including risk profiles, in a timely fashion.

The induction process

10.33 The Gatwick IRCs induction policy requires new detainees to be accommodated on B wing. Paragraph 3 says:

> *"On arriving on [B wing] the Induction Officer will complete an initial induction interview with the detainee which will involve*
> - *an explanation of the induction policy including*
> - *an explanation of the decency policy*
> - *explanation of any additional support the individual can expect to receive i.e. supported living plan*

Following this the detainee will be shown to his room and given a hygiene and bedding pack. This will be recorded [in the] first 24 hours and induction record recorded along with the planned or suggested actions to address them"

The initial introduction will explain the basic induction procedure, familiarise the detainee with his new surroundings and answer any questions he may have…

All detainees WILL have an initial introduction interview, prior to being locked in for the night….

When carrying out the first night interview the Induction Officer is to ensure that any identified needs or concerns are recorded along with planned or suggested action to address them"

10.34 Paragraph 4 of the induction policy sets out a programme to be completed by new arrivals over a period of up to 72 hours. This is to include a core induction session which:

"…delivers the key information new detainees need to know regarding the centre regime and other factors relating to safety and decency …As part of the induction, representatives from Chaplaincy, Diversity, Safer community, Welfare and Paid work will visit the unit and personally deliver information about their respective areas."

10.35 From about May 2017 until March 2018 this induction policy was largely disregarded, and most detainees were not subject to the required programme. This was partly a consequence of other detainees, apart from new arrivals, being accommodated on B wing. Some were disruptive detainees who could be better managed on a smaller wing. In addition, B wing was closed for refurbishment for a few weeks in November 2017. Many new arrivals were sent straight to other larger wings housing long-standing detainees. The minutes of the security meeting held on 22 September 2017 say:

"Induction wing needs to be taken more seriously as some detainees are not being inducted by wing staff and are asking the chaplaincy team instead. Some new arrivals are put on other wings so it is difficult to know if they have been inducted."

10.36 Some managers told us they had tried to find new arrivals on other wings and offer them the parts of the induction they were responsible for, but this had not happened in a systematic way. One manager estimated that only 20 per cent of detainees had received proper induction during this period. He told us it was not possible to verify this figure because the spreadsheet meant for the purpose had not been maintained. A DCM with experience of managing B wing told us:

> *"…we do have a spreadsheet, but the spreadsheet hasn't been used… I think it did get used a little while after I left, but there is a spreadsheet that we are going to try and adapt as well, that will say everybody that came into the centre, where they were located, whether they had an induction and where they were then located after the induction…*
>
> *"I want to adapt it a bit as well, to give a bit more information, because if someone hasn't had an induction, 'Why haven't they?', 'They went on a flight before the induction process could be completed'. You have actually got a justification…"*

10.37 Whatever the reason, it was entirely unsatisfactory and inappropriate for detainees not to have been given the support needed to enable them to cope during the initial stages of their time at Brook House. The failure to house detainees in an induction wing where they could be properly assessed and any concerns about them identified presented a risk to their welfare and wellbeing.

10.38 A DCM experienced in managing new detainees was assigned to B wing in March 2018. The wing was being managed once again as the induction wing. We saw that officers on the wing were maintaining records to identify which detainees had received the necessary induction interview and had completed the induction programme. Nevertheless, a few long-standing detainees were still being housed on the wing.

Recommendation

R30 The SMT and DCMs must ensure continued adherence to the induction policy.

The welfare team

10.39 The welfare office is staffed by G4S officers and is open every day for a morning session and afternoon session. The DCOs who act as welfare officers told us that the most common problem they dealt with was detainees' lost property. They also referred to work they did to help detainees resolve problems managing their lives at the centre, such as making appointments for healthcare; making contact with family members and others outside the centre; and sorting out problems such as housing and other matters relating to their lives in the community. The welfare officers are not allowed to advise detainees about their immigration cases, but they tell them where they might get help.

10.40 The welfare team at Brook House consisted of four DCOs to allow for two officers to work in the office while it was open. We interviewed one of the more experienced members of the welfare team who told us that from about October 2017 staff shortages at the centre meant welfare officers had frequently been assigned to other duties. Frequently only one officer had been available to staff the welfare office. This meant long and sometimes fruitless queuing by detainees to see a welfare officer. The welfare officer told us in mid-April 2018 that he had complained to senior managers about the staffing of the welfare office. He said that as a consequence, there were fewer occasions when only one officer was on duty.

10.41 The welfare staff told us they were hampered by a lack of technological and administrative support. They spoke of relying on old printers, a single poor-quality scanner and old, slow computers. The welfare officers had to spend significant time while the office was open sending emails and making phone calls chasing up lost property or dealing with other matters. This delayed them seeing other detainees. They said they needed an administrator who could follow up on their casework.

10.42 We observed welfare officers explaining to detainees the meaning of letters and notifications they had received from immigration caseworkers. We also saw the experienced officer we interviewed discussing with a detainee his options for returning to his country of origin. These matters were dealt with sensibly, realistically and with sensitivity.

10.43 The experienced welfare officer we interviewed had spent five months working with the Home Office on site team as an integration officer on a pilot project to encourage voluntary returns. He told us this had given him a greater understanding of Home Office

procedures. He had attended a course run by Amnesty International on basic immigration law. He said other G4S staff would benefit from basic training in immigration processes. We agree that the welfare staff at Brook House would be better able to undertake their duties if they had training in immigration processes. We believe that this would ensure that welfare staff could then correctly identify and understand documents received by detainees and point them to help elsewhere. They could do this without becoming involved in discussions about the details or merits of individual cases

10.44 The welfare officer we interviewed told us about the team's contacts with other organisations able to help detainees in the UK, such as the Gatwick Detainees Welfare Group, BID (Bail for Immigration Detainees) and the Red Cross. Few if any contacts took place between the Brook House welfare team and charities and other organisations that offer networks and support with resettlement overseas in the way that the Hibiscus charity helps women in detention. The welfare team should develop such contacts. We were pleased to learn from the interim director in May 2018 that the new head of residence at Brook House had had discussions with the charities The Change Foundation and Alliance in Sport with a view to offering detainees resettlement support.

10.45 The welfare officers told us that many detainees wrongly believed that welfare staff could help them with their immigration case and procure their release from detention. They were disappointed when they discovered that this was not the case. Nevertheless, we saw that the Brook House welfare team fulfilled a necessary and valuable function. They were caring, sympathetic to detainees and their concerns, and helpful in trying to resolve problems. The welfare team should be adequately staffed and supported at all times.

Recommendations

R31 G4S and the SMT should ensure that the welfare team is adequately staffed at all times.

R32 G4S and the SMT should ensure that the welfare team has the technological and administrative support it needs.

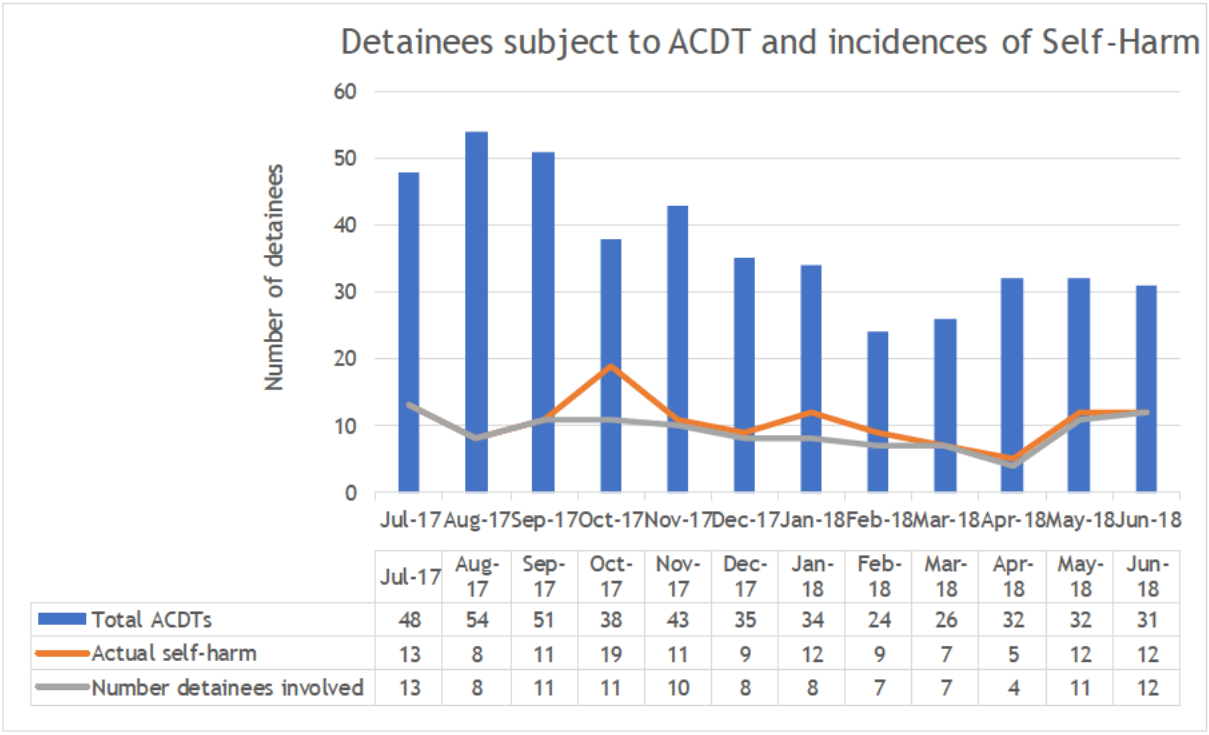
R33 G4S and the SMT should consider with the Home Office the possibility of providing the welfare team with training in immigration processes.

R34 G4S and the SMT should ensure that the welfare staff at Brook House should develop links with charities and other organisations able to support detainees with resettlement overseas.

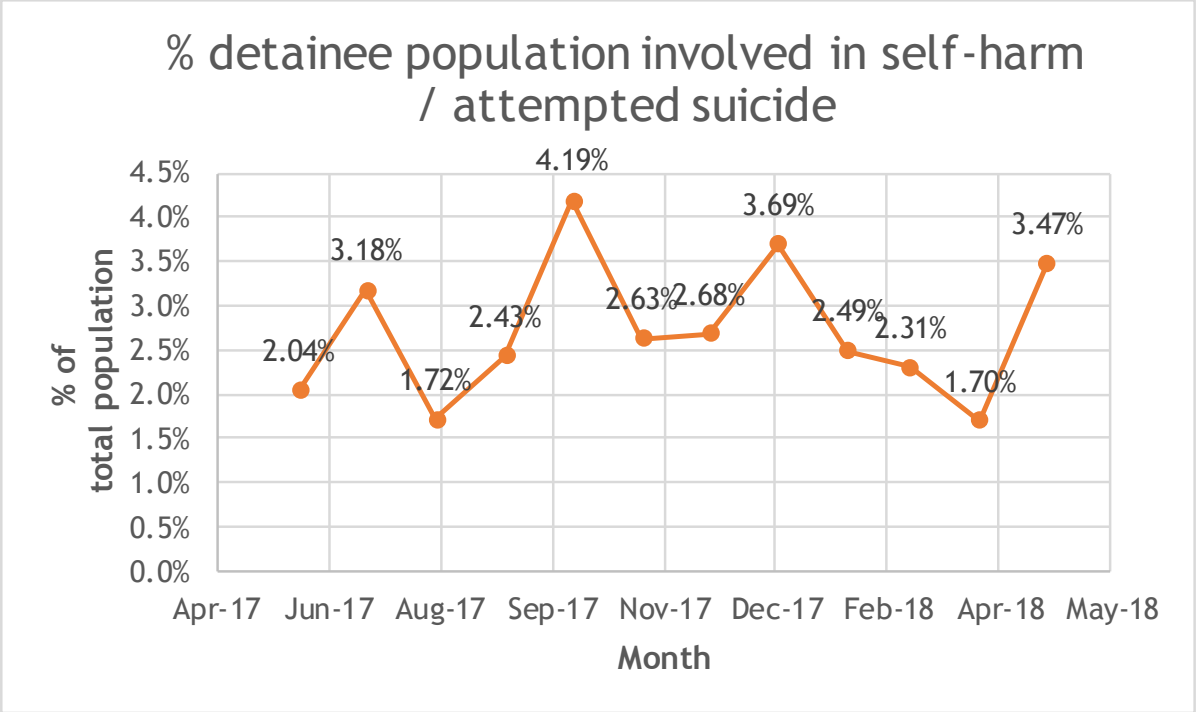
Safer community arrangements

The management of self-harm and suicide and the care of vulnerable detainees

10.46 The graph below displays the figures the safeguarding team gave us for the numbers of detainees subject to the ACDT process and for those who have self-harmed:



	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total ACDTs	48	54	51	38	43	35	34	24	26	32	32	31
Actual self-harm	13	8	11	19	11	9	12	9	7	5	12	12
Number detainees involved	13	8	11	11	10	8	8	7	7	4	11	12



10.47 Detainees identified as being at risk of self-harm or suicide are managed under the ACDT process. Our conversations with staff and our examination of the ACDT paperwork in wing offices suggested that staff understood their obligations in respect of identifying, monitoring and documenting the progress of those thought to be at risk. However, we noticed that DCOs undertaking observations of a detainee did not as a matter of course engage with the detainee but often relied on visual observation alone. Entries in ACDTs and other assessment documents were minimal and not always informative.

10.48 Staffing and rostering difficulties at Brook House meant the DCMs in residential units with responsibility for doing ACDT case reviews were not necessarily available so the reviews were sometimes done by DCMs from other areas. Clearly it is of benefit in ensuring the care of those at risk that they should be assessed in as consistent a fashion as possible, by staff who have a good understanding of their case. In our view a detainee on ACDT should be reviewed by a DCM accompanied by a DCO acquainted with the detainee.

10.49 Healthcare managers said they often learned of ACDT case reviews only at the last minute, and that this meant they sometimes had difficulties in juggling the diaries of staff so they could attend. Sometimes the healthcare team had to make their contribution by phone rather than face to face. We believe that healthcare staff should always be present at ACDT reviews to assist the assessor and the detainee in their decision making and planning.

10.50 Although it is not a requirement of the DSO on ACDT, Gatwick IRCs provide refresher training for DCMs in ACDT case management. The DCM with responsibility for training the DCMs in ACDT case management told us that only two of the residential DCMs had had their refresher training in 2017.

10.51 The ACDT process is vital in ensuring the safety and wellbeing of detainees at risk. The requirements of that process must be closely adhered to and staff involved in the ACDT process must be properly and regularly trained to ensure robust and effective case management.

Recommendations

R35 The residential DCMs should ensure that ACDT case reviews are conducted by DCMs accompanied by a DCO acquainted with the detainee whose case they are assessing.

R36 Residential DCMs responsible for ACDT case management should receive regular refresher training.

10.52 Detainees with identified disabilities and chronic conditions are managed under the supported living plan (SLP) policy introduced in 2016. The policy explains that the SLP is:

> *"a social model of support that is designed to highlight the detainee's disability related needs and the support or reasonable adjustments they require, in order to maintain their independent living while they are in [the care of] Gatwick IRCs"*.

10.53 Detainees subject to SLPs were discussed at a weekly multidisciplinary meeting.

10.54 The equality and diversity manager who has responsibility for managing the care and welfare of disabled detainees expressed concerns about the level and quality of the observations undertaken by staff in relation to those on SLPs:

> *"…the documents…, the level of observations, the quality of observations… at Brook House, I would say… four and a half/five [out of 10], simply because the number of*

documents you have comparing to your staffing level on the wings, staffing levels have been atrocious… Recently there you can see better observations being made, which includes 'What are we doing for individuals?', so things like 'Escorting John in the lift, so he can go up to ...' and so on, so you get better quality observations and that is increasing gradually."

10.55 A number of ground floor rooms in Brook House have been adapted for use by detainees in wheelchairs or with limited mobility. They have in-room showers, but the showers flooded the rooms and attempts to keep water in the showers had failed. The call bells in these rooms were inaccessible and the toilets were difficult for taller people to use.

10.56 Few wheelchair users were sent to Brook House. We saw none on our visits, but we did see detainees with mobility problems and learned that their presence was common. Detainees are accommodated in a three-storey building. Most of the activities, healthcare, education, welfare and religious facilities take place on the first and second floors. Detainees cannot access the lifts on the ground floor without being accompanied by a member of staff. This severely limits the opportunity for disabled detainees to access the facilities and engage in the life of the centre. We do not consider it appropriate that wheelchair users or those with limited mobility are detained at Brook House.

10.57 We consider the care of detainees with mental health issues in chapter 11.

The management of age dispute cases

10.58 The Panorama programme included the case of a detainee who claimed, and who appeared to be, under age for detention. The programme alleged that local social services might not have been told about his presence at Brook House. The film also shows a DCO saying she would not raise the issue with managers or the Home Office.

10.59 We were told that age dispute cases were infrequent with only four cases in the 18 months from January 2017.

10.60 The staff we spoke to about underage detainees told us they understood that children should not be held in the centre and that if they suspected that a detainee was under age they would raise the matter with managers. One highly experienced and

respected officer told us he thought staff lacked a sense of responsibility to raise concerns about whether a detainee was under age:

> *"As far as I know there's never been a formal procedure of what you do if you think there's an age dispute, you think 'I'll just leave it to the next person to deal with'…*
> ***Q**. Do you think there needs to be a bit more explicit education here about age disputes?*
> ***A**. About age disputes yes.*
> ***Q**. How it is everybody's responsibility to identify that?*
> ***A**. Exactly yes. Not just one person… we all have responsibility - don't just shrug it off"*

10.61 We asked the head of support services whether staff received training in the management of age dispute cases. He told us the subject was *"mentioned within the ITC"* but *"It has been requested that a section on age disputes is added to the safeguarding by the tutor".*

10.62 Staff of E wing alerted the Home Office to their concerns about whether a detainee was under age during one of our visits. This was prompted by the detainee's appearance and by his claim to be under age. In another case a DCO suggested that the physical appearance of a detainee had given her cause to question whether he was under age. But it was unclear from her account of the case whether she had followed the matter up appropriately.

10.63 Gatwick IRCs have an age dispute policy which says:

> *"Residents identified as/or claiming to be a minor will be subject to discussion with the duty director and the onsite Home Office manager as soon as possible. The person reporting the age dispute will complete a notification form (annex1) and pass to the Detainee Custody Manager, who in turn will inform the duty director and the Home Office.".*

10.64 The policy does not make it explicit that it is the duty of staff members who for any reason have cause to believe that a detainee is under age to report it to a manager or ensure that it has been reported.

10.65 The policy needs to be amended for this purpose.

Recommendations

R37 The age dispute policy should be amended to make explicit that it is the duty of staff members who have any cause to believe that a detainee is under age to report it to a manager or ensure that it has been reported.

R38 The SMT must ensure that staff are trained in the management of age dispute cases.

10.66 Managers said they referred cases of possible under-age detainees to the Home Office on site team and expected the case to be referred to social services. They also said that if they suspected a detainee was a child, but the Home Office was not willing to involve social services, they would do so themselves.

10.67 Staff and managers said that, in keeping with the age dispute policy, an age dispute detainee would be made the subject of a risk assessment. They would be housed on E wing where they could be given more care and attention. Residential managers and the Home Office representatives on site would devise a care plan in consultation with the detainee, including a plan for access to the facilities in the main centre and association with other detainees.

10.68 The internal investigation into the operational aspects of allegations in the Panorama film made the following findings in relation to the age dispute case in the film:

> *"[the detainee arrived 1:50 on 02/05/17 from Bethnal Green Police Station.*
> *IS91 states his DOB is 28/01/1999 indicating he is 18 years of age.*
> *At 20.55 he stated he was 14 years of age. Moved to Eden Wing. Raised Age Concern and Age Dispute Risk Assessment/Care Map compiled (chaired by the now head of Tinsley House), he was moved to Eden Wing on 03/05/17*
>
> *[the detainee] received a letter from the Home Office. The letter states that there is a credible and clear documentary evidence that he 18 years of age or older.*

Concerns passed to social services and investigated, [The detainee] is deemed to be 18 years old."

10.69 These findings suggest that managers followed correct procedure.

Safeguarding issues

10.70 The Gatwick IRCs safeguarding policy was amended in April 2017. It is set out in a series of documents including two purporting to be the *Policy Statement* relating to safeguarding children, adults at risk and vulnerable adults; a document headed *Guidance Note*; and another headed *The Child Protection, Vulnerable Adult and Adult at Risk Procedure*.

10.71 The scheme of these documents is confusing, with documents contained in annexes and appendices that are not numbered in a coherent or sequential manner and wrongly cross-referenced in the text. Evident cutting and pasting has led to the text in one place not running in an understandable or meaningful way, and the insertion of references to *"vulnerable adults"* into sentences that do not have any meaning in relation to them. The child protection, vulnerable adult and adult at risk procedure set out in annex B appendix 1 refers only to the local authority children's social care and the LSCB (local children's safeguarding board) and makes no reference to the need to refer adult matters to the local authority's safeguarding adults board. A clear and helpful flow chart appended to the policy sets out the specific steps that staff and identified managers are required to take in the event of a staff member having concerns about a child's welfare.

10.72 The policy is confusing, but it covers the essential matters that G4S and managers must consider in ensuring appropriate safeguarding. Apart from the need to edit and revise the policy documents to correct the errors we have referred to, the document would be more effective and understandable if it contained a clear, comprehensive statement of the principle obligations and duties for staff and the procedures they should follow in safeguarding matters.

10.73 The policy statement at the beginning of the policy documents refers to safeguarding being about *"taking steps to ensure that children, young people and vulnerable adults are kept safe from harm. This includes protecting children, young people and vulnerable adults*

from [inter alia] harm from adults". It also says G4S understands its obligation to implement policies and arrangements designed to:

- *"protect the children resident and vulnerable adults from significant harm, including self harm and suicide, harm from other residents (bullying and other potential forms of abuse which may occur) and harm from staff and other adults, e.g. Visitors;*
- *Safeguard children who are not held in their care but with whom staff have routine contact- when in contact with those children, e.g. visiting children;*
- *minimise the risks of harm to children or vulnerable adults in the community by detainees who have been identified as presenting such a risk, which could occur during any form of contact with a child, including telephone, internet and visits…"*

10.74 The policy does not make clear that staff also have a duty to report any matter that comes to their attention which suggests that a child or vulnerable adult is at risk in the community, whatever the reason and whether or not that risk is posed by a detainee. Some detainees may have sought to conceal the existence or whereabouts of children in the community or may have made ill-considered or unorthodox arrangements for the care of children or other dependents during their detention. Safeguarding the children of detainees is central to the welfare and wellbeing of the detainees. It is important that staff understand their obligation to report all matters of concern.

10.75 We have already remarked on a lack of management capacity in the safeguarding team. We also found that managers who delivered safeguarding training as part of the ITC were not adequately trained and that staff were not given refresher training in safeguarding. The new senior manager appointed in December 2018 as head of safeguarding (but subsequently moved to head of residence) accepted that safeguarding training was not being done well. He told us about recent discussions with the West Sussex local safeguarding team to identify training for the Gatwick IRCs managers who deliver safeguarding training. The head of support services told us that refresher safeguarding training at Gatwick IRCs would be introduced during 2018.

10.76 Two of the more experienced members of staff gave us good examples of occasions when they had identified and raised legitimate safeguarding concerns about detainees and ensured they were acted on. One related to a detainee who had been unwilling to say where

he was going on release from Brook House. The staff member had reason to be concerned that the detainee might pose a risk to his own children and had informed the social services team responsible for them. Social services did not know the detainee was being released and welcomed and acted on the information. We also heard of an occasion when staff in the visits hall noticed a detainee's inappropriate treatment of his partner. They alerted social services. The interim director told us of an occasion when he allowed a detainee with mental health issues who had nowhere to go to stay until social services could find him accommodation rather than obey a Home Office direction to release him.

10.77 Most of the staff we spoke to however seemed to understand safeguarding largely in terms of matters affecting detainees at Brook House and in particular the risks of suicide and self-harm. They did not appear to have much understanding of the need to be alert to and report concerns about matters affecting the lives of detainees and others outside the centre.

Recommendations

R39 The SMT, in consultation with the local safeguarding boards, should review and redraft the safeguarding policy to ensure that it:

- has a clear and easy-to-follow scheme and does not contain errors in drafting and meaning;
- makes clear to staff their principle duties and responsibilities in relation to safeguarding, including their responsibility to share all relevant information about children and vulnerable adults in the community

R40 The SMT in consultation with the local safeguarding boards must ensure that all staff receive appropriate annual safeguarding refresher training.

11. Healthcare

How the service is commissioned

11.1 NHS England health and justice commissions and funds the healthcare services at Brook House. The commissioning team is based in Kent and covers prisons and IRCs in the southeast. The G4S healthcare manager described having well established relations with NHS England and felt that they had a good understanding of detainee need and responded promptly to problems. A health needs assessment had been conducted recently.

Healthcare at Brook House

11.2 G4S Health Services Limited provide most of the health services at Brook House. The healthcare service at Brook House is registered as a GP practice with NHS England. New detainees come under the care of a GP when they are admitted at Brook House. Someone coming in from the community would have their GP care transferred to G4S healthcare.

11.3 The head of healthcare works closely with the deputy director of the centre but reports to the G4S Health Services head of secure. She is responsible for the oversight of three G4S healthcare teams/facilities including Brook House, Tinsley House and Yarl's Wood IRC in Bedford. She spends time at all three. A clinical lead is usually in post at Brook House. This post became vacant in January 2018 and was filled a few months later. The candidate was waiting for security clearance at the time of writing.

11.4 The head of healthcare is the Care Quality Commission registered manager. HMIP last inspected the centre in October 2016. We asked the deputy head of healthcare inspection, HMIP, for her overall assessment of the service at that time:

> *"There were no breaches of the regulations from the CQC perspective, so I think our judgement was that overall it was reasonably good. We were quite clear that fewer detainees were satisfied with the quality of it than they had been previously, and there was a lack of a health needs assessment. There were some issues around the health complaint system and primary care services, the feeling was that it was quite accessible, and the care planning was good, the waiting lists were short. Therefore, I think our general sense of it was that it was reasonably good."*

11.5 The HMIP inspection report published in February 2017 said:

> *"In our survey, 29% of detainees said the overall quality of health care was good against the comparator of 42% and 40% at the last inspection. Many detainees we spoke to were negative about their experiences of health care, but we could find no evidence to support these perceptions apart from health notices displayed in English. The health interactions that we observed were polite and professional."*

11.6 The inspectors concluded:

> *"Health care provision was adequate. There were shortcomings in some areas, including pharmacy. Outcomes for detainees were reasonably good against this healthy establishment test."*

Services provided

11.7 Services provided at Brook House include primary care, mental health, substance misuse, dentistry (triage) and eye care.

11.8 The centre has 24-hour nursing staff cover. General practitioner cover is available seven days a week. A psychiatrist from a private provider visits the centre weekly. There are no inpatient beds. Detainees with more serious health problems are cared for on E wing or moved to hospital.

11.9 The healthcare suite is on the first floor at Brook House. There are two admission rooms in reception and a room for mental health consultations in visits. The first-floor suite consists of a main office, pharmacy, two clinical rooms and a detainee waiting area with wall-mounted television. Healthcare staff share space in the single office. The clinical facilities are stretched by demand and are cramped. The practice manager would like to turn the main office into a third clinical room. Healthcare has been painted recently and looks fresher than when we first visited.

11.10 [redacted] is responsible for cleaning. Healthcare staff told us that the standard of cleaning was routinely poor and that deep cleans were rare. [redacted] cleaning

improved during the recent flu outbreak and included wiping door handles regularly to help minimise the spread of the virus.

11.11 The head of healthcare or one of her team attends the daily 8.30am operational centre management meeting. This allows the healthcare team to participate fully in the running of Brook House.

11.12 Healthcare services provided to the centre include: health screening in reception, GP and nurse appointments, prescribing and dispensing medication, responding to incidents in the centre and providing mental health care. Nursing staff also attend planned use of force and provide support to detainees being removed from the country: for example, by ensuring that those with medical conditions leave with a supply of their prescribed medication and the necessary information for medical practitioners in the country to which they are returning.

11.13 Within two hours of admission each detainee has a health screening carried out by a health care assistant. A two-hour triage clinic with a nurse takes place every morning. GP appointments are offered where the nurse considers it necessary. Waiting times for non-urgent GP appointments were four to five days at the time of our investigation. Patients needing an urgent appointment were seen the same day.

11.14 Detainees admitted to the centre with medication are subject to a risk assessment. Detainees assessed as suitable can be *"in possession"* of their medication and administer it themselves. They sign an *"in possession"* compact to this end. Where healthcare staff have doubts about the detainee's understanding of their medication or concerns that the drug has a tradeable value, it will be taken from them. Medication is then dispensed from the centre pharmacy.

11.15 Healthcare staff attend first response incidents in the centre and visit detainees on their wings if they are unwell. They participate in ACDT reviews and the assessment of detainees held under rule 40 and rule 42[1]. We saw examples of them undertaking these roles during our work in the centre. This included nursing staff attending a first response when

[1] Rule 40 Detention Centre Rules 2001 provides for the removal of detainees from association with others in the interests of security or safety. Rule 42 Detention Centre Rules provides for detainees who are refractory or violent to be temporarily confined. The manager, the medical practitioner and (at a contracted-out detention centre) an officer of the Secretary of State are required by the rules to visit all detained persons who have been removed from association or temporarily confined at least once each day for so long as they remain so removed or confined.

we reported that a detainee had swallowed razor blade shards. He was moved to E wing for care and observation. Our impression was that staff responded in a caring and timely way.

11.16 Officers on the wings are permitted to dispense paracetamol to detainees. This is agreed with healthcare and is recorded in the detainee's record. Some officers felt uncomfortable at dispensing medication to reduce pain and fever, but we consider it allows officers to respond promptly to the health needs of detainees.

Recommendation

R41 Healthcare should agree with [redacted] how cleaning must be improved and how these new standards are adopted and maintained. Healthcare facilities should be deep-cleaned at least twice yearly.

Management of healthcare

11.17 Healthcare has a quarterly commissioning meeting with NHS England. The meeting covers contractual performance and service quality and concludes with a partnership discussion. This includes G4S and healthcare management, the general practitioners, a representative from the mental health team, the Independent Monitoring Board (IMB) and Home Office. Health and Justice performance indicators are discussed at the meeting.

11.18 An internal quality meeting takes place every quarter that covers Brook House and Tinsley House. Members of the senior management team from each centre attend along with healthcare management. The IMB is also present.

Staffing

11.19 Healthcare has an establishment equivalent to 30 staff. These staff work across Brook House and Tinsley House.

11.20 The head of healthcare told us at the beginning of our fieldwork that healthcare had not had a full complement of staff since 2012. She said current vacancies included: clinical

lead (1), senior RGN (1), RGNs (2), RMNs (3) and healthcare assistants (7). The shortfall in staffing was made up with agency and bank staff.

11.21 The healthcare practice manager is responsible for the rostering of healthcare staff in the centre. He said:

> *"we have a paramedic on shift every single day of the week, along with general nurses, mental health nurses, HCAs and a pharmacy technician."*

11.22 Three psychiatric nurses work between Brook House and Tinsley House on weekdays only.

11.23 A career structure in nursing at Brook House offers the possibility of advancement. We interviewed one member of staff who had been recently promoted. However, if nursing staff are to be retained G4S need a more comprehensive and explicit pathway for career advancement. This will require the generation of customised training materials.

11.24 The head of healthcare said that recruiting good quality healthcare staff to Brook House remained a considerable challenge. Despite the expectation from G4S management that all candidates are interviewed, she said it was necessary to be selective given the specialist nature of the work and therefore did not see all applicants.

11.25 The practice manager told us towards the end of our fieldwork that healthcare staffing was improving. Nine staff were waiting Home Office and G4S vetting and security clearance. Two of them were paramedics. We asked him how healthcare had managed this improvement:

> *"About a year ago we had a pay review. We looked across the local area and at what the NHS was offering because they are our main competitor. Our salaries at the moment are really competitive and that is an improvement. We have had a real recruitment drive and we have refreshed all our adverts."*

11.26 Potential recruits are interviewed in the healthcare centre's administrative office and see the centre as they arrive and leave so they are exposed to the 'vibe' of Brook House. The manager concerned said it was '*useful to have interviews in the centre*' and that potential future employees '*hear the noise and see the patients (detainees) wandering*

around the centre'. He said that exposure to the environment allowed those interviewing to assess the likely suitability of a candidate. For example, a nurse who had worked in a secure psychiatric unit would be less likely to be concerned about locking and unlocking doors. All interviewees are classed as visitors and are searched on entering Brook House. They are always escorted. We believe that a similar approach would benefit the recruitment of all other staff and we are surprised that differing practice exists at Brook House.

11.27 Nursing staff told us that they received regular clinical supervision.

11.28 G4S healthcare are in discussion with a national pharmacy provider at time of writing about more pharmacist and pharmacy technician input to Brook House. This would allow detainees the opportunity to discuss medication concerns with a pharmacist/technician.

Recommendation

R42 G4S Health Services should develop a career pathway for nurses working in Care and Justice. This should be accompanied by the development of customised training materials.

The views of officers and managers about healthcare

11.29 We asked officers, managers and organisations with knowledge of the centre for their views about healthcare. Some of the responses were hearsay.

11.30 The following is a summary of the views expressed:

- Detainees complain about overuse of paracetamol
- Detainees report that they are asked to *"come back tomorrow"*
- Detainees are concerned about medication being taken away on admission
- Detainees are not always seen by healthcare within 24 hours of admission
- Healthcare appear not to advocate sufficiently for detainees who are mentally ill
- Healthcare are unwilling to challenge the Home Office
- Healthcare claim patient confidentiality too readily and thereby restrict the flow of information

- Healthcare are good at working with officers/managers -particularly over first responses
- A lack of activity in the centre results in healthcare being busier than it might otherwise be

Detainee views of healthcare

11.31 Detainees expressed strong views about healthcare at our two meetings. Concerns ranged from access to services to the relationship between healthcare professionals and the Home Office immigration staff. Summary points from our discussions include:

"You cannot make an appointment to see healthcare. Every morning there is a first come first serve queue. There are long lines of people waiting to be seen."

"There is no such thing as mental healthcare in Brook House"

"Healthcare give paracetamol for mental health issues."

"Doctors play the part of the Home Office. They seem to ask questions on behalf on the Home Office and talk to detainees about their immigration cases inappropriately. Doctors minimise medical issues to enable the Home Office/push Home Office agenda. Detainees feel like doctors are trying to please Home Office re rule 35 assessments."

"Detainees feel that the attitude of healthcare staff is not kind."

11.32 Many detainees in our forums had a poor opinion of healthcare. Distress and anxiety are common to many of those at Brook House and this is hardly surprising given their circumstances. It appears to colour detainees' attitudes towards healthcare. The deputy head of healthcare inspection for HMIP said:

"I think in any prison setting or otherwise, there is always a level of distrust around health. It is deemed to be part of the establishment, and the respect is much poorer than [in the] community even though the evidence is often that treatment is better

because there is a real push for delivery to be based on need rather than just equivalence, based on being the same as the community."

11.33 She went on:

"In most cases, what we have tended to find is, actually, it is not bad provision and most of the time it is ending up as reasonably good in actual terms, but it is very different when you are living with this. Sometimes, what staff will say to me is that their perception is that some detainees will have an investment in being perceived to be particularly unwell or being more unwell than their clinical judgement is, because if the judgement is that they are too unwell to be detained, therefore, they won't be detained and so healthcare are basically keeping them in. That is a big factor."

11.34 This underlines the need for healthcare professionals always to keep their primary purpose in mind: providing a professional healthcare service free of inappropriate judgements about individuals and their circumstances. The nurse featured in the Panorama programme overstepped this mark. We were also told by some of those who attended about the training event on 22 February 2018 where healthcare staff engaged in inappropriate banter with control and restraint trainers during personal safety training. G4S management investigated this and the trainers were dismissed. The practice manager told us that the two staff from healthcare present at the event were investigated. Both returned to work. One received a written warning.

Participation in the ITC and detainee induction

11.35 Healthcare managers make a presentation to new officers during their initial training course (ITC). The head of healthcare usually delivers the session. It includes material about infection control, needle stick injuries, communicable diseases and the need for patient confidentiality.

11.36 Healthcare staff do not contribute directly to the detainee induction, but officers show detainees where healthcare is located and explain what services are available.

Participation in ACDTs

11.37 The lead for mental health said that she and her colleague attended most ACDT reviews. An ACDT officer assessor conducts these reviews. They cover an assessment of the individual's potential for self-harm and any changes in circumstances, including news from the Home Office about their case. Officers and nursing staff discuss the nature and level of observations needed after the review. ACDTs are closed with the agreement of the detainee. We asked the mental health lead nurse how empathetic officers were:

> *"I think they are very good, considering it (mental health) is not their field of work. I think they are very tolerant and as I say if you tend to explain why somebody is doing something, they are more understanding."*

11.38 She went on:

> *"I think sometimes they got a lot thrown at them and I think sometimes they work short-numbered, but I would have said the majority are caring. I think like everywhere, you get some that are less caring than others.*

Participation in use of force

11.39 Nursing staff play an important role in planned use of force in the centre. They attend use-of-force incidents to ensure the safety and good health of detainees. They have the responsibility to direct officers to take their *"hands off"* the detainee if they have concerns during an incident. However, we learned during our interviews that nursing staff have no formal training for their role and responsibilities. As a manager put it to us:

> *"They (nurses) have personal protection training but I think there needs to be a little more education around C and R for the nurses and their role."*

11.40 We agree with this suggestion.

Recommendation

R43 Healthcare and G4S management should ensure that nurses involved in control and restraint understand their role and responsibilities. This should be as part of their induction and refreshed yearly.

Management of detainees with mental health problems

11.41 Mental health care is provided by three psychiatric nurses, a visiting psychiatrist and psychologists. We interviewed the senior mental health nurse at Brook House. She said the most common mental health problems were situational stress and post-traumatic stress disorder. Brook House also cared until a recent court ruling[1] for homeless rough sleepers from countries in the European Economic Area who had been detained by Home Office Immigration and Enforcement. Some of these people were acutely mentally ill and needed hospital care under the Mental Health Act.

11.42 Mental health provision in the centre consists of drop-in groups allowing detainees to chat in a supportive environment, one-to-one work with the nurses and consultations with the visiting psychiatrist. Talking groups are held in the nurses' office. The psychologists run a peer support group once a week. The group takes up to eight people by referral. Sessions last 1.5 hours. Lack of space means the centre has no dedicated therapy room.

11.43 Detainees who need a mental health assessment are seen within two days. Most referrals to the mental health team come from officers, welfare or reception staff.

11.44 Those who are acutely ill are cared for on E wing and moved to a mental health facility as soon as a bed is available. This means that they might spend some weeks with detainees with other vulnerabilities or challenging behaviours. In recognition of this, some 'at risk' detainees are moved to Tinsley House with the agreement of the Home Office. Patients needing hospital admission may be transferred to Langley Green hospital, which is part of Sussex Partnership NHS Foundation Trust. The senior mental health nurse said she had developed a good relationship with the trust.

[1] R (on the application of Guereckis) v Sec of State for the Home Department [2017] EWHC 3298 (Admin)

11.45 Medication is prescribed by the GPs or the visiting psychiatrist. The mental health nurses carry out a daily medication round in E wing/CSU. They use this opportunity to check on detainees on constant observations or under Rule 40 and rule 42.

11.46 The senior nurse said that officers *"are very good"* at dealing with detainees with mental health problems despite their limited training. She thought it would be helpful to have a small number of officers with more advanced knowledge.

11.47 One of the GPs at Brook House described the mental health team:

> *"We have an excellent mental health team, and a lot of our issues are mental health-based. I feel we are very well supported."*

11.48 He described similar relationships with the visiting psychiatrists.

Management of detainees using drugs &/or alcohol

11.49 Staff told us that the centre had to manage more detainees with drug and alcohol problems than they had in the past. This included people who were withdrawing and those needed methadone. The deputy head of healthcare inspection at HMIP said that use of drugs in IRCs had emerged as a problem four years earlier:

> *"We are noticing in the last, I would say, few years an increase in misuse within IRCs. The male IRCs specifically, and we are noticing an increase in NPS use, and particularly synthetic cannabis coming in, and that's fuelling some problems."*

11.50 She described HMIP inspections as showing drug misuse in IRCs caring for men as *"definitely much more a significant issue than it was"*. This included an increase in organised crime and violence, particularly related to trading synthetic cannabis.

11.51 The deputy head of healthcare inspection told us that Brook House did not have a drugs strategy at the time of the 2016 inspection. However, she acknowledged that the centre had been doing good work nonetheless, including developing relations with local police. The centre has developed a drug and alcohol strategy since the inspection. Partners involved in tackling substance misuse include: NHS England, Forward Trust, Surrey and

Sussex Police and the Home Office. The strategy has three main themes – disrupting supply, reducing demand and treatment and support.

11.52 Detainees at Brook House can access help with substance misuse from both the Forward Trust and healthcare. The Forward Trust has three drug and alcohol practitioners in the centre. They deliver one-to-one sessions and group work. Interventions are tailored to individual need and include cognitive behaviour therapy, relapse prevention and general education about using drugs. Interventions are kept short-term given the rapid turnover of detainees. However, the trust's office is in an administration area at Brook House which cannot be accessed by detainees and the team leader said this meant that practitioners had less contact with detainees than they would like. He believed that the trust should be more visible in the centre and one way to achieve this would be to locate the office where detainees could easily drop in.

> *"It's nice and quiet (the office in the sterile area) so I can do my admin but it's not good for the detainees because the office should be more central. These guys who are stigmatised culturally they could not come to us without being exposed, we are not reaching these people enough."*

11.53 Given the prevalence of substance misuse in the centre we think the trust's office should be relocated into the centre.

Recommendation

R44 G4S and the Home Office should discuss relocating the Forward Trust's office at Brook House so that detainees have ready access to it.

11.54 We asked healthcare managers about the challenges associated with detainees who abuse drugs and/or alcohol. They told us about the demands placed on the healthcare team by detainees who use new psychoactive substances (NPS). Smoking is the most common way to take NPS. The side effects of ingestion can include paranoia, psychosis, seizures and death. These risks are exacerbated by their use with other substances and alcohol. The head of healthcare reported that in January 2016 nursing staff responded to 22 incidents of NPS ingestion in a single day. These included dealing with acute physical symptoms such as

respiratory arrest requiring emergency admission to hospital and managing detainees who had become acutely psychotic.

11.55 Healthcare also manage the care of detainees who are withdrawing from opiates. This includes prescribing and overseeing the administration of their substitute medication. Detainees who arrive on a high dose of methadone and are due to be removed from the country may have to be kept at the centre while their dose is reduced. In some cases, their removal will be delayed until they are drug-free as methadone is not available in the country to which they are returning.

11.56 The deputy head of healthcare inspection gave us a more general insight about why detainees might misuse drugs. We think this has relevance to Brook House where the activity programme has been so sporadic. She told us:

> *"People don't use substances in isolation. People often do it to change how they feel, or to feel something different, or to pass the time. All of that comes in, and so some of that wider element around activity is a huge deal.* ***Boredom is often a big trigger*** *[our emphasis]. Therefore, around there being a regime that actually keeps people busy."*

Impact of the regime on healthcare

11.57 We heard evidence from a manager on the impact of the lack of a regular activity programme on the demand for healthcare. He said this about morning triage:

> *"Yes, it depends on what is going on in the centre. If there are activities in the centre, we tend to be quieter, with not as many patients for triage. However, if it is a bit chilly outside and a bit damp, a bit wet, we tend to have more people coming through the door. I don't know whether that is because there isn't enough going on in the centre. Sometimes they like to come just to have a chat really, it is quite nice and quite a safe environment for detainees to talk to staff, I feel."*

Overall assessment

11.58 Detainees at Brook House have access to a good range of healthcare services. Long-standing challenges to do with staffing are being tackled. Access to a range of healthcare services is probably faster for most detainees than it would be if they were in the community. Overall, provision is good.

11.59 However, the findings of our detainee forums suggest significant levels of distrust of healthcare staff. So, despite access being better than in the community, healthcare is easily mistaken as part of the immigration enforcement system. This view of healthcare is reinforced by healthcare staff being identified as part of the management of the centre and by, for example, their necessary involvement in use of force, the planning for removals of groups of detainees on charter flights, and their presence at removals. Healthcare staff should be alert to the need to explain themselves to detainees and adopt a caring, open and independent-minded attitude. They need to make clear to detainees that their involvement with Home Office immigration enforcement is to provide an independent clinical opinion. This must be emphasised from reception onwards. Healthcare managers should reinforce regularly this message to healthcare staff.

12. Security and safety

Governance and management of security and safety matters

12.1 As we point out in chapter 7, the work of the management team responsible for security at Brook House has been hindered by lack of staff. From the end of 2016 until June 2017 a security DCM acted up as head of security. During that time, she and a DCO covered the work of the security team that should have comprised seven people (four collators of information, two DCMs and a senior manager).

12.2 The lack of staff meant they had not been able as a matter of course to process all the prison files of TSFNO detainees. This raised the possibility that important information about the risks posed by TSFNOs arriving at Brook House, which had not been included in their prison escort records (PERs), had been missed. The security team had also not had the resources to investigate all the security information reports (SIRs) giving information about potential risks to safety and security at Brook House. A security DCM talked to us about the effects of the failure to process some prison files:

> *"Now I know that doesn't sound particularly like much of a concern. However, going through a prison file you could identify that somebody is a sex offender or a hostage-taker or something, so they could be a significant risk that hasn't been highlighted to Immigration. Only by processing that you will highlight that and that does happen, things are missed. It's an easy job, but you had to prioritise all the time, so risks were being missed… I think it added to the pressure in Security because you can see this pile mounting and mounting, you know you have to deal with it at some point but it is actually what takes priority. You have a threat of 'I am going to stab somebody' or you have a prison file that may not contain something, so you are going to deal with that immediate risk that you are aware of."*

12.3 We asked about the staffing of the security team during the time of the filming of the Panorama programme in the first half of 2017. The current head of security, who was previously the head of safeguarding, told us:

> *"The [security]staff… have been unloved in my opinion. There has been no Head of Security, so in terms of day-to-day engagement it has not been there"*

"There was not a security manager and the collator, so it should be two detainee custody managers and four collators, and there was one collator in post… I think they were overwhelmed. I really felt for them, they really struggled."

12.4 The [redacted] told us:

"I was aware that there was some stretch. The feedback that I had was that it was being managed, it was manageable."

12.5 The staffing levels in the security team improved in the months after the appointment of the head of security. Nevertheless, an internal report dated November2017 commissioned by the interim director to evaluate the risk factors for violence at Brook House on the principles of *Promoting Risk Intervention by Situational Management* (the PRISM report) identified the constraints being placed at that time on the security team by a lack of operational staff. The PRISM report says:

"Information is provided to security in terms of risk and intelligence through the SIR process. Any urgent intelligence is acted upon immediately i.e. when there is a potential risk to staff or detainees such as a weapon. Lower level SIRs, are not always actioned in a timely manner due to lack of staff availability to carry out the search. Examples were provided of some searches waiting up to a month when intelligence had been received in relation to drugs"

12.6 We learned in April 2018 that the continuing lack of staff had meant that backlogs of unreviewed detainees' prison files were still building up. A DCO assigned from a residential unit to help review the prison files told us that this review had led to the discovery that the risk posed by a detainee who had been put in a shared room meant he should have been given a single room. A security DCM told us that the lack of staff meant that the security team still could not undertake trend analysis and planning of mitigation strategies for security issues. She said the security team worked reactively:

"…we are playing catch-up from Panorama. We don't have the time to go back. We are literally churning through them to just cover ourselves and get actions in place. We are not being proactive at all, we are just being reactive."

12.7 Oversight of matters relating to bullying and violence at Brook House is the responsibility of the safeguarding team and in particular the violence reduction manager. As we say in chapter 7, from June 2017 until December 2017 he had had to act up as the head of the whole safeguarding team. He had not been able to fulfil his workload and had not been able routinely to investigate reports of bullying and acts of violence by detainees. He had not been able to analyse data from SIRs and investigations of incidents of bullying and violence to identify trends and the wider lessons to be learned or to plan mitigation strategies.

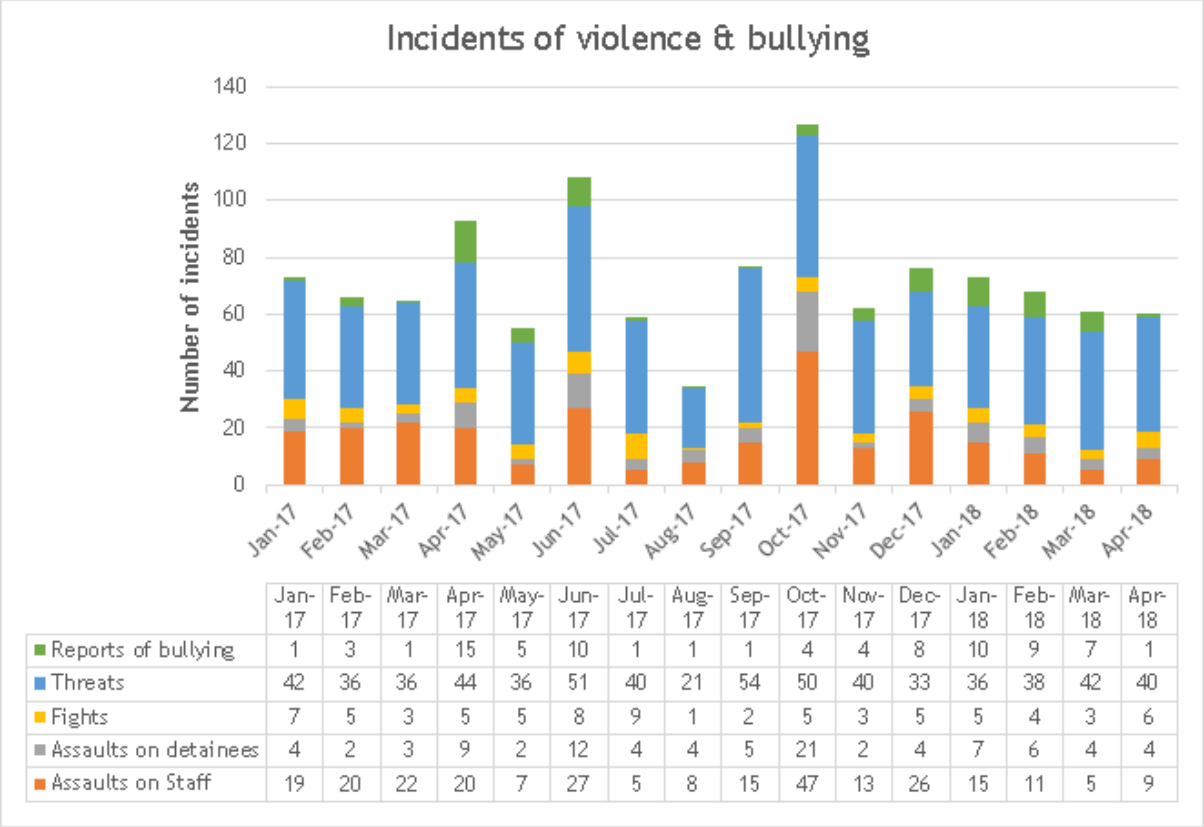
12.8 The reactive response to the management of violence at Brook House was identified in the PRISM report:

> *"Data is collected on a daily basis about the incidents and what has happened though there is little avenue for this information to be effectively analysed and utilised to prevent violence from occurring. The data is utilised from an operational perspective to ensure that detainees who are at risk either to each other or from each other are separated on different units.*
>
> *"More effective analysis and use of the violence data is needed to deliver an effective strategy to reduce violence at Brook House,"*

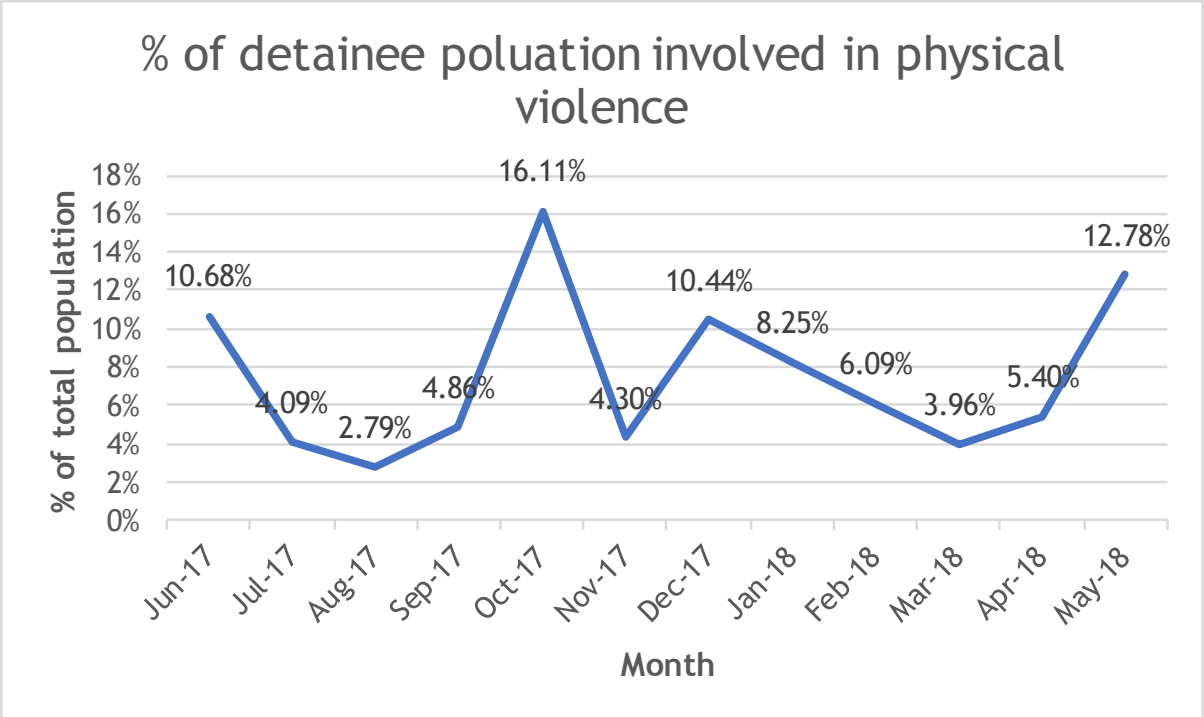
12.9 In April 2018 we were told that the safeguarding team still had a vacancy for a DCM. The security team had a vacancy for a collator.

The experience of violence and assaults at Brook House

12.10 The reports complied by the violence reduction manager record the following levels of assaults, violence and threats perpetrated by detainees at Brook House.



	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Reports of bullying	1	3	1	15	5	10	1	1	1	4	4	8	10	9	7	1
Threats	42	36	36	44	36	51	40	21	54	50	40	33	36	38	42	40
Fights	7	5	3	5	5	8	9	1	2	5	3	5	5	4	3	6
Assaults on detainees	4	2	3	9	2	12	4	4	5	21	2	4	7	6	4	4
Assaults on Staff	19	20	22	20	7	27	5	8	15	47	13	26	15	11	5	9



12.11 Managers undertook a survey among Brook House detainees in December 2017 to ask them about their experience of threats, assault or mistreatment. We saw some of their

responses. They suggested that any physical violence or assault they experienced had been at the hands of fellow detainees.

12.12 A number of detainees spoke to us about having experienced violence and bullying from other detainees. Detainees at our focus groups told us that staff shortages meant that violence among detainees was not properly managed. They told us:

> *"officers cannot react quickly to fights between detainees"* and that *"detainees break up their own fights before officers have enough back up to intervene"*.

12.13 Many officers told us that they had been threatened or assaulted by detainees. Their evidence suggested most incidents of violence or assaults on staff were not serious, involving for example pushing and verbal abuse but we heard of many incidents that were more serious and some resulting in staff needing hospital treatment and significant time off work. The director of detention and escorting services, HOIE, said more assaults on staff took place at Brook House than at any other detention centre.

12.14 Some staff and managers said Brook House was not a safe environment. We asked staff to tell us how safe they felt Brook House was on a scale of one to ten, (with one being safe and ten being unsafe). The average rating was seven. Staff made the following comments about the safety of Brook House:

> *"…it's a matter of time before I see a death in custody here. It's a matter of time whether I see a death in custody or whether I see an officer being seriously, seriously assaulted."*

> *"Right now it's the most unsafe it's ever been…It's most unsafe by miles since I've been here."*

> *"Bearing in mind there are five officers off sick through injury, I would be concerned about my safety"*.

> *"I don't feel safe working here anymore… apparently there were two knives in the centre; one has been found and the other is still at large… It's quite worrying when you hear that there's a knife in the centre and I don't know what's going on behind the scenes as to whether there's any plans to close the centre and search it room*

by room. I would have thought that would have happened straightaway, as soon as there was information about a weapon. It could be used on either a detainee or an officer."

"I believe they [female officers] are not safe a lot of the time in this place because they have a lot of verbal abuse. Some of them even get physically touched and what's stopping that happening? What are the repercussions of somebody doing that to an officer, female or male? There should be something in place to stop detainees thinking they can do this to a female officer… She is as hard as nails. She can handle it, but it shouldn't be happening…"

"…. we've just seen more experienced staff go because they don't like the way the centre's going…Meaning that it's becoming more dangerous"

12.15 We did not witness serious incidents of physical violence, but we learned of occasions when detainees had been violent or when there had been a significant threat of serious violence. The first occasion was on 28 November 2017 when a small group of TSFNOs due for deportation that day instigated a mass refusal by detainees on C wing to be locked up for the lunchtime roll call. Officers present on that occasion told us that detainees continued to defy officers throughout the day and became extremely threatening. Detainees turned furniture over. They gathered items such as mop handles and tore some metal discs off of the feet of a pool table, with a view to using these as weapons. Staff told us they thought they had lost control of the centre and would be attacked. They told us how frightening the incident was and how unsafe it had made them feel. The national response team was summoned to Brook House but was not deployed.

12.16 A DCO told us:

"I pressed my panic button and people arrived. At dinner time someone stands there with a list of what people have ordered and they'll tick people off as they come up to collect their dinner, and they'll stand at the servery with their back to the queue that's behind them. I've worked here for eight years and I've never felt the need but I did it from inside the servery because I didn't want to have my back to anyone. That's because the pool table had been turned over on the first floor, paintings had been ripped off the wall, showers had been ripped down, I'd seen a couple of people walking round with things in their hands. That's why I felt the need to do it."

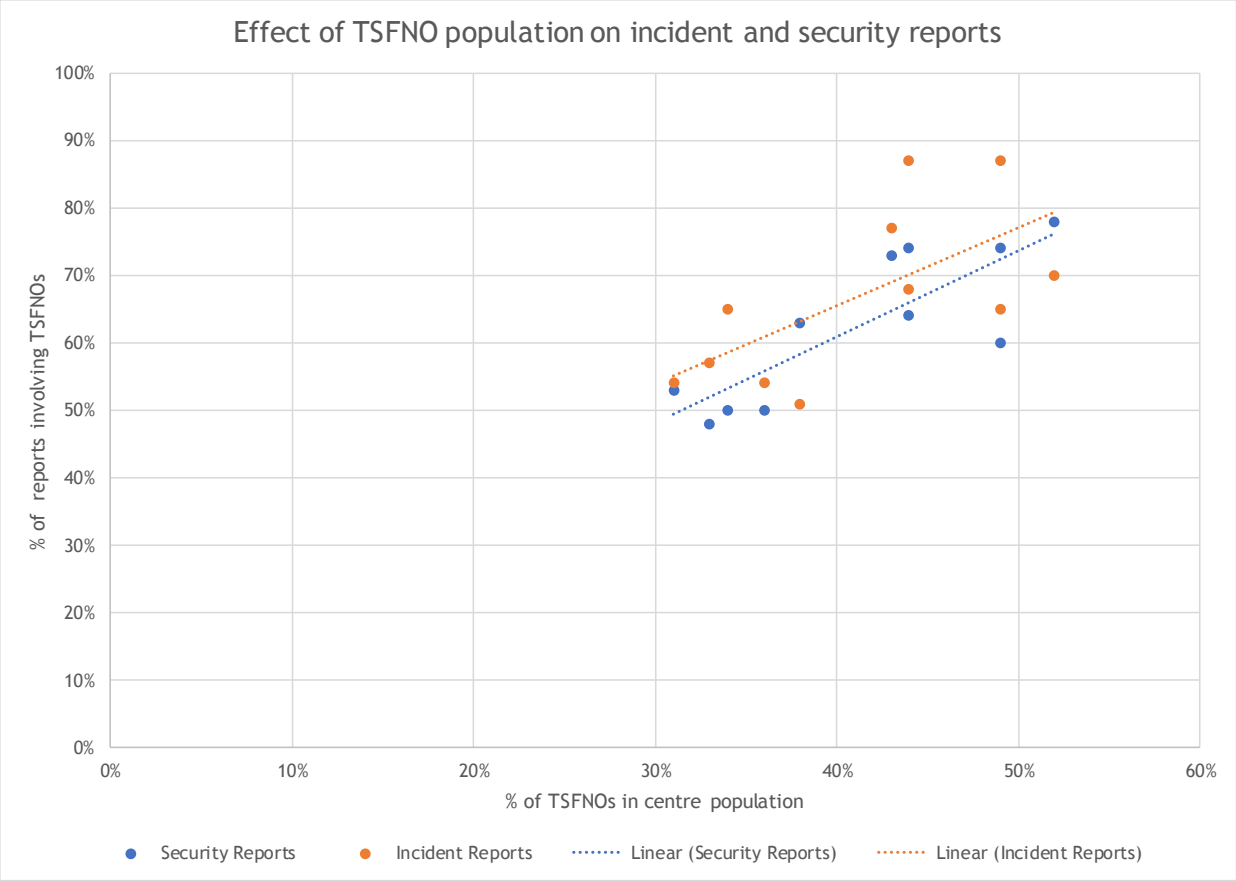
12.17 It was not until late at night on 28 November 2017 that all the detainees on C wing were persuaded to return to their rooms to be locked up for the night.

12.18 The instigators of the events described were removed to the care and separation unit (CSU). At the insistence of the Home Office, one of them was soon transferred from the CSU to E wing where he broke a pool cue in the office and then hit a DCO across the face with it. The DCO sustained a broken nose, which needed surgery. Other staff were also hit with the pool cue and two were bitten. Four officers were taken to hospital. The detainees caused £16,000 damage to their rooms in the CSU, including smashing a toilet.

12.19 A number of detainees barged past a DCO staffing the door to a wing at the beginning of 2018. They ran into one of the bedrooms and assaulted two detainees. One of the detainees was seriously injured and had to be taken to hospital.

12.20 We heard of a further occasion in February 2018 in which three TSFNOs due for removal barricaded themselves in the room they were sharing. They spread washing up liquid across the floor to make it slippery. During the C and R operation to remove them from the wing a number of officers sustained injuries.

12.21 People we interviewed gave a number of reasons for the rise in assaults and violence during 2017 and early 2018. Some thought the increase in the numbers of TSFNOs coming into the centre from prisons had played a part. The head of security told us in November 2017 that in the previous month 29 per cent of the TSFNOs in Brook House had been involved in the incidents of violence, assault and other matters reported via the SIR process, compared with only 6 per cent of other detainees. The security department undertook work to assess the extent to which the TSFNO population contributed to security and violence incidents at Brook House. The following graph shows that TSFNOs were disproportionately the subject of reports of security incidents and incidents of violence or threatening behaviour.



Month	Roll count	% of TSFNOs in centre population	Security reports involving TSFNOs[1]	Incident reports involving TSFNOs[2]
Jul-17	444	36%	50%	54%
Aug-17	465	33%	48%	57%
Sep-17	452	31%	53%	54%
Oct-17	453	34%	50%	65%
Nov-17	418	38%	63%	51%
Dec-17	355	52%	78%	70%
Jan-18	327	49%	74%	65%
Feb-18	328	44%	64%	87%
Mar-18	237	49%	60%	87%
Apr-18	296	44%	74%	68%
May-18	295	43%	73%	77%

[1] Security reports are intelligence based – it could relate to a suspicion / observation – not an actual event.
[2] Incident Reports follow actual events.

12.22 The interim director told us however that a few more disruptive TSFNOs, such as those involved in the incident on 28 November 2017, were often responsible for a large number of incidents of violence and assault and other behavioural problems.

12.23 The head of Tinsley House, who undertakes the duty director role on a rota at Brook House, suggested that the presence of many inexperienced staff unable to deal with detainees' problems as they would like led to detainees becoming frustrated and aggressive. She said:

> *"It can be very difficult. There are not the same control mechanisms within the immigration detention that there are in prisons, so you very much have to manage detainees with relationships and respect, and if you are going to do something for someone, actually doing it. I think some of that comes with experience. When you have new staff teaching new staff they don't have that experience, and I think sometimes I can totally understand why detainees become frustrated. If there is one thing I have learnt over the 14 years that I have worked in this field is to be completely honest with people. They might not like what you are telling them, but they will respect the fact that you are being honest."*

> *"I think the way detainees can present at times, a lot of the time it is through frustration. Sometimes it is to deliberately try and intimidate, and I find that despite the fact that I am in civilian clothing, detainees quickly realise that I know what I am talking about. I think that is just because I am firm with them and I will say to them, "yes, the fax machine is broken, but that doesn't mean that you can go onto the wing next door. We need to resolve this issue. Can you step away from me, please, and keep your voice down. I am not shouting at you. I expect the same respect back from you." I think it is about challenging detainees, but in a way, that you would challenge anybody in the street who was shouting and hollering at you and getting too close."*

12.24 Some interviewees told us that low staff morale and lack of ownership of their responsibilities meant that staff were not prepared to challenge detainees, which encouraged them in further poor behaviour.

12.25 A DCM said:

"I had somebody, because I stopped and dared to ask him for his ID card, he came round the back, squared up to me… Then he picked the table up, smashed it, the fax machine, all for me just challenging him for an ID card, so I understand the intimidation side of it… I understand why they [new staff] go 'Well I'm not asking them', but you get the managers who don't ask, so if I am not prepared to challenge how can I expect somebody else to challenge?"

"If you look at the state of some of the wings, then you look at the people who, dare I say, manage it and if you look at the people that manage them, then it takes somebody to care and have a bit of ownership and to actually get challenged."

12.26 A DCO said:

"smoking in the centre was a big issue, we were asked to give people warnings, and I tried to complete my job, which made me more of a target from detainees, but I… came across [a senior manager] walking past a detainee smoking right in front of his face, and he didn't charge him at all. If duty directors aren't going to challenge, in that manner, you set a standard, why should I be challenging?"

12.27 A senior manager said:

"It's open that a foreign national offender will come to the shop window, he will push in the queue, no-one will stop him. He will be using someone else's ID card or he will force someone else to buy him his stuff from the shop and just walk off."

"Every officer is aware that there is a warning system in place, three warnings and you are in trouble or whatever it is but officers, they are just not challenging anyone. There are people smoking cigarettes, people smoking Spice in front of your face and you are not doing anything about it."

12.28 We met with members of the Independent Monitoring Board (IMB) who questioned whether the lack of activities had played a part in increasing levels of violence and assaults.

12.29 Many DCOs and DCMs told us they believed that detainees would behave better and there would be less violence and assault if they could rely on an effective and rigorous

incentives and earned privileges scheme similar to those in the prison system and as had once existed at Brook House.

12.30 Many of our interviewees acknowledged that staffing problems were a contributing factor in the increase in violence and assaults at Brook House. The violence reduction manager told us in late April 2018 that the monthly figure for incidents of physical assaults on staff in March 2018 had reduced by 45 per cent and for assaults on detainees by 55 per cent. He attributed the fall in the numbers above all to the presence of more staff in the centre.

12.31 Lack of staff at Brook House may not account for or contribute to every incident of violence or assault at Brook House but many staff and detainees said it sometimes left them feeling insecure, unsafe and unsupported and that they perceived Brook House as unsafe.

12.32 In our view the cramped space at Brook House, which is inadequate for the number of detainees held there, the lack of outside space available for detainees and the need for large numbers of detainees to push past each other as they move about the centre adds to the risk of violence and assault.

12.33 We identified two pinch points that appeared to be triggers for violence at Brook House. The first is the locked wing doors. These are kept locked at all times to prevent detainees congregating on particular wings and to allow the separation of detainees who might be a risk to each other. Detainees are allowed access only to their own wing. They have to bang on the door and wait for an officer to open it. They are required to show an ID card to prove that they live on the wing. This causes a constant noise of banging on doors that can be heard throughout the wing and beyond and creates a sense of commotion and unease. Staffing wing doors takes up significant time. The process also leads to frustration to detainees who have to wait for the door to be opened and significant tension when detainees are unable, or refuse, to show their ID. It sets up an opportunity for confrontation between detainees and staff. We regularly saw detainees push in an aggressive and threatening way past officers staffing doors. As the current vice chair of the IMB said:

> *"the entrance into the wings, the bottleneck, is just grief. It just seems to me (a) it's a waste of staff time, and (b) it leads to massive frustrations."*

12.34 G4S installed an electronic gate at the entrance to B wing in 2017. However, detainees could jump over it and its use was discontinued. The interim director told us that G4S planned to install more robust electronic turnstiles at the wing entrances as part of any bid for a new contract for the centre. The installation of new turnstiles is necessary and overdue as a solution to some of the tension and poor behaviours at Brook House. It would also help to ease staffing pressures. We believe that G4S and the Home Office need to agree that electronic turnstiles will be installed as soon as possible rather than waiting for this to happen as part of the implementation of a new contract to manage Brook House.

Recommendation

R45 G4S and the Home Office must ensure that robust, full-length electronic turnstiles are installed at the entrance to the residential wings as soon as possible.

12.35 The serving of meals is another source of tension and a risk point for violence and assault at Brook House. We heard from detainees and staff that violence often flared up in the meal queues. The reasons were queue barging, paid detainees who served food giving preferential treatment to certain detainees and detainees not being able to have the meal they had ordered as a result of mismanagement of the serving process. Staffing problems, and a failure to manage when staff took their breaks, often left mealtimes with too few staff.

12.36 The [redacted] contract manager told us:

> *"The issue that tends to happen on the wing serveries is that where there is perhaps the lack of supervision and you have detainees going down and they are either not taking the choices that they have booked, or because their friends are working behind the serveries they are getting two of something, it means that people towards the end of the meal perhaps are not getting what they have ordered because there is none of it left."*

Repeated recommendation

R22 The SMT and residential DCMs must ensure that adequate numbers of staff are on duty throughout the service of meals to ensure orderly queues and service of meals.

Bullying

12.37 The Gatwick IRCs anti-bullying policy provides that all complaints or reports of bullying must be investigated and that logs will be compiled of all incidents of bullying and of all perpetrators and victims. Wing managers are required to make a decision about what to do about any incident of bullying. For perpetrators this will be *"no further action"*, a formal warning or being placed on the centres' anti-bullying programme. For victims it may mean opening an ACDT document or a referral for personal development training with the safer community manager (now referred to as the violence reduction manger). The violence reduction manager told us staff would first try to mediate between a victim and a perpetrator, but the anti-bullying policy says:

> *"If the investigation reveals that the bullying was of a serious nature or the detainee has been involved in bullying before (he has received a Formal Warning within the last 4 weeks for involvement in bullying) then the detainee will be placed on the Anti- Bullying programme."*

12.38 The anti-bullying programme involves a meeting between the detainee, the detainee's wing manager and the violence reduction manager at which a monitoring-challenge-support book is completed. This book includes a record of the initial meeting, an anti-bullying programme compact setting out guidelines for behaviour that the detainee is expected to adhere to and a support plan detailing the agreed objectives and actions to help the detainee while he is on the programme. The detainee is monitored via weekly case reviews. The policy sets out a three-stage programme. The detainee can move up or down, depending on their attitude and behaviour. A detainee at the most serious stage three is deemed to pose a significant risk to the safety and wellbeing of others and the policy makes clear that he should be considered for removal from association under rule 40 of the Detention Centre Rules 2001.

12.39 We refer above to the lack of management capacity in the safeguarding team until at least early 2018 that meant that cases of bullying and violence at the centre had not been routinely or promptly investigated. The violence reduction manager told us that incidents of bullying and violence had not been investigated properly since 2015. Monitoring-challenge-support books do not appear to have been opened routinely even when an investigation had found bullying. The annual report of the Brook House IMB says only seven victims and six perpetrators were reported and dealt with under the monitor-support-challenge process in 2017. The minutes of the security meeting on 21 November 2017 record:

> *"Five bullying investigation [sic] but no challenge booklets"*

12.40 We asked DCOs about the management of cases of bullying and found that many seemed to have little understanding of the anti-bullying policy and little involvement with cases of bullying. One told us that he did not know what happened to perpetrators of bullying and thought that victims were put on a supported living plan.

> *"The only thing I know that happens is they get put on a document called a 'Supported Living Plan'. As for what happens after that I have no idea."*

12.41 We examined some of the monitoring-challenge-support books kept in wing offices. They appeared to record observations about the behaviours of detainees who had been found to be bullying but did not always set out coherent plans for tackling the detainee's bullying behaviour. It was not clear that the plans had resulted in proactive management of the detainee's behaviour or led to improvement in behaviour. The violence reduction manager agreed with these observations.

12.42 The violence reduction manager told us at the end of April 2018 that he was working to improve the response to and management of bullying and violence at Brook House. His programme was to include:

- A new policy on tackling anti-social behaviours;
- A review of the anti-bullying policy, including amending it to cover bullying and violence against staff, and to allow for DCOs as well as wing managers to open monitoring-challenge-support books; and
- A revised incentives scheme for detainees.

- Nominating a violence reduction representative from among the DCOs on each wing

12.43 The work planned by the violence reduction manager needed to encompass further efforts to raise awareness among DCOs about the anti-bullying policy, the ways and means by which the perpetrators and victims of bullying are managed, and to encourage DCOs to take greater ownership and responsibility for identifying and tackling bullying.

12.44 The current version of the violence reduction strategy refers at paragraph 7.3 to an annual survey of all detainees at Gatwick IRCs with the aim of collecting information on the scale and types of bullying they experience. In the light of the issues in the Panorama programme, the survey should be widened to encompass all forms of violence, assaults and threats experienced or witnessed by detainees. Given the importance of monitoring violence and the overall climate at Brook House and the reticence among staff in reporting concerns about the behaviour of their colleagues (which we discuss in more detail at chapter 13), the staff should also be surveyed to elicit their experiences of violence, assaults and threatening behaviour.

Recommendations

R46 The SMT and safeguarding team should ensure that all incidents of violence and bullying at Brook House are investigated in a timely way.

R47 The SMT should undertake a programme of awareness-raising among staff to improve their understanding and use of the anti-bullying policy.

R48 The safeguarding team should survey staff at Brook House regularly to ascertain their experience of and perspective on violence and bullying and its causes.

Incentives and privileges

12.45 Many DCOs and DCMs said detainee behaviours had improved and the incidence of violence and assault had been lower when Brook House had a traditional prison-style incentive and earned privileges (IEP)scheme. Even some staff who had not been at Brook

House while it was in operation lamented its end. Many felt the lack of an IEP scheme meant there was no effective means of enforcing rules and that this gave detainees the upper hand. One said:

> *"Personally, I feel the biggest issue has been the level of discipline… We have lost the ability to incentivise and take away privileges from detainees who are not behaving according to the regime."*

…

> *"it did provide a source of authority. Right now, I tell you to please stop smoking in the corridor, I give you a warning and it has become such a far, far, far, far, far - and I do want to accentuate this - far lasting process, whereas before basic could happen within a week if you had the correct evidence and supporting mechanisms. Officers do not now feel they have the power to enforce the regime, that is a fact. A detainee will just go: "what are you going to do about it?", "I'm going to give you a warning"; "you can give me all the warnings you want!"."*

12.46 Another DCO said:

> *"There has to be something regarding repercussions on detainees' actions. There has to be something done about that. Bring back a basic wing, or do something. Give us more power so that we are not [powerless]"*

12.47 A DCM said:

> *" No. I'll be honest, and the DCOs don't [give detainees warnings] because for that reason, what's the point? That's how they see it. I know there is a point because if you can give people warnings there is a point, but they say nothing gets done about it, because you can't do anything about it.*
>
> *"We need [an IEP scheme]."*

12.48 The HMIP report on its inspection in June 2013 criticised the Brook House IEP scheme:

> *"The centre continued to operate a prison-style three-level reward scheme and an enhanced wing which were divisive and inappropriate for a detainee population. At the time of the inspection, 102 detainees were on the enhanced level and 293 on*

the standard level. No detainee was on the basic level, although there had been 16 in the previous six months.

"Detainees on the basic privilege level were locked up for most of the day, their television was removed and they had limited access to activities. The scheme no longer used separation as punishment. Detainees told us the enhanced wing was unfair and many had limited understanding of the rewards scheme.

12.49 HMIP recommended:

"The rewards scheme should not involve an enhanced wing or a prison-style three-tier incentives and earned privileges system."[1]

12.50 The IEP scheme was consequently abandoned in favour of a rewards scheme centred on detainees being denied the opportunity to do paid work if their behaviour was deemed unacceptable. This scheme too was criticised in the HMIP inspection report in November 2016: [2]

"The centre operated a two-level rewards scheme. Staff could downgrade a detainee following three warnings or a serious incident but we did not find evidence of this happening. All new detainees started on the standard level. At the time of the inspection, 30% were on the enhanced level and 70% on the standard level. The only material difference was that enhanced detainees could work while those on standard could not. This was an inappropriate and punitive restriction. Detainees we spoke to were unaware of the scheme and it did not appear to be useful in motivating good behaviour."

"….. paid work was only available to detainees with enhanced status…and security and Home Office clearance. The Home Office continued to veto individual applications for work for non-compliance…

[1]Her Majesty's Inspectorate of Prisons (2013) Report on an unannounced inspection of Brook House Immigration Removal Centre 28 May – 27 June 2013. https://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/brook-house-2013.pdf p.26

[2]Her Majesty's Inspectorate of Prisons (2017) Report on an unannounced inspection of Brook House Immigration Removal Centre 31 October -11 November 2016. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/03/Brook-House-Web-2016.pdf pp. 25, 42-43

12.51 HMIP recommended:

> *"…Detainees should not be prevented from taking up jobs because of noncompliance with the Home Office."*

12.52 The director of detention and escorting services, Home Office Immigration Enforcement (HOIE), told us that the Home Office relied on the guidance in relation to paid work set out in DSO 01/2013 to justify the use of the removal of paid work from those who did not cooperate with immigration processes or did not comply with the standards of behaviour centre managers expected. The DSO says at paragraph 10:

> *"Provision of opportunities to work should be directly linked to a level of compliance by the detainee on two levels:*
>
> *a. with a centre operator- only detainees who are on the enhanced level of incentives scheme may be allowed to engage in paid work…Detainees should be advised that… non-compliant or violent behaviour (ie move to R40/42) will prevent them from continuing to qualify for this entitlement. They will automatically lose their paid work opportunity.*
> *b. With the UK Border Agency- only those detainees who are actively cooperating with the Agency in relation to the resolution of their immigration case may be allowed to engage in paid work…"*

12.53 The director of detention and escorting services, HOIE, defended the withdrawal of paid work opportunities for the purposes set out in the DSO but she acknowledged that more general use of traditional tiered IEP schemes with detainees on differentiated regimes depending on their behaviours had been the subject of criticism. She said the Home Office would not promote such schemes in future. She said the Home Office wanted individual IRC directors to devise their own incentives and privileges schemes instead.

12.54 She told us:

> *"The only people that really use incentives and privileges in the way you might recognise it is Morton Hall, because they are an HMPPS run immigration removal centre, and it is in their DNA. I don't think they place a huge amount of weight on*

it, but if I said to them "Get rid of it", they would explain that it actually helps them.

…

"Most of the other suppliers, so the private sector suppliers have, by and large, got used to operating without it. We said to them, and I can't remember precisely, but we said "You must have an Incentive and Earned Privilege policy" but left it up to them as to how they managed it. In practice they are not really managing it."

…

"The prison service incentive comes with an internal governance system that we don't have, and we don't want to introduce. The related discussion is the more interesting one, which is what sanctions do our detention centre operators have for bad behaviour?"

12.55 The Detention Centre Rules set out in Statutory Instrument 2001 No 238 say at paragraph 17 (1):

"All detainees shall be entitled to undertake paid activities to the extent that the opportunity to do so is provided by the manager."

12.56 The expression *"all detainees <u>shall be entitled</u>"* (our underlining) suggests that the Home Office's DSO guidance on paid work and its constraints on non-compliant detainees' opportunities to undertake paid work are at odds with the statutory instrument.

12.57 The HMIP inspection team leader said he agreed with our interpretation of the Detention Centre Rules. He reiterated the view set out in the HMIP reports referred to above that detainees should not in any event be subject to punishment regimes and the withdrawal of opportunities for paid work should not be used as punishment for non-compliance.

12.58 Managers responded to the criticism in the HMIP 2016 report on Brook House of the Gatwick IRCs rewards scheme and its apparent use of the removal of the opportunity for paid work for punitive purposes by seeking other means to incentivise good behaviour. They introduced a disruption policy in January 2017 that refers to a number of measures to address the behaviours of disruptive detainees. They include:

- *"Detainees will be informed that they will be subject to elevated levels of room searches, and that their wing location will be subject to regular reviews*

- *Those subject to the disruption policy will become ineligible for certain employment within the centre and on an individual risk assessed basis could be excluded from employment. This will be reviewed via monthly assessments ….*
- *Visits arrangements will be reviewed by security and closed visits could be considered*
- *It will be made very clear to the individuals that they will be subject to a higher level of scrutiny due to their behaviours..."*

12.59 The disruption policy still contains confusing and obsolete references to detainees' IEP status. In particular it says in the section on measures to deal with disruptive detainees: *"Alerts and IEP status will be reviewed and used appropriately"*. The policy should be amended to remove these references. The newly appointed DCM in charge of the paid work programme at Brook House assured us that detainees were taken off a paid work role only if they were assessed as unsuitable for it and not for punishment purposes.

12.60 Overall the disruption policy is a sensible, appropriate and useful contribution to the efforts of DCOs and managers to prevent poor behaviour including violence and assault. We saw the deputy director encouraging staff to use the policy in the morning meeting with staff but we learned that the policy was widely misunderstood both by DCMs and DCOs and not much used by them. One DCO told us the policy for dealing with misbehaviour by detainees was that they be given three warnings and then put in the care and separation unit:

> *"We can issue written warnings and what's meant to happen is you have three written warnings you go to CSU, but I am not sure if that is allowed anymore, because anyone who is taken to CSU the Home Office have to approve them being in that place. More often than not, if someone is taken there for something the next day they are taken out again. They will happily walk there because they have done something. For example, getting in a fight, and one day later they are back out again."*

12.61 We believe that managers need to work with staff to promote a better understanding of the disruption policy and to encourage its use. We also believe there is a need for managers to undertake development work with staff aimed at ensuring that they have the confidence and skills, including inter-personal and engagement skills, to allow them to

tackle poor behaviours, and to disabuse them of the notion that their hands are wholly tied by the lack of a punitive IEP scheme.

Recommendation

R49 The SMT with the violence reduction manager should undertake a development programme with staff to:

- develop their confidence and skills in dealing with disruptive detainees; and
- improve their awareness and understanding of the anti-disruption policy and how it should be implemented.

12.62 We believe the lack of activities, entertainments and other distractions available to detainees has played a significant part in some of the poor behaviours and violence at Brook House. Thought should be given to how activities and entertainments can incentivise and improve detainee behaviours as part of an improved programme. For example, we heard at Rye Hill prison about a monthly competition for the cleanest wing. The competition was closely fought by staff and prisoners. The winning wing was awarded a certificate and its prisoners were given a celebratory tea. We heard too from the former activities manager at Brook House about how he had organised competitions that promoted desired behaviours, for instance, football tournaments in which it was a foul if the ball was kicked onto the security razor wire and punctured.

The use of force

12.63 One of the more disturbing incidents in the Panorama programme involved the unauthorised restraint of a detainee who tried to strangle himself while under constant observation. The Panorama film appears to show a DCO holding the detainee's head, digging his fingers into the detainee's neck to restrain him and choking the detainee. The Panorama film showed a number of other officers present but doing nothing to prevent the mistreatment of the detainee. None of the officers who saw or were made aware of the incident reported it as required under paragraph 9 of the Gatwick IRCs use-of-force policy.

The Panorama film shows officers on a number of other occasions referring to and bragging about their use of unauthorised restraint.

12.64 The report of the G4S internal investigations into the allegations of inappropriate staff behaviours undertaken after the Panorama programme says:

> *"Use of Force is an area of concern from the investigation process. There is evidence of inappropriate and excessive use of force, as well as non-approved use of force. The fact that the use of force trainer was one of the individuals featured in the programme and has been dismissed for his conduct adds to this concern. The investigation process has demonstrated that force has been employed without any documentation being completed on at least two occasions."*

12.65 As set out below, we were given further cause for concern about staff attitudes to the use of force on detainees and about the processes for managing and overseeing the use of force at Brook House.

12.66 As we say in chapter 8, our experience of the personal protection training we received from C and R instructors at Brook House led us to question the quality of training. The report by Hibiscus charity staff of the personal protection training they received on 22 February 2018 magnified these concerns. Their report led to the dismissal of the two C and R instructors who delivered the training.

12.67 The dismissal of staff after the Panorama programme meant that only one on-site C and R instructor was present at Gatwick IRCs for most of the time we visited Brook House. This and the lack of staff more generally resulted in some officers not receiving their mandatory annual C and R refresher training in time to retain their Home Office accreditation as a DCO. The interim director told us that in late 2017 he had received approval from on-site Home Office managers for 20 officers without up-to-date training in C and R to continue to work at Brook House for periods of up to a month. That approval was subsequently withdrawn.

12.68 Some DCOs told us about planned and unplanned use-of-force incidents they felt had been poorly planned or managed and had resulted in unnecessary staff injury.

12.69 Managers told us when we began to visit Brook House that oversight of the use of force was supposed to be provided by scrutiny meetings and a weekly use-of-force meeting. At the scrutiny meetings the C and R coordinator and the C and R trainers were supposed to review all reports staff filed after their involvement in a use-of-force incident. They were also to view footage from the centre's CCTV cameras, and in the case of planned use-of-force incidents, footage from handheld video cameras and the supervisor's body camera. At the weekly use-of-force meetings the C and R coordinator and senior managers were to consider any concerns about the use of force identified in the scrutiny meetings, to decide on any further necessary actions, including disciplinary proceedings, and to consider any wider strategic issues in relation to the use of force.

12.70 The scheduled scrutiny and use-of-force meetings were usually cancelled while we were at Brook House. The deputy director told us this was because of the lack of a use-of-force coordinator and C and R trainers to view and consider the film footage of use of force incidents.

12.71 Managers told us that two use-of-force meetings took place in late 2017 or early 2018 but had been largely concerned with administrative matters. The interim director told us in May 2018 that substantive use-of-force meetings had not taken place regularly since 2016 when the former use-of-force coordinator moved to another role. He explained the difficulties since that time in recruiting a use-of-force coordinator and use-of-force trainers. He said this problem was common to all prisons and detention centres. He also pointed out that a C and R trainer had been dismissed from Gatwick IRCs as a result of the events in the Panorama programme. The replacement C and R coordinator appointed in early 2018 had been dismissed as a result of inappropriate behaviour at the personal protection training course on 22 February 2018.

12.72 The former director told us that while use-of-force committee meetings had not happened, film and written records of use-of-force incidents had been reviewed by use-of-force instructors. In answer to why no use-of-force committee meetings had taken place, he said:

> *"I don't think we fully cracked the Use of Force committee meeting issue to be honest with you. We talked about it. I had a very good reference point of what that looked like from my experience in Medway [secure training centre] and we went into a lot of detail, a lot of management information around it. However, we didn't*

fully crack how we could achieve it at Gatwick. We talked about it, [the deputy director and I] about what kind of thing we would implement, and I am sure they would have done it by now because it is a key issue, but that would have been helpful. I don't think it would have flagged up the incidents we saw in Panorama, to be honest, because you can't review what you don't know about.".

12.73 After the dismissal of the C and R coordinator at the end of February 2018, the interim director instituted a process under which use-of-force incidents were scrutinised by the duty director and the C and R trainer the day after an incident. Formal use-of-force meetings do not take place, but the interim director told us that any use-of-force matters would be discussed *"at the back end of"* SMT meetings.

12.74 The interim director acknowledged that the fact that Gatwick IRCs had only one C and R trainer meant that the scrutiny of use-of-force incidents was sometimes undertaken only by a duty director without the necessary training. He conceded that the failure to hold regular and dedicated meetings to examine all issues arising from the use of force was a significant weakness in the oversight and assurance process.

12.75 The fact that staff at Brook House did not wear body cameras was a further weakness in the management and oversight of the use of force. Oscar 1 and Oscar 2 DCMs (who have responsibility for overall daily management of the centre) were supplied with cameras in 2015. One body camera was made available to staff in the visits hall and one for staff on each residential wing. Body-worn cameras for all staff were bought in 2017 but a lack of trainers delayed their introduction. Staff showed a marked reluctance to wear them. One DCO told us:

"I believe if I am wearing a camera, is it for my safety or is it if anything goes wrong it is to point the blame at whoever is wearing the camera?"

12.76 Senior managers began to insist in March 2018 that staff use body cameras. We noticed most staff wearing them from that time.

12.77 The fact that staff were not using body cameras meant that filming of unplanned use-of-force incidents and the capacity to review such incidents relied on CCTV footage. But CCTV does not cover all areas at Brook House. Stairwells, for example, have no cameras. Staff told us the images were poor and often failed to provide a clear view of what had

happened until an upgrade in February 2018. It improved the quality of the CCTV images although not the coverage.

Use of force: conclusion

12.78 We identified matters of concern in relation to training of staff in the use of force, including the quality of that training. We also found that since 2016 no reliable and effective process had been in place at Brook House for overseeing the use of force and ensuring that use-of-force incidents were appropriately and properly conducted. This meant managers could not be confident that they were identifying and addressing any wider concerns about the use of force including training issues. Given the potential consequences for both detainees and staff of any unauthorised use of force or of any poorly planned or poorly managed use-of-force incident, it is essential that there is regular and rigorous review and oversight of all use of force at Brook House.

Recommendation

R50 The SMT must ensure regular and timely review of all use-of-force incidents by appropriately trained staff and that regular meetings take place, involving the SMT, dedicated to considering matters arising from use-of-force incidents and to ensuring that any concerns are addressed.

Drugs

12.79 The Panorama programme contained criticism of the availability of drugs in Brook House. Managers and staff told us that in recent years there had been a significant increase in drug use and drug finds in the centre, particularly of NPS[1]. The deputy head of healthcare inspection at HMIP explained that the experience of drug use at Brook House mirrored that at other IRCs. She told us:

[1] NPS stands for new psychoactive substances; chemically based drugs designed for recreational purposes.

"With the IRCs, traditionally, I would say, up until about three or four years ago drugs didn't present as a significant issue by comparison, and compared to prisons, where there is much more focus on drug misuse, but also a lot more people coming in with drug problems you weren't getting the same proportion coming in to IRCs with problems…

"We are noticing in the last, I would say, few years an increase in misuse within IRCs, the male IRCs, specifically. And we are noticing an increase in NPS use, and particularly synthetic cannabis coming in, and that's fuelling some problems.

"We saw that at Brook House at the last inspection, which was in October 2016. We saw that in Harmondsworth, and we are seeing that more in the male IRC estate than we were previously, but because it is a hidden activity and people are deliberately hiding it is difficult to quantify it accurately, but it is definitely much more significant an issue than it was."

12.80 When we asked the deputy head of healthcare inspection whether she thought the presence of drugs within IRCs was linked to organised crime, she said:

"… by the nature of it, illicit drug use is a criminal activity, but there is less organised crime appearing to be involved compared to prisons, but, again, it seems to be beginning to come through because there is a lot of profit to be made, particularly from synthetic cannabis."

12.81 The deputy head of healthcare inspection explained the greater difficulties faced by IRC managers and staff than their counterparts in prisons in detecting the presence of drugs and drug use:

"… in terms of identifying covert use, mechanisms are more limited. In prison there is a lot more searching, there is a lot more of this mandatory drug testing, all of which will give indications. With the IRC that doesn't exist because it's structured in a different way. People are there for administrative detention, they are not there for committing a crime."

12.82 Members of the security team told us about the particular difficulty of the security staff in detecting NPS because many of the substances are colourless and odourless. Much of it is smuggled into Brook House by impregnating paper. The centre does not have

equipment to analyse any paper suspected of being impregnated in this way on site, but it can send it away for analysis.

12.83 We asked the deputy head of healthcare inspection whether she thought it would be appropriate for detainees to be allowed only photocopies of mail. Her response was:

> *"I think the position of photocopying everything regardless, and then only giving the photocopy to people is quite a strong reaction and we would want to feel that it was based on a very high level of risk and a very high level of intelligence, and that it wasn't then just open-ended."*

12.84 Managers at HMP Rye Hill told us that they had procured two of the Rapiscan machines which had been reconditioned following their use at the London Olympics. They could analyse all detainee mail on site.

12.85 The Brook House security team told us that apart from mail, the other means by which drugs could enter the centre were via staff, detainees' visitors and detainees' property. We consider below the arrangements for preventing drugs and other banned substances from entering the centre by these means.

Searching for drugs and other banned items

12.86 Managers in the security team told us that under its contract to manage Brook House G4S is required to search each detainee's room every 3 months and to undertake daily checks on the fabric (windows, flooring etc) of detainee rooms. Each member of staff must be searched at least six times a year. Detainees are routinely searched on each occasion that they arrive and leave Brook House and on entering and leaving the visits hall and the corridor where visits and interviews with official visitors take place.

12.87 Staff and managers told us that before the Panorama programme broadcast in early September 2017searches at Brook House had not been as consistent or thorough as they should have been. We found evidence in the minutes of the security meetings that searching had been a concern. An entry in the minutes of the security meeting on 11 July 2017 says:

> *"some fabric checks not being done because of staffing levels".*

12.88 The spreadsheet the security team maintained detailing monthly searches shows that no staff searches were undertaken in three of the five months before the Panorama programme. In the other two months, 309 staff searches were undertaken. In the same five months, when the average roll count of detainees held at Brook House was 446, 64 detainee room searches took place.

12.89 Searches increased significantly after the Panorama programme. In the eight months up to the end of April 2018, staff searches were undertaken each month and there were 2150 searches in total. In the same period there were 309 room searches. This figure includes 233 room searches undertaken during a complete lock down search of the whole of Brook House which took place in March 2018. The search included the use of dogs.

12.90 In the five months before the Panorama programme there were: 138 security intelligence reports (SIRs), 36 drugs finds, and 22 banned item finds. In the eight months up to the end of January there were 188 security intelligence reports, 42 drugs finds and 77 banned item finds. The security teams' note on the spreadsheet states that: *"substance finds have dropped which would be expected with the increased staff searching and the roll count being lower"*. The proportionate drop in drug finds may also have been attributable to a significant increase in the number of visitors who were banned from entering the centre.

12.91 The security staff we interviewed made clear that much of their searching activity was based upon intelligence and had led to some significant finds.

12.92 Notwithstanding the increase in searches from September 2017, fabric checks have continued to be a cause of concern. The security meeting minutes for 21 November 2017 state:

> *"Fabric checks are mainly being done but some were missed due to staffing levels. A full check of every room was completed approximately 3 weeks ago"*.

12.93 The management security meeting we attended on 13 March 2018 heard that the security team had significant concerns about the quality of fabric checks and wanted action to ensure that DCOs were properly managed by DCMs when undertaking the checks.

12.94 The head of security told us that all staff were searched every other week and 40 staff were searched at random in the intervening weeks. We attended a full staff search in the visits hall as all staff arrived for work. They were required to pass through a metal detector and given an airport-style search. Bags were also searched. The search was conducted conscientiously but staff were not required to remove their shoes or socks and no dogs were used. The head of security and the deputy director, who were both present, acknowledged that the search routine had become predictable and needed to be disrupted to catch people off guard.

12.95 Managers and staff suggested some other weak points in the searching arrangements at Brook House. They were concerned about the thoroughness of searches and the observation of detainees and visitors in the visits hall. A security DCM also pointed out that although all the property that detainees took into the centre went through a Rapiscan machine, the centre had no x-ray trainer for some time and less experienced and untrained staff in the reception area did not know what to look for. Reception staff also conducted hand searches of detainees' property. The hand searches we observed seemed to us to be thorough.

12.96 Search and detection arrangements at Brook House have improved in recent times but weaknesses remain, and managers should continue to question and tighten up arrangements where possible.

13. The culture of Brook House: relationships and behaviours

Relations between staff and detainees

The detainee perspective

13.1 We arranged two focus groups with detainees. We sent invitations to detainees selected from a sample managers at Brook House provided. Other detainees who heard that we were in the centre and who wanted to talk us also joined the groups.

13.2 Detainees told us Brook House had too few staff. Many of their comments about the way staff treated them appeared to centre on staff being too busy to give them the attention they would have liked. They told us:

> *"Officers do not carry out their duty of care- they are not there when you need them";*
> *"[Staff] do not have time to talk to detainees about their mental health and wellbeing. They don't do hourly checks on detainees";*
> *"…officers cannot react quickly to fights…detainees break up their own fights before officers have enough back up to intervene".*

13.3 The detainees did not suggest that there were significant or widespread problems with poor or abusive behaviours by staff. Detainees said "some *officers are understanding. They do their job and are nice people"; "some officers are sympathetic towards detainees"* and they said they *"did not have a problem with wing staff - problems are with managerial staff"*. But they had criticisms. Some said they found their interactions with staff *"dehumanising"*. They said staff *"evidently lack training and experience"*. One detainee said *"most DCOs are kids, younger than us and they don't know what they are doing"*. They also said that "*staff lack people skills, communication skills and patience which are essential for the environment they work in"* and that *"detainees who do not speak English are treated worse - no respect for them, [staff] laugh at them to their face, but detainees do not understand"*.

13.4 Detainees were particularly critical of the attitude of healthcare staff whom they described as *"uncaring", "arrogant"* and *"unkind"*.

13.5 Detainees made general complaint about the failure of staff to communicate. They cited in particular the flu outbreak at the end of February 2018, which resulted in the centre being quarantined for over two weeks. Detainees said no announcement was made about the outbreak and they were given no information about spotting symptoms or what to do to avoid becoming ill. They said they had found out about the outbreak only by talking among themselves and seeing staff wearing masks.

13.6 We asked detainees we met informally while we were walking around Brook House for their views on how staff treated them. Most said they had no cause to complain. Some were complimentary. Some said a few staff had attitudes they did not like.

13.7 Managers at Brook House undertook a simple written survey of detainees in January 2018. They asked detainees if they had been threatened or experienced physical or verbal abuse by other detainees or staff or if they had been mistreated in any way. Some responses we saw mentioned being the victim of threats, violence or bullying by fellow detainees. None mentioned physical assault by staff but a few of the responses referred to staff being verbally abusive. Most responses suggested that detainees appreciated the work of staff.

The behaviours of DCOs and DCMs

13.8 We observed staff at work at Brook House. We saw staff and detainees greeting each other in a friendly way and staff dealing with detainees in a cordial and appropriate fashion. Staff seemed mostly willing to help detainees with their inquiries and requests, but they were sometimes too busy and their interactions with detainees rushed and may have seemed brusque to a detainee. We did not see staff routinely going onto wing landings and engaging in conversations and more substantial interactions with detainees, even when there appeared to be enough staff on a wing to allow them to do so. However, we were present on occasions when detainees were identified as being at risk of harm or their behaviour was giving cause for concern. We saw DCOs and particularly DCMs trying to engage with the detainees in question and to offer appropriate care and support.

13.9 We did not witness any member of staff behaving inappropriately or making inappropriate or disrespectful comments to detainees.

13.10 We asked staff and managers about their reaction to the incidents and behaviours featured in the Panorama programme. They told us they were shocked, surprised and upset.

13.11 One member of the healthcare team told us:

"It really surprised me, that TV show; it made me cry. It still surprises me now."

13.12 Another said:

"I was quite angry at the end of it. I was angry from two sides. It left you emotionally quite disturbed. Angry at what I saw and angry at the way it was done. There were two things to it, some of it was awful and some of it was misrepresented."

13.13 A DCO told us:

"It shocked everyone. It came out of the blue… we didn't know anything that was going on. What we knew at the time or that evening was people getting called up to the office and people were being escorted offsite, so we didn't know what was going on. "

13.14 A manager said:

"I was watching the programme with my mum and she was saying 'Well…You better leave that place', and I was saying 'Well, when I am there, I don't see this kind of behaviour.'…I was thinking 'Did this really happen at Brook House?' Not in a million years would I have thought that would happen at Brook House."

"I was thinking 'Wow…Did people really just not listen to anything I have said on the training courses or is it people are just thinking yes, we will hear him, but whatever he says is not important.' I think people just don't understand actually those kinds of behaviours are illegal, it is unlawful behaviour, people don't understand you could be arrested."

13.15 Another DCM said:

"It was horrible, it was a really horrible reaction. My reaction was one of shock, you instantly feel unnerved, I think, and apprehensive, even though you know you do a good job, and you professionally think, have I said something once that could be construed in a different way if taken out of context? … I went through a stage of thinking, no, we're a good Centre, we do a good job. Yes, it's hard, and yes, there's violence and yes, there are drugs, but actually the officers do a really good job in a really difficult environment."

"… for a place like Brook House and Tinsley to operate, you are so reliant on the people you work with to be there for your safety, and for everyone's safety…to think that it was someone you worked alongside who had done that, I think really rocked people, it just destroyed trust amongst colleagues."

13.16 Another DCM said:

"I was embarrassed. Genuinely, I was embarrassed. I was ashamed to be associated with any of that, because that is not the way that we should be working, and that is not where I wanted to be. At one point I actually thought I don't want to be part of that, I am better finding another job"

13.17 The deputy director said:

"I thought it was horrendous… The actual bit that we saw [of the physical assault of a detainee] was absolutely horrendous. I am absolutely shocked that not one member of staff intervened."

"We know TV programmes will edit and re-edit to make something look different, but you couldn't make that look any different to what it was, and I thought it was shocking."

13.18 The leader for the Forward Trust team at Brook House, which provides drug and alcohol treatment services to detainees, told us he had been working at Brook House since 2016 and had not seen officers behave inappropriately towards detainees. He said:

"What really shocked me is that many of the officers I knew, because I saw them on the wing and also a number were, I would say, really approachable, polite. I found

it more like there are some rotten apples in the bucket, like in any organisation… You have to identify them and get rid of them. The shifts are very stressful here because they work like eleven hours, … so you get snappy, anyone would, it is normal. Then it's quite a demanding population as well and I have seen it with some guys that they just snapped - they were quite good officers but I am not justifying that."

"Personally, my impression was more that it was a few rotten apples who I think really deserved to be sacked but the majority of the cases was like really I would say they snapped, with the stress, too long hours for work… it's a big turnover, there is an officer who just started has to already teach another one which is really hard because then you don't have role models if you don't have an experienced ones… It's all these connected things."

13.19 Dominic Aitken, a PhD student at the Oxford University school of criminology spent a month at Brook House in June–July 2017. He told us he never witnessed abusive behaviour by staff and had heard few complaints about staff from detainees. He told us:

"…from my discussions with detainees, I didn't hear a great deal of complaint about the way staff behaved; it certainly doesn't surprise me that in a closed institution like that you could have staff behaving inappropriately through their words or actions. I think it would be naïve to think that that didn't happen, but when I was there that wasn't the detainees' primary complaint, in my opinion. That is looking at what detainees said to me."

13.20 Dominic Aitken expressed concerns about the attitude of some staff to self-harm by detainees.

"a thing that I was quite concerned by was on issues to do with self-harm and suicide prevention, I heard a lot of people speak about self-harm in particular as manipulative, or as being in some way sort of instrumental, and that struck me as not a very caring or professional way to speak about an issue that is so serious… [staff suggested] it was being used to try and influence members of staff, being used to try and influence the outcome of someone's case, despite the detainees being told that it wouldn't have that effect; that people didn't mean it, or that they were faking it, or any number of other things. I think that was quite concerning

and I feel that there are many ways that that kind of attitude can go wrong and that that can lead to any number of [issues]. … i heard that from detainee custody officers, so people on the wing. I also heard it from some managers, and I also heard it from some senior managers, and I think that is what concerns me most maybe, because I would perhaps expect that DCOs who work long shifts, deal with detainees regularly, it's tiring, it's emotional work, it's quite physical work sometimes, they might say things like that. I think it was more concerning when I heard a couple of senior managers or ex-senior managers saying similar things, I thought that was quite concerning."

13.21 He saw a member of healthcare conducting the initial screening of a detainee in reception.

"One of the questions I think is something along the lines of 'Have you had thoughts of suicide or have you ever harmed yourself',… and I remember that the man said "no". There were no particular concerns about drug use or anything like that, so it was pretty standard, it seemed, or low risk, low concern, but he [the member of healthcare] said to him something along the lines of… 'Just don't die in the meantime, okay? Terrible paperwork. Think of the trees.'"

13.22 We understand that this member of staff was dismissed from G4S shortly after this incident due do wider concerns about his performance.

13.23 A long-standing and respected DCO told us that groups or cliques of staff (DCOs and DCMs) had exhibited the wrong attitude towards detainees and other members of staff. He also spoke of an incident some time ago, when an officer working with him in reception used racist language and of another who had spoken with pride about *"smashing"* a detainee with a shield. He reported both incidents. The DCO thought that the disciplinary procedures after the Panorama programme had led to the dismissal of a number of DCOs and DCMs and had *"cleared things out"*.

"There was a bit of a clique about four years ago, of a young guy who was predominately quite lazy, works in security and they were very cliquey with each other. Fortunately that lot have gone"

13.24 Nevertheless, a few DCOs and managers told us that Brook House still had officers who exhibited the wrong attitudes and behaviours. One told us:

"Yes. I think it may be a quarter of staff, but I don't think there's a level where it starts or stops. I think it's actually right up the scale."

13.25 We were also made aware of the cases of the two C and R instructors who were dismissed for inappropriate behaviours and attitudes during the personal protection training session on 22 February 2018 which we refer to in chapter 8.

Culture and relationships among DCOs and DCMs

13.26 The Panorama programme featured evidence of staff being abusive, unduly aggressive and unsympathetic in their attitudes and behaviours. It also featured instances where staff who had witnessed such behaviour had evidently not felt obliged or able to challenge or report their colleagues. This prompted us to ask DCOs and DCMs whether individuals or groups of staff at Brook House may be exhibiting aggressive or unsympathetic attitudes and dominating, influencing or even bullying their colleagues.

13.27 The DCO who told us about hearing and reporting a colleague for using racist language, told us that he had been victimised as a result.

13.28 A few other members of staff spoke to us about inappropriate behaviour by colleagues and how it was not possible to challenge them without being bullied. One DCO alleged that managers had protected a member of staff who had bullied detainees and other staff.

13.29 Another DCO suggested that managers were not prepared to take responsibility for investigating and addressing bullying among staff and did not handle allegations of bullying with tact or discretion.

13.30 These staff said they knew about tight-knit groups of DCOs and DCMs from which they felt excluded and whose behaviour could not be challenged without fear of repercussions. They said:

"…if you are the nail that sticks out, you are going to be hammered down very quickly."

"no-one trusts anyone any more, in this place"

"if your face doesn't fit you are out of the door"

"[it] takes the form of if we like you and your face fits, you will be in a club. If you don't you will be sacked. If you make a mistake you are bullied until you reach a level where you can no longer take it, and you leave."

13.31 We asked one member of staff whether there was a culture of bullying at Brook House. He said:

"It is a bullying culture… Yes, they have a bullying culture, of course they have… It got better after the [Panorama] programme. The main bullies lost their jobs. They were there. I was glad."

13.32 We were not able to examine and come to firm conclusions about the allegations of bullying made by these members of staff. But we were left with concerns that some staff and DCMs at Brook House might exert a malign and undue influence over colleagues and that their behaviours were not subject to appropriate challenge.

13.33 Our observations of and interactions with DCOs and DCMs led us to believe that there were a few high-profile DCMs and DCOs who demonstrated a particular degree of physical and social confidence and assertiveness. Their colleagues held them in high esteem, as did members of the senior management who, as we describe in chapter 7, favoured a more disciplined and regimented approach to management. These DCOs and DCMs, appeared to be valued for their operational competence and effectiveness, especially in dealing with challenging or threatening situations. At times, their behaviours and interactions could be characterised as 'laddish'.

13.34 DCOs and DCMs must be able to manage difficult and challenging detainees and to offer leadership in sometimes threatening or violent situations. Physical and social assertiveness may sometimes be indispensable qualities. But DCOs and DCMs must always be empathetic and able to engage and sympathise with detainees and colleagues. As the Head of Tinsley House put it:

"you want people who can get things done, but you want people who will get things done in a right way and if everybody is just task-focused all the time, then you lose sight of people as individuals. That is where I think at Brook House there's this real thing around desensitisation and people not being able to understand why detainees behave the way they do, or not wanting to understand…However, in order to be able to manage someone's behaviour you have to understand it, but I don't know how much we do to understand it other than just write them off as disruptive. Then we almost perpetuate the issue because these individuals become notorious, and then we are almost so nervous about dealing with them that we go in heavy-handed. That just adds fuel to fire."

13.35 Some DCOs and DCMs we interviewed and observed at work did not always appear to strike the right balance between assertiveness and task-focused operational competence on the one hand and empathy and emotional intelligence and care on the other. The head of Tinsley House shared our concern about this. She spoke about one DCM:

"He is very good operationally. He is very good at resolving incidents, deescalating. … He has done advanced C&R, so absolutely, if you send him to an incident he will resolve it. He is very strong in that regard, and I think I talked last time about because he ticks that box we don't necessarily think about other areas in which we could develop him. "

13.36 We discussed with the head of safeguarding our concerns about the effects of the culture we describe among some DCMs and DCOs and whether it was appropriately managed and challenged. He said:

"I think there are definitely inconsistencies with training and inconsistencies in the way that things are done from an operational management point of view. I think that's more than fair and that does come down to a lack of mentoring because new managers are thrown straight in and there's scope for that to be better managed, for them to have some sort of mentoring and for them to have a set way of doing things in place and for everybody to follow that same thing. I wouldn't necessarily say that develops that 'laddish behaviour' that led to some of the incidents in Panorama; I would like to think that was individual on those people who were involved in that. But, to a degree, that sort of behaviour can only develop if those

people aren't managed so they've had time to push the boundaries. They haven't started off by choking somebody, have they? They started off by pushing one rule and then another and then another and then got to the point where they feel comfortable to do that."

13.37 The dangers of an unchecked assertive, laddish culture were brought to life in some of the behaviours towards detainees shown in the Panorama film and by the testimony of one of the officers subject to disciplinary proceedings after the programme. He claimed that he had talked about assaulting a detainee in order to *"fit in"*. The report of his testimony states:

"[The DCO] did make the comments that have been alleged, but states did not actually carry out the actions stated… reason provided for this was that it was said to colleagues to better fit in with the staff team and help make friends at work."

Conclusions on the behaviours of staff

13.38 Staff at Brook House are required to deal with demanding and challenging detainees. They often have to respond to or witness frightening, threatening and distressing events. We saw many staff dealing with detainees with tact, compassion and good humour. We witnessed some staff, particularly when overworked, treating detainees a little brusquely. We did not identify a serious problem of poor behaviours by staff towards detainees.

13.39 Nevertheless, we are concerned that the absence of strong and visible management arrangements, ensuring the modelling and reinforcement of the behaviours expected of staff; the lack of staff and the inexperience of many; and the assertive laddish culture among some DCMs ad DCOs heightens the risk of inappropriate behaviour by staff.

13.40 The evidence of some of the officers dismissed in the wake of the Panorama programme to explain their behaviour reinforced these concerns. As just mentioned, one claimed to have assaulted a detainee in order to *"fit in"*. Another said: *"Brook House were up against it staffing wise"* and said he had not been able to take breaks, had been working 60 hours a week, and felt he *"couldn't let colleagues down and go sick, the pressure is immense"*.

Raising concerns and whistleblowing

13.41 A few staff told us that they had challenged colleagues who they felt had behaved inappropriately. As a result, they had experienced bullying and victimisation. Nearly all the staff we questioned on the matter said they did not feel they could or would raise with managers concerns about colleagues' behaviours. Some DCOs told us they thought DCMs were too busy or simply not willing or able to address matters of poor or inappropriate behaviour by DCOs. Some staff told us that they did not trust managers to handle matters appropriately. In particular they feared that managers would deal with issues in an over-punitive way. One DCO said:

> *"I think there's a distinct lack of trust with the senior management and you just feel as if you can't approach… They've got a very vindictive nature and that and so if they get their teeth into someone then they don't let go."*

13.42 Another DCO said:

> *"I also think there's definitely, definitely a culture here of people not necessarily wanting to report wrongdoing that occurs above, for fear of having a target on their head."*

13.43 A DCM said:

> *"maybe they [staff] think the reports will get out and they'll be victimised and maybe they don't know the right channels, because the whistle-blowing policy, I don't think everyone is aware. I think it's like a trust thing, they don't know where it might lead. That's what I gathered as well, that people weren't sure and they don't know who they can really turn to as in the SMT. They don't want to say something about a certain person and maybe that person got on well with SMT."*

13.44 Some DCOs thought managers could not be trusted to be discreet or to act impartially. One said:

> *"I personally feel I cannot approach [a member of the SMT]….If I'm honest with my opinion, I feel I was used to get as much information about [a bullying DCO] to assist*

[the member of the SMT] with getting rid of him, and then once I had served my purpose I was only worthy of being kicked in the gut…..initially I trusted them [management], and then I found that whatever I was saying to them was being fed back to [the bullying DCO]."

13.45 Large, eye-catching, posters and displays in the gatehouse and other staff areas at Brook House draw attention to the G4S whistleblowing process, known as Speak Out. They were put up after the Panorama programme was broadcast.

13.46 The G4S whistleblowing policy at Brook House is a general document for use across the company. It says:

"In the first instance we encourage you to raise your concerns through your normal reporting line, HR manager or the G4S lawyer that supports your team.

"If you wish to report serious wrongdoing or the matter involves a senior manager (such as members of the business, country, or regional management or the group executive committee) you can contact the G4S Speak Out hotline or website to report these matter"

13.47 Serious wrongdoing is defined as:

"behaviour or actions such as major breaches of group policy or the law, actions that pose a real and significant threat to the wellbeing or safety of its employees or others or may cause serious financial loss."

13.48 The policy gives the following examples of serious wrongdoings that may be raised using the Speak Out process:

"Breaches of law or regulation
Deception of customers or exploitation of customer relationships and /or standards
Unsafe work conditions or health and safety risks
Breaches of company policies, procedures or values by senior managers-
bribery and corruption
Criminal offences, violence or threats of violence by senior managers
Misuse of confidential information

Falsification, concealment or destruction of financial documents or accounting fraud-conflict of interest
Price fixing, other cartel or anti-competitive activity
Insider trading."

13.49 The policy's many references to wrongdoing by senior managers and the emphasis on wrongdoing of a commercial nature makes it off-putting and undermines its relevance to ordinary staff at Brook House who may wish to raise issues relating to inappropriate behaviour by fellow DCOs and frontline managers. This concern is heightened by the fact that one of the Speak Out posters displayed most frequently at Brook House gives as its only example of a scenario in which a staff member should phone the helpline a case of financial misconduct: a staff member who sees a manager apparently helping himself to office furniture.

13.50 Brook House needs a more relevant local policy that refers explicitly to the need to report inappropriate conduct or abusive behaviours by fellow staff members or other serious concerns about them. It would be helpful, too, if the title of the local policy used the more understandable and user-friendly term *"raising concerns"*.

13.51 We learned that the designated Speak Up Champion at Brook House, who is responsible for publicising and guiding staff through the whistleblowing process and supporting anyone who raises a concern under the policy, is the personal assistant to the interim director and the deputy director. Her closeness to the senior management team makes it inappropriate for her to have a role in arrangements for staff to report matters of concern without having to go through the senior management team.

13.52 A few staff told us of their experiences of trying to use the whistleblowing hot line. One said the person he spoke to was based in Portugal, did not appear to know about Brook House or the G4S Care and Justice services and did not appear to understand what he was saying. Another member of staff told us that he reported concerns and was told that someone would get back to him within five days. When this did not happen, he followed up with G4S's head office who told him that it was not clear what he had reported.

Raising concerns and whistleblowing conclusions

13.53 Staff at Brook House told us they were unwilling to report concerns about fellow staff and managers, were not confident that managers would handle such matters appropriately, and did not have confidence in the Speak Up arrangements. Managers need to address these issues.

Recommendation

R51 The SMT and G4S managers should review the policy and arrangements for raising concerns and their own handling of such matters to ensure that they encourage and support staff to report wrongdoing or misconduct or inappropriate behaviour by colleagues and managers.

The handling of complaints and allegations

13.54 Detainees at Brook House can make a complaint about the care and services provided, including matters relating to mistreatment or misconduct by staff, using a DCF 9 form. Copies of this form are available on all the wings and in the library. Forms can be submitted anonymously. They are deposited in collection boxes on the residential wings.

13.55 The forms are collected by the on-site Home Office staff who submit them to Home Office Immigration and Enforcement (HOIE) Detention Services. If a complaint involves serious misconduct by a member of staff, HOIE Detention Services refer it to the Home Office Professional Standards Unit, which is part of a separate directorate in the Home Office. HOIE Detention Services will also send complaints to Gatwick IRCs complaints team for internal investigation.

13.56 The complaints manager at Gatwick IRCs distributes complaints about services at Brook House for investigation by managers. The responses to complaints are checked and approved by a relevant senior manager before they are sent to detainees. The support services manager and the Home Office Area Manager for Gatwick IRCs make sample checks to assess the quality of the complaint-handling and responses. The complaints manager told us that staffing pressures at Brook House meant that managers had fallen behind in dealing

with complaints and the centre was exceeding the 20-day turnaround time for complaints by as much as a month.

13.57 Members of the senior management team or more senior G4S managers investigate more serious complaints, including those alleging misconduct by staff.

13.58 The complaints manager for Gatwick IRCs maintains computer spreadsheets recording all complaints received from HOIE Detention Services, the progress of the complaint process and their outcomes. She also maintains a spreadsheet recording all complaints containing or relating to allegations of misconduct by staff. That spreadsheet does not include or cross-refer to any allegations of misconduct by staff that have not been the subject of formal complaint but have come to light via the security incident report (SIR) process, incident reports, HR reports and processes, use-of-force reports or any other way.

13.59 We asked the interim director and the deputy director how senior managers ensured that they captured all allegations relating to an individual member of staff and how they could be sure of identifying all officers whose behaviour might be a cause of concern. They told us that the complaints manager provided them with a weekly complaints log and they considered it in light of their own knowledge and understanding of concerns about the conduct of individual staff arising from SIRs, incident reports and HR reports and processes.

13.60 In order to give assurance that managers are able to identify those members of staff whose behaviour might be a cause for concern and are addressing any concerns, there should be a single spreadsheet in which all instances of alleged misconduct by staff, however they might have come to light, are logged, together with the action being taken in respect of such allegations.

Recommendation

R52 The SMT should ensure that a single log is kept of all allegations or instances of misconduct by staff and the actions taken in respect of them.

The Panorama allegations

13.61 The producer of the Panorama programme declined our requests for a meeting to discuss the programme's allegations and for us to have access to all unedited film shot in connection with the programme. Our correspondence with the producer is at appendix G.

13.62 We viewed the film as broadcast and made a note of all alleged comments and actions of staff criticised in the film and the other issues and concerns it raised about the treatment of detainees at Brook House. That note is at appendix H.

13.63 21 members of staff were alleged to have been involved in incidents in the Panorama film. As a result, 17 were the subject of formal disciplinary processes. Six were dismissed. Seven were issued with a written warning. In three cases this was a final written warning. The three officers given a final written warning by G4S subsequently had their accreditation to work as a DCO revoked by the Home Office following consideration of their cases by the Home Office Professional Standards Unit.

13.64 We spoke with the G4S senior manager who led the team that carried out the investigations into the allegations about staff and we examined the investigation files. The investigations appeared to have been rigorous and well managed.

13.65 Appendix I sets out issues and concerns, aside from the behaviours of individual members of staff, that featured in the Panorama film and identifies where those matters are considered in this report.

Other allegations of misconduct

13.66 Allegations of misconduct were made against two C and R trainers, one employed at Brook House, the other employed at a prison managed by G4S, about their behaviour during a personal protection training session at Brook House on 22 February 2018. The allegations included that they had been dismissive of officers' legal obligations to adhere to a duty of care when using physical force on detainees, had encouraged swearing, aggression and violence in dealing with detainees, had suggested that de-escalation techniques were ineffective and had frequently referred to detainees as prisoners and to Brook House as a prison.

13.67 The two C and R instructors were dismissed after disciplinary proceedings.

13.68 The interim director of Gatwick IRCs and the chief operating officer for G4S's Custodial and Detention Services assured us that no further instances of serious staff misconduct had been reported or investigated since the Panorama broadcast.

14. Intelligence and information gathering

14.1 In other sections of this report, where we deal with specific aspects of the management and welfare of detainees, we comment on the arrangements for investigating monitoring and reporting on those matters. We also identify any weaknesses in those arrangements. This chapter considers other arrangements and channels available to G4S managers for gathering more general intelligence and identifying concerns about the management and culture of Brook House and the treatment of detainees.

Reports on Brook House

14.2 The Brook House IMB In their annual report for 2016[1] gave a largely positive assessment of it. The opening paragraph of the executive summary of the report says:

> *"Much of this report has been said in the past. Once again, the IMB judges Brook House IRC to be a well-run establishment, providing a decent environment where detainees awaiting removal are treated humanely and fairly. Management, under the direction of [the former director], has high expectations of staff and there are many examples of good and dedicated work by officers and managers and a continuing commitment to safety. The Board remains pleasantly surprised how open management is to suggestion and constructive criticism. There is a real will among the management team to seek to improve and a "can do "culture of transparency. This attitude permeates to the officers in their attitude to the IMB, which is one of cooperation and helpfulness."*

14.3 The 2016 IMB report mentions a number of matters of concern. Some featured in the Panorama programme. The change in the make-up of the detainee population was among the matters raised:

[1] The role of the IMB includes satisfying themselves "as to the state of the detention centre premises, the administration of the detention centre and the treatment of detained persons" and to directing " the attention of the manager to any matter which calls for his attention, and shall report to the Secretary of State any matter which they consider expedient to report" See: Rule 61 The Detention Centre Rules 2001. Statutory Instrument 2001 No 238 Immigration. HM Stationery Office. London

"Home Office policy is now to accommodate time-served FNOs in the IRCs unless the nature of their crime or behaviour dictates it is safer they should remain in prison. Their numbers have grown from an average 22% of the Brook House population in the last four months of 2015 to an average of 42% over 2016, a significant increase. This population imbalance may be behind some of the increase in violence and drugs entering the centre. Just before a charter there is likely to be an influx of ex-offenders from prisons."

14.4 The report mentions too the issue of detainees with mental health problems:

"There were only two transfers to mental health establishments in 2016, one to a local hospital and one to a medium secure unit, both experiencing significant delays owing to the difficulty in locating a bed"

14.5 On healthcare more generally, it says:

"Healthcare tells us it receives few formal complaints- only 11 in 2016. The IMB received 20 written applications over the year…In almost every case the IMB were satisfied with reassurances from the healthcare as to the treatment being given. Verbal complaints about healthcare figured in both the concerted indiscipline of May and the forum held following a petition signed by 38 in May- where access to GP appointments, rudeness of some medical staff, paracetamol being used as a panacea for everything and being allowed medicine in possession were raised."

14.6 The report also highlights the emerging problem of staffing numbers, which, as we say elsewhere, lay at the heart of so many of the problems and weaknesses in the management and culture of Brook House. The report says:

"It is the view of the IMB that where wings are appropriately staffed and officers have time to interact with detainees, the frustrations which detainees experience can be reduced. The board observes much good work done in this respect by wing officers. During the year there have been times, notably in July and August, where officer numbers have fallen, increasing pressure on those on duty and impacting, adversely, not only on staff motivation, but also on the operation of the centre…. Problems were increased by the knock on effects of the escape, courtyard closures and short-term loss of the Director in the aftermath of the Medway scandal.

Nevertheless, the board noted a period from August when officer numbers were a matter of concern. Since that time there has been a series of recruitment and training exercises in order to have the staff team up to par for the expansion of Brook House and the re-opening of Tinsley House."

14.7 The IMB report sets out the issues on which it required a response. These were night-time transfers of detainees; the management of detainees with mental health issues, in particular the delays in access to beds in mental health hospitals; the lack of detainee access to internet social networks; and the length of time detainees spent in detention. The board said it would monitor among other matters the effects of the planned population increase at the centre and the poor attitude of some nurses towards detainees.

14.8 The HMIP report published in January 2017 after an unannounced inspection at the end of October 2016, was less generous than the IMB report in its praise of the management of Brook House and the treatment of detainees but it was positive. The overall assessment is set out in the chief inspector's introduction to the report:

"Overall, this was an encouraging inspection. The centre had improved upon the standards we found at the last inspection, and on this occasion was assessed as "reasonably good" in all four of our healthy establishment tests. This also marks excellent progress from the standards we were seeing at Brook House when it first opened. There is no doubt in my mind that the standards now being observed at the centre are the result of a great deal of hard work by the management and staff. They should be congratulated on their efforts and I hope are encouraged by this report to maintain and build upon the clear improvements they have made."

14.9 The report comments on relations between detainees and staff:

"In our survey, about three quarters of detainees had a positive view of the attitudes and behaviour of staff, and the proportion was higher for those who did not speak English. We saw staff dealing with a range of issues with resilience and evenhandedness. Many staff integrated well with detainees, although there was limited evidence of regular contact with individual care officers."

14.10 The inspectors make a passing reference to staff being *"under pressure"*. The main concerns and recommendations in the report relate to the time detainees spent in detention and the prison-like living conditions.

14.11 The HMIP inspection team leader told us in October 2017 that the events shown in the Panorama film had caused HMIP to consider whether it needed to adopt a more systematic approach to ascertaining the staff perspective as part of its inspection process. HMIP have since introduced anonymous staff surveys and scheduled interviews with staff.

14.12 It is not possible for us to judge the precise state of affairs in relation to the management and culture of Brook House and the care and treatment offered to detainees at the time that the IMB and HMIP produced their reports in early 2017. However a number of issues such as lack of staff, the disaffection and turnover of staff and the weaknesses in management arrangements and behaviours, all of which might adversely affect the treatment of detainees, had begun to be evident from at least the middle of 2016. We do not suggest that either the IMB or HMIP should have uncovered or predicted behaviours of the type shown in the Panorama film, but we think that more focused questioning of staff and frontline managers might have more clearly identified some of the issues that played a significant part in the matters raised in the Panorama programme and their potential consequences . We welcome the fact that HMIP are now surveying and interviewing staff as part of their inspection process.

The Brook House IMB

14.13 The most recent report published by the independent monitoring board (IMB)at Brook House in May 2018 covers the year to the end of December 2017. The executive summary refers to Brook House having had *"a tough year"* and identifies a number of challenges and problems. The executive summary says:

> *"Tinsley staff moving back just as Brook's population increased left a decided feeling of pressure. There was a spike in violence- detainee on detainee and detainee on staff- challenging individuals, common across the immigration detention estate in the Spring. There were serious incidents, protests associated with imminent removals; some where the national C and R teams had to be called in, though others where G4S skilfully de-escalated incidents. An attempted escape*

meant yards were closed again unless an officer was present. There were some very unwell men, major challenges for any immigration centre to care for, who were being kept safe"

14.14 On the subject of the Panorama programme and its impact on the centre the summary says:

"Most centre staff were in total shock. G4S managers moved fast to keep the centre steady, detainees calm and staff encouraged at what was a hugely difficult moment. The IMB were horrified at the completely unacceptable behaviour of the small group of staff shown in the footage. We have never witnessed instances of ill treatment of this kind, nor have we had any indication that it was happening. If we had we feel confident that we could have taken our concerns to the top management of G4S and the Home Office at the centre. The Board regularly reported on, or discussed with management, other issues focussed on in the programme.

"In the aftermath of the programme, investigations were undertaken and a number of staff were dismissed and there was also an impact on staff morale leading to departures. This has led to a drop in G4S staff numbers which exacerbated existing staff shortages and has had a material impact on the running of the centre, as reflected in the following pages."

14.15 Among the issues the IMB say need attention and about which it makes recommendations to G4S are the need to prioritise staff recruitment and retention, the need to reintroduce and improve induction, the need to reopen the cultural kitchen and restart organised activities and the need for advanced mental health training for staff who interact with vulnerable detainees.

14.16 The principle findings and recommendations in the latest IMB report largely coincide with our own. However, we are concerned that the report does not mention the weaknesses in the administration and governance arrangements at Brook House, in particular the fact that, as we describe elsewhere, no effective and consistent scrutiny and assurance in relation to use of force incidents had taken place since at least the end of 2016. On the subject of the use of force the IMB report says:

"The IMB rota member is notified about any use of force, normally via a telephone call from the duty Oscar 1; failure to notify is rare and inadvertent. The IMB can review the related paperwork. After the Panorama programme, G4S set up a weekly multidisciplinary Scrutiny Panel at which use of force in the preceding week is reviewed, both paperwork and camera footage. The IMB has a standing invitation to attend and the Board finds Brook House management to be extremely open on the subject.

"There has been a dramatic increase in the use of force in 2017, more than double the previous year. It is difficult to explain this, but there are indications that it may be as a response to an increase in the number of difficult and more volatile detainees in the centre."

14.17 The report does not mention the fact that few if any meetings dedicated to reviewing use of force took place during 2017, a state of affairs that continued while we were visiting Brook House in 2018.

14.18 The IMB make many references to difficulties and obstacles G4S faced in its management of the centre. The tone of the report is more accepting and not as critical and challenging as it might be. This is in keeping with the tone and substance of the IMB meeting we attended and of some of our interviews with members of the IMB. We were struck during the IMB meeting by a sense of collegiality between the IMB and G4S and a tendency on the part of IMB members to over-empathise with the G4S management team and the Home Office, rather than to hold them vigorously to account and press them on their plans for action to address concerns and make improvements at Brook House.

14.19 We asked the former chair of the IMB about the IMB's relationship with G4S. She said:

"… it is excellent, and it always has been for the four years that I have been here. We have always had an excellent relationship with both the Home Office and G4S. They listen and they hear what we say. They don't always make a big song and dance about it, but is amazing how many times suggestions of ours have been incorporated quietly in"

14.20 We asked whether the relationship was spikey or challenging:

A: "No.
Q: Should it be?
A: If we needed to challenge we challenge. I would feel I have permission to do that…they listen to us, and we have a very good working relationship, and always have done."

14.21 We interviewed the new chair and vice chair of the IMB, who both took up their appointments in January 2018, but had been on the board for some time. We put it to them that the IMB had not been as critical of arrangements at Brook House or as demanding of managers as they might have been. They did not accept this criticism, but the new chair suggested that it was a matter they might reflect on further. She said:

"Yarl's Wood I suppose had their own particularly horrendous moment. Maybe that changed their Board. Maybe we need to think more about it."

The relationship with the Gatwick Detainees Welfare Group

14.22 The Gatwick Detainees Welfare Group (GDWG), a charitable organisation based in Crawley, undertakes research and campaigns in relation to immigration policy. It also provides a support, befriending and visiting service for detainees at Brook House. Detainees make an appointment to see a GDWG representative during one of the group's regular drop-in sessions. The GDWG representative and the detainee discuss the detainee's support needs. The drop-in sessions take place in the official visits corridor at the centre.

14.23 GDWG managers told us that relations with centre managers and the Home Office had become strained in 2017. They said they believed this was because of concerns that GDWG was over-identifying with detainees and was trying to advance their immigration cases or campaign on their behalf. The [redacted] has said that the actions of certain GDWG visitors, including writing statements in support of detainees and in one case standing bail for a detainee, had led managers to question the integrity of GDWG visitors and their understanding of their role.

14.24 The director of GDWG told us that GDWG did not protest at the centre nor campaign locally for its closure. He said GDWG did not give legal advice to detainees nor campaign for their release, although it might direct detainees to other organisations that do.

14.25 The director of GDWG told us he was asked to a meeting with the [redacted] in August 2017 at which they threatened to remove GDWG's drop-in arrangement with detainees. The director of GDWG told us:

> *"Two weeks before Panorama came out, so in August [2017] I had a meeting with* [redacted] *… where they said that they were very seriously considering taking our drop-ins away…"*
>
> *"…they had earlier in the year said, in effect, 'we don't like the fact that you are, when you are seeing people that are very vulnerable and you are referring them to groups, such as particularly they were mentioning IMB and also The Forward Trust, who are the drug support group, but also implicitly groups like Medical Justice and BID. They didn't like those referrals and they wanted all of us to refer any vulnerable people that we saw straight to Centre Management. I, at the time, drew a distinction because for various reasons we are not going to refer everyone we see. When somebody tells us something in confidence it is not necessarily going to be appropriate or helpful for us to talk to Centre Management about it. There has to be a clear line if we see someone who is in imminent danger, has active suicidal thoughts and we are not sure the Centre are already aware of those things, which usually quite often they will be, but if we don't think they are aware of them, then we do have a responsibility to raise that with Management."*
>
> *"When I met with them in August, though, the concern had moved on to the fact that we were raising these concerns even with them. They cited three examples that each of the three Coordinators had – respectively - raised in the last few weeks, concerns about particular detainees…"*
>
> *"… they thought it was insulting. They said it was insulting that we had raised these concerns."*

14.26 A member of the staff of GDWG went on:

"Yes, they raised this with me in the August meeting and were aggressive about it.

…

"…the manner in which we raise things and we can show this from the emails we send them is very, very polite, very respectful, and we don't do it every day by any stretch. We don't inundate the Managers with concerns, but where we, for example, see someone who is not able to walk around the Centre we politely say, 'we would really like this to be looked at.' … it was … the [redacted], who said, "it is insulting to think that we would need you to do that because G4S has lots of money. They would be able to supply equipment. We could supply this. This is just an insulting thing. We assess everybody. Everybody who comes in is assessed and the support is provided."

14.27 The former chair and deputy chair of the IMB at Brook House told us about GDWG's relationships with the IMB, G4S and the Home Office. The former chair told us:

"The relationship has been a little rocky. It is certainly rocky between the Home Office and G4S and [GDWG] because on the one hand, everybody acknowledges the very good work they do. In practical terms, there is a definite feeling of suspicion of their motives. Whether this is justified or not really isn't our area to see, but they were beginning to contact me with concerns over individuals, which I thought was becoming a little bit inappropriate. I was beginning to serve their ends, so just before Panorama broke both G4S and the Home Office were getting cross about it and about some of, what they felt, was inappropriate behaviour, because they want them to be a welfare organisation only".

14.28 We asked why the IMB objected to being approached by GDWG about the welfare concerns of individual detainees. The former chair said:

"We are monitors really rather than resolvers of problems".

14.29 The former deputy chair said:

"I think there was a concern that we might not be perceived as being independent, of we appear to be to some extent at their beck and call."

14.30 He also said:

"I think there are people within the Gatwick Group who, if not of the view that detention is wrong full stop, are certainly approaching that…I think that there is a potential danger at the very least of this conflict between the campaigning and the welfare role…we may well get sucked into something in which we really shouldn't be involved"

14.31 We have seen emails GDWG sent to managers at Brook House raising issues relating to individual detainees. Managers at Brook House had apparently found the emails objectionable. They included the case of a disabled detainee. GDWG asked if the detainee might have an assessment for crutches, which GDWG offered to provide for him. Another email asked if managers would consider transferring a detainee with mental health problems to more appropriate accommodation at Tinsley House. The tone of the emails was polite and measured.

14.32 What we learned about the SMT's relationship with GDWG suggested to us that they had been unnecessarily defensive and had possibly been over-identifying with the Home Office and its interests in relation to immigration casework. G4S managers should welcome the referral of matters that may need to be addressed. In any event, GDWG is one of few independent organisations with direct contact with detainees at Brook House. It therefore offers G4S a potential channel of information about the wider experiences of detainees and insights into the way the centre is run.

14.33 The IMB may have been too quick to see ulterior political or campaigning motives in GDWG's raising of welfare concerns about individual detainees. They may thus have missed opportunities to help detainees and to gain insights into their care and treatment and systemic issues at Brook House. Although the IMB have told us that their concern has been to protect their own independence, what we learned about the IMB's response to approaches from GDWG reinforced our concern that the IMB have been over-empathetic to G4S and the Home Office.

14.34 We were pleased to learn from GDWG that their relationship with managers at Brook House appeared to have improved in recent months. The interim director told us that GDWG and other groups supporting detainees had a role at Brook House, including by referring matters of concern about individual detainees and by directing them to other organisations. He told us:

"I said we should engage with all agencies, because ultimately, we are the advocates for the people in our care, that's what we are. Yes, we provide a service to the Home Office to look after people, but we should also be the advocate for those in our care… What I am trying to get within that wider resettlement was yes, we engage with them to prepare them for release, also for removal, but also, make them feel as if they have been listened to and had the opportunity to - that's the part I would like to see." …

"… [my] vision for staff, is getting them to ensure that they are advocates, that they have an access team, so I don't just want to signpost to the welfare team, I want the staff on the frontline to understand that and think about the giving of wider support."

14.35 The IMB have told us that, having been made aware that G4S do not always respond when GDWG raises detainee welfare issues, the IMB have now proposed that GDWG should copy the IMB chair into its emails to G4S. The IMB have also provided GDWG with a copy of their own application form so that GDWG can help detainees who wish to contact the IMB directly.

The role and focus of the Home Office

14.36 Home Office managers told us that Home Office staff at Gatwick IRCs, who are based at Brook House, had previously worked as one team with responsibility for handling both local immigration matters and the performance of the G4S contracts. Home Office managers decided to create two teams at the end of 2017 to undertake the on-site Home Office functions. One was a contact team dealing with immigration matters. The other was a service delivery or compliance team responsible for liaising with G4S managers and making sure they fulfilled their contract. The head of the service delivery team told us that this move was designed to make contact between immigration caseworkers and detainees easier, as recommended in the Shaw review [1]into the welfare in detention of vulnerable persons.

[1] Stephen Shaw (January 2016), Independent Report: Review into the Welfare in Detention of Vulnerable Persons. The Stationary Office, London. Available to view online at:

14.37 Home Office managers in the service delivery team explained that they gathered information about G4S's performance of the contract and held them to account in a number of ways. They told us that members of the team were regularly out and about in Brook House, observing and discussing performance of different aspects of the contract, including tasting the food. A Home Office manager attends the centre director's daily meeting with his senior staff. A weekly meeting chaired by the Home Office's area manager for Gatwick IRCs with G4S senior managers considers operational performance matters. A monthly contract meeting with the G4S senior management team is chaired by the Home Office service delivery manager for Gatwick IRCs. It focuses on overall contract performance. Home Office managers told us they discussed the financial penalties G4S had incurred for failures in delivery under the contract and any possible mitigation. They said they asked the centre director and members of the senior management team to explain how they planned to address any failings under the contract.

14.38 The Home Office compliance manager (who reports to the Home Office area manager) told us in April 2018 that he had recently asked for detainee forum meetings to be reorganised so that detainees could voice any concerns to G4S managers and the Home Office about the way Brook House was run. The deputy director had handed responsibility for running detainee forums to the residential DCMs, but the forums had not been happening regularly. Furthermore, they had been held in rooms at the centre and they had sometimes been disrupted by uninvited detainees. The Home Office compliance manager had required the meetings to be held in the visits room weekly and for more senior G4S managers to attend.

14.39 The former director told us that Home Office managers he dealt with during his time running Brook House up to September 2017 had been primarily concerned with how G4S supported the immigration removal process. He said:

> *"Their primary focus was all about the removal process. …of course they care about the welfare and at different degrees but yes, their primary focus was the removal process… We manage charters well, but if we didn't manage that well, then that would be a big issue for them…"*

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https://www.gov.uk/government/publications/review-into-the-welfare-in-detention-of-vulnerable-persons

14.40 We interviewed the former Home Office contract manager who left at the end of 2017. He appeared to concede that during his time in the role, when there had not been a separate service delivery team, his priority and that of those he reported to had been with delivery of elements of the contract that supported the removals process, such as the requirements that detainees be presented within specified times for meetings with the Home Office and for legal hearings, for transfers and removals. He told us:

> *"If they needed to present a detainee ready for discharge for the escorting provider, the expectation was that detainee was ready to be handed over to the escorting provider. If they failed to do that it was a performance failure. Unless there was very good reason or mitigation presented it would be a financial penalty for them… There wasn't a huge amount of performance measures compared to what was actually in the schedule D, the operational requirements. The concentration was focused on the ones that we could performance measure because they were deemed as the most important part of the contract. It was things like admitting somebody and discharging somebody, making sure that activities were open, making sure that the Welfare Service was there. It was making sure that cleaning was done every day and people were released within the four hours. So admission, discharge, and areas such-like that we concentrated on."*

> *"Immigration work always took priority because the focus was having people's cases progressed to the end, whatever that may be – released or returned".*

14.41 The Home Office service delivery manager (who has overall responsibility for contract compliance and performance at Gatwick IRCs) also acknowledged that the Home Office had been more focused on those aspects of the contract with G4S that supported the delivery of immigration objectives. She told us:

> *"I think there is a real distinction between contact and doing contract and compliance activity and where we have a combined team, and there is so much drive on operational contact, we never got around to doing compliance work; that is the honest truth. It is always the kind of thing that ends up being left."*

14.42 Home Office managers also acknowledged that the Home Office monitoring of the performance of the contract at Brook House tended to be based on consideration of the individual elements of contract performance and compliance and that they had not taken

an approach that examined and questioned the wider concerns of the care and welfare of detainees, their quality of life and experience of being detained in Brook House.

14.43 The service delivery manager said:

> *"Activities is something that is only just emerging as a bit of an issue. I have seen in a couple of IMB reports, they do a weekly IMB inspection about aspects of activities not being on, so I have asked my team to do some work on that, but, for example, cleaning, catering, we are probably more advanced in our monitoring of those particular aspects than we have some of the stuff around reception. We have got quite involved in adults at risk, so I think we are probably more on point with those elements at the moment than we are with some of the regime aspects… historically, because where we only had a combined contract and compliance team there was no capacity to carry out compliance work outside of staffing levels which we monitored quite robustly. We didn't really do any other compliance monitoring, so you only knew what you knew, because we didn't have any capacity to go and find out anything."*

14.44 The Home Office compliance manager told us that the overall welfare of detainees and the quality of life of detainees was not a matter he was required to report on to his managers.

14.45 The service delivery manager told us that the Home Office was developing a framework based on identified thematic areas of risk to delivery of the contract and the information that will support the monitoring of the risks. She suggested that this would allow the Home Office to have a better grip on contract performance as a whole:

> *"…I have identified eight risk areas and bespoke compliance activity underneath each risk area, so if it was security I am not going to look at the whole of security because I don't have the capacity to do it, but, I can focus on use of force, I can focus on searching, particularly around visitor searching. I have identified some thematic areas inside those risk areas, which I and the team will go off and focus [on]. Depending on the scale of the job, depending on how I divide up the work between the six EOs [executive officers], so I have eight risk areas, six EOs, so for example, [one member of the team] is doing vulnerability as well as welfare and regime, so he will be looking at that and he is developing his framework for that at*

the moment, getting his head around contractually what they are required to deliver. He will be attending Adults at Risk meetings, because he is doing the vulnerability bit, and making sure they follow the Adults at Risk procedures. He will be doing that. Once we have that fully up and running we will then have the first feedback from the guys on what they have done in the last month…..Obviously G4S have a contract which requires them to self-audit, so they have identified the self-audit that will be relevant to the work they are doing so they can accompany the self-audits, just to make sure they are auditing themselves properly. All of that will start to feed into how we have discussions in the monthly meeting. I think we are on our way, but I wouldn't say we are where we need to be yet."

14.46 The Home Office on-site team enter the centre regularly and have regular contact with detainees, staff and managers. We believe they should take greater responsibility than they appear to have done in the past for monitoring the overall experience of detainees at Brook House and whether G4S is providing detainees with enough to occupy their time and are adequately ensuring the overall welfare of detainees.

G4S's own information gathering and assurance process

14.47 Senior managers in G4S's Custodial and Detention Services oversee and receive information about individual contracts principally via trading review meetings. The senior management team at each G4S-run prison or IRC makes a presentation on their performance against their key contractual performance indicators to senior managers of the sub-division. The managing director and chief operating officer of the sub-division have trading review meetings in turn with senior managers in the G4S Care and Custody division.

14.48 The [redacted], told us that each trading review meeting involved a prison or IRC management team preparing more than 100 slides of information. He told us the meetings used to be held monthly with each prison and IRC management team but since the beginning of 2018 organisations about which the sub-division managers had less concern had had trading reviews every two months. The [redacted] identified some of the limitations and shortcomings of the trading review process. He referred to the size of the information slide packs used, and the fact that trading review meetings often had to conclude before all relevant business had been covered. He also pointed out:

"It's a process that relies on the quality of information, the accuracy and veracity of the individuals telling us what's going on."

14.49 We questioned whether trading reviews gave a full picture of a prison or IRC and in particular whether they gave adequate assurance about the management of risks and conveyed softer intelligence about the culture of the institutions. The [redacted] told us:

"They have the Exec Summary for that, so their introduction is where you would expect them to do that. They also include their risk register in there, we always go through their risk register, and certainly the conversation about staffing. We also look at incidents as well, we will always review the levels of incidents, assaults, self-harm, any security incidents, the whole range of information that gives me a sense of the temperature check on it."

14.50 We asked the [redacted] how he personally kept a grip on what was going on at Brook House. He told us:

"Not as well as I'd like to. I should be doing regular assurance visits myself, there is nothing better than walking around a centre to find out what's going on.

Q. *When you say you don't, that's just simply time, is it?*

A. *Yes. It sounds like a dreadful excuse, but we are very busy sorting out [HMP] Birmingham, which is a major headache to us…. it's incredibly time-consuming. The governance that sits above us, my relationship with here [G4S head office] and the extremities of [Custodial and Detention Services] being geographically very dispersed, means that I get very limited time to do what I think is my job."*

14.51 We asked the [redacted] what he remembered of any problems during Brook House's trading reviews at the time of the Panorama programme. He told us:

"I think it was probably largely around the number of time-served offenders going in there. The challenges that they were experiencing were more prisoner-like behaviour, a more challenging population, and the increasing prevalence of drugs, NPS in particular, in there, that they had not seen before. So those sorts of "prison issues" were starting to come into the centre"

14.52 He also said:

> *"During the summer, at trading reviews, we would review the staffing. I distinctly remember one conversation where we saw a significant gap, should I say, in staffing data, and* [redacted] *was absolutely clear that it was a manageable situation. Bearing in mind that he was expecting to make reductions for the new contract, so he had one eye on the new contract, and saw this as a manageable situation to get through, he was very confident"*

14.53 The [redacted] told us that trading review meetings included discussions on health and safety, staff learning and development, contract finance, operations (including incidents violence) and HR issues. The [redacted] was keen to assure us that finance was not the principal focus of the meetings. Samples of information slides prepared by senior managers within the Care and Justice sub-division show that their trading reviews with senior managers of the G4S Care and Custody division cover a spread of management and operational concerns. Nevertheless, the [redacted] of Brook House told us:

> *"I think the focus seemed to be on targets and profit. People will talk about people and we need the best people, the values, and how we manage that, and how we look after people, but, in reality, all our targets were finance focussed…*[redacted]
> [redacted]
> [redacted]*"*

14.54 The [redacted] of Gatwick IRCs said he had felt under pressure to improve the profitability of the Gatwick IRCs contract, notwithstanding an in-built profit margin. He told us:

> *"These contracts, when you have them, yes, you have a set profit margin as part of it but…. there was an expectation that you deliver more…"*

14.55 We asked whether G4S senior managers expected improved profits year on year. The [redacted] answered:

> *"Yes, there was some target, but that is wrapped up in all sorts of other ways. It is not just about making the profit. I don't know if I am allowed to talk about the 60*

beds, but it could be about new business, or organic growth. It could be through other initiatives. There was an expectation that I would have discussions with the customer about how we might extend the contract or how we might develop different services….

"We made our savings from looking at how we could save on budgets that we had set against the year, about any kind of savings opportunities we could do, being more economical with the cleaning products…Staffing vacancies generated some profits because you were saving on costs that you had already looked at…"

14.56 He also said:

"There was an absolute determination to fill posts. We weren't looking to hold any, but you know that through the course of the year the ebb and flow of staff that you will end up making a bit of money out of staff vacancies."

14.57 We heard from more than one interviewee that some IRC and prison managers felt under unreasonable pressure at trading reviews, particularly in relation to financial performance. Another told us: *"people are fearful of delivering bad news"*.

14.58 G4S has a legitimate concern for the financial performance of contracts and delivering value for money. Senior managers should be able to deal with robust performance management, including in relation to financial performance. As the interim director at Brook House said:

"I'm spending somebody else's money, so it should be quite robust, and it should be challenging, but - I mean this - 100 per cent I've been supported… by the organisation…"

"I think it's challenging, in my view, in the right way. Nobody likes giving bad messages, but we are in a position where we will always have good and bad to present."

14.59 Nevertheless, we have been left with the impression that the trading review arrangements are time-consuming and inefficient. They have not always been constructive

and have not encouraged openness and transparency. They have not focused to the extent they should on risks to the delivery and quality of care offered to detainees.

14.60 [redacted]

14.61 The former director accepted that his priority had been on managing the relationship with the Home Office and other external stakeholders:

> *"I saw my role as being one of customer-focused and managing external stakeholders. [The deputy director] did deal with the more operational day-to-day elements. He is head of Brook House as well. Part of his role is dealing with the operational day-to-day business, so, yes, there is an expectation around that"*

14.62 The former director told us about the many issues he had been dealing with from the end of 2016. We asked him how much of his time had been taken up with the tender for the new contract to run Gatwick IRCs:

> *"Quite a lot of time. The bid plus the mobilisation of the 60 beds, the reopening of Tinsley House, the refurbishment of Tinsley House, dealing with the commercial issues. We were very transparent with the Home Office, again, around that… There was quite a lot of time spent on those… big issues…*
> *Q: Rather than the nuts and bolts of what was [going on] in the centre?*
> *A: Yes."*

14.63 The former director accepted that he had not been as visible at the centre as he would have liked:

"I would say that I would have liked to have been out and about more, and I would have liked to have been more visible. I am not sitting here saying I was around all the time. I didn't go around every day, and I think with hindsight it would have been good for me to have done that a bit more. I did do duty director shifts, which I found really useful…..

Q: Did you not go around because of pressure of other things, or did you not go around because… " I don't think that's my job- I have a team"?

A: A bit of both, I think. I don't know what was going to happen, and I think with hindsight I would probably carve out more time each day to go and have a presence around the site and ask questions. I think sometimes if you are really stretched and you can't physically get out every day. You have to rely on a team to do that, and you have to set expectations of people being present…"

14.64 [redacted]

14.65 The former director acknowledged the staffing problems but he did not appear to appreciate their full impact on daily operations. We asked him what he knew about staff sometimes being left in sole charge of a wing. He replied:

"I knew it was happening to some extent, and my view was that we have operational managers who are responsible for managing the day to day and a lot of that goes with deployment, and this was about deployment. I would walk around and if I found a person on the wing on their own I would stay with them and I would make a phone call to see where other people were because we would find staff elsewhere in the

centre. It wasn't because there weren't enough staff on duty in the centre, but sometimes there were issues about where the people were deployed."

14.66 The managing director of Custodial and Detention Services [redacted] shared with us a note of meetings he held with the former director and other members of the senior management team in 2014, prompted by concerns about their dysfunctional behaviours. [redacted] He explained that pressure of work and his consequent inability to visit the prisons and IRCs in his division had led him to appoint the chief operating officer in 2017.

14.67 However, the chief operating officer explained that his workload, and in particular the demands of dealing with pressing operational issues at Oakhill Secure Training Centre as well as HMP Birmingham, a lack of staff, the burden of trading reviews and other tasks assigned to him and a lack of staff to support him had meant that he too had not had time to visit Brook House as often as he would have liked. [redacted]

[redacted]

14.68 The fact that senior managers in the G4S Custodial and Detention Services had not had time for regular visits to Brook House to question managers and staff and see for themselves how the centre was being run was a further weakness in G4S's information gathering and assurance processes, both before and after the Panorama programme. The managing director and chief operating officer of G4S Custodial and Detention Services told us that in recognition of this weakness, they had a plan for the interim director of Brook House to lead a new assurance team. As the chief operating officer put it:

"…we are really missing having [the interim director] in the business, in the job that he should be doing… [the interim director] would head up the assurance line, reporting to [the managing director], so separate to me."

"… we end up in the same position, we're replicating, as a business, the same issues that have got us into this position, in my view…My fear is that unless we get [the interim director] out and we start building this assurance team – and I still don't think that that's the silver bullet, I still think there's something about me being able to go out and do what I need to do."

Intelligence and information gathering: conclusions

14.69 We found no evidence that any agency, organisation, or individual senior manager knew of a significant problem with staff behaviour and treatment of detainees at Brook House before the airing of the Panorama film. Neither do we believe that the behaviours and treatment of detainees depicted in the Panorama film should have been predicted.

14.70 However, a number of issues, including the lack of staff, the disaffection of staff, the inadequacies in management arrangements and behaviours and the size and nature of the detainee population, which posed a risk in terms of the way that staff might behave and interact with detainees, were starting to be apparent from at least the middle of 2016. Most of these matters were not highlighted to any significant degree in HMIP and IMB reports.

14.71 Home Office and G4S managers knew about some or all of the issues referred to, but contract performance management and assurance arrangements and discussions were more concerned with the delivery of the immigration agenda, contractual minutiae and financial considerations rather than the culture and overall care and experience of detainees at Brook House.

14.72 G4S performance management and assurance arrangements did not encourage openness and transparency and individual senior managers did not have time to find out for themselves about issues at Brook House or to act on any concerns they might have had.

15. Overall conclusions

15.1 Brook House offers the highest level of security in the detention estate. It houses detainees deemed to be the highest escape risk and some whose behaviour is too challenging for other removal centres. Many of the detainees at Brook House are time-served foreign national offenders. Many have mental health issues. Most have reached the end of their attempts to stay in the UK. They face enforced removal and are highly resistant to it.

15.2 Inadequate facilities, particularly the lack of outside space and a sports hall, and facilities for other activities, or accommodation suitable for the care of detainees with mental health problems and other vulnerabilities add to the difficulties of managing such a challenging detainee population.

15.3 The physical constraints and the lack of facilities at Brook House make it unsuitable to house the number of detainees it does. They also make it unsuitable to hold any detainee for more than a few weeks.

15.4 A failure to retain staff and low levels of staffing have been a problem at Brook House since at least the second half of 2016. Staffing problems became more acute in May 2017 when Tinsley House reopened after refurbishment and the bed capacity of Brook House rose from 448 to 508.

15.5 The lack of staff and the high turnover of staff has had a detrimental effect on many aspects of life at Brook House, both for detainees and staff. Staff have not had the time to give detainees the attention, support and care they need. The activities and entertainments programme has been severely curtailed and detainees have been under-occupied and bored. Many staff have become disaffected and disengaged. The fact that so many staff are young and inexperienced has meant that poor behaviour by detainees has not always been robustly and consistently challenged. Rules and procedures have not been consistently adhered to. Some staff and detainees have felt insecure and unsafe.

15.6 Problems of staff retention and staffing levels need to be addressed as a priority to ensure that other concerns about the management of Brook House can be resolved.

15.7 Weak management has compounded the staffing problems. The senior management team has a history of dysfunctional and un-collegial behaviour. They have not been visible

to staff. They have not adequately engaged with staff nor demonstrated an appreciation of their experience of working at Brook House and their concerns. Managers have tended to deal with shortcomings in performance in a heavy-handed, disciplinary and punitive way, rather than taking a more developmental and understanding approach.

15.8 Frontline management has been a particular weakness, with inadequate numbers of DCMs and a lack of management capability among them. This has meant they have not provided the leadership, guidance and support staff require. The lack of DCM presence and in some cases their failure to take ownership of their responsibilities has been mirrored by disengagement and a lack of ownership by some DCOs.

15.9 The lack of visible, supportive management, managers' heavy-handed approach to performance issues, and a lack of confidence in the arrangements for reporting and dealing with concerns, has meant staff have tended to rely on each other for support and guidance. These management shortcomings have discouraged staff from raising concerns, including those about the behaviour of colleagues and managers.

15.10 Staff at Brook House must deal with some demanding and challenging detainees. They often must respond to or witness frightening, threatening and distressing events. We saw many staff dealing with detainees with tact, compassion and good humour. We did not see any member of staff behave inappropriately or make inappropriate or disrespectful comments. Detainees we talked to and other witnesses did not suggest a significant or widespread problem with poor or abusive behaviours by staff. Nevertheless, a small number of people we interviewed suggested that some DCOs and DCMs sometimes exhibited inappropriate attitudes and behaviour. We learned of the cases of two C and R instructors who had shown wrong attitudes during a training event towards the management of detainees.

15.11 We were concerned about the extent to which managers and staff appeared to value assertiveness and operational competence above empathy, emotional intelligence and care, the tendency among some DCMs and DCOs towards a laddish culture. These cultural issues, together with an absence of strong visible management modelling and reinforcing the behaviours expected of staff; the pressures on staff and the inexperience of many; and the weakness or absence of effective oversight and assurance, especially in relation to the use of force, heightened the risk of incidents of inappropriate or abusive behaviour by staff at Brook House.

15.12 A number of the matters of concern relating to the management of Brook House that we refer to above have been apparent for some time. However, Home Office and G4S performance management and assurance arrangements have not focussed on them to the extent that they should nor on the risks they posed to the care and experience of detainees.

Appendix A

Team biographies

Kate Lampard

Kate Lampard spent 13 years in practice as a barrister before moving into the public sector where she has held a number of non-executive appointments. She undertakes investigation and consultancy work related to management and service arrangements and their effectiveness. Her high-profile projects include leading the NHS investigations into Jimmy Savile by quality assuring 34 independent investigations and producing an oversight report for the Secretary of State for Health. In 2016 Serco published the report she produced with Ed Marsden following their review of the culture and treatment of detainees at Yarl's Wood Immigration Removal Centre.

Kate is the lead non-executive director in the Department of Health and Social Care, chair of GambleAware, and a trustee of the Esmée Fairbairn Foundation and the Royal Horticultural Society.

Kate has previously been chair of the Southeast Strategic Health Authority, vice chair of the South of England Strategic Health Authority, vice chair of the Financial Ombudsman Service and interim chair of the Independent Advisory Panel on Deaths in Custody.

Ed Marsden

Ed has a clinical background in general and psychiatric nursing and NHS management. He has worked for the National Audit Office, the Department of Health and the West Kent Health Authority where he was director of performance management. He combines his responsibilities as Verita's managing director with an active role in leading complex consultancy. He worked with Kate Lampard on a 'lessons learnt' report for the Secretary of State for Health arising from the publication of the Jimmy Savile investigations. The Serco board commissioned Kate and Ed to conduct an independent investigation into concerns raised about Yarl's Wood immigration removal centre. He has advised the Jersey government about the inquiry into historical child abuse. Ed is an associate of the Prime Minister's Delivery Unit where he has carried out three assignments on immigration.

Terms of reference

Brook House Independent Investigation – Terms of Reference

Brook House is an immigration removal centre (IRC) situated near Gatwick Airport. It holds up to 508 adult male detainees. Decisions about who should be detained in an IRC are taken by the Home Office who are also responsible for managing the immigration case of each detainee. G4S is responsible for housing and caring for the detainees in a secure environment on behalf of the Home Office.

The purpose of this independent investigation is to understand the extent and root causes of the matters highlighted in a Panorama programme, dealing with the treatment of detainees at Brook House, which was aired on 4 September 2017. The investigation will examine G4S's management, operational and staffing arrangements and the practices and behaviours of G4S's staff.

This independent investigation is commissioned by the Group General Counsel of G4S PLC on behalf of the CSR committee of the G4S board. A report of the investigation findings will be provided to the G4S CSR committee and board.

The independent investigation is asked to examine:

1. the adequacy and appropriateness of G4S's operational policies, management and practice for the care and welfare of detainees, including in relation to mental health issues and self-harm , violence prevention, the availability of drugs, the handling of age disputes. Such investigation to include management arrangements within the IRC and the G4S Custody and Detention Business Unit
2. the attitudes and behaviour of staff towards detainees, including in relation to their welfare and wellbeing, self-harm and violence prevention
3. the extent and causes of any mistreatment of detainees by staff and whether the incidents reported on in the Panorama programme were isolated or reflective of a wider improper or inappropriate culture at Brook House
4. whether the use of force on detainees is subject to appropriate and adequate reporting, governance, assurance and improvement arrangements
5. the reasons for failures by staff to use the whistleblowing procedures and to report their colleagues' inappropriate attitudes and behaviours towards detainees
6. the appropriateness of staffing arrangements, including all aspects of recruitment, selection, training, appraisal and development; staffing levels and the deployment of staff; oversight and support offered to staff
7. the use and deployment of technology (CCTV, body cameras, listening devices) at Brook House and the efficacy of the same
8. Whether the information and intelligence gathering and monitoring arrangements relied on by managers (locally and centrally) to assess the care and welfare of detainees are appropriate, robust and reliable.

The investigation will include the healthcare services provided by G4S at Brook House but will not include transport services and/or matters or other services where they are not provided by G4S staff and/or where G4S is not responsible for their provision but will look at the extent to which such services impact on G4S's ability to deliver their services and how they work in practice.

The investigation will not include matters of detention and Home Office policy or mandated procedure, but the investigation will consider how their application in practice affects the management, operation and culture of Brook House, and the welfare of detainees.

The investigation team will make recommendations based on the findings of their investigation and in particular will make recommendations for actions that G4S should take to address any material weaknesses or issues identified

Methodology

Kate Lampard and Ed Marsden will carry out the investigation supported by Nicola Salmon, and, as necessary, a consultant from Verita. Transcribing of interviews will be carried out by Fiona Shipley Transcription Limited.

Employees will be given notice of any interview and the facility to be accompanied by a trade union representative or relevant work colleague.

G4S management will make themselves available for interview and will facilitate interviews with relevant G4S staff.

The investigation team will be able to draw on expert advice as necessary.

The investigation team will produce and agree a guide for interviewees taking account of the scope of the investigation.

The investigation is not a disciplinary investigation nor an investigation into contract compliance, or civil or criminal liability. The investigation team will not share transcripts or other evidence with G4S, other than what it sets out in its written report. The report may raise matters that G4S would wish to investigate that could lead to disciplinary action.

The investigation team undertake to inform G4S of any matters which come to its notice during the course of the investigation which it believes or knows to present a current and real risk of illegal activity or of harm to detainees or staff at Brook House. However it is not the responsibility of the investigation team to identify and determine whether matters which come to their notice do or do not amount to illegal activity or present a risk of harm to others.

Support

The investigation team will be supported on a day to day basis by the Centre Director and the Brook House Improvement Project Director and in areas beyond the scope of the investigation by the UK&I Regional General Counsel

Authority

The investigation team will have the authority of the Group General Counsel to access the areas of the Brook House contract site, subject to Home Office approval, and for the investigation team members and support staff (including relevant employees or contractors of Fiona Shipley Transcription Limited undertaking transcribing) to have appropriate security clearances, to interview any current employees or contractor and to obtain original and copy documentation as is necessary to progress the investigation and to ensure it has integrity and sufficient probity and rigour.

Reporting

The investigation team will report to the chair of the CSR committee of the G4S board.

The investigation team will offer regular updates on progress, including any areas of concern.

The investigation team will work as quickly as possible but its' primary concern will be to undertake a thorough and rigorous investigation and to produce a reliable report.

Peter Neden
Regional president (UK & Ireland),G4S Regional Management
November 2017

Appendix C

Documents reviewed

HM Government (March 2015) *Working Together to Safeguard Children*: *a guide to inter-agency working to safeguard and promote the welfare of children* The Stationery Office, London

HM Government (July 2018) *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children* The Stationery Office, London

HM Inspectorate of Prisons (2013) *Report on an unannounced inspection of Brook House Immigration Removal Centre 28 May – 27 June 2013*.

HM Inspectorate of Prisons (2017) *Report on an unannounced inspection of Brook House Immigration Removal Centre 31 October -11 November 2016*.

Home Office Detention Service Orders

Home Office (August 2016) Immigration Act 2016: Guidance on adults at risk in immigration detention

Independent Monitoring Boards (April 2017) *Annual Report of the Independent Monitoring Board at Brook House IRC 1 January 2016 – 31 December 2016*

Independent Monitoring Boards (May 2018) *Annual Report of the Independent Monitoring Board at Brook House IRC for the reporting year 2017*

Shaw. S, (January 2016), *Independent Report: Review into the Welfare in Detention of Vulnerable Persons*. The Stationery Office, London.

The Detention Centre Rules 2001. Statutory Instrument 2001 No 238 Immigration. The Stationery Office, London

G4S and Gatwick IRCs documents

G4S group standard policies

G4S internal investigation and management reports

Gatwick IRCs policies, strategy documents, code of conduct, action plans, management reports, minutes of management meetings, presentation materials, correspondence

Gatwick IRCs' training materials

Appendix D

Staff interview invitation and guide for interviewees

Independent investigation into concerns about Brook House immigration removal centre

[Name]
[Position]
[Address]
[Address]
[Address]

[Date]

Private and confidential

Dear [Name]

Independent investigation into Brook House immigration removal centre – interview request

G4S has asked me and my colleague, Ed Marsden, to carry out an independent investigation into concerns about Brook House IRC.

The purpose of the investigation is to understand the extent and root causes of the matters highlighted in a BBC Panorama programme, dealing with the treatment of detainees at Brook House, which was broadcast on 4 September 2017. As well as the issue of the attitude and behaviour of staff towards detainees, we will be looking at the overall care and welfare provided to detainees including in relation to mental health issues and self- harm, violence prevention, the availability of drugs within the centre, the use of force, whistle blowing arrangements, and the staffing arrangements. Our terms of reference are attached.

As part of the investigation we would like to meet with you. The interview will be held in private and, subject to your agreement, will be recorded and transcribed to make sure nothing you say is lost. We will send you a copy of the transcript so that you can check that it is accurate. You are welcome to have a friend or colleague come with you to the interview. A guidance note for interviewees is enclosed.

Your interview has been arranged for [date] at [time]. The interview will be held at [location] in [room]. If this time is no longer convenient please call Nicola Salmon at the Verita office on 0207 494 5670.

If you would like any further information about our work or the interview, please call me or Ed on the same office number.

Yours sincerely

Kate Lampard & Ed Marsden, appointed by G4S to lead the independent investigation.

Diary management c/o Nicola Salmon
Telephone: 020 7494 5670 Email: nicolasalmon@verita.net

Secretarial support c/o Verita Consultancy Ltd, 338 City Road, London EC1V 2PY
Telephone: 020 7494 5670

Independent investigation into concerns about Brook House immigration removal centre

Kate Lampard

Attachments: Terms of reference
Team biographies
Guide for interviewees

Independent investigation into concerns about Brook House immigration removal centre

Guide for interviewees

The purpose of the investigation is to understand the extent and root causes of the matters highlighted in a Panorama programme, dealing with the treatment of detainees at Brook House, which was aired on 4 September 2017.

1. The investigation will be held in private. The record of interview proceedings will be strictly confidential except to the extent that extracts may be included in the report submitted to the commissioning body, that is, G4S. Please note that the commissioning body may, at their discretion, decide to publish the report.

2. The investigation team will invite interviewees to give evidence on a voluntary basis. Some interviewees may wish to give evidence in person, other individuals may wish to submit a written statement of evidence or to rely upon evidence previously given, but this is at their discretion.

3. The proceedings will be informal and interviewees may bring with them a friend or relative, a member of a trade union, lawyer or any other person they wish to accompany them (although we want to hear from each interviewee in their own words and do not expect the person you bring with you to speak on your behalf). Those accompanying interviewees may not be interviewees themselves unless this has been agreed with the investigation team in advance.

4. All interviewees and persons accompanying them will be expected to keep confidential all information disclosed to them. The investigation team may, at their discretion, exclude any person from any session should this appear to them to be desirable for the conduct of the investigation.

5. Interviewees may refer to records or other documentation should they think this necessary in order to answer questions. Interviewees may also submit to the investigation team any relevant documents in their possession.

6. A transcript will be taken of the oral evidence given by each interviewee, with a copy being sent to the interviewee for confirmation or amendment if necessary. The transcript will be subject to the same undertaking of confidentiality referred to in paragraph 4 above.

7. Documentary material, and evidence (oral and/or written), submitted to the investigation will be kept confidential, except to the extent that it is disclosed in the report(s) or is used in the handling of the report's publication.

8. The investigation team will seek out documentary and other material that it considers will assist in fulfilling the terms of reference. This may include the collection and analysis of contemporaneous records and reports and assistance from experts or professional advisors.

9. The investigation team has formed no view, provisional or otherwise, as to whether it is necessary to make any criticism of any individual or organisation. Should any points of potential criticism arise, the person or organisation concerned will be informed of them, either orally, when they give evidence, or in writing. They will also be given an opportunity to comment on the potential criticism before the investigation team reach a conclusion on it. Before receiving written notice of the detail of any potential criticism, the recipient may be required to give an undertaking to keep the written notice and the information contained in it confidential, except for the purpose of taking advice or preparing a response.

10. Representations on various aspects of the investigation, including on any draft recommendations, may be invited from or made by relevant statutory and voluntary organisations, professionals and other interested parties.

11. Any other person who feels they may have something useful to contribute to the investigation may provide a written submission or ask to meet with the investigation team.

12. The investigation team may make such amendments to this procedure as appear to be necessary. Should any such amendment be made, the investigation team will endeavour to notify those affected as soon as is reasonably practicable.

13. The investigation team comprises Kate Lampard and Ed Marsden. All questions about the investigation and any communication to the investigation team should in the first instance be addressed to Nicola Salmon at the address and contact numbers at the bottom of this letter.

Verita
338 City Road
London, EC1V 2PY

Office: 020 7494 5670
Email: nicolasalmon@verita.net

Appendix E

Detainees interview invitation

Independent investigation into concerns about Brook House immigration removal centre

To be delivered by G4S to:

Mr «Name» «Surname» («CID_Ref»)
«Wing» Wing
Brook House IRC
Perimeter Road South
Gatwick Airport
West Sussex
RH6 0PQ

Private and confidential

21 March 2018

Dear Mr «Surname»

Independent investigation into concerns about Brook House immigration removal centre

G4S has asked me and my colleague, Ed Marsden, to carry out an independent investigation into concerns about Brook House IRC. I have enclosed some information about us and the type of work we do.

In our investigation we are looking in to matters highlighted in a BBC Panorama programme, dealing with the treatment of detainees at Brook House, which was broadcast on 4 September 2017. As well as the issue of the attitude and behaviour of staff towards detainees, we will be looking at the overall care and welfare provided to detainees including in relation to mental health issues and self- harm, violence prevention, the availability of drugs within the centre, the use of force, whistle blowing arrangements, and the staffing arrangements. Our terms of reference, which set out the scope of our investigation are attached to this letter.

In order to fulfil the terms of reference, Ed and I are conducting a range of interviews with residents, staff, experts, policy leads, practitioners and managers.

We would like to meet with you as part of a group meeting with other residents. This has been arranged for «Date» at «Time». The meeting will be held in the «Location». This is a voluntary meeting. If you would prefer not to attend, please contact Loraine Higgins PA to the centre director, via the wing officers at Brook House.

The group meeting will be held in private and we will take a note of the points discussed. We will send you a copy of the note of the meeting so that you can check that it is accurate.

Kate Lampard & Ed Marsden, appointed by G4S to lead the independent investigation.

Diary management c/o Nicola Salmon
Telephone: 020 7494 5670 Email: nicolasalmon@verita.net

Secretarial support c/o Verita Consultancy Ltd, 338 City Road, London EC1V 2PY
Telephone: 020 7494 5670

Independent investigation into concerns about Brook House immigration removal centre

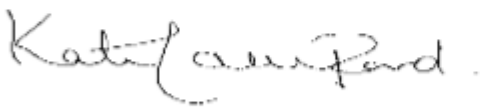
A guidance note for interviewees is enclosed. Please do look through it. We will not share the note of the meeting with either G4S or the Home Office immigration service.

We will report our findings and any recommendations for improvement to the G4S board. It is for the board to decide what it will publish once it has received our report. We think you should work on the assumption that G4S will make the findings and outcome of our investigation public.

If you would like any further information about our work or the meeting please contact Ed Marsden or me through Nicola Salmon at nicolasalmon@verita.net .

We look forward to meeting you shortly.

Yours sincerely



Kate Lampard

Enclosures: Team biographies
Terms of reference
Guide for interviewees

Appendix F

List of interviewees

G4S central office

[redacted]	Divisional business development director, G4S - Care and Justice
[redacted]	Chief operating officer, G4S Custodial & Detention Services
[redacted]	Managing director, G4S Custodial & Detention Services
[redacted]	UK & Ireland head of learning & development
[redacted]	Group corporate affairs director

Brook House local staff

Senior management team

[redacted]	Director Gatwick IRCs
[redacted]	Deputy director Gatwick IRCs
[redacted]	Former residential and regimes manager
[redacted]	Head of safeguarding / residential and regimes manager
[redacted]	Head of security
[redacted]	Support services manager
[redacted]	Former director Gatwick IRCs
[redacted]	Head of Tinsley House, borders and PDA

Managers

Manager of religious affairs

Race relations & diversity manager

Interim safeguarding manager/ violence reduction manager

Staff

7 DCMs
9 DCOs
ACO
Central detail manager
Complaints clerk
Former DCM activities
HR advisor
Teacher
Training officer
Welfare officer

2 detainee groups

Healthcare

Head of healthcare IRCs, G4S Health Services
Healthcare practice manager, G4S Health Services
GP, G4S Health Services
Senior mental health nurse, G4S Health Services
Learning disability nurse, G4S Health Services

Brook House Independent Monitoring Board

[redacted] Chair
[redacted] Vice chair
[redacted] Former chair
[redacted] Former vice chair

Home Office Immigration Enforcement

[redacted] Director, Detention and Escorting Services

[redacted]	Head of operations, Detention and Escorting Services
[redacted]	Area manager - Gatwick
[redacted]	Assistant director: delivery manager - Gatwick, Detention Operations

Former home office contract monitor - Gatwick IRC

Operations & compliance manager

PDT operational manager, Detention, Progression and Returns Command (DPRC)

Representatives of organisations operating within Brook House

General manager, [redacted]

Team leader, The Forward Trust

British Red Cross

Gatwick Detainees Welfare Group

Hibiscus

Experts

Dominic Aitken	DPhil candidate in criminology, Wadham College, Oxford University
[redacted]	Deputy head of healthcare inspection, HM Inspectorate of Prisons

Visits to other facilities

HMP Rye Hill

Colnbrook IRC

HMP Preston

Correspondence with BBC Panorama

Independent investigation into concerns about Brook House immigration removal centre

Mr Joe Plomin
Producer director
BBC Panorama
Zone D, Floor 4
BBC New Broadcasting House
Portland Place
London
W1A 1AA

12 October 2017

Dear Mr Plomin

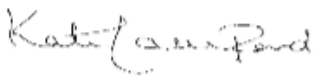
Ed Marsden and I have been appointed by G4S to conduct an independent investigation into the concerns raised about Brook House immigration removal centre in the BBC Panorama documentary film broadcast on 4 September 2017.

We have suggested to G4S that before the terms of reference are finalised that we wanted to consult a small number of people and organisations about the focus of the investigation. With this in mind, Ed and I would welcome the opportunity to talk to you.

Perhaps someone in your office could contact Nicola Salmon at Verita. Her contact details are at the bottom of this letter.

I look forward to hearing from you.

Yours sincerely



Kate Lampard

Kate Lampard & Ed Marsden appointed by G4S to lead the independent investigation.

Diary management c/o Nicola Salmon
Telephone: 020 7494 5670 Email: nicolasalmon@verita.net

Secretarial support c/o Verita Consultancy Ltd, 338 City Road, London EC1V 2PY
Telephone: 020 7494 5670

From: Joe Plomin <joe.plomin@bbc.co.uk>
Sent: 08 November 2017 17:25
To: Nicola Salmon
Subject: FAO KATE LAMPARD RE: Independent investigation into Brook House IRC

Categories: Client/ Case Work

Dear Ms Lampard.

Thank you for your letter and email. As you will have gathered from my out of office, I was away on leave when you tried to contact me.

As you will no doubt be aware, events that took place at Brook House which were uncovered by Panorama are now the subject of an active police investigation. The BBC is co-operating with that investigation. In the event that criminal charges are brought, I am most likely to be called as a witness. Accordingly, the approach that the BBC is taking in relation to the numerous requests for assistance/material/meetings is that whilst the police investigation is active, our assistance is limited (wherever possible) to co-operating with that investigation.

In any event, I am not sure it would be appropriate for there to be any perception that the BBC had been assisting with the terms of reference into an investigation, which has only come about as a result of the BBC having exposed the very practices which are the subject of the investigation. The BBC's role is to tell stories and make programmes in the public interest. On this occasion, we uncovered a number of matters of concern at Brook House which we brought to the public's attention. G4S were provided with the substance and detail of what Panorama had uncovered ahead of transmission. The areas of concern were spelt out for G4S and they were given an opportunity to respond. G4S have subsequently viewed the programme. No doubt they have therefore already formed a view on what ought to be the focus of any investigation.

In the circumstances, the terms of reference in respect of an independent investigation that G4S have themselves commissioned is entirely a matter for them and so I am going to have to decline your invitation I'm afraid.

Thank you again for contacting me. I am sorry not to be able to assist you further.

Yours Sincerely,

Joe Plomin

From: Nicola Salmon
Sent: 10 November 2017 16:35
To: 'Joe Plomin'
Subject: RE: FAO KATE LAMPARD RE: Independent investigation into Brook House IRC
Attachments: 2017 11 10 UF letter.pdf; 2017 11 10 RI letter.pdf

Dear Mr Plomin,

Thank you for your email response.

Please see attached letter from Kate Lampard in reply.

Please also see a separate request from Ed Marsden (co-investigator).

Kind regards,

Nicola

Independent investigation into concerns about Brook House immigration removal centre

Mr Joe Plomin
Producer director
BBC Panorama
Zone D, Floor 4
BBC New Broadcasting House
Portland Place
London
W1A 1AA

10 November 2017

Dear Mr Plomin

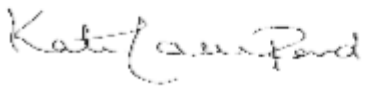
Thank you for your email reply of 8 November.

We are aware of the police investigation and we will be writing to the senior investigating officer in the next few days.

Meanwhile we would be grateful if the BBC would consider releasing to us the unedited footage from the filming carried out by Callum Tulley. As you rightly say, the Panorama programme brought to wider attention matters of concern about Brook House. We would like to assure ourselves that our investigation covers all of the issues raised by Mr Tulley's filming, regardless as to whether the footage was broadcast or not. We are, of course, happy to provide a signed undertaking to keep the footage confidential.

I look forward to hearing from you.

Yours sincerely



Kate Lampard

Kate Lampard & Ed Marsden, appointed by G4S to lead the independent investigation.

Diary management c/o Nicola Salmon
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Independent investigation into concerns about Brook House immigration removal centre

Mr Joe Plomin
Producer director
BBC Panorama
Zone D, Floor 4
BBC New Broadcasting House
Portland Place
London
W1A 1AA

10 November 2017

Dear Mr Plomin

As you will know from our earlier letter, Kate Lampard and I have been appointed by G4S to carry out an independent investigation into the concerns about Brook House IRC broadcast by the BBC on 4 September. We are reporting the outcome of our work to Clare Spottiswoode, a non-executive director on the G4S board.

Kate Lampard and I have been through the Panorama programme in some detail this morning. We have identified a good number of people we would like to interview. Included among these is Alif Jan, Harshad Purohit and Mustapha Zitouni. If we were to provide Panorama with letters of invitation, would you be prepared to deliver them to these individuals? We realise that both Harshad and Mustapha have now returned to their home countries. I would be grateful if you would consider this request.

I look forward to hearing from you.

Yours sincerely

Ed Marsden

From: Joe Plomin <joe.plomin@bbc.co.uk>
Sent: 23 November 2017 16:32
To: Nicola Salmon
Subject: RE: FAO KATE LAMPARD AND MR MARSDEN RE: Independent investigation into Brook House IRC

Dear Ms Lampard and Mr Marsden,

Thank you for your reply to my email of 8 November. I'm afraid that as outlined to you in my earlier email, we are unable to assist with your request for the untransmitted material recorded by Callum Tulley.

In relation to your request that we forward letters of invitation on to contributors that appeared in the programme, given that I do not know whether the police are already in contact with those individuals (or would wish to be), I am afraid that I am going to have to be guided by the police as to whether or not this would be appropriate. I have asked our legal team to make contact with the relevant officers to canvass their views on your request. If the police are satisfied that this does not in any way interfere with their investigation then we will pass on your letters of invitation. In this regard, can I please ask that any future correspondence on this matter is addressed to Elizabeth Grace in our litigation team. Elizabeth can be contacted on Elizabeth.grace@bbc.co.uk.

I am sorry not to be able to assist more at this time.

Yours sincerely,

Joe Plomin

Appendix H

Notes on the Panorama programme

Below are the initial notes made by the investigation team setting out the allegations made in the Panorama programme.

Detainee mix

- *"toxic"* atmosphere. Violence can erupt any time- film of detainee alleging he has been hit by another detainee wielding a pool ball. Film of detainees banging on a cell door - the implication being that this is a more vulnerable detainee being intimidated (but no assertion about who is inside the cell)
- Fear engendered by TSFNOs

Length of stay

- Case of Mustapha highlighted- false pass port, drug offences waits 11 months for flight then turned back at airport because Algerian Embassy doesn't supply documents. Protests by climbing on netting with razor blades. Says he wants to go. Nationals come and subdue him with spray

Induction

- Mixing of TSFNOs and existing detainees with new arrivals on induction wing
- Presence of known and suspected drug dealers on induction wing

Drugs

- Staff say only matter of time before a death occurs
- Adds to fears of non-drug takers and other detainees

- Drugs entering through visits- visits hall not adequately patrolled/supervised. Film of 2 officers (DCOs H and I) just chatting together. New and inexperienced officer in charge (DCO B)
- Alleged child detainee that staff think is being used as a guinea pig for batch of spice

Staffing

- Staff overstretched (often 2 officers for 100 detainees on a wing)
- Make mistakes
- Detainees therefore subject to lock up at roll calls for longer than necessary
- Affects attitude of staff

Detention of a child

- Issue of a person suspected by staff of being a child not raised by a member of staff with managers *"I'm not going to be flagging it up"*
- Person in question not released into care of social services for 2 weeks (HO says this is an age dispute case)

Despair and self-harm by detainees

2016

- 53 cases of treatment for self-harm
- 451 recorded as at risk of self-harm
- 316 cases of food refusal

Detention and treatment of detainees with MH issues

- not recording food refusal- which might be first sign of more serious MH issue
- inappropriate attitude to those with MH problems (see allegations below)

Assaults and inappropriate language and attitudes by staff

DCM 1 – disrespectful and callous behaviour re detainee on spice with eyes rolling round *("Does your face taste nice" "Lay still you div"*. Not taking situation seriously/as medical issue. *"Scrotum"*. Allegation that DCM 1 encourages other officers to taunt detainees.

DCO A doing observations /suicide watch on detainee *"Detainee A"*. DCO A claims he bent back fingers of Detainee A and banged his head up and down *"It was funny" "You're an attention seeker, you prick"*. DCO A confesses what he has done to other staff and no one challenges or bats an eyelid. In same section DCO B is asked what is best way to deal with them- answers *"turn away, Hopefully they're swinging"*

DCO C -- a C and R trainer, prior to a forcible removal (from which, in the event, officers are stood down) says others should use racist language *"N*****"*. Discussion of a removal *"Fuck him up round the corner" "Can't fuck about" "I'll scrub the CCTV" "He had his fucking chance"*

DCOs D and DCO E- Film of forcible removal of detainee with heart problems. DCO D says *"If he dies he dies"* DCO E: *"All you have to worry about, all you have to know is to roll his fucking head or hit him with a shield"*. Detainee wails and swears at officers. When returned from airport unidentified DCOs heard to say, *"it's a fucking joke" "It's fucking wrong"*

Reporter enters cell of same detainee to find blood everywhere – detainee has cut arms, wrists and taken pills

DCM 1 says of a food refusing detainee who film shows saying he isn't eating as protest *"he's a penis"*. Tells reporter not to record food refusal.

DCO F shouts at detainee with MH issues through door *"clean this fucking window or I'll beat the fucking shit out of you" "If this keeps going I'm going to smash the fucking shit out of him" "you'll be in trouble boy"*. Detainee in question so ill he is taken to hospital and sectioned.

Another detainee with MH issues chucks milk at officers (unidentified) who respond *"for fucks sake" "your fucking attitude depends on how it is going to be for you" "piss us off and you won't have a shower"*

DCM 1; Nurse X; DCO E; DCO G:
Film of emergency on E wing -detainee Detainee A has tried to kill self - ligature with own t shirt, and tried to swallow batteries. Detainee A says, *"I'll die". "I don't care what I do"* DCM 1 comments *"If he wants to suck batteries plug him up like a Duracell bunny"* Nurse X says *"he's an arse basically"*. Reporter then does observations during which Detainee A tries to strangle self with own hands. DCO E comes to cell, Holds Detainee A's head and says, *"I'm going to put you to fucking sleep"" Don't move you fucking piece of shit"*. DCO E pushes his fingers into Detainee A's mouth *"Are you going to stop being an idiot yes or no"*. DCO G *"are you going to be man or a mouse"*
Reporter says *"easy DCO E"* No suggestion of reporting.
Later DCO E filmed saying *"that wasn't really C and R"*
Nurse X doesn't mention restraint in her notes. In staff room DCO E says *"if I killed a man, I wouldn't be bothered"*

Later incident of Detainee A on the netting- a DCO (unnamed) asked what should be done about Detainee A laughing says *"what DCO E did"*.

Appendix I

Issues/ concerns raised by Panorama

The table below shows where issues raised by the Panorama have been addressed within this report.

Issue raised/allegation/incident in BBC Panorama programme	**Relevant section of this report**
There is a culture of menace towards some detainees and a conspiracy of silence and/ or misrepresentation concerning incidents of violence or neglect.	Relations between staff and detainees from para 13.1 Staff behaviours from para 13.8
a. Known drug dealers have been moved onto the induction wing, which should inculcate good behaviour in new detainees. We understand this happens because the induction wing is effectively being used as an overflow wing and that such mixing of detainees is inappropriate in a custodial environment that there is no good explanation for it.	The induction process paras 10.33 to 10.38
b. A number of employees (who we are not naming) have raised concerns and been assured issues would be resolved which have not been resolved. Officers labelled "snitches" or "grasses" can be singled out at the IRC, leaving some staff afraid to speak out about concerns to management.	The failure to support and engage with staff paras 7.91 – 7.101 Culture and relationships among DCOs and DCMs Paras 13.26- 13.40 Raising concerns and whistleblowing paras 13.41.- 13.53

	c. On a number of occasions staff at the IRC could not correctly count or locate all detainees. At times there are insufficient detainee custody officers to provide good pastoral care and those low staff numbers have caused detainee custody to lose confidence and affected morale.	Recruitment and retention paras 8.37 -8.69 The effects of low staffing and the failure to retain staff para 8.70 Relations between staff and detainees paras 13.1-13.7
	d. Illegal narcotics are used regularly in what should be a secure centre. There are specific security lapses particularly within the visits regime. This suggests illegal narcotics are not taken seriously enough by staff and management at the IRC. There is an allegation that some officers are corrupt and have smuggled in contraband.	Drugs paras 12.78-12.84 Searching for drugs and other banned items paras 12.85-12.95
	e. Unprofessional and/or insulting attitudes and poor behaviour demonstrated by a number of staff. This includes towards detainees with pre-existing mental health difficulties who are not treated appropriately at times by some staff at the IRC. This directly undermines the Home Office's policy that detainees with mental illnesses can be "satisfactorily managed" within the IRC.	Staff training paras 8.108-8.115 Management of detainees with mental health problems paras 11.41—11.48 Relations between staff and detainees paras 13.1-13.40
	f. Poor attitudes demonstrated by one nurse, one detainee custody manager and one G4S restraint trainer and supervisor towards detainees. These attitudes were known to senior managers at G4S but have continued as	The handling of complaints and allegations paras 13.54-13.60 The Panorama allegations paras 13.61-13.65 Other allegations of misconduct paras 13.66-13.68

	has their supervision of detainees, some of whom are vulnerable.	
	g. A poor attitude by at least two different detainee custody managers, towards food refusal by detainees. At least one incident of food refusal was covered up and deliberately not reported.	The care and welfare of detainees chapter 10.
	h. There have been incidents of near loss of control and incidents of violence.	The experience of violence and assaults at Brook House paras 12.10 – 12.36
	i. There have been repeated incidents of self-harm or attempted suicide by detainees.	The management of self-harm and suicide and the care of vulnerable detainees paras 10.46 – 10.51
	j. There have been occasions where a number of detainee custody officers have mistreated detainees in their care, including deliberately hurting them. At least one incident of harm or mistreatment has been covered up because the events were deliberately not reported.	Relations between staff and detainees paras 13.1- 13.40 Raising concerns and whistleblowing paras 13.41-13.53
	k. A larger number of officers and other G4S employees have turned a blind eye to or helped to cover up those actions. This includes some managers and medical staff.	Culture and relationships among DCOs and DCMs paras 13.26-13.40 Raising concerns and whistleblowing paras 13.41-1353
	l. The IRC has a toxic atmosphere in which some detainees struggle, psychologically. Detainees who were never in jail before have been frightened and left at risk of exploitation or violence by being mixed with convicted criminals at the IRC.	The detainee population at Brook House chapter 6. Security and safety chapter 12 paras 12.9-12.61
	m. The mental health of some detainees who did not have pre-existing mental health conditions can decline	The detainee population at Brook House chapter 6.

	significantly in detention. This is particularly true for those detainees in respect of whom there is neither a realistic prospect of removal or of release. Those detainees are in indefinite detention, which we understand is inappropriate and should cease.	Our terms of reference preclude consideration of matters of detention and Home Office policy. As a result we do not comment on the length of detention.