Annual Report of the Independent Monitoring Board at Gatwick IRC

For reporting year
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Introductory sections 1 - 3

1 Statutory role of the IMB

The Immigration and Asylum Act 1999 requires every immigration removal centre (IRC) to be monitored by an independent board appointed by the Secretary of State from members of the community in which the IRC is situated.

Under the Detention Centre Rules, the Board is required to:

- monitor the state of the premises, its administration, the food and the treatment of detained people
- inform the Secretary of State of any abuse that comes to their knowledge
- report on any aspect of the consideration of the immigration status of any detained person that causes them concern as it affects that person's continued detention
- visit detained people who are removed from association, in temporary confinement or subject to special control or restraint
- report on any aspect of a detained person's mental or physical health that is likely to be injuriously affected by any condition of detention
- inform promptly the Secretary of State, or any official to whom authority has been delegated, as it judges appropriate, any concern it has
- report annually to the Secretary of State on how well the IRC has met the standards and requirements placed on it and what impact these have on those in its custody.

To enable the Board to carry out these duties effectively, its members have right of access to every detained person and every part of the IRC and all of its records.

The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is an international human rights treaty designed to strengthen protection for people deprived of their liberty. The protocol recognises that such people are particularly vulnerable and aims to prevent their ill-treatment through establishing a system of visits or inspections to all places of detention. OPCAT requires that states designate a National Preventive Mechanism to carry out visits to places of detention, to monitor the treatment of and conditions for detained people and to make recommendations for the prevention of ill-treatment. The IMBs are part of the United Kingdom's National Preventive Mechanism.

2 Description of the establishment

2.1.1 Gatwick IRC comprises Brook House and Tinsley House. These two centres have been managed as one since Serco took over as contractor in May 2020. The previously separate IMBs were merged from 1 January 2021.

2.1.2 Brook House opened in 2009 as a purpose-built IRC for adult men. It is located about 200 metres from the main runway at Gatwick Airport and was built to prison category B standard. The maximum capacity was 426 in 2024, accommodated in two-bedded rooms.

2.1.3 Brook House has four wings designated as 'general population', one of which is smaller and used as an induction wing where newly arrived men can receive support in adjusting in their first days at the centre. Facilities provided on each wing include a laundry, table tennis and pool tables and a large screen for viewing films.

2.1.4 The fifth wing, E wing, is a care and separation unit (CSU) used to accommodate men separated or segregated under Rule 40 (the removal of a detained person from association) or Rule 42 (temporary confinement). For some time, the larger part of this wing has been used to accommodate men with significantly higher support needs; however, in late May these men were placed onto other wings.

2.1.5 Tinsley House is located close to Brook House. Its capacity is for 162 men, accommodated in two-, four- and six-bedded rooms. Separate, dedicated spaces for families have previously been provided in the Borders and Pre-Departure Accommodation; however, no families have been accommodated in 2024 while the centre is being renovated to provide more general accommodation.

2.1.6 The Home Office has two local teams at Gatwick: detention services (DS), who oversee service providers' compliance and the detention engagement team (DET) who provide on-site engagement with men and a link with case owners.

2.1.7 Medical, mental health and substance misuse services were provided in 2024 by Practice Plus Group in both centres.

2.1.8 Samaritans, Gatwick Detainees Welfare Group (GDWG), Bail for Immigration Detainees (BID) and British Red Cross provide support to detained men. From around June 2023, BID and GDWG have held regular in-person surgeries in Brook House and Tinsley House.

3 Key points

3.1 Background to the report

3.1.1 In 2024 the Conservative government continued its efforts to remove people seeking asylum in the UK to Rwanda, under the Migration and Economic Development Partnership (MEDP). In 2023 the Supreme Court found that Rwanda was not a safe country and these arrangements were unlawful, which stalled the implementation of the policy for some time. However, the then government enacted the Safety of Rwanda (Asylum and Migration Act) 2024 on 25 April, resulting in the detention under immigration powers of a significant number of people destined for removal to Rwanda. Seventy-nine of these men arrived at Brook House over the course of a single weekend, in considerable distress, described by local Home Office as “shocked and bewildered”. This was particularly true of those picked up by police in high-profile raids on their homes, some having had their doors broken down and been removed from their homes in handcuffs. When a general election was announced on 23 May it was clear that the Rwanda plans would be put on hold. However, although a first cohort was released that week, it took an unreasonably long time for the rest to be released. The Board noted that 40 were still in detention on 2 June and on 7 June 27 men remained. The last did not leave until 26 June. The Board considers this an unacceptable length of time for these men to have been detained. The Board also noted on several occasions that the language used to discuss them, such as “MEDP cases”, felt dehumanising and risked creating the type of toxic culture that was mentioned by the Brook House Inquiry.

3.1.2 Operation Safeguard continued throughout 2024 to reduce pressure on space in the prison estate (a contingency measure to allow prisoners to be held in police cells when prisons are becoming overcrowded. This has included the transfer to immigration detention of men who might normally have remained in prisons under immigration controls). Prison capacity continued to be under strain in 2024, and the Gatwick Board reported in its 2023 annual report that this had resulted in a lowered risk threshold for transfer to the detention estate and a greater proportion of men with elevated levels of vulnerability or higher risk profiles. In 2024 we see the same consequences, which have become the 'new normal'.

3.1.3 Plans for the expansion of the detention estate to increase the number of available beds were maintained under the new Labour government. At Gatwick this meant that the pre-departure accommodation for families was closed throughout the year while renovations were undertaken under 'Project Optimise' to increase bed space at Tinsley House.

3.2 Main findings

Safety

- As in 2023, both Brook House and Tinsley House continue to feel volatile and less safe than in the preceding years. Examples include violent altercations and assaults on both detained men and on staff, and concerns reported by detained men about drugs, unpredictable behaviour and tensions between nationalities. Levels of violence, self-harm and suicidal ideation remain high at Brook House. Many staff conduct themselves with care and solicitude, but there remains a culture of disbelief and sometimes a lack of empathy (paragraphs 4.1.2; 4.4.1).
- A detained man died at Brook House during the reporting year. This is the second death in two years. While legal and procedural issues were adequately managed, communication with and support for detained men was clumsy and insufficient (paragraphs 4.3.1; 4.3.2).
- The Detention Gatekeeper has not been robust enough in its purpose of preventing vulnerable people from being detained (paragraph 4.5.5) and safeguards in the centre have been insufficiently effective in detecting these vulnerabilities. Among other evidence of the unacceptably high levels of vulnerability at Brook House in 2024 is the fact that five men were sufficiently unwell that they were sectioned under the Mental Health Act (paragraph 4.5.1).
- Vulnerabilities are not being identified early enough, either through healthcare screening on arrival or Rule 34 reviews. These reviews, which require that every consenting detained person receives a physical and mental examination by a GP within 24 hours of their arrival at an IRC, are poorly attended (paragraph 4.5.6). Healthcare has not done enough to improve uptake in 2024.
- Wait times for Rule 35 appointments (which require doctors working in IRCs to report to the Home Office any detained person about whom they have health-related concerns) in both Brook House and Tinsley House are unacceptably long. There are still insufficient numbers of men being assessed for deterioration in detention and suicidality under Rules 35(1) and 35(2). In most cases a Rule 35 report does not lead to a man's release (paragraph 4.5.8).
- There is a tendency to presume that if a risk related to a man's vulnerability can be managed in detention, then it should be, which the Board feels exacerbates the risk of both short- and long-term harm to detained men (paragraphs 4.5.9; 4.5.10).
- Safeguarding governance, such as the Safer Community meeting, is adequate in that it meets minimum requirements, but meetings can often

be perfunctory, poorly attended, and the voice of the detained man is absent (paragraphs 4.5.12 - 4.5.14).

- Safeguards that should be used in combination to provide a reliable safety net are not adequately aligned (paragraphs 4.5.4; 4.5.8).
- Lack of case progression is an important contributor to tension and feelings of insecurity and has led to an unprecedented 28 serious incidents in 2024, including large-scale protests and men climbing onto the anti-suicide netting (paragraph 4.1.4).
- There is insufficient consideration of how distressing and confusing arrival can be, particularly for men with no prior history of detention (paragraph 4.2.6). Reception areas can be noisy, chaotic and lack confidentiality (paragraph 4.2.3) and the process can take too long, with men sometimes waiting for long periods of time in coaches or minibuses (paragraph 4.2.8).
- While Home Office engagement with detained men has improved in the centres, there are concerning examples of detained men being dealt with in ways that are, at a minimum, legally and ethically questionable. This includes presenting papers to be signed by men who have been deemed to lack legal capacity and failure to provide men with their IS.151F monthly progress report (paragraph 4.5.3).

Fair and humane treatment

- The Board repeats its view that detention without a time limit is unfair and inhumane.
- Interpretation has been a serious problem in every area of centre operations, with poor practice including not providing interpretation based on the presumption that men can understand ‘well enough’; poor use of interpreters; and use of staff members or other detained men to interpret, with an impact on impartiality and confidentiality. This is unfair, putting men at a disadvantage and heightening the risk that vulnerabilities are not detected or that the men are unable to represent themselves or understand their entitlements, including to legal and healthcare services (paragraphs 4.2.5; 5.5.4; 6.1.10).
- Virtually every man attending a hospital visit in 2024 did so in handcuffs. Out of a total of 380 escorts to hospital, only 9 (2.4%) were not handcuffed. The Board considers this inhumane and unfair. While the Board understands that the use of handcuffs is determined by a risk assessment, it is unreasonable to believe that nearly 100% of men would be assessed as high risk. The Board feels that this assessment is inequitable and demonstrates a presumption toward handcuffing (paragraph 4.6.8).

- Both Brook House and Tinsley House are run down and grimy, despite regular cleaning. Ventilation in both centres is problematic, with poor temperature control, and Tinsley House often smells of damp and mildew (paragraphs 5.2.1 - 5.2.5).
- There has been a substantial increase in the use of separation and segregation under Detention Centre Rules 40 and 42 in 2024. This is largely attributable to the 'positioning' of men in advance of removal. The Board considers this has happened in 2024 too often and sometimes too early, unnecessarily restricting access to legal and social support, as well as exercise and activities (paragraphs 5.3.2 - 5.3.4).
- The Board reiterates the concern it raised last year about the use of separation when a man refuses to share a room which, in many cases, we consider unjustified (paragraph 5.3.6). Separation has been used too often to respond to behaviour resulting from mental health difficulties or distress, including self-harm (paragraph 5.3.7).
- The Board has noted improvements in the conduct of Rule 40 reviews, particularly in engagement of men. However, quality remains somewhat varied, and they still sometimes feel perfunctory (paragraphs 5.3.8 - 5.3.10).
- Despite wider systemic issues, there is commendable work being done and positive interactions observed at an individual and a team level by staff at Gatwick, with particularly good practice reported about officers working with vulnerable men on E wing, by the welfare department, by social workers and the religious affairs department and by some residential officers on the wings (paragraphs 5.4.1; 5.6.1).
- There remain, however, some instances of intimidating, callous or disrespectful behaviour both to and about detained men across all organisations at Gatwick. This is especially concerning from those with particular care and safeguarding responsibilities such as healthcare. Too often, public use of callous and dehumanising language about detained men goes unchallenged (paragraph 5.4.2).
- The proportion of complaints across Gatwick about centre operations or staff behaviour that are upheld has decreased again this year and seems unreasonably low (paragraph 5.7.2). About 30% of complaints relate in some way to staff conduct or behaviour (paragraph 5.7.3).

Health and wellbeing

- Unfilled permanent staffing positions and prolonged recruiting times have had a negative impact on healthcare (paragraph 6.1.1).

- A concerning staff culture of callous and unempathetic treatment by healthcare staff has been reported by men and observed by Board members (paragraph 6.1.9).
- PPG's delivery on Detention Centre Rules 34 and 35 is insufficient to ensure that their role as key safeguards is being fulfilled (paragraph 6.1.1).
- The shift from subcontracting with DrPA Secure to working with directly employed GPs has had a positive impact on delivery (paragraph 6.1.5).
- The Board remains concerned by the policy of not attending first response calls, as it is a time when detained people are both vulnerable and a situation where there is a risk of harm (paragraph 6.1.6).
- Communication between healthcare and detained men appears weak, resulting in missed appointments, frustration for men and, anecdotally, cases of self-harm (paragraph 6.1.8).
- The number of formal complaints about healthcare seems disproportionately low, for example relative to the number of Applications raised with the Board, and thus potentially unrepresentative of men's satisfaction with the service (paragraph 5.7.6). The complaints system is opaque to the men, who have little trust in it, and to the Board, which has no data about how many are upheld (paragraph 5.7.8). The Board considers a turn-around time of 60 days, or even 30 days, for a response to a complaint to be too long and unfair to the men (paragraph 5.7.7).
- Weak provision of mental health support is a major concern, particularly given the high number of individuals with diagnosed and undiagnosed mental health disorders (paragraphs 6.1.3 - 6.1.7).
- Welfare provides a vital role in the centre and is highly valued by the men. It is too often understaffed when officers are moved to cover gaps elsewhere in the centre (paragraph 6.2.2). Changes made in the way Welfare is organised have improved confidentiality and privacy for men accessing the services but may not provide sufficient space for urgent issues to be addressed (paragraph 6.2.3).
- Lock-up times are too long. Men are locked in their rooms for 12 hours out of every 24. The Board considers this inhumane. (paragraphs 6.3.1 - 6.3.4).

Preparation for return or release

- Only a small proportion of the detained men take part in face-to-face or online educational courses, which can be haphazard and elementary (paragraphs 7.1.2 - 7.1.4).
- Computer resources available to the men are heavily used (paragraph 7.1.5).

- There have been major improvements in the presence and visibility of DET staff to the detained men. There is now a welcome proactivity in chasing cases and engagement, which the Board hopes will continue. This can help minimise instances of issues causing distress to men, such as not receiving their monthly report or adequate updates on their cases (paragraph 7.2.1).
- Men spend too long in detention. The average stay is just over 30 days; but 20% to 25% of men stay longer than 70 days, with an average stay for these men of 160 days. One man had had been in detention for 708 days (paragraph 7.2.2).
- Slow case progression has a major effect on the detained men, leading in some cases to deep distress, mental illness and self-harm. Protests about slow case progression were a significant factor in increased disruption and serious incidents during 2024 (paragraph 7.2.3).
- The majority of men continue to be released (60%) rather than removed (40%). This is concerning given the known negative impact of detention. (paragraph 7.4.1).
- There continue to be considerable difficulties and delays in men finding bail accommodation and the 'probation pilot' has had no discernible effect on this (paragraphs 7.4.3; 7.4.4)
- Skype facilities have had a considerable and positive impact. The Board is pleased to hear that plans for the refurbishment of the Tinsley House library include installing several booths for video calls with family and friends (paragraphs 7.3.2; 7.3.3).
- The Centre has begun to roll out new 'smartphones' to the detained men in Tinsley House, which will, we are told, resolve the perennial issues with the poor mobile phone signal. While this is welcome, there have been teething troubles and implementation is being delayed (paragraph 7.3.4)

3.3 Recommendations

TO THE MINISTER

- Introduce a time limit for immigration detention (repeated from IMB annual reports since 2018).

TO HOME OFFICE IMMIGRATION ENFORCEMENT

- Review how key mechanisms intended to safeguard the detained men operate together to ensure that they provide effective outcomes: Detention Gatekeeper, healthcare arrival screening, Rule 34 assessments, Rule 35 processes, assessment, care and teamwork in detention plans (ACDT, used to monitor detained people who are considered at risk of self-harm),

ACDT and vulnerable adult care plan (VACP) processes, and Adults at Risk policies and process.

- Operate with a presumption of release in cases of vulnerability, considering not just whether vulnerabilities can be accommodated in detention, but also at what cost to the detained man.
- Ensure that suitable training and support is provided so that professional interpretation services are used effectively to ensure communication with detained men is clear and transparent. Ensure that a translation into their own language is provided alongside all documents.
- Reclassify welfare officer roles as ‘red roles’ to maintain staffing levels in this important function.
- Revise lock-in times to provide the detained men more association time.
- Eliminate unnecessary delays as far as possible in immigration case decision-making and travel booking and work with the Probation Service to improve timeliness in bail accommodation approval.
- Conduct an audit to identify how it is possible that men deemed to lack legal capacity have been asked to sign immigration papers in detention and why men are not receiving their monthly report or not receiving it on time.

TO THE CENTRE DIRECTOR

- Ensure that professional interpretation is used during the reception process, to ensure that detained men fully understand what they are being told and are able to make properly informed commitments (such as the IT use policy).
- Establish suitable mechanisms with relevant other parties to ensure that information regarding men's medical conditions/medication, vulnerabilities or security risks arrives with them or is shared in a timely way.
- Provide appropriate training and support to ensure effective use by officers of the Monitor, Challenge, Support documents/process.
- Review (in conjunction with Practice Plus Group) the appropriateness of risk assessments undertaken before undertaking planned uses of force with kitted teams and establish protocols and guidance that adequately balance (physical and mental) risk to staff against (physical and mental) risk to the detained man.
- Implement the provision of travel plans (in a suitable language and with suitable explanations) to men being released from Gatwick who will be travelling on their own by public transport.

- Ensure that suitable training and support is provided so that professional interpretation services are used effectively in communications with the detained men, particularly in sensitive contexts such as ACDT, VACP and Rule 40 reviews.
- Consider adapting the appointments system in Welfare to allow men to access the service soon after they have been at a Home Office surgery meeting, if they wish to do this.
- Create a set of educational and training opportunities that are more appealing to a wider cohort of men and are more effective as preparation for return or release.

TO NHS ENGLAND

- Review the mechanisms for informing and encouraging detained men to take up the offer of a Rule 34 appointment, as these are a vital safeguard, greatly increasing the likelihood of detection of vulnerabilities.
- Provide suitable training and support to ensure that all healthcare staff, including General Practitioners, are clear about their obligations under Detention Centre Rule 35, and understand how these are to operate.
- Ensure that suitable training and support is provided so that professional interpretation services are used effectively in communications with the detained men, particularly during critical safeguards such as initial screening, and Rule 34 and 35 appointments.
- Provide more transparency about healthcare complaints and shorter timeframes for response. Provide adequate information to allow the IMB to assess the nature of the complaints and the effectiveness and efficiency of this complaints process.

Evidence sections 4 – 7

4 Safety

4.1.1 Maintaining safety in immigration detention carries both positive and negative obligations. People must be protected from physical or emotional threats but also monitored for physical and emotional deterioration resulting from being detained, particularly for those with pre-existing vulnerabilities. The concerning safety conditions that the Board noted in 2023 have persisted, affecting both physical safety and the wellbeing and safeguarding of vulnerable people.

4.1.2 While there is limited information about the subjective feeling of safety of men in the centres, there are indicators that Brook House in particular is perceived as unsafe. Of 144 men who chose to give feedback using the centre's kiosks, 48 (33%) said they did not feel safe. The Board has also heard that these feelings of insecurity have resulted in some men restricting their movement in the centre and even asking to be locked in their rooms for their own protection. A survey conducted by His Majesty's Inspectorate of Prisons (HMIP) during their inspection in August reinforced these findings, with over a third of respondents reporting feeling unsafe. They cited volatility among detained men due to frustration with detention and dynamics associated with imbalances in the distribution of nationality groups in Brook House. Men reported feeling particularly unsafe in the courtyards. The Board also heard that the presence of illicit drugs in the centre increased men's concerns for their own safety, both due to the unpredictable behaviour of men under their influence and because of illness resulting from their use. These concerns were intensified by the death of a detained man, which other detained men understood to be due to the use of illicit substances.

4.1.3 Levels of violence and disruption were generally higher in 2024, particularly at Brook House. As in 2023, assaults between residents and on staff were much higher than in previous years (see section 4.4).

4.1.4 There were 28 serious incidents at Brook House in 2024, as compared to four in 2023. Large-scale protests involving between 25 to 40 men took place on several occasions. Three occurred in February and March, one related to case progression and two others to frustration with detention. In May there were simultaneous protests, with 38 men detained for removal to Rwanda refusing to come in from one of the courtyards while men frustrated with the progression of their cases climbed on the anti-suicide netting in two separate wings. Toward the latter part of the year there was an increase in the number of men climbing onto the anti-suicide netting on the wings to express frustration or prevent removal. Many of these incidents were managed locally by Serco negotiators, but on at least a dozen occasions the National Tactical Response Group (a specialist unit trained to respond to serious incidents such

as protests) was called in. Often their appearance was sufficient to spur on negotiations, but several times they intervened physically. PAVA spray (an incapacitant spray similar to pepper spray) was used on two occasions.

4.1.5 There was reason for concern this year about institutional relationships within the centre, and the impact that these had on the safety of both detained men and staff members. The Board was particularly concerned by the impact of poor communication between PPG and Serco. Serco personnel told Board members there was insufficient information-sharing by PPG staff, leaving them ill-equipped to do their job. PPG personnel appeared overextended, overwhelmed and reticent in sharing information. This led to a real breakdown in communication and coordination, reducing the level of support that detained men with vulnerabilities received, and significantly impacting PPG capacity.

4.2 Reception and induction

4.2.1 The reception area at Brook House consists of a long corridor-like room with a line of desks where men sit to be registered. There are private interview rooms to the sides. There is a locked door at the end with a waiting area behind it. There is soft seating there and men are often served food while they wait to be taken to the wings. It is adjoined by a small consulting room where healthcare conducts initial assessments.

4.2.2 Due to renovations as part of 'Project Optimise' the reception area at Tinsley House moved around quite a bit over the course of the year. The Board observed that this did not have a substantial impact on the experience of the men, who were generally received in an organised and reasonably comfortable fashion.

4.2.3 Reception areas at both centres are generally neat, clean and well-organised. Men tell us that they are treated with respect and dignity, and officers seem comfortable with the work and do it efficiently. At Brook House the main area can be noisy with through-traffic, despite Serco's request to staff to use other areas for entrance and exit. The Board rarely sees the private rooms used, including at times when they perhaps should have been; for example, a man was observed having a tag attached while standing by the door, rather than in a separate room.

4.2.4 The most serious concerns consistently expressed by Board members relate to the provision of information to men on arrival and the assessment of their underlying vulnerabilities. The Board considers that there is insufficient awareness or understanding of how overwhelming and confusing arrival in immigration detention and the reception process can be. While officers provide basic information, a more proactive approach is required to make sure that men understand what is happening and are able to benefit from safeguards and entitlements available to them. Not enough time is taken to ensure men understand what rights they have and their implications, such as

the right to be interviewed in a private area or to access the medical appointment offered under Detention Centre Rule 34. The IMB has advocated for the use of a script by healthcare personnel to ensure the safeguarding purpose of the medical appointment is conveyed clearly and consistently, but this has been refused by PPG and the NHS commissioners. The Board maintains that more effort should be made to actively encourage men to attend these appointments, which greatly increase the likelihood of detecting physical or mental health vulnerabilities.

4.2.5 Importantly, it is our view that officers and healthcare staff too often assume that men can understand and express themselves well enough in English to proceed without interpretation. 'Well enough' is not adequate for such a sensitive time, when men are often already overwhelmed by the environment and the volume of information provided.

4.2.6 The Board was particularly concerned about the adequacy of communication in April and May, when men were brought into detention in preparation for their removal to Rwanda under the Migration and Economic Development Partnership (MEDP). These men arrived, in the words of Home Office staff, 'shocked and bewildered', with many having been very publicly arrested from their homes and taken away in handcuffs. Although initially accommodated on the induction wing, most were rapidly dispersed throughout Brook House, where some expressed anxiety about being accommodated with people they knew to be former prisoners.

4.2.7 On a number of occasions in 2024 information regarding men's medical conditions/medication, vulnerabilities or security risks did not arrive with them or was not shared in a timely way. This is very concerning, putting men at risk. Measures should be taken to ensure that lessons are learned by both sending and receiving institutions.

4.2.8 The length of time that men spend in reception is a serious concern. It can take hours to go through the process. This is often in addition to long waiting periods before they arrive – at prison for time-served foreign national offenders or, for those coming from the community, in facilities such as short-term holding centres, police stations or Home Office immigration reporting centres. On a number of occasions, the Board has commented on how long men have waited in minibuses or coaches, particularly when they have already had long journeys to the centres. This concern was also raised by HMIP during their inspection in August 2024.

4.2.9 The Board was pleased to see that B wing remained an induction wing this year, providing a more supportive environment for new arrivals. The work of Welfare officers in helping men to orient themselves is also invaluable, particularly in ensuring that they understand their right to, and can access a solicitor, how to communicate with family and friends, how to track down missing property, and how to access additional support, among other roles.

4.3 Suicide and self-harm, deaths in detention

4.3.1 A detained man died at Brook House during the reporting year. The coroner opened an inquest which remains adjourned while investigations are ongoing.

4.3.2 Board members heard from other detained men and centre staff that the man's death felt symbolic of feelings of despair and lack of safety among men detained in Brook House. Little about the way that communication was managed helped to mitigate this feeling. On the day of the man's death, an oddly worded notice from the Centre Director was given to each detained man in the centre informing them of the facts and saying, ‘staff are upset by this sad news and would welcome your support through a very difficult period’. It encouraged them to provide any information they might have. The notice did not offer information about what support would be available for detained men distressed by this death and the Board is not aware of any proactive efforts to identify men who were particularly affected in order to provide them with additional support. Religious affairs held memorial events for different faith groups, but no secular memorial was held.

4.3.3 As investigations into the death were ongoing and the inquest not yet held – and still has not been at the time of writing – no information was provided about the cause of death.. However, further messages were circulated on 29 and 30 October, urging men to dispose of any uncontrolled substances. The third such message provided contact numbers for substance misuse hotlines and for Samaritans.

4.3.4 Rates of self-harm at Brook House were slightly lower than in 2023, hovering between 4% and 6% as a proportion of population, and the proportion of men on ACDTs at any given time were lower than in previous years. It is important to highlight, however, that these figures still indicate a significant amount of distress. The Board heard detained men describe using self-harm as a way of managing distress on several occasions and noted that there did not seem to be much proactivity in supporting them to identify alternative ways of coping.

4.3.5 As in previous years, the Board has seen staff members treating men with solicitude and real care, but the Board has also raised concerns on occasion about apparent expressions of disbelief or lack of empathy. On numerous instances in 2024 men reported to the Board that they didn't feel taken seriously when they expressed distress or concern, particularly by healthcare and mental healthcare personnel. Some ACDT paperwork also suggested an inattention to detail and lack of concern with the man's specific situation.

4.3.6 There has been a welcome continuation in the reduced use of constant watch in response to self-harm and expressions of suicidal ideation, with less than 10% of (daily) instances of ACDT on constant watch. This has been a deliberate shift in strategy from a more rigid approach focused on harm

prevention, to a more dynamic approach that aims to put the wellbeing and comfort of the men first.

4.4 Violence and violence reduction

4.4.1 Levels of violence between men and toward staff at Gatwick are very concerning, particularly in Brook House. Resident-on-resident assaults remained similar to the previous year, with 74 cases of assault by detained men on other detained men in Brook House and 86 across both centres, compared to 82 in 2023. However, this was still significantly higher than in previous years (33 in 2022 and 20 in 2019). There was an increase in assaults on staff in real numbers, though proportionately in line with the increased population, with Serco reporting 180 as compared with 146 in 2023 in Brook House. Again, both years showed a substantial increase from previous years: 55 in 2022 and 82 in 2019.

4.4.2 This was the first full year that saw use of the Monitor Challenge Support (MCS) documents, which replaced the Tackling Antisocial Behaviour (TAB) system to address behaviour deemed antisocial, such as violence, harassment and bullying. MCS documents were used only 61 times in 2024: 54 at Brook House and 7 at Tinsley House. By comparison, the Board had considered the use of TAB documents in 2023 low at 99 uses across both centres. While the data show increasing use of MCS documents over the course of 2024, the relatively modest usage suggests to the Board that officers may not be comfortable with the documents or clear on how to use them. The Board remains concerned that antisocial behaviour is not being adequately monitored and addressed.

4.5 Detained people with specific vulnerabilities, safeguarding

4.5.1 Even more than in previous years, the Board has been extremely concerned about the number of men with significant vulnerabilities who have been brought into a stressful detention environment and often kept there for what we consider unreasonable lengths of time. This includes men with often very serious mental and physical vulnerabilities. Indeed, five men detained at Brook House in 2024 had such serious mental health issues that they were referred for sectioning under the Mental Health Act. The Board can only conclude that either the conditions of detention were so damaging that they deteriorated to this point or that they should not have been in detention at all. Either way, it is clear that safeguards are not working as they should.

4.5.2 For some time, E wing had accommodated men requiring more attention or support, or whose behaviour on the wings was likely to create problems between them and other residents. At the end of May 2024, this use of E wing was terminated and the men resident there were returned to the general population on other wings. While the co-location of vulnerable men with those removed from association for other reasons was problematic, it is unfortunate that no similar space has been provided at Brook House. Detained men and

Board members frequently mentioned the compassion and dedication of the officers on E wing, often in the face of very challenging situations, from lack of self-care and personal neglect to violence and aggression.

4.5.3 It is useful to give specific examples to illustrate the Board's concerns:

- In early 2024 a 68-year-old man with dementia and reduced mobility was detained at Brook House. The Detention Gatekeeper did not prevent his detention, and no issues were raised on arrival except concerns about his mobility. A multi-disciplinary team agreed he was 'fine to stay at Brook [House]' in March, and his vulnerable adult care plan was actually closed in June in consultation with healthcare, due to 'no further vulnerability concerns'. It was reopened less than a month later when a psychiatrist recommended a dementia assessment and he was deemed unfit for detention by healthcare. He remained in detention a further nine months, until April 2025. This case illustrates that vulnerabilities are not being detected and escalated in a timely way and demonstrates that even when safeguarding measures are applied, they are not achieving their intended result. It also demonstrates the catch-22 that the vulnerabilities that should have prevented detention end up prolonging it by creating a barrier to release, further exacerbating the harmful impact of the detention environment.

- Two other cases support the Board's view that these are not one-off occurrences but serious systemic failings. The first concerns a man whose wellbeing was already in question when he arrived in early September 2023. He was distressed for much of his time at Brook House, most often accommodated on E wing where he could be given more individualised attention. During his stay there were numerous assessments of his mental capacity, and his situation was repeatedly discussed at vulnerable resident and multi-disciplinary team meetings, and he was referred for sectioning under the mental health act. Some exceptional work by the Serco Social Worker resulted in re-connection with his family and improvements in his wellbeing and he was not ultimately sectioned. However, he remained at Brook House for eleven months. Another man who arrived in June 2023 was held for well over a year at Brook House despite numerous acts of self-harm and repeated reports that he was deteriorating in detention. His detention was maintained after a Rule 35(1) report (that his health was likely to be injuriously affected by continued detention) in December 2023, and in June 2024 he was reported to be spending his days in the dark in his room, refusing medication and eating only when food was brought to him. He was reported to have expressed fear of being in the centre. He nonetheless remained a further two months at Brook House, bringing him to more than 400 days in detention. Efforts to release him failed on the first attempt because he refused to leave and there was speculation that he had become institutionalised. It was only after several weeks of preparatory work that he was finally able to leave.

It is important to note that in these three cases the men were all ultimately detained for very long periods before being released. It is not clear to the Board why the Home Office did not determine much sooner that there was no reasonable prospect of removal. It is also not clear why the men's evident and acknowledged deterioration (caused by detention or made apparent by detention) was not sufficient to have them released earlier.

4.5.4 These cases illustrate several key failings. Common to them is the weakness in safeguards and the fact that they do not work in harmony with one another. The Board considers that these safeguards at Gatwick, and Brook House in particular, are not adequate to provide consistent, coherent and connected assistance for people with serious vulnerabilities. These will be addressed in turn.

4.5.5 The Detention Gatekeeper (DGK) is not sufficiently preventing vulnerable people from being detained. The Adults at Risk policy does provide for the detention of vulnerable individuals on some occasions, but the Board considers this is overused. This is evidenced by the consistently high number of people on vulnerable adult care plan (VACP) documents, particularly for mental health issues. The Board has consistently raised its concerns about the DGK's failure to always ensure that detention decisions are appropriate and proportionate. We have noted that it is far more difficult to safely release someone once they have been detained than it is to avoid their detention in the first place. We finally requested a meeting with the DGK, which took place 4 December 2024. Their openness and willingness to engage with our questions was appreciated, as was their explanation of DGK decision-making, and confirmation that detention should be a measure of last resort. Nonetheless, the mechanism is failing to prevent unsuitable vulnerable men from being detained.

4.5.6 Healthcare screening and Rule 34: Healthcare screening on arrival is not systematically detecting vulnerabilities and healthcare is not succeeding in increasing detained men's attendance of Rule 34 appointments. PPG data shows that 3,474 or 61% of men arriving at Brook House and Tinsley House in 2024 did not attend (DNA) their Rule 34 appointments. This suggests that men have not fully understood the purpose of the appointment. The Board is concerned that this lack of understanding may also extend to healthcare staff. The Board has seen PPG-issued guidance to healthcare staff regarding communication to men about this appointment at intake and noted that it makes no mention of its safeguarding purpose. Importantly, this guidance was created after the decision was taken by PPG not to automatically book men a Rule 34 appointment on arrival, which was implemented on 16 December 2024. Gatwick Board members have consistently expressed our concern that the rationale behind this decision placed too much emphasis on improving efficiency and not enough on ensuring that vulnerabilities are identified.

4.5.7 Rule 35 reports are intended to ensure that particularly vulnerable individuals are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention and to inform other risk management processes. There are three cases where Detention Centre Rule 35 requires a GP to make a report: 35(1) a detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention; 35(2) a detained person suspected of having suicidal intentions; and 35(3) a detained person who may have been a victim of torture.

4.5.8 Concerns around Rule 35 processes have been repeatedly raised by the Gatwick Board in its annual report and were highlighted by the Brook House Inquiry. Despite consistent attention to the issue, there has been no improvement in 2024. Key concerns at Gatwick this year include:

- Wait times for a Rule 35 appointment increased in comparison to the previous year and were unacceptably long. The average wait for a Rule 35 appointment was around 17 days at Brook House and 12 at Tinsley House. There was a slight decrease in wait times toward the end of the year, but in the first quarter wait times were between 20 and 24 days at Brook House. Since a detained man is only referred for a Rule 35 appointment if there is a serious concern about their well-being requiring rapid action, including the consideration of release, a wait of three to four weeks is unacceptable.

- Despite very high levels of vulnerability, according to PPG reports, slightly fewer Rule 35 reports were produced in 2024 as compared with 2023. Of these, the vast majority – 91% – concerned torture. Of the 466 reports produced, only 32 (6.9%) concerned deterioration in detention and 2.4% concerned suicidal intentions or thinking. The Board can only conclude that Rule 35 is still not being used appropriately, as it seems very unlikely that so relatively few men were either suicidal or deteriorating in detention, particularly given the high rates of men on ACDT documents and vulnerable adult care plans. The Board is further concerned that lessons are not being learned, as we noted again this year that staff sometimes fail to conduct a Rule 35(1) assessment on the basis that a man was ‘not engaging with healthcare’. Our view is that this turns a symptom of deterioration into a barrier to intervention.

- One purpose of a Rule 35 report is to provide evidence for a review of the maintained detention of an individual who is or may be expected to deteriorate in detention. However, the data at Gatwick show that it does not significantly increase the prospect of release. Home Office data showed that detention was maintained for:

  - Rule 35(1): 43% of men at Brook House and 44% at Tinsley House.

  - Rule 35(2): 83% of men at Brook House and 60% at Tinsley House.

- Rule 35(3): 69% of men at Brook House and 72% at Tinsley House.

- Finally, the Rule 35 mechanism demonstrated how poorly the different safeguards work together. Home Office figures show that the Adults at Risk policy was not engaged for 15% of men for whom a Rule 35(3) report was produced. This number should be zero, as a Rule 35(3) relates exclusively to torture, and a man's declaration of having been tortured should result in a designation of Adults at Risk level 1.

4.5.9 The Board is particularly concerned by what appears to us to be an increasing tendency to presume that if a physical or mental health condition can be 'managed in detention' that it should be. The Board heard on several occasions that men were not referred for Rule 35 assessments because it was felt that their condition could be managed in detention. This is directly contrary to the Rule, which requires GPs to conduct an assessment in defined circumstances, and makes absolutely no reference to the ability or otherwise of the centre to 'manage' a detained man's situation. We are concerned that this has created a culture of normalisation of high levels of vulnerability.

4.5.10 This trend of managing risk rather than releasing vulnerable individuals was also noted in relation to the detention of people with protected characteristics. In 2024 four transgender women were accommodated in general population at Brook House and one in what was the PDA at Tinsley House. These individuals did not come to harm, but the Board did hear that some were anxious and stayed in their rooms. The same was true of some gay men accommodated at Tinsley House. In these instances, the Board's concern is less with whether these individuals actually came to harm, than with the risk that was taken and the distress that it caused.

4.5.11 There was one age dispute, when a young man arriving at Tinsley House in 2024 said that he was 16 years old. He was accommodated separately within Tinsley House while the social worker, Home Office and safeguarding staff reviewed the situation. His family was able to provide documentation proving his age and he was released two days later. However, significant concern is triggered by the fact that such a young person could end up in an adult detention facility simply because he 'looked older'.

Safety Governance

4.5.12 There were changes in leadership on safeguarding from the beginning of July, and the transition was generally fairly smooth, with ongoing engagement and support from the previous leads. However, vulnerable resident multidisciplinary meetings have been inconsistent, with Board members sometimes reporting them to be effective and useful, but equally often finding them perfunctory and superficial. Case owners do seem to attend more regularly than in the past, but there is still insufficient representation of residential staff, especially on wings where there are more vulnerable men.

The Board commented on several occasions during the year about the absence of healthcare staff.

4.5.13 The Safer Community meeting is too often poorly attended and at various times the Board noted the absence of key contributors such as healthcare, Home Office and security. In one meeting a representative of an outside agency commented on how many departments lacked representation, and the December meeting was cancelled due to poor attendance. Detained men are not represented in this meeting and there are rarely residential officers present. The Board considers that this meeting benefits considerably from the input of external agencies who work with detained men. Some, like Samaritans, continue to attend, but the Board understands that the Home Office discontinued the standing invitation for the Gatwick Detainee Welfare Group. The rationale for this is unclear. Their contribution would be very useful, as they hold weekly surgeries in the centres and some men are more inclined to share concerns with them.

4.5.14 Board members have found monthly meetings with relevance to safeguarding to be generally weak, including Safer Community, use of force and Rule 40/42. These typically follow a set agenda and too often consist of provision of statistics with little to no analysis and no real challenge, discussion or debate.

4.6 Use of force

4.6.1 There is no prescribed definition of use of force for the immigration setting, but as applied at Gatwick it is very broad, encompassing everything from a touch on the shoulder to a planned intervention involving staff wearing full protective clothing, including helmets and shields. The Board confirmed last year that we welcomed the recommendation of the Brook House Inquiry for a definition of use of force tailored to the immigration setting rather than borrowing from prisons. Such a definition has not yet emerged.

4.6.2 Use of force has increased at Gatwick in 2024, particularly at Brook House. There were 785 uses of force across both centres in 2024, up from 599 in 2023. This is particularly concerning, as the 2023 figure itself represented a doubling of use of force from previous years. While the average population has increased by 21% from 2023 to 2024, use of force has increased by roughly 30% at both centres.

4.6.3 90% of use of force occurrences at Gatwick in 2024 were spontaneous. This is typically to respond to altercations on a wing or association area, to prevent men from moving somewhere they are not permitted to be (e.g. onto a wing on which they do not reside) or to prevent self-harm. Staff members are required to demonstrate attempts to de-escalate before force is actually used and to demonstrate this in their reports. We have seen some positive examples of real efforts to de-escalate, as well as of the reverse.

4.6.4 The Board is concerned about use of force, sometimes in conjunction with separation, on men who are vulnerable and at risk of self-harm or suicide. We

recognise that sometimes this is applied to prevent men from self-harming, as in one case in 2024 when a man on Rule 40 at Brook House was subjected to use of force three times in response to four attempts to self-harm in the space of three hours. Under such circumstances, use of force may satisfy the required test of being reasonable, necessary and proportionate, while also underscoring our concern that some vulnerable men are held in the centres who should not be. Other examples this year have been questionable. For example, when a man under ACDT supervision had force used to facilitate moving him to the care and separation unit (CSU) when he was put on Rule 40 for refusing to share his room. It is difficult to see any justification for such treatment for someone judged to be at risk of self-harm or suicide.

4.6.5 Planned interventions most often take place in conjunction with moving men either to pre-position them for removal from the centre or to facilitate their departure either to the airport or to another facility, whether a prison or immigration removal centre. This should only occur when a man has indicated that he is unwilling to go and/or has a history of disruptive behaviour, such as fighting or jumping on the anti-suicide netting. The purpose of the vast majority of planned interventions (93%) is described as in order to 'maintain good order', which the Board considers too broad to be really useful as a descriptor. It is positive that in just over half (51%) of cases where force was planned, it was not in fact used. The Board is nonetheless concerned about the impact on men of the intimidating stance of staff involved in these interventions. This is due both to the appearance in full protective clothing with shield and rigid bar handcuffs as well as aggressive shouting, which the Board has witnessed on video footage. This is intimidating by intent. The Board considers that even though there is no physical intervention in these cases, they are frightening and distressing for the detained men, particularly for those who may have been subjected to abuse by authorities in the past. The Board feels that a blanket approach of using a fully kitted team on every planned intervention does not achieve fair treatment. As last year, the Board again recommends that each man be individually risk assessed.

4.6.6 The Board has noted instances of both good and poor practice with regard to monitoring of use of force. Members have noted on several occasions when reviews and debriefs were careful, considered and reflective. On other occasions, however, the Board has noted what appears to be procedural issues or lack of attention to detail on the part of Serco, Home Office and/or PPG. Sometimes this related to physical failings, like the insufficient number of body-worn cameras at Brook House. The Board's review of use of force paperwork saw that on numerous occasions officers reported being unable to activate a body-worn camera because they had not been able to obtain one on arrival. Some issues were procedural, as in one instance when a man at Tinsley House was handcuffed to facilitate his transfer to Brook House without having obtained the required prior authorisation. Still others reflected a lack of curiosity or imagination. For example, in a routine review of use of force

paperwork, a Board member saw that healthcare, on asking a man how he had been cut, said that it had been caused by an officer. When the Board member asked Serco and Home Office what follow up had been done, they were told that their review of the footage had shown no abuse. The Board member noted that the man had not explicitly said that this occurred during the use of force in question and asked whether further inquiries would be made. Despite the Board member pursuing and escalating this case over the course of about a week, however, no further steps were taken. This seemed a striking failure to ensure that any allegation of abuse on a detained man by a member of centre staff should be followed up and clarified.

4.6.7 This last incident also raised concerns about the engagement and proactivity of healthcare staff when engaged in these important safeguarding activities. In this instance, the individual mentioned the allegation of abuse in the report but took no further steps to escalate or highlight it. The Board has noted on other occasions that healthcare documentation of use of force seems pro forma and perfunctory and has also expressed concern about their attention to detail in preparing for use of force or Rule 40/42 reviews. At one planned use of force a man who required an inhaler was moved without it and the healthcare staff member only remembered it when the man began to gasp on his way to CSU.

4.6.8 The Board repeats its concern from 2023 about the extent of handcuffing when men are escorted outside the centre, particularly for medical tests and treatment. In 2024 almost 100% of men were handcuffed to attend hospital, whether for routine appointments or an emergency. Paragraph 7 of Detention Service Order 07/2016 states “there is a presumption against use of restraint equipment during visits to outside facilities”. The Board has asked repeatedly about this and has been told that each case is individually risk assessed. Two examples in particular this year raised questions about whether the risk threshold is too high. In one, a man determined to resist removal took such extreme physical measures as he was on the cusp of leaving the centre that he fractured some vertebra. He was lifted into an ambulance on a bed board. The Board understood he could not walk. He was nonetheless handcuffed. In another instance, a man of 70 with no indicators of potential disruption was handcuffed for a planned hospital appointment. The Board considers that the risk threshold needs to be reconsidered, as this seems unreasonably risk averse.

4.6.9 The Board notes again the important role of healthcare, as paragraph 11 of the Detention Service Order makes it clear that restraint should not be used on any individual whose medical condition renders use inappropriate on the advice of a healthcare professional. It is not clear to the Board to what extent and how healthcare is actually engaged in this decision-making.

4.6.10 Finally, the Board is concerned at a broader level about the extent to which staff are conscious of how detained men may experience detention, particularly in Brook House. While a show of force – particularly on a planned

intervention – may seem helpful in discouraging resistance, it is important that staff understand this happens against a backcloth of enormous power disparities and an experience of detention that for many is already frightening, dehumanising and degrading.

4.7 Substance misuse

4.7.1 This year again saw significant use of illicit substances at Brook House with an impact on the health and safety of men. There have been waves of different types of substances at various times and periodically men have been monitored due to behaviour thought to be associated with use of illicit drugs. Some men have expressed concern in general about the presence of these drugs in the centre and failure to control them, as well as specific concerns about risks associated with particular drugs or batches of drugs, e.g. a man who went to healthcare saying that he was concerned about feeling unwell after he 'vaped from the same batch' as the man who died in the centre.

4.7.2 Security informed IMB that there had been an increase in the prevalence of tetrahydrocannabinol (THC, the primary psychoactive compound found in cannabis) and spice (chemical compound that mimics the effects of the active ingredient in cannabis) in the centre and that there have been 'throw-overs' of doctored vapes into one of the wing courtyards. On occasion, small batches of cannabis/illicit drugs have arrived at the centre by post or have been passed to residents in the visits hall.

4.7.3 Targeted room searches have taken place on numerous occasions, and larger-scale searches using dogs were done in October, November and again in December. Searches with dogs were also conducted on staff on several occasions. The men have generally been compliant with these searches, and the Board was told that precautionary measures were taken for those who were uncomfortable with or allergic to dogs.

4.7.4 Despite these efforts, the use of illicit drugs in the centre has had an impact on safety, and on a few occasions men required medical treatment as a result of these substances. Also, measures need to be put in place to guarantee the safety of the staff who provide substance misuse support, particularly to men on methadone treatment. Likewise, when people arrive at Brook House, there should be advance notice if people have been using substances and action needs to be taken to support them on arrival.

5 Fair and humane treatment

5.1 Escort, transfer and transport

5.1.1 Almost every man escorted to hospital was taken in handcuffs in 2024. Men describe this as humiliating and stigmatising and say it affects their willingness to attend external appointments. The Board has been told that there is a presumption that men will be handcuffed, which the Board believes is inhumane and unfair.

5.1.2 Transport, particularly removals, often take place at unsociable hours, resulting in a very disrupted night for the men. This is particularly problematic if the removal or transfer fails. In December a man's removal on a charter flight was cancelled or deferred, and he returned to Brook House. He spent ten hours in arrivals before being moved to a residential wing. When this was raised by the Board, Serco agreed that this was an unacceptably long time.

5.1.3 When men are released, if no one collects them from the centre, they are provided with transportation to the airport and a token for an onward train ticket. Board members, many of whom take the minibus to and from the airport, have often helped these men locate the train station. Many of them are confused about the onward journey and need more guidance than train staff at the airport can be expected to provide. This is particularly true for men whose English is limited. The Board feels that provision of a travel plan to their destination, as we understand is foreseen for the future, would be of significant help to these men.

5.2 Accommodation, clothing, food

5.2.1 Both Brook House and Tinsley House are showing their age: despite regular deep cleaning, many areas are grimy and worn, for example floor coverings that are lifting and peeling as well as being ingrained with dirt. Bins are frequently overflowing.

5.2.2 Toilets and showers regularly become blocked and have unpleasant smells emanating from them; this is the case at both centres but is a particularly frequent occurrence at Tinsley House. There have been occasions when toilet paper and soap have been in short supply.

5.2.3 Laundries in both centres are often messy, with piles of dirty laundry, despite the employment of laundry orderlies. Machines are frequently out of order for weeks at a time and detained men complain that there is insufficient capacity for their needs, so a backlog builds up. At one point the single machine on E wing at Brook House was out of order for an extended period and staff were forced to do the men's laundry on other wings during their night shift. This was of particular concern, given that many of the men on E wing are vulnerable and some already needed support with personal hygiene issues.

5.2.4 The carpets in both of the visits halls are badly stained and do not create a positive or reassuring impression for families.

5.2.5 Ventilation continues to be a cause for complaint for the men at both centres, but particularly at Tinsley during the warm weather, where fans in the residential areas do little even to move air around, let alone lower the temperature. Residential areas often smell and feel musty and airless.

5.2.6 Smoking had become both a health and a discipline problem, particularly at Brook House. Men were smoking indoors, which was upsetting to those who did not smoke, particularly if they had respiratory problems. Many smokers ignored officers' challenges, and because officers lacked the ability to sanction the behaviour, they simply stopped challenging it. This improved considerably when the centres went smoke-free – Brook House at the end of May, and Tinsley House somewhat later due to issues with the smoke alarms. Smoking was not permitted in any indoor or outdoor areas, and cigarettes ceased to be sold in the shop. The fact that vaping was still permitted eased the transition considerably, but the Board has noted that men now vape freely throughout the centre, including in front of officers, without challenge.

5.2.7 In mid-August major works started inside Tinsley House. These will be in three main phases: Phase 1 will reconfigure the existing reception and discharge areas to 'improve resident processing times' and includes a new private consultation room for healthcare and Serco. There will be a new laundry on the first floor, and the shop will be expanded. Phase 2 starts in October and will re-develop the existing pre-departure area to create 37 additional male dormitory beds, shared bathroom areas, a care room and two medical rooms. This will also include a separate family suite comprising bedroom, living area, kitchen, bathroom, medical room and a refurbished dedicated outdoor courtyard and play area. This will hold up to six family members. Phase 3 will start in January 2025 to expand the care and separation unit by two new rooms, including a dedicated outside courtyard. This is due to be completed in March 2025. After completion there will be one apartment for Family Returns and Border Force to share.

Food

5.2.8 Although there have been some complaints from the men about the type and quantity of food on offer, the majority of comments have been positive. Board members have noted that sometimes meals are very carbohydrate heavy and 'beige', with many breaded and fried items. While salads and fresh fruit are also available, this could be improved. Errors with meal ordering can easily lead to frustration amongst the men.

5.2.9 Both centres can provide for different dietary requirements and special arrangements are made to cater for religious observances.

5.3 Separation

5.3.1 Detention Centre Rule 40 allows a detained person to be removed from association and separated from the general population, and Rule 42 provides for men to be placed in temporary confinement when deemed necessary for reasons of safety (their own or others) and/or security. Separation and temporary confinement must be justified and proportionate to the risk presented and is authorised by the Home Office or, in certain spontaneous cases as per the published DSO, by Serco. Separation may be planned, for example to facilitate removal from the centre for someone who has threatened disruptive action, or spontaneous in response to disruptive or dangerous behaviour in the centre.

5.3.2 Levels of separation in 2024 were substantially higher than previous years, with a total of 525 uses of Rule 40 and 17 of Rule 42 across both centres (399 in 2023). Rule 40 was used 477 times at Brook House and 48 at Tinsley House, as compared to 382 and 17 the previous year. While Rule 42 was used only once at Brook House and not at all at Tinsley House in 2023, in 2024 it was used 16 times at Brook House and once at Tinsley House. The average number of hours on the Rule remained more or less consistent with the previous year.

5.3.3 The principal use of separation was to pre-position men in advance of removal, making up about 24% of uses at Brook House as compared with about 6.5% in 2023 and about 46% at Tinsley House compared with about 35% in 2023. The Board feels that this represents an unwelcome change in approach on the part of Serco and Home Office and has regularly expressed concern about men being removed from association earlier than necessary, restricting their access support, exercise and activities. This is particularly frustrating for men separated in this way only to have their removal cancelled or deferred a few hours later.

5.3.4 Other main uses of Rule 40 continued to be disruption/drugs and fighting/assault, each of which represents about 18% of uses across both centres. While this represent a proportionally lower use of Rule 40 for these purposes than in previous years, this is mainly attributable to the increase in its use to pre-position men for removal. That said, the Board has again this year witnessed good use of de-escalation and mediation measures rather than resorting immediately to use of Rule 40 to respond to altercations.

5.3.5 Men frequently climbed on the netting in 2024, often from frustration with case progression and sometimes also to prevent removal on planned flights. This accounted for 13% of instances of use of force and contributed to the higher likelihood of men being separated from association in advance of particularly charter flight removals.

5.3.6 The Board remains concerned, as it was last year, about what it considers an inappropriate use of Rule 40 for men refusing to share a room in the absence

of other disruptive behaviour. The Home Office data shows 21 incidents in the reporting period. In 2023 the Board was told by Home Office that Rule 40 was used for refusal to share only when it became a safety concern because of threats to other residents. However, the Board maintains that the pressure put on a man to share is sufficiently significant that it may practically compel him to resort to statements that may be understood as threats, e.g. not being able to guarantee the safety of anyone he is forced to share with. This includes being asked on multiple occasions and facing sanctions such as loss of paid work if he continues to refuse. Men lost paid work 11 times in 2024 for this reason. This is particularly concerning given that the Board is aware of at least two occasions on which a man was put on Rule 40 for refusal to share only to be taken off after it was determined that there were compelling reasons for him to be in single occupancy accommodation. On one occasion this only came to light on the 14th day of his separation – the maximum time permissible.

5.3.7 The Board repeats the concern it raised in 2023 about the removal of men from association for behaviour that was a consequence of mental ill health and/or propensity to self-harm. This is particularly concerning following the shift in the use of E wing from a more supportive space for vulnerable men to a more traditional Rule 40 separation environment. For example, one man who repeatedly self-harmed and was on an ACDT was on Rule 40 under constant watch for 15 days prior to his removal, requiring both escorts and a medic. The Board recognises that the decision to remove men in this way is sometimes to protect the individual, but it remains an inappropriate response to mental distress. This is acknowledged in DSO 02/2017 on Removal from Assocation, which state that separation should not be used as a routine means to manage detained individuals with serious psychiatric illness or presenting with mental health problems (DSO 02/2017 paragraph 83).

5.3.8 Separation must be reviewed daily, including weekends. Depending on who is conducting them, these reviews can be thoughtful and compassionate or perfunctory and somewhat hectoring. At times they feel more like a lecture to a recalcitrant child than an effort to understand the issues underlying the problematic behaviour and resolve or address them. The Board has sometimes felt that language is a problem in these interviews, including both the use of jargon (e.g. ‘I’m here to conduct your Rule 40 review’) and the fact that interpretation is not always used, or used well.

5.3.9 Reviews are attended by a large group of people, including the Duty Director, officers, Home Office, healthcare, religious affairs and, when present, observed by the IMB. This can feel quite overwhelming particularly when the director leading the review forgets to introduce everyone or explain who is present, which is not uncommon. The Board has expressed concerns on several occasions that Home Office and healthcare staff did not adequately brief themselves on the situation of the men before they came to the review,

meaning they were unable to answer questions or provide meaningful context to the review.

5.3.10 In the early part of the year, Rule 40 reviews often took place in the man's room with everyone clustered around the door, adding to the levels of stress. Efforts were made in the latter half of the year to invite the man to come out of the room and sit at a table, creating a more relaxed atmosphere.

5.3.11 The Board has been concerned about occasions when separation under Rule 40 reached its maximum 14-day time limit and was formally closed and then immediately re-opened under a new authority. This happened six times in 2024, with the longest continuous period on Rule 40 being 32 days, which the Board considers far too long. On six other occasions separation went into the 13th day before being closed. The Board understands that there are few other options when a man engages in behaviour that might result in harm to himself or others, but the time limit is intended to reduce the harm caused by separation and the risk of abuse, an aim which is frustrated when Rule 40 is extended in this way.

5.3.12 The Board also raised concerns again this year that on a few occasions Detention Centre Rule 15 was cited as the authorisation for removing a man from association when Rules 40 or 42 did not apply. Rule 15 does not confer such authority. The Board is concerned that while the rationale for such cutting of corners may not be malign, it is irresponsible and can be dangerous in a context where people have been deprived of their liberty and subject to enormous power disparities.

5.4 Staff/detained people relationships

5.4.1 Board members have observed many positive interactions between staff and detained men and have heard positive feedback from men at both Tinsley House and Brook House. We have been particularly impressed by the care and compassion shown by some officers working with men with vulnerabilities and/or challenging behaviour, especially when these men were being accommodated on E wing at Brook House. Staff in welfare, education, art, the chaplaincy team and social workers have all demonstrated commitment and professionalism in their care and support for the men. There have also been occasions where Serco staff have shown high levels of empathy and understanding in engaging with the men or working to de-escalate difficult situations.

5.4.2 However, there have also been times when Board members have witnessed and received reports of intimidating, callous or disrespectful behaviour and attitudes from staff. This includes an occasional tendency to minimise or disbelieve the seriousness of illness or distress. These have been sufficiently concerning that on a few occasions the Board has reported incidents to centre managers. In addition, some staff use prison-type language (for example, "the block", "seg") about and in front of the detained men. These behaviours have

been noted across all organisations working at Gatwick IRCs: Home Office, Serco and PPG. However, we are especially concerned by the number and type of complaints about healthcare, particularly given the importance of their care and safeguarding role.

5.4.3 Resident Consultative Committee meetings, which are held in both centres, provide a positive forum for detained men to raise concerns and complaints. However, when Board members have attended, they have noted that meetings are often sparsely attended by detained men and can disproportionately represent some nationality groups. When asked, some men have told Board members that they believe these meetings make no difference to their living conditions. The Board recognises that staff have made significant efforts to encourage attendance, but if this model of consultation is not effective, other means may need to be found. This might be facilitated by consultation with different populations in the centres around how they prefer to raise concerns and complaints.

5.5 Equality and diversity

5.5.1 Gatwick has an equality, diversity and inclusion (EDI) team covering both centres. Cultural activities, such as Black History Month and Pride are respected and promoted significantly by the equality, diversity and inclusion team. Equality officers have consistently been committed and have supported individual men positively. Over the course of the year the team has set objectives to improve their monitoring of protected characteristics, including a focus on mental and physical disability.

5.5.2 Notwithstanding these positives, the Board feels this area still needs considerable development. The Board, which has a standing invitation to observe the EDI monthly meeting, noted sparse attendance on a couple of occasions in 2024.

5.5.3 The Board is also concerned that discriminatory and threatening behaviour by some detained men towards others, sometimes due to protected characteristics, is not always challenged, or dealt with adequately. Occasionally, it has resulted in some residents being kept separated, moved to Borders for their own protection, or transferred to another centre rather than dealing with the behaviour of the aggressors. Board notes from an EDI meeting in late 2024 recorded a concern that the monitor, challenge, support documents were not being used effectively.

5.5.4 Access to and appropriate use of interpretation has been a major concern again this year. Interpretation is available through Big Word, but the Board has noted that it is not always used or used well. The Board has observed and been told by men that at times no interpretation has been provided, including at reception. Day-to-day, there is a tendency to rely on staff or other men to interpret, which can undermine confidentiality and objectivity.

5.6 Faith and religious affairs

5.6.1 Faith and religious affairs staff continue to work effectively in both centres. The service is well promoted and provides extensive support to the men, which is highly valued. Efforts are made to ensure that all men are able to practise their faith regularly and engage in religious observance, activities and festivals. Both the chapel and the mosque are well-attended, and Friday prayer is held for Muslims in the visitors hall to accommodate the larger numbers. When the Sikh religious affairs representative stepped down due to illness in 2024, a new priest was rapidly recruited to support men. Efforts are made to ensure that special needs are met during festivals. For example, during Ramadan food can be ordered two days in advance and is provided out of normal hours to ensure men can eat before dawn and break their fast. Following a death in detention, religious affairs held memorial events for men of all faiths.

5.7 Complaints

5.7.1 During 2024 Home Office Detention Services has begun providing monthly summaries[1] of complaints received and responded to, which the Board has found helpful. This data indicates that a total of 238 complaints were made about the operation of Gatwick IRCs in 2024, of which 25 were withdrawn before investigation. This total is the same as the number of complaints against Serco made in 2023 (238) and continues to be higher than numbers of complaints in 2022 (150) and 2021 (104). Data about complaints provided by Serco at year-end is wildly inconsistent with the Home Office figures: they show total of 439 complaints received (80% higher). The Board is not able to explain the difference in the numbers reported.

5.7.2 The Board recognises that the number of complaints does not directly correlate with dissatisfaction or with issues arising in the centre. Increased complaints can also result from higher levels of awareness or confidence in complaints mechanisms and/or changes in population size or demographics. Of greater concern is the lower number of complaints that were upheld, fully or partially. Using the Home Office's data, of the 219 complaints that were closed across Gatwick in 2024, only 10% (22) were substantiated or partially substantiated. This is lower than in 2023 (11%), 2022 (14%) and 2021 (13%). Taking into consideration those that were withdrawn, all complaints at Tinsley House and 87% at Brook House were considered unsubstantiated. The Board remains concerned about the low and declining success rate.

5.7.3 The data provided by Serco, although different from the Home Office data, does provide a categorisation of the subject of the complaints received. This indicates that a significant number of complaints concerned property (31%). However, it is notable and concerning that many of the other categories of

[1] This data has been "provided and assured by UKVI's Performance, Data & Systems team and is gathered from its complaints management system".

complaint involve staff behaviour; allegations of unfair treatment (16%), staff behaviour (7%) and unprofessional conduct (7%), together making up 30% of complaints. This is particularly concerning because of the important power differential in a place of detention and the relative powerlessness of men relative to staff. As noted in section 5.4, the Board has heard many positive comments about staff from men, but these figures confirm that work remains to be done to ensure good behaviour and professionalism. A substantial proportion of complaints fall under the category of 'other' (17%), which are unspecified.

5.7.4 The Home Office data shows that, overall, 91% of complaints received a response within the required time limit of 20 days. In December, the timely response rate was 82%.

5.7.5 19 complaints from Brook House and three from Tinsley House were investigated by the Home Office Professional Standards Unit, which investigates complaints alleging serious misconduct by Serco officers. The Board does not see the resulting reports.

5.7.6 PPG reported receiving 107 complaints in 2024. These concerned, from greatest number to least: access to treatment, GP care and treatment, medication, sub-contractors and attitude of staff to detained men. The relatively low number of complaints may reflect a concern raised by men that they cannot anticipate a fair outcome as complaints are received and managed by PPG themselves, so they are effectively 'marking their own homework'.

5.7.7 PPG report that all complaints are acknowledged in writing within two days and that the deadline in NHS guidelines for a full written response is 60 days. They note that they endeavour to respond in half that time in consideration of the context at Gatwick. PPG report that their policy was changed in June 2024, to set the deadline at 30 days, although the Board is unable to confirm this. The Board welcomes the change but notes that even 30 days is a long time for men to wait. It is certainly not sufficiently timely for remedial action to be taken.

5.7.8 The Board received no data about how many complaints were substantiated or any follow-up that was made. In fact, PPG report that they "do not uphold complaints" and that all are "responded to". This suggests that PPG are not identifying and acknowledging instances where their service or staff did not meet expectations.

5.8 Property

5.8.1 Although property issues were among the most frequent dealt with by Welfare in 2024, the Board received very few applications on this topic – only seven within the centre and four about property gone missing during transfer. This suggests that these issues are being adequately addressed by Welfare staff.

5.8.2 Two of the applications that we have received related to letters (including a registered letter) not being delivered to detained men. This is particularly concerning when one of the letters contained money intended for the addressee.

5.8.3 The property store has appeared to be in good order and well managed. We have noted that men arriving from prisons will have their property with them in the plastic bags used at prison. Sometimes, these have been filthy, but they are put into the store as is, because otherwise reception officers would have to search all the contents.

6 Health and wellbeing

6.1.1 The Board recognises that considerable effort has gone into improving healthcare provision, but concerns raised in our 2023 annual report remain unchanged in 2024:

- Unfilled permanent staffing positions and prolonged recruiting times have had a negative impact on care
- Staff culture, including complaints from men about the attitudes and behaviour of some staff toward them and callous or unempathetic behaviour witnessed by Board members
- The absence of talking therapies and weak mental health support offering
- Failings in the use of safeguards in Detention Centre Rules 34 and 35, including the low uptake of Rule 34 appointments, the low number of GP assessments made under Rules 35(1) and (2), and waiting times for Rule 35 appointments (see section 4.5).

6.1.2 PPG has struggled with staffing and significant gaps persisted throughout the year, with vacancies at over 50% at the beginning of the year and remaining around 40% for the rest of the year. Senior leadership roles remained unfilled, including a clinical lead and a mental health lead and, when appointed, remained in vetting and security clearance for months. For much of 2024 the Board's perception was of a healthcare service that wanted to do well but was constantly struggling to fulfil basic requirements, let alone improve quality.

6.1.3 For example, when men were detained for removal to Rwanda, PPG reported that they were all being given medical appointments within 24 hours as required by Detention Centre Rule 34. Board members discovered during monitoring, however, that some men who attended these appointments were instead being given an appointment for a week later. The appointment was then marked as having been completed or that the man did not attend (DNA). This is a very concerning failure to deliver on an important safeguard and calls into question PPG statistics about the high rate of men failing to attend their Rule 34 appointment.

6.1.4 This last is worrying because the high DNA rate has been used to justify a shift from automatic booking of a Rule 34 appointment on arrival to only booking the appointment if men agree at reception. The Board remains concerned that this undermines the safeguard as it is not clear that men clearly understand the purpose or the value of the appointment.

6.1.5 In a positive move, PPG cancelled the contract with DrPA Secure, whose lead for immigration detention, including Gatwick IRCs, came personally under heavy criticism from the Brook House Inquiry. The Board has subsequently heard improved feedback about GP care, including from external actors who have noted improvement in quality of some Rule 35 reports.

6.1.6 Healthcare has continued its policy, begun during 2023, of only attending at planned removals and medical emergencies; they do not attend other first-response calls. The Board repeats its concern that the decision not to regularly attend when force is used increases risk, as it is a time when detained people are both vulnerable and in circumstances where there is a risk of harm. The Board again questions why coverage cannot be ensured by increasing healthcare staff numbers.

6.1.7 From 1pm to 4pm every Friday healthcare staff only attend new arrivals and medical emergencies and issue medication. The Board considers it positive that PPG has allocated this protected time for staff to address wider issues, reflect and offer peer support and hopes it is having a positive impact on staff culture. However, it is important that PPG ensures this does not reduce access for detained men to medical or mental health care.

6.1.8 Communication from Healthcare to detained men can seem confused, unclear or absent. Detained men report not being aware of appointments or having them scheduled with very late notice. Similar problems have been raised with regard to medication, as in one example when a man was not informed that a change in the dosage of his medication had also resulted in a change in its timing. Failures like this cause understandable frustration among the detained men – they often lead to applications (written representations from people in detention) to the IMB, to complaints submitted about healthcare services and, anecdotally, to self-harm from frustration or an effort to get attention. The Board understands that fortnightly resident health forums restarted at Brook House in August but has not heard any feedback either from PPG or the detained men.

6.1.9 Staff culture and the attitudes and behaviour of healthcare staff toward detained men remain a serious concern. Of all applications received by the Board, complaints about healthcare made up the second largest category of applications received from men by the Board, at 29% of the total in Brook House and 24% of the total at Tinsley House. Many of these concern staff behaviour and attitudes. Board members have remarked on what appear to be cold, detached or unempathetic comments or demeanour from healthcare staff. Examples include the comment of a registered mental health nurse (RMN) in response to concerns raised by a detained man's family about his mental capacity, that 'there are no concerns', suggesting instead that his cognitive problems were caused by drug use. On another occasion, during IMB monitoring, an RMN came unprepared to a meeting and was unable to speak to the impact of a man's diagnosis of PTSD on his well-being in the centre, responding that 'he is doing fine' and 'PTSD is a fairly common diagnosis'. In a third example, in a briefing before a man's Rule 40 review a Board member was shocked to hear an RMN say they had refused to comply with a man's request to move the time he received his medications from morning to evening because they made him sleepy, commenting that it was, 'tough s**t' for the man, as that was when medications were provided.

6.1.10 As in other aspects of the centres' operations, the Board is concerned by reports in Applications or in conversations with detained men that language interpretation is not sufficiently used by healthcare. These are particularly sensitive areas, and the Board has queried why healthcare does not better prepare in advance for language interpretation. The Board understands that PPG engaged a new service provider for on-demand interpretation, but the Board has had no indication that this had made a significant improvement.

6.1.11 Healthcare has been operating under significant space constraints in Brook House, affecting working conditions for staff, and limiting the confidential and safe spaces for clinical (e.g. substance misuse) and therapeutic (e.g. psychological therapies) work. By the end of the year plans had been made for relocation of various contractor and Healthcare staff and refurbishment of some rooms which will hopefully mitigate the impact of this problem.

6.1.12 Creation of a dental suite in Brook House, discussed throughout 2023, was again delayed and was not in place at the end of 2024. A weekly mobile dental service continued as an interim measure. The Board was informed in January 2025 that new plans had been agreed for creation of a suite within Brook House.

Mental healthcare

6.1.13 Although healthcare provision in general has been concerning, the Board is particularly concerned about mental healthcare. In one conversation with a representative of the mental health team in November, a Board member was told that there were around 50 men at Brook House with a history of trauma and numerous diagnoses of serious disorders, including schizophrenia, anxiety disorders and PTSD. In 2024 five men at Brook House were referred for sectioning under the Mental Health Act.

6.1.14 PPG has considerably increased its mental healthcare staffing over the course of 2024, and by the end of the year the mental health team consisted of a clinical lead, registered mental health nurse, mental health practitioner, an assistant psychologist and mental health social worker, with a psychiatrist onsite once a week. As noted in section 4, the mental health clinical lead was redeployed by PPG to another institution following security issues apparently exacerbated by the poor relationship between PPG and Serco. Staff members' effectiveness was also hindered by long onboarding processes, including long waits for security clearances.

6.1.15 Despite the increase in staffing, the Board did not perceive a substantial increase in the amount or quality of mental health service provision this year. During the period when the mental health clinical lead was in place, Board members noted a more proactive approach, but this was not sustained after her departure. The Board heard that group work was hindered by lack of space, and that there wasn't capacity for individual interventions. Although the Board understood there had been investment in supporting Serco staff to be

more trauma-informed, we neither witnessed any training nor perceived a significant change.

6.1.16 The Board commented numerous times on the absence of mental health personnel from reviews and meetings such as vulnerable residents and safer community. When they did attend, the Board often noted lack of preparation and/or lack of empathy and concern for the men. Except when the clinical lead was in place, who was not herself a mental health professional, there was a complete absence of senior mental health leadership in these meetings.

6.1.17 When mental health staff did attend meetings or reviews, the Board often heard a man in need of support was on 'the list' without any information about what this meant in terms of service provision or waiting times. The Board learned that mental health appointment dates are not provided to men in advance, in order to avoid frustration if the appointment is cancelled at short notice. The Board is concerned that there is little accountability to men, who feel their distress and concerns are not being heard and by the absence of a realistic timeframe for care. This is concerning given the urgency of needs and the high likelihood of deterioration in detention.

6.2 Welfare and social care

6.2.1 Welfare continues to be one of the most valued services at Gatwick, with consistently high praise for the officers from detained men. Welfare officers are almost continually busy dealing with a wide range of issues raised by detained men including access to solicitors, help with locating missing property or family members (with support from the British Red Cross), accessing new clothes or phone vouchers (with support from charities), and general signposting in the centre.

6.2.2 Welfare in both Brook House and Tinsley House has been frequently understaffed in 2024. The Board understands this is because, despite its importance to the detained men, the Welfare role is not a 'red role', or essential, for contractual staffing purposes. This means Welfare officers can be re-assigned to red roles elsewhere when there are gaps. The Board believes that extra efforts should be made to ensure sufficient staffing in Welfare.

6.2.3 The Welfare office in Brook House was often overcrowded, noisy and lacking in confidentiality. Measures were taken early in 2024 to manage this problem with a one-in/one-out policy. This was effective in managing the space better but sometimes led to large numbers of men standing and queuing in the corridor outside, resulting in frustration and occasional altercations. The system was further improved mid-year with the introduction of an appointment system. This was effective, but the Board understands that this can be frustrating for men who try to access help after attending a Home Office

surgery and are unable to do so until the following day. There may be a need to further adapt the system to ensure that urgent needs can be met.

6.3 Exercise, time out of room

6.3.1 The longer lock-up times established toward the end of 2023 continued throughout 2024. In both centres detained men are locked in their rooms for one hour before mealtimes, with activities stopping at 11.15am and 4.15pm to allow time for men to return to their rooms for roll counts.

6.3.2 Men's access to association is therefore considerably restricted. Board members have themselves noted how much more difficult it is to find time to speak to the men during their visits. It is clear that the decreased association times limit how much men can achieve when they are off the wing. This can mean, for example, that they are forced to make choices between attending Home Office surgeries, Welfare or medical appointments and activities such as education, art or using videoconferencing facilities to contact family and friends.

6.3.3 Importantly, this results in significant more time that men spend locked in their rooms. They have a total of 8 hours and 15 minutes when they are off the wing on association and 3 hours and 30 minutes when they are out of their room but unable to leave the wing. On a daily basis, then, they are locked in their rooms or on their wing for a total of 12 hours, which seems excessive. The Board has also noticed during monitoring visits that, because unlocking is done sequentially to avoid the servery being overwhelmed, some men spend even longer locked in their rooms before meals, causing considerable frustration.

6.3.4 The Board repeats its concern that this change in regime goes directly against the recommendations of the Brook House Inquiry, which held that the existing regime was already too restrictive. It stated, 'they are not prisoners and are entitled to as much freedom of movement and association as possible. Any time during which they are locked in their cells must be justified by the strongest reasoning.' The Board does not feel that the various explanations that have been provided for this change, including staff numbers, justify the restriction, and recommends reverting to the shorter lock-up times.

6.3.5 Brook House has two gyms: a larger one on the first floor and a smaller one on the ground floor catering to those who need a quieter environment. Some courtyards also have exercise space and equipment and can accommodate games such as cricket. Tinsley House has a gym, a sports hall and an outdoors sports field.

6.3.6 Exercise facilities are well used at both Brook House and Tinsley House and the Board's impression is that men are satisfied with their access, which is supported by results of a survey conducted by HMIP in 2024 indicating 77% of men felt they could visit the gym as often as they wanted. However, the Board has noted that equipment is ageing, with machines frequently out of

service and sometimes taking a long time to repair. On occasion we heard the Brook House gym was not opened at the scheduled times.

6.3.7 Courtyards at Brook House and Tinsley House receive good use when the weather permits, but space and facilities are limited. When weather is good, the playing field at Tinsley House is also used for sport, which is generally well attended.

6.4 Soft skills

6.4.1 Facilities for the practice of soft skills are available at both Brook House and Tinsley House. At Brook House art activities are particularly popular, with regular competitions organised. There is relatively limited space available at Tinsley House, with both education and art accommodated in the same room.

6.4.2 There has been some increase in use of the library/resource centre at Brook House, particularly for cards or other games. However, there has been no updating of the physical books in the library, and the Board understands that use of e-readers is limited. The survey undertaken by HMIP during their 2024 inspection confirmed that only 24% of people felt the library met their needs.

6.4.3 The Brook House library/resource centre has been used in 2024 to accommodate surgeries held by Home Office DET and (separately) the Gatwick Detainees Welfare Group. The Board welcomes this increased face-to-face engagement with men but notes that the use of this space for these surgeries makes it unavailable for reading, games or other leisure activities.

6.4.4 At Tinsley House the library receives good use, with high demand for computers. As noted in the Board's 2023 report, there is general acknowledgement of the need for modernisation and refurbishing, however this did not take place in 2024.

7 Preparation for return or release

7.1 Activities including education and training

7.1.1 There are about 100 paid ‘activity opportunities’ in Brook House and about 40 in Tinsley. This is more than when Serco took over, when the figures were around 50 and 20 respectively. About 70% of the paid positions were taken up in December 2024. Serco hoped to increase this to 90%.

7.1.2 Serco provides face-to-face educational offerings, particularly English as a second language (ESOL) and English grammar. On average nine detained men attend each session at Brook House, but many men do not attend a full course. Serco reports 7,218 instances of attendance at a face-to-face lesson across both centres in 2024. The Board understands that some of those who attend the ‘Life in the UK’ course – a mandatory test to obtain UK citizenship – are hoping thereby to increase their chances of being able to stay.

7.1.3 Online courses are provided through the Virtual College, and about 30 new people sign up to courses each month. Serco reports 1,092 uses of Virtual College throughout the year. The most popular courses were Level 2 Food Safety and Hygiene, Awareness of Health and Safety, Barista Training, and Customer Service. Some paid jobs in the centre require applicants to have completed relevant courses: Level 2 Food Safety was a requirement for working in the serveries for example.

7.1.4 The educational learning available through the in-person and online offers is somewhat haphazard and elementary. Although they are clearly important to some detained men, the overwhelming majority do not engage, and it is unrealistic to describe the offerings as preparing the men for life after return or release. The Board appreciates the difficulties brought by differing cultures, languages and expectations and the sometimes-short residencies, but feels that more effort should be put into creating a set of educational and training opportunities that are more appealing to a wider cohort of men and are more effective as preparation for return or release.

7.1.5 The two rooms set aside in Brook House for the men’s computer access get extensive use, for case-related as well as social activity. We have heard only occasional complaints about computer access of printer/scanner difficulties. The computers in the Tinsley House library are also heavily used.

7.2 Case management

7.2.1 There has been a significant increase in DET staff on site in both centres. The Board welcomed the significant increase in presence and visibility of Home Office DET, with more staff and routine surgeries and engagements with detained people. Particularly valuable initiatives include the establishment of trackers to reduce the number of days between engagements with Home Office and proactive measures to seek out those who have not been contacted for some time and may need support.

7.2.2 Despite these positive developments, men are spending too much time in detention. The average length of stay for those that left during the year was 30.2 days. There continue to be some men who get 'stuck' in detention, sometimes due to high levels of vulnerability and lack of social care, waiting for bail accommodation, or waiting long periods for emergency travel documents. Consistently about 20% to 25% of the population had been detained for more than 70 days; and the average stay for this cohort was about 160 days. When discharged, one man had been in immigration detention for 708 days – 1 year, 11 months and 9 days. While DET has taken positive steps to increase engagement and to escalate concerns about case progression, ultimately the decisions remain with case workers.

7.2.3 Case progression is too slow, and it is having a serious negative impact on men's mental health and well-being and the overall environment of the centre. It affects release into the community and removal, including voluntary returns, with numerous cases of men who are eager to return home being unable to leave. This is due to well-documented problems with delays in providing bail accommodation by probation, as well as slow action on the part of different Home Office departments, including case owners and travel booking. Levels of frustration with case progression were evidenced in 2024 by self-harming behaviour and an increase in incidents at height in which men climbed onto the suicide prevention netting in protest or to prevent removal.

7.3 Family contact

7.3.1 On average, there have been about 200 social visits per month in Brook House and 95 in Tinsley House. It is not possible with the data the Board has to determine how many men have had (or have not had) visits.

7.3.2 Videoconferencing facilities have been heavily used. The Board believes that online contact far outnumbers in-person social visits. Videoconferencing booths in Brook House are busy with family calls during the afternoons and especially the evenings. On rota visits we have heard several times that slots are fully booked for a few days ahead.

7.3.3 In Tinsley House there is one room available during the day for video calls, as the Home Office needs the other room for interviews. During the evening, however, between 6.30pm and 8.30pm, there are two rooms available. Taking the time difference with some countries into account, this can mean considerable restrictions on accessibility. The Board has been told that this will all change after the refurbishment of the Tinsley House library, which will then include separate videoconferencing facilities. This refurbishment had not begun by the end of the year.

7.3.4 Since August 2021, the Board has been asking the Home Office and Serco to address the issue of poor mobile phone connection within both centres. Finally, during 2024, new phones were distributed to detained men in Tinsley House (as a 'pilot') which connect through the centre's Wi-Fi, thus avoiding

reliance on the poor mobile signal. These new smartphones had various features disabled, including the camera. However, some detained men soon discovered that they were able to modify the phones to evade the security features, and the phones were quickly withdrawn. After revision, smartphones were again issued in Tinsley House in December, although not all men decided to take them. The Board is told that roll-out in Brook House will be in 2025. The Board will continue to monitor this until completion and is pleased that a resolution seems at last to have been achieved.

7.4 Planning for return or release

7.4.1 During the year 2,165 men left Gatwick IRC for a removal flight, and 3,134 men were released to remain within the UK. Nearly 50% more men were released than were removed. This is a similar pattern to 2023 and previous years. We continue to be disappointed that thousands of men have been subjected to the detrimental effects of detention apparently to no purpose.

7.4.2 Those removed spent on average 22.7 days in detention. Alarmingly, those ultimately released spent an average of 35.5 days in detention.

7.4.3 Many men have suffered delays in release following the grant of bail. This has been due to difficulties finding accommodation or approving accommodation addresses. Sometimes, it seems that the Probation Service (who are responsible) have simply been dilatory. In very many rota visits, Board members have been approached by detained men looking for assistance or just wanting to vent their frustration. These frustrations have sometimes led to disruption and even to self-harm.

7.4.4 The Board was informed during the year of a ‘probation pilot’ and was briefed in person by the Probation officer leading it. It appeared to be focused on speeding up the accommodation process and on improving communication with the detained men (or at least with their caseworker and DET staff). The Board’s view is that this initiative appears to have made absolutely no difference to the situation for the detained men. Recently (May 2025), we have been told that the pilot will be evaluated at some unspecified time in the future.

7.4.5 Both Home Office and Serco assure the Board that detained men are released to 'no fixed abode' (i.e. street homelessness) only in the most extreme circumstances. There were twelve such releases during 2024.

7.4.6 There was a noticeable increase in the number of charter flights during the year, and, starting in July, the re-introduction of some long-haul flights. Towards the end of the year, flights to Albania were planned every couple of weeks or so. Alongside the increase in frequency of charters, there was also an increase in the number of men being collected from Gatwick IRC for each flight – sometimes over 20 men, by comparison with just a handful before this. This imposes a considerable additional, and time-critical, workload on Home

Office and Serco staff, and can also lead to long periods of waiting for the detained men involved.

8. The work of the IMB

Board statistics

Recommended complement of Board members	16
Number of Board members at the start of the reporting period	11
Number of Board members at the end of the reporting period	13[2]
Total number of visits to the establishment	238[3]

Applications to the IMB

Code	Subject	Previous reporting year	Current reporting year
A	Accommodation including laundry, showers	7	15
B	Use of force, removal from association	7	
C	Equality		
D	Purposeful activity including education, paid work, training, library, other activities	1	2
E 1	Letters, faxes, visits, phones, internet access	3	6
E 2	Finance including detained people's centre accounts	1	2
F	Food and kitchens	9	5
G	Health including physical, mental, social care	37	61
H 1	Property within centre	8	7
H 2	Property during transfer or in another establishment or location		4
I	Issues relating to detained people's immigration case, including access to legal advice	53	94[4]
J	Staff/detained people conduct, including bullying	24	26
K	Escorts	1	
L	Other	5	9
L 1	Bail and bail accommodation	19	27
	Total number of applications … of which, received via the 0800 telephone line	**174** 7	**258**

[2] Of whom one is on reduced duties
[3] This excludes January, for which data is missing
[4] A 77% increase. Applications are most commonly about slow case progression or lack of information.

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