Independent Monitoring Boards

Annual Report of the Independent Monitoring Board at Gatwick Immigration Removal Centres

For reporting year
1 January 2025 to 31 December 2025

Published September 2026

national preventive mechanism

Contents

All IMB annual reports are published on www.imb.org.uk

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[1]

2.1 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 Independent Monitoring Boards (IMBs) were merged from 1 January 2021.

2.2 Brook House opened in 2009 as a purpose-built immigration removal centre (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 is 426. Facilities are provided on each wing, which include a laundry, table tennis and pool tables and a large screen for viewing films.

2.3 Tinsley House is located close to Brook House. Its capacity is now for 198 men, accommodated in two-, four- and six-bed rooms. During the reporting year, building works were completed in Tinsley House, increasing its capacity by 36 beds from 162 to 198. Prior to renovations, Tinsley House included a separate, dedicated suite (the Borders accommodation) intended to accommodate one family group, with a separate set of rooms, the pre-departure accommodation, or PDA, providing more space for families. Following renovation, there is now a smaller PDA, appropriate for only one family at a time, situated in Tinsley House. This was not used over the course of 2025. There is also now a set of rooms dedicated for use as a care and separation unit.

2.4 Local Home Office teams at Gatwick comprise detention services (DS, also sometimes known as compliance) and the detention engagement team (DET).

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

2.6 The Samaritans, Gatwick Detainees Welfare Group (GDWG) and Bail for Immigration Detainees (BID) provide support to detained men.

[1] Figures included in this report are local management information. They reflect the centre's position at the time of reporting but may be subject to change following further validation and therefore may not always tally with official statistics later published by the Home Office.

3. Key points

3.1 Background to the report

3.1.1 The previous year saw substantial policy changes, which have continued into the early part of 2026. At the time of writing, in April 2026, there will be significant changes to how vulnerability is assessed in immigration detention going forward[2]. This may render some of the observations and recommendations in this report redundant, while others will remain valid.

3.1.2 The Border Security, Asylum and Immigration Bill was introduced in Parliament on 30 January, 2025. This announced the repealing of the Safety of Rwanda (Asylum and Immigration) Act 2024 and parts of the Illegal Migration Act 2023, including the duty to remove and associated provisions. It confirmed the Home Office's ability to detain an individual at the point of serving notification that deportation is being considered[3].

3.1.3 On 4 August 2025, the government ratified a treaty with France. This agreement provided that anyone entering the UK on a small boat could be detained immediately on arrival and returned to France, with an equal number of migrants eligible to come to the UK, provided they have not previously attempted an illegal crossing. This 'one-in-one-out' scheme was operationalised under the name Operation Hillmore for a pilot period of one year. The first men detained under this agreement arrived at Brook House on 7 August[4].

3.1.4 On 16 April 2025, the UK Supreme Court clarified that, under the Equality Act 2010, the protected characteristic of sex refers to biological sex as recorded at birth. Importantly, the ruling also confirmed that transgender and non-binary people remain legally protected under the Act. This has not yet affected Gatwick, as only one transgender individual was detained at Tinsley House in 2025, and this pre-dated the ruling.

3.1.5 Both Brook House and Tinsley House accommodated fewer men than in the previous year, due to extensive building work. This included a project of refurbishment at Brook House, which saw all the wings spruced up and the removal of upper level suicide prevention netting in D wing, with the aim of reducing incidences of men climbing on the netting in protest or to avoid removal. There was substantial renovation at Tinsley House under the heading 'project optimise', aimed at providing increased bed space. This resulted in a new care and separation unit (CSU), allowing men with a higher risk profile to be accommodated at Tinsley, and a

---

[2] 'Home Office announces major reform of Adults at Risk in Immigration Detention policy': Electronic Immigration Network, 10 March 2026; https://www.ein.org.uk/news/home-office-announces-major-reform-adults-risk-immigration-detention-policy.

[3] 'Border Security, Asylum and Immigration Act 2025: equality impact assessment (accessible)', Gov.uk, 30 January 2025, updated 8 December 2025. https://www.gov.uk/government/publications/border-security-asylum-and-immigration-act-2025-equality-impact-assessment/border-security-asylum-and-immigration-act-2025-equality-impact-assessment-accessible

[4] 'UK-France treaty targeting illegal crossings comes into force': Gov.uk, 4 August 2025. https://www.gov.uk/government/news/uk-france-treaty-targeting-illegal-crossings-comes-into-force

more contained area where men can be accommodated prior to removal, precluding the need to move men to Brook House prior to their flight.

3.1.6 Several issues had an impact on the Board's ability to monitor effectively in 2025. At the beginning of the year, the Home Office DET introduced new procedures for the Board to raise issues identified during our visits. The Board was informed that we were no longer welcome to visit Home Office DET in the centres during our visits, but must send queries by email. This has made our work more difficult and reduced our ability to respond to men's concerns in a timely way[5]. As the majority of applications (detained individuals' written representations) to the Board concern case progression (31%), this is concerning. It is the Board's impression that a cultural shift has taken place in Home Office DET, making the relationship much less constructive than previously.

3.1.7 The Board experienced similar delays in responding to men's concerns related to healthcare in 2025. It was a struggle for the Board to get answers to men's concerns or to receive routine reporting in a timely manner from PPG, the healthcare provider. Indeed, the publication of this report was delayed by PPG's failure to provide data in response to our request, despite numerous reminders over the course of nearly three months. Although the Board judges that this is more likely to be an issue of capacity than culture, the result for us is the same: less accountability and increased barriers to effective monitoring. Given that concerns about healthcare (access, quality, and comportment of staff) account for almost a quarter of all issues raised with the Board by detained men, this is problematic.

3.2 Main findings

A significant number of points are repeated from the Board's 2024 report.

Safety

- In the Board's view, Gatwick IRCs were relatively volatile environments in 2025. Although greatly reduced from 2024, serious incidents continue to occur routinely. Men's self-reported feeling of being unsafe at both Brook House and Tinsley House remains a serious concern. Rates of self-harm were generally higher than in the previous year, with significant spikes in the summer. As in previous years, the Board understands that the disproportionate representation of some nationalities relative to others has sometimes contributed to tensions between groups and men sometimes feeling intimidated, contributing to their concerns about safety and access to services.
- Reception processes are information-heavy and can be overwhelming. Men struggle to take it all in. This is exacerbated by insufficient and inadequate use of interpretation, insufficiently frequent provision of documentation in languages that men understand, and the confusion and distress of men, particularly asylum seekers brought to Gatwick under Operation Hillmore.

[5] Board members are volunteers and typically visit one day per week, spending most of this time talking to men and observing the running of the centres. Corresponding by email means taking time away from this work to sit in front of a computer. Moreover, it is a slower way to communicate, and the inability to easily ask follow-up questions means that we have a far less nuanced understanding of a detailed individual's situation.

- In the Board's view, men are sometimes kept waiting too long in the vehicles in which they have arrived, which is uncomfortable and, we feel, unnecessary and undignified.
- From our observations, interpretation, including sign language interpretation, is not used sufficiently or consistently in assessments, reviews and day-to-day communication. The Serco-contracted interpretation service, Big Word, is of inconsistent quality and can be difficult to access in some parts of the centres.
- Medical screenings are not adequate to detect vulnerabilities, particularly mental health issues. There is vastly inadequate uptake of Rule 34 assessments (which allow a detained person to be temporarily separated from other detained people - similar to segregation - in certain circumstances), and a more proactive approach is required to ensure men understand their purpose and potential benefit.
- 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
- In the Board's view, a blanket approach of deploying a fully kitted team on every planned use of force intervention does not achieve fair treatment.
- Men are often maintained in detention for months, despite evidence of vulnerability and deterioration. The Board feels this is due to a default position of managing vulnerability-related risks rather than considering release which, evidence indicates, contributes to short- and long-term harm to detained men.

Fair and humane treatment

- The Board repeats its view that detention without a time limit is unfair and inhumane.
- The Board has repeatedly heard from detained men and staff of an important accountability gap arising from the lack of presence and poor responsiveness of probation services and the detained duty advice scheme (DDAS) legal aid firms.
- The slow approval of bail addresses by probation services is highly problematic, creating substantial delays in the release of men who have been granted bail by the courts. This is unfair and arguably undermines their legal rights. It causes frustration not only for the men but also for Serco and Home Office staff (paragraphs 7.5.3 – 7.5.6).
- While recognising ongoing work to promote a positive culture at Gatwick, the Board continues to see concerning behaviour from staff, including allegations of a physical assault by a staff member on a detained man. We have also noted use of dehumanising language, such as referring to men as 'cases'.
- In the Board's view, the use of handcuffs in 97% of medical escorts is unfair, stigmatising and lacking in dignity (paragraph 5.1.1). The Board considers the categorisation of such handcuffing as 'consensual', rather than a use of force, to be disingenuous (paragraph 5.1.2).
- There was a significant increase in the use of separation under both Rule 40 (removal from association) and Rule 42 (temporary confinement) at Brook House. However, the Board recognises good efforts to de-escalate and mediate (paragraphs 5.3.2, 5.3.3, 5.3.8). The Board recommends further analysis of the reasons for the increase.

- The length of time that some men spend on Rule 40 is too long (paragraph 5.3.5).
- The Board repeats its concern, raised in 2023 and 2024, that separation is used too often to manage challenging behaviour of some very vulnerable men, often for long periods of time. Published guidance notes that separation should not be used as a routine means to manage detained individuals with serious psychiatric illness or presenting with mental health problems. (paragraph 5.3.7)
- Rule 40 reviews are generally better than in past years, with staff better briefed and a less stressed atmosphere for the men. However, there remains inconsistent and sometimes poor or inadequate use of interpretation, and Board members have sometimes raised concern about the tone used by staff in talking to, or about, men.
- Delays in facilitating voluntary return contribute to frustration and distress for men, who are understandably confused about why they remain detained when they have agreed to go home.
- There is sometimes heavy pressure on limited IT equipment available to men. This creates competition between men using it for leisure and those attempting to progress their immigration case.
- There were fewer men with severe mental health issues detained at Gatwick this year, but too many are still being detained. Safeguards must be improved to prevent the detention of such vulnerable men and, if vulnerability is not detected early enough, ensure rapid release to appropriate accommodation.

Health and wellbeing

- Lock-up times are too long. Men are locked in their rooms for 12 hours out of every 24. The Board considers this inhumane.
- Space constraints make it difficult for healthcare to provide a full range of service. At Tinsley House during renovations, the safety and confidentiality of both physical and mental healthcare was compromised (paragraph 6.1.5).
- Cleanliness in both Brook House and Tinsley House has been acceptable this year. Refurbishment has been welcome, however, toilets and showers in unrefurbished areas still look grimy and smell unpleasant (paragraph 5.2.6).
- Men vape freely in the centres, and more effort should be made to ensure vaping occurs only in permitted areas (paragraph 5.2.7).
- Men seem generally satisfied with the food on offer. Dietary needs and preferences and religious and cultural food-related issues are met. However, the Board feels there should be better provision of fresh fruit and vegetables (paragraph 5.2.8, 5.2.9).
- The Board is very concerned about the standard of healthcare provided at the centre, particularly in light of the findings of the independent investigation of the Prisons and Probation Ombudsman on failings related to a death in detention in 2024 (Paragraph 4.3.2). Promised investments have failed to deliver on key improvements in healthcare staffing and recruitment, staff culture, mental health support and waiting times. Nearly a quarter of all applications received by the Board in 2025 concerned the quality and timeliness of healthcare and/or the professionalism and behaviour of staff (paragraphs 6.1.1 - 6.1.3).

- PPG has invested in patient engagement and in improving clinical governance. The latter, in particular, appears to have delivered results, as shown by greatly improved performance against targets, including in areas such as medication reconciliation (paragraphs 6.1.4; 6.2.2). Also positive have been health promotion days and vaccine clinics on wings (paragraph 6.2.3).
- In the Board's view, PPG is not delivering adequately on key safeguards:
    - Around 12% of men arriving at Gatwick in 2025 did not receive a health screening on arrival (paragraph 6.1.6).[6]
    - Only about 35% of men receive a health assessment within 24 hours, as stipulated in Rule 34 of the Detention Centre Rules (paragraph 6.1.8). The Board believes the high rate of men who decline or do not attend results from their poor understanding of the purpose of the assessment rather than informed withholding of consent.
    - Waiting times for assessments under Rule 35 of the Detention Centre Rules are too long, rising from around 14 days early in the year to 28 days following the arrival of men under Operation Hillmore (paragraph 6.1.10). Such long waiting times render the safeguard ineffectual.
- Communication between healthcare and detained men appears poor, and men report being unaware of appointments or having them scheduled or rescheduled with very short notice (6.1.12).
- Insufficient and/or poor use of interpretation puts men's safety and wellbeing at risk (paragraph 6.1.14/health; 6.2.1/dental).
- The long-promised dental suite has not materialised. The weekly mobile dental service operated by Time For Teeth fills a gap, but the Board has heard numerous complaints about the quality of the service (paragraph 6.2.1).
- Too many men with mental health vulnerabilities are being detained and spending too long in detention. This year, two men were sectioned under the Mental Health Act, while mental health was cited as the reason for opening at least a quarter of all vulnerable adults care plans (paragraph 6.3.1).
- Mental health provision at Gatwick focuses on monitoring and containing distress, primarily through medication, but there is insufficient psychological or psychosocial support (paragraph 6.3.3).

Preparation for return or release

- Only a small proportion of men take part in education or training, with English courses most popular. A new online course provider was appointed in 2025.
- DET reports high levels of engagement. In 2025 the Board heard fewer complaints from detained men about communication with local Home Office.
- Men continue to report difficulties in communicating with their case owners. Mandatory monthly reports are not always received and men report that reports sometimes contain inaccuracies they find it difficult to correct.
- The Board is deeply concerned about what appears to be a chronic problem of delayed and inadequate access to legal representation for detained men.

[6] Based on data provided by PPG and Serco.

Men complain of a poor quality of service from solicitors, including not responding to men after the initial interview, not progressing cases expeditiously and not arranging interpreters, including for hearings. Access to legal support is fundamental, and this must be addressed.

- Some men are detained for far too long, with the longest stayer at Gatwick IRCs in 2025 released after two years and 17 days. Delays in provision of emergency travel documents (ETD) is a major contributor to the problem. The Board considers it unfair to keep someone in detention when efforts to obtain an ETD have failed.
- Most family contact is online rather than in person. Video-conferencing facilities are very well used so there can often be considerable waiting times and/or pressure on facilities.
- New smartphones were fully rolled out in 2025, however, access to legal support and family contact are still negatively impacted by poor signal quality and issues with accounts.
- Men continue to experience long delays in approval of bail accommodation, reporting poor communication and follow up from Probation Service. This amounts to a frustration of the legal process and causes significant distress. A pilot project to address this problem has had no apparent impact.
- Delays in progressing voluntary returns are baffling to men and cause great distress. In 2025, some men anxious to return to sickly or hospitalised family members were delayed so long that their relative died before their return.

Operation Hillmore

The detention of men under Operation Hillmore has exacerbated some issues, such as poor access to legal support and waiting times for Rule 35 reviews, and created additional ones. These are not new, and were reported by the Gatwick Board during the detention of men on charter flight removals under the Dublin Convention in 2020, and in conjunction with the Migration and Economic Development Partnership (MEDP) with Rwanda in 2022 and 2024:

- The Home Office does not appear to have been adequately prepared for the men's arrival. Information packages for men were inadequate, translations were not available until a week after men arrived, with some languages not represented, and insufficient numbers of DET staff to deal with men's questions.
- PPG was equally unprepared and has had insufficient capacity to cope with the numbers or with the specific needs of this group of particularly vulnerable men, who arrive with no medical history, with significant physical and mental health needs, and with limited English. This has increased the burden on healthcare services, with no corresponding increase in resource provision (paragraph 6.1.3).
- In the Board's view, the apparently indiscriminate selection process for removing people arriving on small boats to France has put men at risk. Vulnerable individuals, including a significant number of children and victims of torture, have been detained who should not have been.

These issues could, and should, have been anticipated and avoided. The Board believes that the following statement, extracted from our annual report for 2020, is directly applicable to the current situation: '*The characteristics of these detainees*

made them especially vulnerable, including trauma experienced in their countries of origin and/or during their journeys, limited English-language skills, and their limited awareness of systems in the UK and how to access their rights and entitlements.' We highlighted, in particular, issues concerning inadequate provision of information and interpretation, inadequate access to solicitors, an overstretched healthcare service, delays in accessing safeguards such as Rule 35 assessments, and, critically, failure to adequately protect vulnerable people such as children and victims of torture. The Board concluded in 2020 that these elements and the high levels of stress and suicidality that accompanied them rendered the centre (Brook House) unsafe. While the levels of distress, self-harm and suicide attempts have been less extreme in relation to Operation Hillmore than to the MEDP detentions than in 2020, the primary difference has been the slower pace of removals. No lessons appear to have been learned and no measures have been taken improve protection of the most vulnerable.

3.3 Recommendations

TO THE MINISTER

- Introduce a time limit for immigration detention (repeated in all our annual reports since 2018).

TO HOME OFFICE IMMIGRATION ENFORCEMENT

- Review how key mechanisms intended to safeguard detained men operate together to make any necessary changes to ensure that they provide effective outcomes: detention gatekeeper, healthcare arrival screening, Rule 34 assessments, Rule 35 processes, assessment, care in detention and teamwork (ACDT) plans (used to monitor detained people at risk of self-harm), 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 communication with detained men is clear and transparent, including through provision of adequate and appropriate interpretation, and training and support to staff in working with interpreters. Ensure that documents are provided in a language that detained men understand.
- Ensure there is a quality assurance system and accountability mechanism for probation services and the detained duty advice scheme, which ensures men have meaningful access to legal support and do not suffer unreasonable delays in the progression of their cases.
- Revise lock-in times to provide detained men with 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.
- Establish reliable systems to ensure that men receive their monthly reports on time and can raise any issues or rectify errors quickly and easily.

TO THE DIRECTOR/CENTRE MANAGER

- Review, in conjunction with Practice Plus Group, the appropriateness of risk assessments carried out prior to planned use of force by kitted teams, and establish clear protocols and guidance that appropriately balance the physical and psychological risks to staff and to detained men.
- Record all hospital escorts involving handcuffs as use of force incidents, even where they are presented as consensual.

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 the detection of vulnerabilities.
- Provide suitable training and support to ensure that all healthcare staff, including GPs, 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 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.

3.4 Progress since the last report

The Home Office response to the Gatwick IRC IMB's 2024 recommendations shows a mixed picture of acceptance and follow-up. A number of recommendations were accepted or partially accepted and have seen some degree of implementation, particularly in operational areas such as welfare staffing, case progression, training and information-sharing processes. However, several key recommendations - especially those relating to detention policy (including the introduction of a time limit, greater presumption of release for vulnerable individuals and changes to regime conditions) - were not accepted, limiting scope for systemic change.

Where recommendations were accepted, there is some evidence of tangible progress, although much of this remains ongoing rather than complete. Notable examples include the reclassification and recruitment of welfare staff, the introduction of new training and processes (such as monitor, challenge, support), and efforts to reduce delays in casework and improve coordination on bail accommodation; however, these have not necessarily led to better processes. The Home Office has stated that improvements to safeguarding processes, interpretation services, healthcare engagement and education provision are underway, often supported by new or updated guidance and training. But these changes have not yet been fully embedded or evidenced positively in the centre.

Overall, while the Home Office and partners have taken forward several operational recommendations, progress is uneven and many actions remain in development. A significant proportion of recommendations are still marked as ongoing, and those not

accepted - often relating to broader policy changes or transparency - indicate limited responsiveness in these areas. Consequently, although there has been partial follow-up and some improvements, the IMB's recommendations have only been implemented in part, with further work required.

Evidence sections 4 – 7

4 Safety

4.1 Safety

4.1.1 Maintaining safety in immigration detention carries both positive and negative obligations. People must be protected from physical or emotional threats and 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 2024 have persisted, affecting both physical safety and the wellbeing and safeguarding of vulnerable people.

4.1.2 While we heard fewer concerns from men about their personal safety in 2025 than in the previous year, there were nonetheless several occasions when men told us they felt unsafe, and there were a number of attacks by detained men on other detained men that resulted in quite serious injuries. There was at least one allegation of an unprovoked act of physical abuse by an officer on a detained man. We understand this was witnessed by other officers and was being investigated.

4.1.3 There were 13 serious incidents at Gatwick in 2025, 12 at Brook House and one at Tinsley House. This was a considerable reduction from the previous year's 22, but still a high number. The Prison Service national tactical response group, specially trained riot squads, were called in eight times, though on one occasion their intervention was not required. PAVA spray (an incapacitant similar to pepper spray) was used once. Unusually, the Board was not notified on one occasion when the command suite was opened. This is concerning, as it is a mandatory notification.

Reception and induction

4.1.4 The Brook House reception area consists of a long 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 of the room, with a waiting area behind it. In the waiting area, there is soft seating and men are usually served food while they wait to be taken to the wings. Healthcare conducts initial medical screenings in the adjoining small consulting room. The Board monitors this area routinely and has noted that information is well displayed the reception area, with wall-mounted folders in different languages. In February, one man remarked on the good treatment he had received and the tastiness of the food.

4.1.5 The reception area at Tinsley House is newly renovated and decorated, with pictures on the wall, though it could benefit from being a bit brighter, in the Board's view. Staff have noted that the area is small for undertaking the necessary processes such as sharing information and carrying out property checks, particularly given the expected increase in population. Staff also expressed concern about the chairs being bolted to the floor, which could be challenging for men with mobility issues or of a larger build.

4.1.6 On arrival at Gatwick IRCs, men are registered and given a brief induction. Their paperwork is reviewed. They and their property are searched, and any property that is not allowed in the centre, or which they do not wish to take to their rooms, is stored in clear bags labelled with their names. Cash is put into an account that they

can use to purchase items from the shop. As personal phones are not permitted in the centre, men are given time to copy contacts into their centre-issued mobiles.

4.1.7 In line with detention centre rules, men should be provided with a medical screening within two hours of arrival and given a physical and mental examination by a medical practitioner within 24 hours of their initial admission, subject to their consent.

4.1.8 Reception areas at both centres are well organised, and officers follow a defined process, providing a comprehensive one-to-one induction. However, the Board remains concerned that this is too much information for men to take in at what is already a stressful time, and that interpretation is not always used. Serco's induction compact, an agreement that men are required to sign on arrival, contains information concerning wing inductions, smoking and vaping agreements and IT arrangements, for which men have no context. It is available in 20 languages. From conversations with some men and officers, the Board understands that many men sign without fully understanding the rules, particularly those with no prior history of a custodial or detention environment in the UK or who do not speak fluent English.

4.1.9 The Board has consistently expressed concern that men detained under Operation Hillmore do not receive enough information on arrival and often not in a language they understand. It took a week before the leaflet explaining the UK/France agreement was provided in different languages and men continued to report receiving documents solely in English.

4.1.10 The process can be lengthy and can entail long waiting times. This is especially apparent when men arrive in larger groups, as has sometimes been the case for men detained under Operation Hillmore. For example, on 13 and 18 August, men waited nearly an hour-and-a-half in a small van. These men have access to a toilet, but no food, whereas men waiting inside during mealtimes are often provided with food while they wait. The Board believes that men should not wait in a cramped vehicle for such long periods of time. Importantly, as outlined in the reception induction check sheet, anyone identified as an adult at risk should be given priority and, if this does not happen, the reason should be recorded.

4.1.11 The men receive a huge amount of information on arrival and often struggle to take it in due to uncertainty and confusion. Home Office DET holds regular dedicated surgeries. However, the Board believes that extra measures need to be put in place for the men's information needs and more time for each man to ask questions or raise concerns. Importantly, interpretation should be provided if there is any doubt of the man's capacity to understand. In both centres, this is challenging, not least because acoustics are not ideal for having interpreters on speakerphone, although the new reception area in Tinsley House is better. In general, the Board understands that in reception, as elsewhere, officers too often assume that men can understand and express themselves well enough in English.

4.1.12 The arrival process can be particularly overwhelming for vulnerable people, including those with poor mental health. The Board has been consistently concerned that screenings are not sufficient to capture these vulnerabilities and that the purpose and value of the Rule 34 medical appointment is not well explained to the men on arrival. This results in a very high number of men - just under 50% - who do not attend (DNA) or cancel this review. Previously, Rule 34 appointments were made automatically, but since December 2024 an appointment is simply offered at

reception. The Board is concerned that men do not fully understand the purpose of the appointment and therefore refuse on the grounds that they do not consider themselves unwell. The Board also has concerns that staff do not fully understand the purpose of the appointment and may not always make the offer. On one occasion, a staff member told a Board member that Rule 34 appointments are offered to men who indicate they already have a physical or mental health need and want to see the doctor. The Board believes that more needs to be done to ensure that the Rule 34 assessment is functioning as an effective safeguard.

4.1.13 The Board has been told by Serco that reception staff are notified when people arriving have physical disabilities. If someone is deaf, sign language interpretation should be offered. This seems to be inconsistent. In June, a deaf man at Brook House informed a Board member that he was not offered interpretation even though he wanted it.

4.2 Suicide and self-harm, deaths in custody

4.2.1 There were no deaths in detention this year at Gatwick IRCs. There was one death in detention in October 2024, for which the Board attended a lessons learned review on 20 May 2025. The Board regrets that the PPO report, which contains concerning conclusions, has not yet been made public. We understand that this is because the inquest has yet to take place (something that is outside the control of the PPO and the Home Office). However, the Board is concerned about the delay in holding the inquest and to making the findings public, which it considers a failure of public accountability.

4.2.2 Rates of self-harm were higher than in the previous year at both centres. Acts of self-harm were relatively low at the beginning of the year, with a total of eight acts of self-harm across both centres over the course of January. This increased substantially towards the middle of the year, peaking at 30 acts of self-harm by 14 individuals across both centres in June.

4.2.3 Prior to 2024, the Board had expressed concern about how constant supervision was used in the centres. The approach was risk-averse, resulting in men spending prolonged periods under 24-hour observation a day, which many seemed to find distressing. As in our 2024 report, the Board was pleased to see that Serco maintained a good balance of risk tolerance, moving men to less frequent observations, when possible, to limit the negative impact of constant observation.

4.2.4 Board reporting from 2025 shows that when members inspected ACDT paperwork this year, we generally found it to be up to date. Reviews that we observed were reported to have been conducted, on the whole, with sensitivity. Members were present when officers conducted periodic checks and generally felt that they were friendly and supportive. As noted in section 4.6, however, it is far from uncommon that distress is managed with more coercive means, such as use of force and separation from association. For example, in one case, a man was subjected to use of force three times during his ACDT review when he reacted badly to bad news that, in our view, should have been communicated to him at another time or in a different setting. He was later removed from association under Rule 40 (see 5.3.2 for an explanation).

4.3 Violence and violence reduction

4.3.1 Violence at Gatwick decreased somewhat in 2025 compared with 2024. There were 129 assaults on staff, compared with 180 in 2024, a 28% reduction, and 76 resident-on-resident assaults compared with 86 in 2024, a 12% reduction. However, these remain much higher than in 2022 and earlier.

4.3.2 Despite this modest reduction in violence at Gatwick, the Board remained concerned about men's perception of their own safety at both Brook House and Tinsley House. Five of the written applications (detained men's written representations) the Board received related to men's concerns about their safety and, on several occasions, Board members were approached by men in both Brook House and Tinsley House who asked to be relocated or locked in their rooms for their own safety.

4.3.3 Illicit substances and substance misuse were an important contributor to issues around safety and security at Gatwick in 2024, but this reduced in 2025. The Board heard fewer concerns raised by men and members did not as often report smelling cannabis in the centres. We note that HM Inspectorate of Prisons (HMIP) had similar findings during its visit in July 2025.

4.4 Detained people with specific vulnerabilities, safeguarding

4.4.1 All but two age disputes at Gatwick in 2025 were associated with Operation Hillmore. A total of 43 people detained under Operation Hillmore claimed to be under the age of 18, of whom 10, or 23%, were confirmed as minors and released to social services. Our monitoring reflected that generally once these individuals made their claim they were immediately placed in single occupancy accommodation and treated as potentially vulnerable. While they were all released to social services in under a week, the Board believed that the processing of these claims could have been faster, with the majority remaining in detention between three and five days after they had made their claim.

4.4.2 It was the Board's impression that somewhat fewer men with serious mental health conditions were detained at Brook House this year than in 2024. While this is a positive trajectory, the Board nonetheless feels that an unacceptable number of men with serious mental health difficulties were detained. This is particularly problematic because limited community capacity to meet the needs of these men means that it is difficult to find a way to release them that does not compromise their safety. As a consequence, they often end up detained for prolonged periods of time.

4.4.3 The Board remains concerned about what it considers the failure of key safeguards:

- As in 2024, the detention gatekeeper, a unit tasked with preventing the detention of vulnerable people, too often failed to prevent children under 18 and men with serious physical and mental health conditions from being detained.
- Operational safeguarding tools such as ACDT (assessment, care and teamwork in detention) plans, MCS (monitor, challenge and support) documents (a mechanism used by Serco to manage intimidation, violence or persecution by a man or group of men against another), and VACPs (vulnerable adult care plans) are used, but are not integrated with systems

that might trigger reconsideration of detention, such as adults at risk levels or Rule 35 reports. For example, there is no system that requires a Rule 35 (1) or (2) when a man is repeatedly placed on an ACDT due to self-harm or suicidal intent, remains on an ACDT for a prolonged period, or is placed on constant watch. Similarly, safeguards intended to provide evidence to inform case considerations, such as Rule 35 assessments and adults at risk levels, also are not integrated with other systems. For example, data provided to the Board by the Home Office shows that the adults at risk policy was 'not engaged' in 64 (12%) of all Rule 35(3) assessments. As the Board pointed out in its 2024 report, since a self-declaration of torture should automatically result in a man being deemed an adult at risk Level 1, this should be impossible.

- As in previous years, the Board is concerned about the very limited use of Rule 35 (1) and (2) - concerns that were raised by the Brook House inquiry and were raised again in a court judgement in 2025. Only 44 Rule 35 (1) assessments for risk of deterioration in detention were conducted (36 at Brook House and eight at Tinsley House), alongside 16 Rule 35 (2) assessments for risk of suicide (12 at Brook House and four at Tinsley House). By contrast, 564 Rule 34(3) assessments were carried out. Given the high number of ACDTs open at both centres at any given time, the risk of suicide must certainly be higher than the 2.5% of all assessments that Rule 35(2) represents. Indeed, even men whose repeated suicide attempts or severe mental health conditions result in repeated use of force and separation do not always receive an assessment. The Board is very concerned about this.
- Under the Home Office's Adults at Risk framework, an accepted Rule 35 report implies a strengthened presumption against continued detention. In practice, however, when a detained man receives a Rule 35 assessment, it very rarely leads to release. Of the 624 assessments conducted in 2025 across both centres, only 111 men, or about 17.8%, were released. This means that a substantial number of vulnerable men remain in detention despite significant levels of distress.

4.4.4 As noted in paragraph 4.2.10, the Board is concerned that there is inconsistent provision made for the needs of people with disabilities.

4.5 Use of force

4.5.1 The Brook House Inquiry recommended a definition of use of force tailored to the immigration detention setting rather than borrowing from prisons. It was only in December 2025 that the resultant Detention Service Order was published. DSO 11/2025 defines use of force as physical actions taken to manage risk and stipulates that its use may be considered in situations such as preventing imminent self-harm, protecting others from harm, stopping damage to property, or maintaining safety and order during incidents. Force may only be used when necessary, reasonable and proportionate. These scenarios are not new and use of force was categorised under these headings throughout 2025.

4.5.2 Use of force decreased in 2025, with 557 incidents across both centres, down from 785 in 2024 and 599 in 2023. The incidence at Brook House was significantly higher than at Tinsley, with 517 uses compared with 40. The daily average population across both centres was 406 compared with 445 in 2024 and 368 in 2023.

4.5.3 Around 94% of the use of force incidents at Gatwick in 2024 were spontaneous, typically to respond to altercations on a wing or association area, to prevent men from moving somewhere they were not permitted to be (e.g. on 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 efforts to de-escalate.

4.5.4 While members have noted careful, considered and reflective decisions, we have also observed instances of poor judgement. In one such case, a man's VACP document provided guidance to staff on how to enter his room to avoid causing distress. An officer conducting a routine fabric check of bolts, bars and locks did not follow this guidance, and the result was unnecessary distress for the man and a resulting use of force that could have been avoided.

4.5.5 Pre-planned uses of force in 2025 represented 6.1% of all incidents, with 32 occurrences at Brook House and two at Tinsley House. The purpose of the vast majority of planned interventions is described as in order to 'maintain good order', which the Board considers too broad to be really useful as a descriptor. Planned interventions are often used to pre-position men for removal from the centre to an airport or to another detention facility (a prison or another IRC). 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.

4.5.6 In all pre-planned uses of force, officers are kitted out in protective clothing, including helmets with visors down and one officer carrying a shield. Orders are shouted. It is positive that in cases where force was pre-planned, force was not actually used. However, as in 2024, the Board remains concerned about the impact on men of the intimidating appearance and stance of staff involved in these interventions. In the Board's view, this is intimidation by intent and likely to frighten and distress. This is particularly inappropriate in instances such as one in which the Board noted that a fully kitted team was standing by, but not used, when a man was to leave with hospital escorts on transfer to a mental health institution. The control and restraint Instructor who reviewed the plan afterwards quite properly questioned the need for a fully kitted team, potentially intimidating, to be present. The Board feels that a blanket approach of deploying a fully kitted team on every planned intervention does not achieve fair treatment. We, again, recommend that each man be individually risk assessed.

4.5.7 The Board continues to be concerned about the use of force, sometimes in conjunction with separation, on men who are vulnerable and at risk of self-harm or suicide. The Board has noted 70 use of force incidents in 2025 on the ground of preventing self-harm (around 13%). The high proportion of use of force to prevent self-harm underscores our concern about both the vulnerability of the men in detention and the impact of detention on men's wellbeing.

4.5.8 The Board has noted instances of both good and poor practice with regard to governance of the use of force. In one example, a Board member observed a situation when a man was standing just outside his room took a step towards the Serco Assistant Director conducting his separation review, after which force was used to push the man back into his room. The use of force paperwork recorded three different interpretations of the man's step forward, with the officer who used force

considering it an imminent threat to the Assistant Director's safety. The use of force review was conducted for Serco by the same Assistant Director, and the Home Office representative attending the review did not query his ability to make an objective assessment.

4.5.9 When reviewing use of force paperwork, the Board has noted other procedural or administrative failures. For example, officers recorded being unable to use body-worn video cameras during use of force incidents because they had not been issued with one at the start of their shift. In a week when high levels of violence resulted in 36 uses of force, a Board review of the paperwork found it incomplete and disorganised. While recognising that this is an exceptional amount of paperwork, it is also very important for these records to be correct and complete.

4.5.10 Healthcare staff input is required in completing use of force paperwork after the event, but the Board has noticed it is not always timely and sometimes not accurate. For example, a man registered at Level 3 of the AAR and on an open VACP (for reasons of his mental health) was handcuffed, but healthcare's report described this as a minimal use of force. Healthcare staff are also required to attend pre-planned use of force incidents, which is an important safeguard. The Board noted their absence from two such interventions and expressed surprise given the man's known mental health issues and vulnerability.

4.5.11 The Board has repeatedly expressed its concern about the extent of handcuffing when men are escorted outside the centre, particularly for medical tests and treatment. Of 388 visits to hospital in 2025, 97% of the men were escorted in handcuffs, whether for routine appointments or emergencies. 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 by Serco that each case is individually risk assessed. The Board nonetheless considers that pre-cuffing for a hospital visit has become routine. As in 2023 and 2024, we recommend that the risk threshold must be reconsidered.

4.5.12 Men were also handcuffed in advance for other moves, with four such occurrences at Brook House and 74 at Tinsley House. As men held in Tinsley House are typically assessed as having a lower risk profile than those in Brook House, the disparity in the numbers is surprising. Serco told the Board that some of these incidents concerned men being moved from Tinsley House to Brook House in preparation for removal on a charter flight.

4.5.13 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 how and to what extent healthcare is actually engaged in this decision-making.

4.5.14 Finally, the Board is concerned at a broader level about the extent to which staff are conscious of how men experience detention,
particularly in Brook House. While a show of force - particularly on a planned intervention - may seem helpful in discouraging resistance, it takes place in the context of a huge disparity in power and an experience of detention that men already experience as frightening, dehumanising and degrading.

4.6 Substance misuse

4.6.1 There continues to be a high prevalence in the use of illicit substances at Brook House, creating ongoing challenges to safety and security and often requiring a medical response. In January alone, there were several instances when men were put on observation due to problematic behaviour, suspected to be related to drug use, and at least two suspected passes of drugs in visits. In December, 20 people were on treatment for opioid use and 20 were on the substance misuse caseload.

4.6.2 There were 220 intelligence-led searches across both centres over the course of 2025, with 21 drug finds. In July, the targeted searches focused on men on the substance misuse team's caseload. One man was upset and complained to the Board that he had not received his methadone that week. The Board was told this was to avoid the risk of overdose because he had tested positive for spice (a synthetic cannabinoid).

4.6.3 The Board understands that when men are transferred to another institution, such as a prison or place of detention, information about their treatment as part of the substance misuse programme will be shared with their new prison or detention centre. The Board views this as positive.

4.6.4 In September, a man told the Board that a pamphlet he had received from the substance misuse team was only available in English. Materials given to the men should be provided in languages appropriate to the population in Brook House, and interpretation should be used as a matter of course.

5 Fair and humane treatment

5.1 Escort, transfer and transport

5.1.1 The Board remains seriously concerned by the use of handcuffing detailed men on almost all medical escorts, as documented in section 4.6.11. In one week in August, the Board noted that at least three men refused hospital treatment, some of it urgent, due to the humiliation of being handcuffed on escort. In November, a man who went to hospital for kidney stone treatment told a Board member he had been handcuffed to a Serco officer for the entirety of his visit, a trip that lasted over seven hours. He was handcuffed in the vehicle, at the hospital and when going to the lavatory. Handcuffs were removed only very briefly to allow a CT scan to be done. The man said he had not been given any rationale for the restraint.

5.1.2 The Board has been told that use of handcuffs on men attending hospital is not recorded as a use of force incident, as it is officially considered consensual. As the alternative to consent would presumably mean not receiving medical treatment, the Board believes that it cannot be considered to have been freely given, making it a form of coercion.

5.1.3 The Board is aware of a number of occasions on which Mitie, which manages transfers to the airport, used force on men during their removal. The Board has no oversight of the reporting relating to use of force by Mitie.

Charter flight collection monitoring

5.1.4 The Board monitored collections for long-haul charter flights on several occasions. One of these was also monitored by HMIP. Reports noted both positive and negative practices.

5.1.5 In general, there is a good presence of Home Office and healthcare staff at charter flight removals, as well as a range of Serco staff members, including senior staff members, with different responsibilities. On some charter flights, monitors noted that the sequencing of arrivals was not ideal and the space felt overcrowded, but others were better organised.

5.1.6 A number of positive comments were made about the engagement of various members of staff with men during what is a highly stressful time. On one collection, the member monitoring commented on the positive one-to-one communication with men providing information about the process. On another, however, staff in the waiting area were observed to be disengaged. A member commented on positive responses to last-minute needs and concerns, including retrieving phone numbers from IRC-issued mobile phones, changes of clothing and disposal of various property items.

5.1.7 Men are typically provided with food and drink in the waiting area and a snack bag to take with them. Television and activities are sometimes also made available in the waiting area. This is important, because there are often long delays, with men spending two, three or more hours in the waiting area. Some delays appear to have been caused by the wait for property to be brought after a room clearance.

5.1.8 On a few occasions, the Board noted that men were kept waiting for long periods (e.g. two hours) in a parked vehicle in the secure yard which is, in our view, unacceptable.

5.1.9 Access to last-minute legal support was noted to have taken place although, on one occasion, the member monitoring queried whether this would have happened without their intervention. A concern was also raised that sufficient confidentiality may not always be maintained, particularly during the handover of medical information.

5.1.10 Interpretation and translation are not always reliably provided. On one collection, the Board member noted that a man's information pack did not include the Home Office repatriation leaflet in a language he understood, and another man could not be provided with interpretation and had to make do with his limited English. In addition, information transmission can be confused, which is unhelpful at such a stressful time. For example, during the collection for a flight to Nigeria and Ghana, the coach commander repeatedly referred Nigerian returnees to a process that was not available to them.

5.1.11 The Board has raised concerns on a number of occasions about men being transferred on open ACDT documents and questioned how much care is taken to ensure their safety. This concern remains, although the Board was pleased while monitoring a charter flight collection that a man had a review the day prior to his removal and that there was good transfer of information and documentation from Serco to Mitie.

5.2 Accommodation, clothing, food

5.2.1 There was considerable renovation and refurbishment at both Brook House and Tinsley House in 2025. At Brook House, wings were closed consecutively for refurbishment, including painting and repairs to rooms and shower areas. An important aspect of this renovation was the removal of upper level anti-suicide netting in response to a period of significant disruption in the centre caused by men climbing on to the netting in protest or to avoid removal.

5.2.2 Refurbishment has had some positive impacts on living conditions in both Brook House and Tinsley House, but the buildings remain tired, with erratic systems that are challenging to maintain. Issues have continually arisen over the course of the year, including power cuts, inconsistency in room and shower water temperatures, plumbing out of order, and poor ventilation including, on one occasion, petrol fumes filtering into a man's room at Brook House during routine tests of the generators.

5.2.3 Tinsley House saw extensive works throughout 2025 as part of Project Optimise. The separate borders area was removed, and the size of the pre-departure accommodation (PDA) was reduced. Renovations created 36 additional bed spaces for the general population, including three rooms with six beds, one room with five beds, one room with three beds, another five rooms with two beds and one room with one bed, all of which came into use in May and June. Previously, because it was impossible to control the movement of men in general population areas, any man thought likely to resist removal was moved to Brook House prior to the charter flight removal. As some of the new rooms are on a separate corridor, this issue has been resolved. Following these renovations, Tinsley House accommodates men with slightly higher risk profiles.

5.2.4 Temperature control remains a pressing issue at Tinsley House, which the Board has raised annually since 2022. Men frequently complain about the cold in

winter and the heat in summer, the latter an increasing concern as summer temperatures rise. Newly refurbished areas in Tinsley House appear to have better temperature control .

5.2.5 While the renovations have made positive changes, the process put significant pressure on space at Tinsley House, which had a particular impact on the healthcare department. Staff told Board members on several occasions that they were unable to provide safe and confidential physical and mental healthcare. The Board believes that measures should have been taken to ensure that healthcare provision was not affected.

5.2.6 The Board generally found that both centres were kept in relatively clean and tidy condition. Laundries, a longstanding problem, appear to have been better maintained this year, both in terms of cleanliness and maintenance of machines. From our observations, shower areas could be kept cleaner and in better repair, although we have been told that it is sometimes difficult to find men interested in taking on paid work as cleaners. Showers and toilets in refurbished areas in Tinsley House smell better and are notably less grimy and mildewed than in older parts of the building.

5.2.7 Smoking is not permitted anywhere in either Brook House or Tinsley House, and vaping is permitted only in men's rooms and in specific outdoor areas. The banning of smoking in outdoor areas has resolved the pervasive problem we reported in 2024 of men smoking in the centre, but men still regularly vape throughout the buildings. The Board considers that a more proactive approach needs to be taken to restrict vaping to the permitted areas. This benefits detained men and staff, and reduces the atmosphere of indiscipline that can contribute to a feeling of risk in the overall environment.

5.2.8 Issues with food accounted for only about 7.5% of all applications received by the Board this year which, given that food tends to be a proxy for dissatisfaction in general, may be taken as a sign of general satisfaction. Concerns raised related mainly to cultural food preferences, particularly when there are shifts in representation of nationality groups. These seem to be responded to relatively quickly. Board members' own observations still note that meals can be very carbohydrate heavy and 'beige', with many breaded and fried items.

5.2.9 Both centres can provide for different dietary requirements, and special arrangements are made to cater for religious observances. Errors with meal ordering can easily lead to frustration amongst the men, however, and serveries have sometimes seemed to be flashpoints for altercations between men over the course of the year.

5.2.10 Men do not often raise concerns about clothing with the Board, but several issues arose this year. In March, Board members were approached in the corridor at Tinsley House by two men who complained that they had only flipflops to wear. The fact that they did not seem to know how to raise this issue suggested to the Board that this was not sufficiently well explained at induction or that interpretation had not been adequately used (the men did not speak English). Complaints were also raised in 2025 by men detained under Operation Hillmore that the clothing provided was not satisfactory, especially the shoes. Gatwick Detainee Welfare Group has been very helpful in meeting men's needs relating to clothing.

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 for a maximum of 14 days. Rule 42 provides for men to be placed in temporary confinement when deemed necessary for reasons of their own or others' safety or security. Separation may be pre-planned - for example, to facilitate removal from the centre where there is an assessed risk the man may resist - or spontaneous, in response to disruptive or dangerous behaviour. Separation and temporary confinement must be justified and proportionate to the risk presented and must be authorised by Home Office. In spontaneous cases, Serco has conditional delegated powers to separate. When separated under Rule 40 or 42, men do not have freedom of movement in the centre or access to activities or social interaction. Use of separation at Brook House was more frequent in 2025, with 547 uses of Rule 40 at Brook House compared with 477 in the previous year. This is a substantial increase, and as 2024 was higher than previous years, this may be indicative of a trend. If so, further analysis should be done to establish what might be responsible for the change. Separation at Tinsley House decreased, with 34 uses compared to 48 in the previous year. This may be attributable to the reduced population size in 2025. Rule 42 was not used at Tinsley House, but was used 20 times in Brook House. Rule 42 was used 18 times at Brook House last year, which may indicate a trend in increased use - between 2019 and 2024, Rule 42 was used between once and three times a year.

5.3.2 The amount of time that detained men spent, on average, in separation, nearly 41 hours, has not changed significantly from 2024. The Board remains concerned about occasions when separation under Rule 40 reached its maximum 14-day time limit, was formally ended and then immediately re-commenced under a new authority. This occurred six times in 2025.

5.3.3 The longest continuous period on Rule 40 was 23.5 days and the second-longest 21.8 days. The Board finds this very concerning. Separation means isolation and carries with it access to a very reduced regime. We recognise that, at times, there are limited other options, particularly when a man is unwell and presents with behaviour that might result in harm to himself or others. However, 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.

5.3.4 As in 2024, separation was used to pre-position men ahead of removal and remained by far the most common reason for its use accounting for about 40% of cases at Brook House (up from about 24% in 2024) and around 56% at Tinsley House (up from 46% in 2024). The Board has expressed concern about men being removed from association earlier than necessary, restricting their access to 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.

5.3.5 The Board repeats the concern raised in 2023 and 2024 about the removal of men from association for behaviour resulting from mental ill health and/or a propensity to self-harm. The first man referenced in paragraph 5.3.3 was one such case. Another man was separated for a continuous period of 46 days, pending his transfer to a mental health institution. The Board recognises that the intention behind separating men under such circumstances is to protect them, but it remains an inappropriate response to mental distress. Published guidance stipulates that

separation should not be used as a routine means to manage detained individuals with serious psychiatric illness or presenting with mental health problems.[7]

5.3.6 Other main uses of Rule 40 continued to include disruption and drug-related issues, fighting and assaults, maintaining good order and following incidents of men climbing onto safety netting between floors. 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 all altercations.

5.3.7 The Board was concerned last year about the use of Rule 40 in relation to men refusing to share a room. The Home Office advised us that Rule 40 was used for refusal to share only when it was combined with disruptive behaviour, e.g. because of threats to other residents. However, the Board remains concerned that the pressure placed on a man to share - such as repeated requests and sanctions, including loss of paid work - can be sufficiently significant to compel him, in practice, to make statements that could be understood as threats. We were pleased to see that separation on the basis of refusal to share a room has been less frequent in 2025, but we continue to monitor this vigilantly.

5.3.8 The Board was concerned about some uses of separation. In one case, a man with a history of resisting removal was placed on Rule 40 and subsequently required hospital assessment. His separation status was maintained while he was off site, although we consider that it would have been more appropriate for it to have been closed and, if necessary, re-opened on his return. In another case, an individual pursuing a legal challenge to removal was told that his judicial review had failed, which he disputed. He was nonetheless placed on Rule 40 immediately, and extensive force was used to move him physically to a separation room, including the use of pain-compliance techniques. His Rule 40 was ended shortly afterwards. It later became clear that the information provided about his legal case was incorrect. A Board member subsequently found the individual in a distressed state. The Board sought to establish why he had been given incorrect information but received no explanation.

5.3.9 Separation must be reviewed daily, including weekends. Reviews are conducted by Serco's Duty Director and attended by representatives of the Home Office, healthcare, religious affairs team and, when present, observed by a member of the Board. The Board is concerned that this may be overwhelming for the men, particularly on those occasions when the Duty Director neglects to introduce those present. The Board remains concerned that Home Office and healthcare staff sometimes arrive insufficiently briefed and are unable to answer questions, although this has improved in 2025.

5.3.10 The shift toward bringing men out of their rooms for their reviews began in 2024 and continued in 2025. This makes for a more relaxed atmosphere and is a positive step. When men refused that invitation or it was deemed unsafe to let them leave their room, reviews were conducted at the room door, as previously, with everyone clustered around it.

5.3.11 The Board has observed a thoughtful and compassionate approach by some conducting daily reviews of separation but also the reverse - a perfunctory and

[7] DSO 02/2017 paragraph 83.

somewhat hectoring approach, with no real attempt to understand the issues underlying the problematic behaviour. Sarcasm is sometimes used. In one example, an individual requesting an interpreter, having not been provided with one the previous day, was met with a mocking response questioning his need for interpretation. The Board has also observed a tendency to use jargon in reviews, as when initiating an interview by saying it is a 'Rule 40 review' without checking that the man or his interpreter know what Rule 40 is.

5.3.12 Language interpretation, when required, is provided using the phone service The Big Word or a member of Serco's staff who speaks the same language. The Board questions the appropriateness of staff members interpreting, as they are neither neutral nor independent. In addition, staff are not trained as interpreters, nor are they trained in working with interpreters. As a consequence, best practice is not consistently followed. In one example, during a Rule 40 review, a Board member observed that an officer acting as an interpreter for a detained man at times answered questions on his behalf without first referring to him or providing an explanation. The Duty Director did not require that questions be put directly to the detained man and answered by him, nor did they insist on a word-for-word interpretation.

5.4 Staff and detained people's relationships

5.4.1 The Board has received conflicting reports of the relationship between staff and residents at Gatwick, and the picture seems extremely varied. It is difficult to draw firm conclusions, given that individual experiences differ widely and that the Board's observations are necessarily limited to a sample of interactions. What we can say with confidence is that the standard of staff and resident relationships is inconsistent, and that this inconsistency is itself a cause for concern.

5.4.2 Many members of staff are supportive and helpful towards detained men and actively support their wellbeing. The Board has remarked on instances of staff showing patience and humanity in difficult circumstances, engaging with men as individuals rather than as cases to be managed. In one case, an officer successfully encouraged a vulnerable man on constant supervision to engage in a game of cards. On another, officers on the care and separation unit were observed helping residents to use the complaints system to raise concerns. However, the Board has also received complaints from detained men about the attitudes of some staff members and has observed interactions that fall well short of the standard expected. One detained man reported that an officer mocked him, saying, 'Ha ha, I get to go home tonight.' While recognising the stressful nature of the work, there can be no excuse for this type of comment. If true, it represents a failure of professional conduct and a fundamental disregard for the dignity of the detained man.

5.4.3 The majority of complaints the Board hears about staff behaviour concern healthcare. The volume and consistency of complaints suggest that poor conduct is a systemic problem. This is extremely concerning, as it is not only frustrating for, and unfair to, the men, but also risks impacting men's willingness to access care. The Board is particularly concerned about displays of lack of empathy, as when a member of healthcare staff commented that a detained man who had self-harmed with a ligature was 'faking it for attention'.

5.5 Equality and diversity

5.5.1 From our observations, efforts are made at both Brook House and Tinsley House to acknowledge and promote equality and diversity. Religious festivals are celebrated with decorations, special meals and educational opportunities and events such as International Women's Day were marked. Members noted posters about LGBTQ+ inclusion on display. However, we believe more could be done to improve the overall sensitivity of the system to the diversity of the men and to increase staff awareness and understanding of the countries and cultures of the men in the centres. For example, it is concerning that live documents used in the centre continue to reference 'Zaire' despite the country being renamed the Democratic Republic of the Congo in 1997.

5.5.2 Language remains a persistent barrier. At the start of Operation Hillmore, residents detained under the 'one-in-one-out' policy were provided with Home Office documentation in English only. Moreover, the translation tablets provided to officers are not programmed to translate Kurdish, a common language among detained men.

5.5.3 The Board has noted, again in 2025, what appears to be an assumption on the part of staff from all represented organisations (Home Office, Serco, PPG) that detained individuals who are able to 'get by' in English do not require interpretation, even during official procedures such as Rule 40 reviews. Interpretation should be offered by default to any detained person who does not have English as their first language, especially in contexts where complex legal language and jargon is used, or where disciplinary or medical issues are at stake.

5.6 Faith and religious affairs

5.6.1 The chaplaincy department has a positive impact, both on providing emotional support to detained men and also in assisting them to navigate the various systems in which they find themselves. We have seen particularly impressive examples of chaplains assisting with translation and brokering relationships between otherwise isolated residents.

5.6.2 The prayer room at Tinsley House has been refurbished, with a new washing station that has been welcomed by detained men.

5.7 Complaints

5.7.1 Complaints that allege unprofessional conduct, poor behaviour or unfair treatment of detained men are investigated by Home Office Detention Services. A complaint that alleges serious misconduct by officers is investigated by the Home Office's Professional Standards Unit (PSU).

5.7.2 Data provided by Home Office Detention Services shows 255 complaints against Serco were received in 2025 (192 in Brook House and 63 in Tinsley House), of which 31 were withdrawn before investigation. This is a substantial increase on 2024 (208) and 2023 (187). Serco records having received 403 complaints, 229 of which were dealt with by Home Office Detention Services and 174 by Serco locally. The Board has found, and continues to find, confusing the different definitions of complaints and the number of each type recorded. We do not know whether the Home Office's 255 is counting the same complaints as Serco's 229. We do not know how many complaints were made by detained men against Home Office service/staff or healthcare services/staff.

5.7.3 A low proportion of the complaints are fully or partially upheld. Using Home Office data, 10% of complaints that were investigated and closed by Detention Services in 2025 were substantiated or partially substantiated. This is about the same proportion as in 2024 (10%) and 2023 (8%). The proportion of complaints upheld is substantially different between Brook House (8%) and Tinsley House (21%). The Board has seen no analysis to explain this difference, and would be concerned it might indicate a problem of different patterns of behaviour by officers or relate to different characteristics of the detained population. Serco data shows that, of complaints they investigated locally, only 22% were substantiated or partially substantiated.

5.7.4 Data provided by Serco breaks down complaints by category. Roughly a quarter concerned missing or damaged property, a quarter related to unfair treatment, 10% concerned unprofessional conduct and 10% involved staff behaviour. In 2025, 12 complaints of serious misconduct were investigated by the PSU, representing around 4.7% of all complaints and approximately 10% of those alleging misconduct or unfair treatment.

5.7.5 The Board does not receive records of how many of these were substantiated. Of the complaints investigated by Home Office Detention Services, 90% were completed within the 20-day time limit.

5.7.6 Although the Board is aware of complaints about Home Office staff and services and sometimes see these in applications, we receive no information about the detail. When the Board has requested information about such complaints (e.g. allegations of inappropriate behaviour by named Home Office officials), responses have been, at times, dismissive and unhelpful.

5.7.7 PPG reported receiving 105 complaints between April 2025 and January 2026. Although this information is only partial, it appears to represent a slight increase on the previous year. The majority of the complaints (64, or 61%) concerned clinical decision-making, followed by medication issues, with 17 complaints (16%), and 13 complaints (12%) about ‘primary care’. Although the Board heard many concerns raised by detained men about attitudes and behaviour of healthcare staff, PPG did not seem to have a category for reports about staff behaviour in their complaints process.

5.7.8 PPG aims to acknowledge all complaints in writing within two days of receipt, and they endeavour to provide a full written response in 30 days. As in 2024, the Board notes that 30 days is a long time for men to wait, particularly given the expectation - if not the reality - that men will move through immigration detention rapidly. It is certainly not sufficiently timely for remedial action to be taken. On average during the period April 2025 to January 2026, PPG responded to complaints in 19 days. However, the longest response time each month was, on average, 36 days. One complaint was only resolved after 75 days.

5.7.9 In the Board’s view, PPG made some efforts to improve its complaint management in 2025. From mid-June they improved accessibility of healthcare complaints forms at Brook House and began triaging complaints daily to identify issues that could be resolved by meeting directly with the man within 24 hours. The Board has no direct evidence of the impact of this measure. It is likely that some men will appreciate rapid attention to their concerns; however, despite PPG’s assurances

that the new process in no way compromises men's right to a formal complaint, there is a risk that the new system may result in reduced visibility of men's concerns.

5.7.10 The Board notes, as it did in 2024, that PPG's complaints process is opaque. The Board received only partial information for 2025 and has been unable to obtain information about how complaints are investigated, how many are considered substantiated or not, and what feedback, if any, is given to men about the status of their complaint.

5.8 **Property**

5.8.1 There were 101 property-related complaints handled by Serco in 2025, representing 24% of the total 420 complaints received. The Board received 16 property-related applications over the course of the year, five of which concerned losses prior to arrival at Gatwick IRC, or during transfer. This is a relatively low number given the turnover of the centres, but it is concerning that these tended to be items of monetary value (e.g. cash, watches) or important documents such as passports and ID cards. On some occasions, men were removed from the country without their property.

5.8.2 In the cases reviewed by the Board, staff were reported to have been helpful in resolving issues relating to missing or lost property. There were four cases reported to the Board relating to individuals coming from HMP or police facilities where tracking down the property was more problematic.

5.8.3 The property stores in Brook House and Tinsley appear to be in good order and well managed. However, several issues in reuniting men with their property were noted by the Board during our monitoring of a charter flight departure, including a man being offered property belonging to his roommate prior to his departure.

5.8.4 Issues regarding what property is permitted in the centre and what is not can be contentious. In 2025 on one occasion, a detained person complained following the confiscation of a high value personal item due to noise disruption on the wing. While such items are generally permitted within the centre, documentation available to detained people makes clear that residential management may exercise discretion to restrict their use. The principal frustration seems to have arisen over the man not having had a clear explanation for why the items were removed. This was a single incident, but it illustrates the importance of clarity and transparency in addressing with such issues.

6. Health and wellbeing

6.1 Healthcare: general

6.1.1 The Board remains concerned about the standard of healthcare provision to the centres, with PPG struggling to meet the needs of detained men. Despite efforts to improve healthcare provision, many of the Board's concerns from 2024 remain relevant, notably related to staffing and recruitment, culture, mental health support and failings in the use of safeguards in Detention Centre Rules 34 and 35.

6.1.2 In March, PPG informed stakeholders at Gatwick that higher level management changes would lead to improvements in training, visibility on the wings, phasing in unscheduled care, closer working with men in their initial period in detention, the introduction of a duty worker, and a named member of the team to support more vulnerable detained men. The Board did not see a significant impact of these changes.

6.1.3 In 2025, nearly a quarter of all applications received by the Board concerned the quality and timeliness of healthcare and/or the professionalism and behaviour of staff. This worsened following the arrival of men detained under Operation Hillmore, many of whom arrived without medical histories, with significant physical and mental health needs, and with limited English. PPG recognises that this increased pressure on healthcare services without a corresponding increase in resources.

6.1.4 PPG's feedback data showed that satisfaction with healthcare was 60-70% over the course of the year and dissatisfaction was 30-40%. This contrasted with the Board's experience of significant dissatisfaction expressed by men over the course of the year, both in terms of the quality of care received and the behaviour and attitudes of healthcare staff. However, PPG appointed a patient engagement lead in October 2025, which may help improve both the patient experience and feedback and accountability.

6.1.5 The amount of space for clinical care in both centres has been an ongoing problem and, in Tinsley House, the Board has observed, and been told by members of healthcare staff, that the suitability and cleanliness of facilities is inadequate. Building and repair work has been ongoing in Tinsley House medical offices and spaces throughout the year. This has caused disruption to staff and limited space for them to work. Importantly, it has affected the privacy and confidentiality of care.

<u>Reception screening, Rule 34 and 35 Assessments</u>

6.1.6 The Board has calculated the number of reception screenings as reported by PPG compared with the number of arrivals as reported by Serco in the same months[8]. Based on these calculations, it appears that up to 504 men - just over 12% of the men arriving at the centres - did not receive a medical screening on arrival.

6.1.7 Rule 34 and Rule 35 appointments are very important safeguards. Rule 34 appointments - different from reception screenings - are intended to identify vulnerabilities at the earliest possible stage of detention. 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

[8] PPG did not provide any reporting for three months of 2025.

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.

6.1.8 Since December 2024, PPG no longer automatically books a Rule 34 appointment for men but simply asks men on arrival if they want one. Uptake is poor. At both Brook House and Tinsley House, around 42% of men declined the appointment, 22% DNA, and 1% cancelled. This means only about 35% of men had a Rule 34 appointment. While the assessment is subject to the consent of the detained person, the Board is concerned that men may not understand its purpose. When we ask men why they declined, they often tell us that they were not unwell. This suggests that they do not understand its role in identifying vulnerabilities or risk factors. In 2024, we encouraged PPG to adopt a standardised script, but this was rejected in favour of more general guidance to staff, which had no reference to vulnerability or safeguarding. PPG reported in August 2025 that their clinical and patient safety leads had developed a communication prompt document for staff. The Board has not seen this document, but notes that there does not seem to have been an improvement in the decline or DNA rates following its introduction.

6.1.9 In 2025, waiting times for Rule 35 appointments were, again ,unacceptably long, at an average of about 14 days in each of the centres, and with an average of between 20 and 45 men on the waiting list in any given month. Following the arrival of men detained under Operation Hillmore, waiting times rose to 28 days in September, with 91 men waiting for Rule 35 assessments. PPG acknowledged that they did not have the capacity to cope with the surge of new arrivals or their much higher levels of vulnerability.

6.1.10 PPG implemented a new system to help reduce barriers to Rule 35(1) and (2) referrals. This involved multi-disciplinary team meetings and increased opportunities to flag cases that needed referring. Despite this, the number of Rule 35 appointments has remained relatively stable over the year, with around 25-35 appointments a month. There was a sharp increase in October, when there were 80, possibly due to the rise in men detained under Operation Hillmore, the majority of whom are asylum seekers.

<u>Healthcare: communication and use of interpretation</u>

6.1.11 Healthcare communication with detained men can seem confused, unclear or absent. Detained men report not being aware of appointments or having them scheduled with very late notice.

6.1.12 Staff culture and the attitudes and behaviour of healthcare staff towards detained men remain a serious concern for the Board, and many of the complaints about healthcare raised with the Board concern staff behaviour and attitudes.

6.1.13 This year saw further reports that language interpretation is not sufficiently used by healthcare when engaging with men at the centres. This caused stressful incidents for men: for example, at Brook House, a member of staff was found to have failed to use interpretation for the appointment of a man who did not speak very good English. The person in question had stopped taking medication prescribed by the centre and had complained about treatment by staff.

6.1.14 Building and repair work has been ongoing in Tinsley House medical offices and spaces throughout most of 2025. This has caused disruption to staff and limited space for them to work and hold confidential conversations with patients. In the Board's view, the suitability and cleanliness of facilities in Tinsley house have remained problematic.

6.2 Physical healthcare

6.2.1 Discussions on the creation of a dental suite have been ongoing since 2023. Despite assurances at the beginning of the year that plans had been agreed, it did not materialise over the course of 2025. A weekly mobile dental service operated by Time for Teeth continued as an interim measure. While this does provide men with access to dental care, the Board had some concerns. We heard complaints from men on a number of occasions about the length of waiting times and the standard of care. In August, the Board was informed that a number of men had complained that, due to a lack of interpretation, they had not understood until it was too late that the dentist planned to remove their teeth. Access to dental services was also limited on occasion by administrative failures, such as staff lacking necessary security clearances. In addition to these practical and clinical issues, the Board is also concerned that the use of the courtyard for the dental clinic limits the amount of outdoor space available to men.

6.2.2 The Board has been pleased to see considerable improvement in clinical governance over the course of 2025. Medication reconciliation has shown particular improvement, with those completed within 72 hours moving from around 50% at the end of 2024 to consistently around 95% in the second half of 2025.

6.2.3 Health promotion days were held in both centres in January and June in 2025. These events engage men at the centres with a 'wellman' clinic, and support in diet, smoking cessation, vaccination, dental care, hepatitis C and blood-borne viruses, vaccination, and mental health. These are popular and positive events, and contribute to increasing vaccination coverage. Vaccination clinics were also introduced on wings to improve patient education and address vaccine hesitancy.

6.3 Mental healthcare

6.3.1 Mental health is a serious issue requiring significant intervention in Gatwick IRC. Serco data shows that around a fifth of the 271 men on vulnerable adult care plans in 2025 had mental health listed explicitly as the reason, and mental health would be a factor in at least a proportion of another 70 men listed as 'other' or 'adults at risk Level 3'. Two men this year have been sufficiently unwell as to require sectioning under the Mental Health Act. The presence of so many men with underlying mental health vulnerabilities is particularly concerning given the known harmful impact of detention.

6.3.2 The Board is also concerned about the mental wellbeing of men who crossed the Channel in small boats and have been detained under Operation Hillmore, most of whom are asylum seekers with experiences of conflict or violations of human rights in their countries of origin and during their journeys. A significant number have been referred to the National Referral mechanism as victims of human trafficking and modern slavery.

6.3.3 Mental healthcare provision in Gatwick IRC is largely about monitoring and containing distress rather than providing any real support. Day-to-day support is largely provided by mental health nurses, with a psychiatrist visiting weekly. This support is largely pharmaceutical, and does little to provide psychological support. The exception is the useful but, in the Board's view, utterly insufficient 'making sense of your IRC experience' groups.

6.3.4 The Board had been aware of some improvements being made by the psychologist who was in post; however, they left the role mid-way through 2025 and have not been replaced. The mental health clinical lead was not replaced in 2025, and a mental health support worker was being vetted and had not joined the team by the end of the year.

6.4 Welfare and social care

6.4.1 Welfare continues to be one of the most highly valued services at Gatwick IRC, with officers consistently receiving strong praise from detained men. Welfare officers are generally very busy, although in 2025 there were some slower periods, particularly when population numbers were lower. Officers told Board members that this allowed them to take more time with individual men, providing more in-depth support. The demand on the welfare tam increased as a result of Operation Hillmore, due to the confusion and anxiety of the men and their relatively low levels of spoken English. While demand increased, capacity did not.

6.4.2 Welfare officers typically deal with a wide range of issues, including supporting access to solicitors, help with missing property or family members, accessing new clothes or phone vouchers (with support from charities), and signposting to a range of services within and outside of the centres. Welfare also plays an important role in supporting case progression by providing men with access to solicitors under the publicly-funded Detained Duty Advice Scheme (DDAS), under which each man is entitled to at least a half-hour consultation. For most of the year, we heard that solicitors were available within about two days. Welfare officers also signpost and book men into surgeries and individual appointments with Home Office DET and help men when they are having difficulties accessing probation services or arranging for accommodation on release.

6.4.3 Welfare also supports improved accountability to detained men by reporting complaints/concerns about the quality and accessibility of solicitors under DDAS. These are frequent and are regarding poor communication, lack of follow-up, inadequate information, ineffective use of interpretation, and instances of incivility towards both detained men and staff.

6.5 Exercise, time out of room

6.5.1 In both centres, men are locked in their rooms for one hour before mealtimes. This means that men are locked up for approximately 12 hours out of every 24. Activities stop at 11.15am and 4.15pm to allow time for men to return to their rooms for roll counts, further limiting their access to association. As we noted in 2024, this can force them to make difficult choices between progressing their cases, accessing medical care, visiting with family and friends, or engaging in leisure activities. The Board considers the extended lock-up hours unfair and inhumane.

6.5.2 The Board notes, again, that the Brook House Inquiry found the existing regime - which provided more access to association than is now the case - 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 this standard has been met.

6.5.3 Brook House has two gyms: a larger facility on the first floor and a smaller, ground-floor space designed for those requiring 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. Exercise facilities appear to be well used at both Brook House and Tinsley House.

7 Preparation for return or release

7.1 Activities including education and training

7.1.1 Only a small proportion of the detained men take part in face-to-face or online educational courses. English lessons are very popular. There is a new provider for online courses – iHasco - which seems to have good uptake. The men particularly appreciate receiving certificates when they complete a course. Teachers have prepared a folder containing brief explanations of the courses on offer.

7.1.2 Computer facilities at both establishments appear to be well used, including for casework and family contact. It can therefore be frustrating for the men when computers are out of action. Staff try to ensure repairs take place as swiftly as possible. Men sometimes complain that computers are not prioritised for casework, which can cause frustration.

7.1.3 The cultural kitchen in both Brook and Tinsley remains popular, sometimes with waiting times of several weeks.

7.2 Case management

7.2.1 The Board has been very disappointed by the apparent lack of preparation by the Home Office for the beginning of the 'one-in, one-out' scheme for removal to France. When men first arrived in August, there was insufficient information available to explain to them what was happening. Information that did exist was only in dense, legalistic English. It took several weeks before simpler information was available in multiple languages. Officers appeared overwhelmed and frustrated by the bewilderment and anxiety of these men, whose most pressing queries could only be answered by the Home Office. The Home Office did not anticipate the men's entirely understandable need for information and did not provide additional support. In the Board's view, additional DET surgeries, including at the weekends, could have ensured men could ask questions and raise concerns.

7.2.2 The Board has heard numerous complaints this year that monthly reports are often delayed, missing, incomplete or inaccurate. The caseworker unit appears to have no quality check process to ensure that all reports have been sent, although local DET officers appear to chase and escalate when they find a gap in delivery.

Access to legal advice

7.2.3 Detained men quite often struggle to get responses from solicitors provided through the DDAS scheme. Lawyers fail to return calls or don't follow up promptly. Many detained men report minimal or no communication with solicitors, brief or unsatisfactory consultations (10-30 minutes), and inconsistent engagement.

7.2.4 The welfare team regularly reports unresponsive solicitors to the Legal Aid Agency, which usually triggers quick action - but staff note that such escalation 'shouldn't be necessary'.

7.2.5 The surge in detained people under Operation Hillmore appears to have led to longer waits for legal appointments, leaving men with very limited time to challenge removal decisions.

7.2.6 Although the Home Office does not directly provide legal support, responsibility ultimately lies with the Home Office (via Detention Services) to ensure

that detained men have meaningful access to lawyers. We believe that this obligation is failed in too many instances.

Translation and Interpretation

7.2.7 During the year, the centre has started to use translation tablets, which translate either spoken words or typed text. The Board has been told that these are useful for more routine and non-official communication. However, when men first arrived under Operation Hillmore, it became clear that the tablets do not work with any Kurdish dialect. The Board has also witnessed technical difficulties, as when officers do not know the PIN to access the tablet. We are not aware whether these issues have been resolved.

7.3 Length of time in detention

7.3.1 The 2,843 men who were released on bail from Gatwick IRC or admitted to the country during 2025 had spent, on average, 29 days detained in the centre; the 2,342 removed had spent on average 23 days detained.[9] However, these averages include large numbers of men who spent a short time in the centre, such as, for example, arriving from a prison and leaving on a charter flight within a few hours or a few days. Excluding individuals detained for less than a week, the average length of stay is 37 days for those who are ultimately released and 34 days for those who are removed.

7.3.2 The Board is concerned about how long some men are subjected to the known damaging effects of detention on mental health. A total of 447 men were detained in Gatwick for more than ten weeks, with an average stay of 124 days (nearly 18 weeks). Of these, 58% were ultimately released on bail. One man was detained in Gatwick for 665 days (one year and 10 months) before being removed; and another 608 days (one year and 8 months). In a particularly egregious case, a man was detained for 747 days (two years and 17 days) before being released into the community.

7.3.3 For those who stay longest at Gatwick IRC, the reason is often waiting for emergency travel documents.[10] Months can be spent waiting and chasing embassies for these papers. It is unclear why men are not released while they are waiting, particularly when this concerns countries to which there appears to be no reasonable prospect of removal.

7.3.4 Serco's custody management system records 292 men[11] arriving during 2025 under Operation Hillmore. Of these, 132 were removed to France, having spent an average of 56 days in detention, while 91 were unconditionally released or bailed, having spent an average of 28 days in detention. Nearly 100 of these men remained in Brook House at the end of the year.

---

[9] Data for 2025 from Serco's Custody Management System extracted 22 January 2026; analysis by the IMB.

[10] Information from the Home Office on longest stayers provided as part of the monthly board papers.

[11] The Board is concerned that not all such men have been recorded correctly in Serco's database.

7.4 Family contact

7.4.1 Video-conferencing facilities have had a considerable and positive impact on family contact. They are very well used and, as a result, there can be waiting times. Refurbishment of the Tinsley House library has included several booths for video calls, including with family and friends. Online contact seems to be more heavily used than in-person visits.

7.4.2 Serco completed the roll out of new 'smartphones' (SNIPS) to detained men. This was intended to resolve previous ongoing issues with the poor mobile phone signal. However, men still frequently raise issues of poor or intermittent signal, account problems and high tariffs. They are frustrated by the impact of these issues on their contact with family and access to legal support.

7.5 Planning for return or release

7.5.1 There was an issue, now resolved, whereby medical staff (rather than Home Office staff) were serving removal directions paperwork on men who had been kept in hospital for treatment or observation. The Board was concerned that this might breach medical ethics and was not permitted by the Detention Centre Rules. Legal arguments supported by the IMB Secretariat have prevailed and the Home Office has issued relevant guidance to its staff.

7.5.2 As far as the Board can tell, suitable medical information has been provided to escorts or receiving institutions, where relevant. Serco social workers are particularly proactive in support of especially vulnerable men.

Bail and bail accommodation; the Probation Service

7.5.3 Many detained men face long delays in release after being granted bail, because suitable accommodation has not been secured or not approved. This is often due to slow or unresponsive Probation Service processes. Examples of unreasonable delay include:

- A man who had licence restrictions on living in towns but was repeatedly offered (seven times) unsuitable accommodation in towns.
- A man detained for nearly a year after bail was granted, with his release stalled by the Probation Service's failure to approve accommodation.
- A man who supplied an address and waited more than two months for the Probation Service to check it. He received no explanation for the delay.

7.5.4 The delays cause considerable distress, and Board members on monitoring visits almost always hear from at least one man in this position. Probation Service officers frequently fail to respond to detained people or to progress address checks. Some men have waited months without replies. Even when contact occurs, communication is inconsistent, and detained individuals are left without explanation. There seems to be limited accountability for the poor provision of the Probation Service.

7.5.5 The Probation Pilot, which has been running for over a year and was explained to the Board in 2023 as being focused on improving the situation, appears to have had absolutely no effect. In fact, Welfare staff no longer follow up with Probation Service officers under this system, further reducing accountability.

7.5.6 DET cannot provide information on how many men are waiting for address approval or on the average waiting time. The Board was informed that this is because they do not receive data from the courts or other Home Office departments. If this is the case, it seems a very serious communication failure, particularly as the rights of these men are their direct responsibility.

Voluntary return

7.5.7 The Board has heard numerous times from detained men who are mystified about why, after having signed voluntary return papers, it takes so long to arrange a flight for them. More than once, members have been told of men who wanted to return home and who are still waiting long after their friends were removed on an enforced return. While waiting for a Rule 40 review, one Board member reported hearing a member of Home Office staff make a remark to the effect that the individual's application for voluntary departure might delay the process.

7.5.8 On several occasions, the Board has spoken with detained men who wished to return voluntarily and have sometimes offered to pay for the flight themselves because family members were ill or in hospital. They were understandably distressed and frustrated by the delays. One man's relative died in hospital while he waited for a voluntary return to be arranged.

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	12
Number of Board members at the end of the reporting period	14
Total number of visits to the establishment	65 Brook House 56 Tinsley House

Applications to the IMB

Code	Subject	Previous reporting year	Current reporting year
A	Accommodation including laundry, showers	15	10
B	Use of force, removal from association	-	4
C	Equality	-	5
D	Purposeful activity including education, paid work, training, library, other activities	2	7
E 1	Letters, faxes, visits, phones, internet access	6	10
E 2	Finance including detained people's centre accounts	2	3
F	Food and kitchens	5	21
G	Health including physical, mental, social care	61	62
H 1	Property within centre	7	12
H 2	Property during transfer or in another establishment or location	4	6
I	Issues relating to detained people's immigration case, including access to legal advice	94	101
I1	Bail and bail accommodation	27	12
J	Staff/detained people conduct, including bullying	26	26
K	Escorts		
L	Other	9	24
	Total number of applications	**258**	**303**

This publication is available at https://www.gov.uk/government/publications

Any enquiries regarding this publication should be sent to us at imb@justice.gov.uk.