THE BROOK HOUSE INQUIRY

SECOND WITNESS STATEMENT
OF THERESA SCHLEICHER

I, Theresa Schleicher, of Medical Justice, 86 Durham Road, London N7 7DT, will say as follows:

1. I am the Casework Manager for Medical Justice. This is my second witness statement. The purpose of this statement is set out Medical Justice's casework experience of the treatment of detainees at Brook House IRC.

2. I will first provide the Inquiry with (a) an analysis of our casework related to clients with whom Medical Justice had direct contact between 1 March 2017 and 31 August 2017 at Brook House; (b) an analysis of all Rule 35 reports made available to Medical Justice as a Core Participant through the Inquiry's disclosure platform; (c) a description of Medical Justice's interaction with Brook House and Home Office staff during the relevant period. Matters concerning clinical care arising from the case work will be addressed by Dr. Rachel Bingham, Medical Justice's clinical advisor, in her witness statement.

3. The casework that has been reviewed is compiled into case studies annexed to this statement **(Annex 1)**. In this statement, I explain the methodology we used to identify the case studies, and set out an analysis of the thematic issues that emerge from the case studies. As I will state below, Medical Justice considers that these case studies confirm serious failings, which operated not only in the IRCs but at an institutional and policy level and gave rise to a real and unacceptable risk of detainees being exposed to or actually experiencing abuse and ill-treatment within the detention centre, including of the types exposed by BBC Panorama. The defects identified are not only owing to the arrangements and contractors that operated at Brook House. They can also attributable to the long-standing and pervasive systemic deficiencies in the operation of immigration detention and enforcement policies, their application in practice by the Home Office and the contractor G4S, and the entrenched resistance of the Home Office to learning lessons

where harm has been exposed by the courts, public oversight bodies, independent reviewers, the media and NGOs.

4. I will then address the evidence available to Medical Justice post-2017 about the arrangements and operation at Brook House. Our experience of Brook House in the years following the broadcast of the BBC Panorama Programme in September 2017 is that the failings exposed by the programme and illustrated by the case work we have reviewed, have not been properly or effectively addressed. We show this through publicly available material from independent oversight bodies, Medical Justice's published research based on its case work and case examples of recent experiences of our clients at Brook House. Those case examples are annexed to this statement at **Annex 2**. This evidence is produced to address the Inquiry on a core question in the Terms of Reference that is the lessons that have been and are yet to be learned. We consider this evidence vital to the Inquiry's analysis of and recommendations on how change can be most effectively implemented so that we do not see another repeat of the kind of abuse and ill-treatment exposed by the Panorama programme. This analysis of the post-2017 landscape is to be read with Medical Justice's suggestions to the Inquiry which I set out at the end of this witness statement.

5. I would invite the Inquiry to consider this statement in conjunction with my first statement.

6. This statement will be structured as follows:

   a. Medical Justice's involvement with Brook House.
   b. Analysis of Medical Justice casework experiences related to clients at Brook House during relevant period.
   c. Medical Justice's response to BBC Panorama.
   d. Concerns at Brook House post-Panorama and case study examples.

B. Medical Justice's Involvement in Brook House

Profile of referrals to Medical Justice

4. Brook House is a purpose-built Immigration Removal Centre ("IRC") to hold adult male detainees, which came into use in March 2009, the year I started as casework manager

for Medical Justice. It is our understanding that it was originally intended as pre-departure accommodation prior to deportation or administrative removal action, and only intended for short-term stays of no more than 72 hours prior to scheduled removal. As the Inquiry already knows, the reality is that people are detained at Brook House for far longer.

5. Because of Brook House's location and purpose as a pre-departure removal centre, Medical Justice receives a high number of referrals from the IRC, which are often urgent requests for clinical assessments against the backdrop of imminent removal. The profile of detainees who Medical Justice encounters at Brook House is as follows:

   a. Detained people arrive in IRCs by differing paths in the immigration and asylum system, and can be divided broadly into three categories: (i) those who have served the custodial part of a criminal sentence and are subject to deportation proceedings; (ii) those who are detained pending the determination of an asylum claim; and (iii) those who are thought to have no immigration status or had overstayed beyond their leave to remain. Brook House held a mixture of all three categories of detained persons, but in our experience, principally, time-served foreign national offenders, and overstayers (although that profile changed during the Covid-19 Pandemic, as discussed further below).
   b. Our experience of the regime at Brook House is that it was operated more like a prison (having been designed to a Category-B prison specification), with an emphasis on security and lock-ins.
   c. Almost all of the individuals referred to us report a history of severe trauma, often torture. Many have complex mental health problems.
   d. As many of them are time-served foreign national offenders, they are more likely to present with immigration and public protection risk factors which, from the Home Office's perspective, would outweigh the presumption against detention, even if they are deemed to be adults at risk. This also means that individuals referred to us will often have been detained for longer periods, both at Brook House and other IRCs.
   e. The fact that many of the individuals referred to us have criminal convictions does not make them less vulnerable. On the contrary, as is clearly documented in clinical literature (set out in Professor Katona's and Dr. Bingham's witness statements),

those with a history of criminal conviction can present with the most complex clinical and other needs. Moreover, prolonged detention often leads to deterioration in a client's mental state, and makes a person more vulnerable to harm in detention. Prolonged detention is associated with increased risks of self-harm, self-neglect and suicidal risks. Prolonged detention also means being exposed to others who are in a similar position, suffering distress and a deterioration in their mental health. Witnessing others' suffering also impacts on our clients and the overall environment and atmosphere of the IRC.

f. For some clients, their uncertain immigration status in the community has meant that they have not accessed healthcare prior to their custodial sentence or prior to detention.

6. This profile changed during the Covid-19 Pandemic when the overall detained population reduced. For a period of time from March 2020 to August 2020, because of the reduction in the detained population, those remaining in immigration detention were almost all time-served foreign national offenders. That changed in August / September 2020 when Brook House IRC became used as the primary detention centre for people arriving into the UK via Kent in small boats. From September 2020 onwards, the Home Office operated a programme of compressed charter flight removals (with two flights a week) with the aim of removing about 1,000 people to EU countries before the end of the Brexit transition period and the UK's departure from the EU Common Asylum System operated under the Dublin III regulations on 1 January 2021. After that point, it would not be possible for the Home Office to remove people to the EU country that they had previously been through. During that period, as I explain further below, the majority of people detained were new arrivals from small boats.

7. The majority of referrals we received from Brook House during the relevant period of time were for Medico-Legal Reports ("MLRs") to assess the nature and extent of the detainee's vulnerabilities and whether and to what extent that impacts on continued detention. We were also often asked to undertake urgent medical assessments in advance of removal action on fitness to fly issues. Often the urgent clinical assessments would also reveal indicators of past torture or trafficking which had not been picked up previously and only at a point in time when the person is facing imminent removal. This has consistently been the case since Brook House was opened in March 2009. During the

charter flight removal programme from August to December 2020, the demand for urgent clinical assessments increased as a proportion of the population of deatined people, as compared to previously, because most detained had been issued removal directions, although often without any consideration of their medical condition or their immigration case.

Relationship with Home Office

8. As we are mostly asked by legal representatives to conduct clinical assessments of their clients and produce an MLR report, we leave communications with the Home Office on behalf of detainees to their legal representatives. We would complete the MLR and give that to the legal representatives to advise the detainee on whether or how to use the report. We have no say in that consideration.

9. There are occasions where a client referred to us did not have a legal representative. We would assist the detainee to find a legal representative or signpost him to the Detained Duty Scheme for legal advice and assistance. If, in the interim, there was an urgent medical concern about the client that we consider that the Home Office ought to be made aware of, then we would, pass on those concerns but make clear that we were not the detainee's legal representatives. The Home Office seldom provide any substantive response to our letters of concerns; sometimes they would provide us with acknowledgment of the letter but tell us that they were unable to enter into correspondence with us about confidential matters concerning the client and would therefore write to the client directly to respond to our clinical concerns.

10. Sometimes we also contact the Home Office's Detention Engagement Team. where the client is not legally represented, or the legal representative could not be contacted, and the client asked us to do so. This has happened more frequently of late, especially in relation to clients who are facing imminent removal but present to us with clear indicators of trafficking that have not yet been investigated by the Home Office (acting as the Single Competent Authority, with responsibility for victim identification). The Home Office's policy on trafficking is to not remove a potential trafficked victim pending an investigation into their circumstances. Whilst normally, we consider it more appropriate for referrals for identification of a potential victim of trafficking or modern slavery to be better dealt with by a designated First Responder, such as The Salvation Army, the Home

Office's main contractor, this is, unfortunately, difficult to achieve. This is because the Salvation Army has taken the view that where a potential victim is in detention, the referral should be made by the Home Office itself. The problem is the reason a referral has not been made is because the Home Office has failed to do so, which is why the detained person is at risk of imminent removal without having gone through the victim identification process. The Salvation Army's unhelpful position and the Home Office's own failure to identify victims of trafficking put us in a position where we feel we have to do what we can to protect the detained person's position prior to removal, at least until they have had their circumstances properly considered through the trafficked victim identification process. The situation is wholly unsatisfactory and it should not really be down to small NGOs like ours to act to protect a vulnerable detained victim of trafficking.

Relationship with Healthcare

11. As a clinical organisation, our casework team had (and continues to have) fairly regular contact with the healthcare unit at Brook House. We have to contact them to book visits, and make request to them for healthcare records for the preparation of MLRs.

12. Requests for healthcare records have to be made in writing. The turnaround time can anytime between one day and several months. Sometimes, if the MLR is urgent, we will contact the healthcare unit by telephone to chase up requests for medical records, or alternatively, we would ask the client's legal representatives to chase this up.

13. We did not log any systemic issues with booking appointments for medical assessments for clients during the relevant period, although it would be normal for our doctors to have to wait for half an hour or more for the detainee to be brought to the assessment room to see the doctor. Our volunteer doctors would normally be provided a room in which they can conduct the clinical assessment. The healthcare unit accommodated our volunteer doctors when they asked to see the client again or arrange for the client to see a doctor of another specialism because of clinical issues identified in the initial appointment. But that is rare as our doctor try to complete the assessment in one session if possible.

14. Beyond the administrative processes, we had very little interaction with Brook House's healthcare unit, but not by our design. When our doctors came across urgent clinical concerns or treatment needs in the course of the clinical assessments, we would routinely

send on a letter from the doctor to the healthcare unit to alert them to the medical concerns. This could relate to concerns that the client presented as mentally unwell, as lacking mental capacity ot make decisions about his welfare, treatment or detention or presenting with risks of self-harm or suicide. If our clinician considers that a review by the treating GP is needed or onward specialist referrals are necessary owing to the detained person's physical or mental health, we would also contact the healthcare unit to invite them to action those referrals. We very seldom got any feedback from the healthcare unit as to whether any action was taken in response to the clinical concerns expressed by our volunteer doctor. It was extremely difficult to get any feedback. Sometimes we would call just to establish that the healthcare unit had received our letter by fax or email. When we telephone, we never get to speak to the GP, only the administrator and only to find out whether our clinical letter had reached the right person for consideration. It is rarely possible for our volunteer doctors to have a clinical discussion with either a GP or a nurse at Brook House about a client's medical concerns, unless it concerns an immediate risk of harm, in which case we have been able to speak to a relevant clinician about our concerns. Often we would only find out what if any actions had been taken by healthcare by getting an updated copy of the healthcare records.

15. I have been shown statements submitted by G4S Healthcare from Karen Churcher, who was at the relevant time a Senior Registered Mental Health Nurse at Brook House, and from Michael Wells, a Practice Manager for Brook House's healthcare unit. They have both made unparticularised allegations about Medical Justice's conduct which I would like to respond to below.

Karen Churcher

16. I have not had any direct contact with Karen Churcher, but am aware of her role at Brook House from reviewing healthcare records of clients where she has been involved in their care.

17. At paragraph 50 of Ms. Churcher's witness statement to the Inquiry (DWF000003_0001), in the context of addressing her relationship with the Home Office, she said that:

> *"I have a vague recollection that I once raised an issue with the Home Office that was investigated. Medical Justice were sending their representatives to talk to the*

detainees and I noticed that three reports had been received from Medical Justice, written by the same person. All three reports were exactly the same in content and only names had been changed. I raised it with the Home Office and it was discovered that the Doctor had not been there on one of the occasions and had not even examined the detainee. I'm not sure what the outcome of this investigation was, but I remember I was told about this as it had been escalated to more senior colleagues. Unfortunately, I can't remember any further information or detail about this incident".

18. I was shocked by this allegation, which if true, would be a very serious one, especially if a doctor produces an MLR without seeing the client. Ms. Churcher does not name the Medical Justice doctor who is alleged to have done so or give any indication of when this happened. However, I have investigated this allegations by looking back at our log of complaints, not limiting it to the relevant period but for the whole time that I have been the casework manager (i.e. since 2009). I cannot see that there has been any complaints brought to our attention of this nature from Brook House, another IRC or by the Home Office.

19. I note that Ms. Churcher states that the issue was escalated to a senior manager and then to the Home Office. She does not name the senior manager or who at the Home Office the issues was escalated to. It surprises me that, if it was serious enough that a senior manager was involved as well as the Home Office, that Medical Justice was not approached about these concerns at all, and this issue has not been mentioned by any other G4S Healthcare witness.

20. We have clear processes for the production of an MLR, including a rigorous peer review process before an MLR gets sent out of the organisation, including to a detainee. All MLRs are reviewed in draft form by either a senior caseworker or myself. It is then sent for a clinical peer review by one of a small group of reviewers we have. The current clinical reviewing team is four experienced volunteer doctors including one psychiatrist, Dr. Bingham and Dr Allinson. The clinical review will have access to the same background documents that the volunteer doctor was provided for the assessment. The reviewer would be expected to look at the medical documents alongside the report, as a minimum.

21. The clinical reviewing team meet regularly as a group to ensure quality control and to discuss difficult cases and emerging themes from the MLRs. The aims of the clinical reviewing process are to ensure objectivity, readability and that the conclusions clearly follow from the clinical findings, and the report addresses all relevant questions. It is a detailed process and it is common for discussion to take place between the reviewer and the author of the report before the report is finalised.

22. The reason that we have this process is to ensure a consistent quality of reports. This makes it highly unlikely that a doctor having difficulty in their assessments or report writing would go unnoticed. It also makes it implausible that generic reports with limited if any relevance to the individual would be provided by Medical Justice.

Michael Wells

23. I have interacted with Michael Wells, as the healthcare manager, when booking medical visits for our clinicians and when sending follow up letters from our clinicians with concerns regarding clients. When booking visits, he usually responded promptly and has been helpful in assisting us with our bookings.

24. At question 12 of Mr. Well's Rule 9 statement to the Inquiry (DWF000004_0001), he was asked to set out his understanding of Medical Justice's role, involvement at Brook House and the nature of any interaction or communications that Mr. Wells had with us. He states in his statement in respect of Medical Justice that:

> *"Medical Justice provide supportive legal aid. They are a registered charity and we would have regular dealings with them during information requests and site visits by practitioners to carry out assessments on residents.* ***One of the medical practitioners from Medical Justice was very rude and abusive to staff. He was very abrupt in his manner and was a very challenging individual with us*** *but always appeared to be supportive to the residents, however these consultations were in private".*

25. I was surprised to read about the assertion that one of our doctors had been rude and abusive to healthcare staff. I checked the log of complaints that we keep and I could not see any concerns recorded from Brook House at any point about this, either at the time in 2017 or thereafter. I would normally expect that this sort of concern would be raised with us by Brook House healthcare so that as an organisation we can take appropriate

action. We do not condone our volunteers being rude and abusive to anyone, whether it is a detainee or staff at the detention centre. As part of their training, all new volunteer doctors initially shadow more experienced volunteer doctors. They also start undertaking assessments by doing this jointly with a more experienced doctor. This also allows us to see how they interact with the detainee, detention centre staff and healthcare staff in the context of an IRC visit.

26. We have only had one case where several complaints were made about the attitude and conduct of a Medical Justice clinician but this was more than 10 years ago. Action was taken as a result and he has not worked with Medical Justice since 2011.

27. Mr. Wells does not identify the clinician who is said to have been abusive or rude to staff but identifies him as a male doctor who had been to Brook House for more than one consultation. I therefore checked our records to see which male doctors had been to Brook House twice or more since January 2017. There were only two doctors: Dr Joe Bourdillon-Schicker and Dr Hugh Grant-Peterkin Both have volunteered with Medical Justice for a number of yours and Dr Bourdillon-Schicker is now employed as a member of staff. . As I said, I cannot see any record of any concerns raised with Medical Justice about their behaviour or attitude by anyone, whether from Brook House or from any other IRC.

28. I therefore am not in a position to comment on the experience Mr. Wells is referring to. Further to my checks, it does not appear to us that the doctor referred to by Mr. Wells is a doctor who is employed or volunteers with Medical Justice.

29. Before leaving the topic of Medical Justice's relationship with IRC healthcare at Brook House, I should add that we are frankly surprised to learn of these allegations made against Medical Justice in witness statements to the Inquiry for the first time. We are always willing to engage with IRC healthcare or the Home Office where there are complaints raised about our clinicians or staff. We do not, however, feel it is acceptable for these witneses to cast aspersions on the integrity of our clinicians in this way without particulars or documents to support these bare allegations. Our clinicians are independent and attend the IRC in good faith to investigate clinical concerns that appear on the face of the documents and information provided to us on referral to require such investigation.

They are in no different position to any clinican and bound by their relevant codes of practice. Of course if there is a well-founded complaint, we will deal with it accordingly as is the right thing to do.

C. Case Studies of Ill-treatment at Brook House

Methodology

30. We carried out an initial sift of our database when the Terms of Reference were published for the Inquiry, and identified a possible 110 individuals who appeared to have been held at Brook House in 2017. A further sift led to the identification of 44 individuals who appeared to have been at Brook House during the relevant period of time. This sift was done without looking at the documents that we had in respect of each individual.

31. We then looked at the documents we held in respect of each of the 44 individuals in further detail. We eliminated six cases of detained people whose documents do not show they were held at Brook House during the relevant time in 2017. In six further cases, the individual's detention at Brook House was either too short (a few days) or the documentation we held on our database was too limited to carry out any constructive analysis of the person's treatment at Brook House.

32. We did not consider the documents of three Medical Justice clients who had already been appointed Core Participants by the Inquiry as at September 2020. This left us with 29 case files pertaining to Medical Justice clients who were detained at Brook House during the relevant period.

33. Medical Justice contacted each of these individuals at their last known contact details to inform them of Medical Justice's role in the Inquiry and to seek their consent to use information held in respect of them for case studies as part of our evidence to the Inquiry.

34. Through this process, Medical Justice was able to establish contact with four former detainees who were not already involved in the Inquiry and who gave consent for the use of their documents to be used as long-form case studies, subject to their names remaining anonymous. Medical Justice was able to obtain further documentation in relation to these detainees through subject access requests ("SAR") to the Home Office to gain a more

complete picture of their experience in detention. We seldom have a complete set of documents at the point of referral, or even at the point when we complete the MLR. We would also have no access to Home Office documents other than what the legal representative or the client provide us at the point of referral and often at the point of assessment. Even the Home Office records we have obtained for the purposes of these case studies will be incomplete because disclosure obtained through the Subject Access Request process has been limited to what is held electronically by the Home Office and will not include any handwritten or paper-based internal records such as ACDT, Rule 40 / 42 segregation records and Use of Force documentation. Sometimes IS91 RA Part Cs will be included in the medical records if they have been sent by IRC healthcare, but not always. Sometimes even Rule 35 reports completed by healthcare are not included in the medical records, although the records may refer to an entry about it. Nevertheless, as we were able to make contact with these four detainees, we were able to speak to them directly about their experiences at Brook House and record their accounts in their own words. Their experience at Brook House has been produced in long-form case studies.

35. Despite concerted efforts, Medical Justice was unable to establish contact with the remainder of the clients to obtain consent to seek further disclosure of relevant documents and to obtain specific instructions to be taken about their experience at Brook House. By this point nearly three years had passed since the events in 2017. It is very possible that a number of them may have been removed from the country and others were impossible to trace without current contact details. However, on further review, Medical Justice identified a number of clients who had had representation from Duncan Lewis or Deighton Pierce Glynn either during their detention at Brook House or more recently. As both firms represent some of the non-state Core Participants and witnesses in the Inquiry, we approached them to ask for their assistance to reach some of these clients. We were able to receive agreement from eight clients of DPG / Duncan Lewis to use information that Medical Justice already has on its database in respect of them; one client did not give us consent so we have excluded his case from the case studies.

36. In the remainder 16 cases, we considered there to be sufficient documentation on our data base – IRC medical records and some Home Office documents – related to their time at Brook House (and several clients were moved between IRCs) to carry out a meaningful analysis.

37. Shorter case studies have been produced pertaining to these and the DPG / DL cohort of individuals, based on the more limited documentation available to us.

38. As the Inquiry did not produce a list of ciphers with corresponding names of detainees, it was not possible to marry up our clients with the Inquiry ciphers for all formerly detained people, but where it has been possible for us to identify a client by a cipher, we have done so, and have checked the Inquiry's disclosure platform for any additional relevant disclosure and reviewed that accordingly. Those clients with long-form case studies have given us consent to use initials to identify them. Otherwise, detained persons whose ciphers are unknown are identified using Medical Justice's internal case reference.

39. All 28 case studies are annexed to this witness statement at **Annex 1**.

Summary of key thematic issues

40. Contemporaneous records provide only an incomplete and documentary snapshot of an individual's time in detention. They cannot capture a detainee's direct experience of, for instance, the everyday attitudinal abuses and indifference of Brook House staff culture nor, for obvious reasons, unchecked acts of deliberate mistreatment. Such experiences will be spoken to in the direct testimony of former detainees giving evidence to the Inquiry. However, these case studies provide a clear overview of the structural failings in respect of the care and treatment of individuals detained at Brook House with serious mental illness, which serves as important context to understanding the overt deliberate acts of physical ill treatment and abuse that occurred, or may themselves be seen as mistreatment which constitutes inhuman or degrading treatment in breach of Article 3 ECHR.

41. The key themes that emerge from these individual case studies highlight fundamental defects in the operation of statutory safeguards and the Adults at Risk policy as well as other safeguards for preventing detainees from being harmed. They are as follows:

    a. Failure to conduct a Rule 34 mental and physical examination, and consequential failure to trigger a Rule 35 report;
    b. Failure of health screening to trigger Rule 35 assessments / reports;

c. Failure to identify mental health problems and consider their relevance to the impact of detention to the detained person;

d. Failure to operate Rule34/35 proactively; instead of waitingfor detainee to request a Rule 35 assessment;

e. Delay in assessments and preparation of R35(3) reports

f. Refusal to prepare a R35(3) report where there is a previous report;

g. Defective Rule 35 assessments and reports, in particular failure to consider the impact of continued detention at all or properly and risk of harm to detainees;

h. Failure to produce Rule 35(1) reports;

i. Failure to issue a Rule 35(2) report, where there are suspicions of suicidal risks;

j. ACDT Process as (i) a containment strategy with little therapeutic purpose; and (ii) disconnected from Rule 35 and the Adults at Risk policy.

k. Inability of the Rule 35 process to properly identify indicators of trafficking and modern slavery;

l. Defective Rule 35(3) Responses and Misapplication of Adults at Risk policy;

m. Failure of the AAR policy to identify those at particular risk of harm in detention;

n. Failure of the AAR policy to secure release of vulnerable detainees with a history of torture or trauma-related mental illness or other serious mental illness and evident risk of harm or further harm in detention;

o. Defects in the approach to identifying, assessing and safeguarding those detained persons who lack or may lack mental capacity to make decisions about detention and their welfare and treatment in detention;

p. Inappropriate routine use of Rule 40 / 42 to remove vulnerable detainees from association.

42. I have addressed thematic deficiencies identified above that concern casework. Where the deficiencies concern clinical care and judgment, Dr. Bingham, our clinical advisor, has addressed them in her witness statement in view of her clinical expertise. The two statements therefore need to be read together as Medical Justice's analysis of and identification of the failures in the safeguards for protecting vulnerable detained persons from harm in detention.

43. We have not been able to document and address our clear concerns about the use of force on vulnerable detainees of the kind shown on the BBC Panorama programme through our case work. This is because documents pertaining to the use of force are not included in standard disclosure from the Home Office and are not included in medical records when those are disclosed to us. Normally we only see such documentation when our client's legal representatives are able to obtain them in the course of litigation.

44. It is generally challenging for us to document the use of force. It is dependant on being alerted to the incident by the deatined person, another NGO or a legal representative, and having the capacity to allocate a volunteer doctor to visit the detainee swiftly to record any physical signs of injury. Otherwise, often bruises and other physical signs of injury may fade.

45. Dr. Bingham has however, had the opportunity to consider the documents disclosed by the Inquiry pertaining to the use of force on vulnerable detainees and her witness statement contains a summary of the conclusions that can be drawn from this extensive material and with the benefit of her clinical expertise. We have also been able to draw upon the expertise of Dr. Brodie Paterson who combines both clinical and use of force expertise. His witness statement is provided to the Inquiry for this purpose.

(1) <u>Failure to conduct a Rule 34 assessment</u>

46. My first witness statement explains the role of the Rule 34 medical examination and why it is an important safeguard. It is Medical Justice's experience that neither the Home Office nor IRC healthcare staff properly understand the difference between a Rule 34 medical examination and an initial reception health screening. At its most basic, Rule 34 medical examinations are to be conducted by a medical practitioner, defined in Rule 33 to be a GP or an equivalent qualified person under the Medical Act 1983, whereas reception healthcare screening is usually done by a nurse. The more important difference is that a Rule 34 medical examination should involve a physical and mental examination, a primary purpose of which is to assess whether there are clinical concerns that a person may have been a victim of torture or other forms of serious ill-treatment or he is likely to be injuriously affected by detention, such that the medical examination should result in a Rule 35 report notifying the Home Office of the case. In this way, Rule 34 functions as a first line safeguard for prompt identification of adults at risk who are vulnerable to

suffering harm if detained for those who were not "screened out" of detention by the Detention Gatekeeper. It is also the mechanism by which the Home Office discharges its duty of enquiry to make a properly informed decision about whether detention is consistent with published policy.

47. However it is apparent from the case studies that we have reviewed, Rule 34-compliant medical examinations are not routinely done within 24 hours of the detainee entering the IRC or at all. The failure to do so been held by the courts to be unlawful: see for example *EO v SSHD [2013] EWHC 1236 (Admin); R (SW) v SSHD* [2018] EWHC 2864 (Admin) and *R (KG) v SSHD* [2018] EWHC 1767 (Admin). This is because the failure or delay in operation the Rule 34 safeguard leads to vulnerable detainees remaining in detention for longer, possibly unnecessarily and in breach of policy, exposing them to risks of harm and ill-treatment. See for example:

a. **D2567** is an Iraqi national and a victim of torture with a history of sexual assault, torture and exploitation and trafficking by agents in Turkey. He disclosed his history of torture and active self-harming ideation and attempts, and showed the nurse at the reception health screening scars on his arms from past self-harming. However, he was not seen by a GP for a Rule 34 medical examination within the first 24 hours during his time at Brook House. He self-harmed on the first night of being detained there. Although an ACDT was opened with hourly watch because of that, no arrangements were made for him to see a GP until the 4th day of his detention. The GP (Dr. Chaudhary) recorded mental health symptoms and a history of sexual abuse and prescribed anti-depressant medication, but appeared not to have done a physical examination. Nor did Dr. Chaudhary consider the need for a Rule 35(3) report in the light of RS' disclosure. The impact of detention was also not considered. RS only got a Rule 35(3) assessment (completed by Dr. Oozeerally) because he specifically requested one, nearly two weeks after being detained.

b. **MJ8375** is an Indian national with a history of torture and a history of self-harming and suicidal ideation. He was seen by a GP (Dr. Chaudhary) the day after arriving at Brook House IRC, but did not have a physical and mental examination at that time. It does not appear that hist history of torture or any vulnerability to suffering

harm in detention was explored at all. Despite being a victim of torture and sexual violence with numerous scars and trauma-related mental ill-health, in the absence of a Rule 34 examination, he was not seen for a Rule 35(3) assessment (Dr. Oozeerally) until 3 weeks into his detention at Brook House and it was only then that he was identified as an Adult at Risk with Level 2 risk evidence.

c. **D668** is a national from the Ivory Coast. He reported a history of torture during his reception healthcare screening. He was seen by a GP (Dr. Chaudhary) at Brook House 2 days later (having been returned there following a failed removal attempt). According to the healthcare records, no physical or mental examination took place and his history of torture was not explored with him. The need for a Rule 35 assessment was not identified until AKO expressly requested this assessment two weeks later. A Rule 35(3) was therefore only carried out almost a month after AKO arrived at Brook House and he was identified as an Adult at Risk Level 2.

d. **D1318** is a Pakistani national with serious limb injuries attributed to torture by the Taliban. He suffered from pain in both feet due to deformity; he had no toes on either foot. He could not walk with shoes, had reduced mobility, requiring a wheelchair / crutches to walk. Although it was self-evident that he had physical disabilities, and his account of torture was disclosed at a reception health screening when he was first detained at Brook House, and, although he did have an appointment with a GP (Dr. Oozeerally) within 24 hours of arrival at the IRC, it appears from the records that the appointment was extremely brief and no physical or mental examination is recorded despite what would appear to be obvious physical disabilities. He was advised to bring his walking stick in from home and ibuprofen was prescribed for the foot pain. On the face of the records, no consideration was given to his vulnerability to suffering harm in detention and or to the need for occupational therapy input at the outset. A physiotherapy referral was only made a week after arrival in Brook House when it was obvious that he required walking aids. As a result of having no walking aids, he fell in the shower. He wrapped a plastic bag around his foot to ease the pain. No questions were asked about the context of the fire that caused his physical disabilities despite it having been identified as 'torture' in the initial healthcare screening.

(2) Disclosure of torture at health screening or subsequent nursing appointments does not trigger a Rule 35 assessment and report

48. All detainees are subject to an initial health screening when they arrive at Brook House (or another IRC). The health screening is primarily for the purposes of identifying immediate medical needs to inform any medical treatment decisions. But the health screening pro forma, used at Brook House at the time, and at other IRCS, included a question directed at eliciting information about whether a person had suffered past torture. It is usually posed as a Yes / No answer, but gives detainees, who feel able to disclose, an early first opportunity to indicate their vulnerabilities arising from past torture or serious ill-treatment. If a detainee answers "Yes" to the torture question, that should trigger a referral to an IRC GP to investigate and consider whether to raise a Rule 35 report even before the Rule 34 medical examination has taken place.

49. A number of the case studies reviewed showed that at the time at Brook House, health screenings were failing to identify the need for a Rule 35 assessment either because the health screening failed to explore where there was a history of past torture, or because where it was disclosed, no steps were taken to arrange a Rule 35 assessment. In circumstances where the Rule 34 mechanism also did not function properly or at all to identify indicators of risk requiring a Rule 35 report, the failure of the health screening to prompt such a report meant that the two safeguards early on in a person's detention were incapable of operating as an effective tool to screen out people who are potential adults at risk who would be vulnerable to suffering harm in detention, and therefore expose such people to risks of being harmed by being detained and being unsuitable for detention.

50. The facts of the case studies where this has occurred illustrate the significant detriment that can be caused to detainees of prolonged detention in the absence of a Rule 35 assessment to identify whether they are Adults at Risk and assess the impact of detention and continued detention upon them. See for example:

    a. **MZA** is a Turkish national and a victim of torture who was beaten violently and raped. He was detained on reporting. Prior to detention he had been treated for severe PTSD arising from his torture by a psychologist. He disclosed thoughts of

self-harm by using a razor and biting himself and suicidal ideation to the mental health nurse who carried out the health screening. He asked for a knife or razor. Scars were observed and he was put on ACDT, but no consideration was given for a Rule 35(3) report in view of the scars. Nor was a report considered under the other two limbs of Rule 35 despite his disclosure of active suicidal ideation and self-harming ideation. Although he was put on ACDT, the fact of his clinical vulnerabilities was not formally alerted to the Home Office. He did not receive a Rule 35 report of any kind for the first month of his detention from 17 July to 21 August 2017. He had to request one on 9 August 2017 before a Rule 35(3) was carried out.

b. **D1318** is a Pakistani national whose serious limb injuries were attributed to torture by the Taliban. He disclosed an account of torture at his reception screening. However no referral was made for a Rule 35(3) assessment during the whole month that he was detained at Brook House. He was therefore not assessed and considered under the Adults at Risk framework and not identified as vulnerable and at risk of harm for that purpose.

c. **D13** is a Sri Lanka national whose history of torture was already known on his arrival at Brook House, but the healthcare screening wrongly recorded no concerns about torture so it did not trigger a Rule 35 assessment. He subsequently repeated his torture claim to healthcare staff on four separate occasions. He also told a GP (Dr. Oozerally) that he felt suicidal and had nightmares about what happened to him in Sri Lanka. However, no consideration was paid by the GP to the need for a Rule 35 report. A referral for a Rule 35 assessment was finally made, a month after being at Brook House. D13 faced a serious delay of four months from first raising his torture claim to being referred for a R35 assessment. During this time, he reported active suicidal ideation.

d. **D745** is a Sri Lanka national with a history of detention and torture and had already been diagnosed with PTSD together with psychotic depression in an MLR that had been submitted to the Home Office prior to his immigration detention. He disclosed a history of torture including being beaten with a stick and cut with a knife to his left lower leg. He also disclosed a history of attempting suicide by overdosing and

that he was on anti-depressant medication. But he was not referred for a Rule 35 assessment until he requested one over a week after being detained at Brook House and a report was only completed 2 weeks after his arrival.

(3) Delays in completing Rule 35 assessments

51. In addition to multiple cases showing a failure to initiate Rule 35 assessments on disclosure of torture and other indicators of vulnerabilities as an Adult at Risk on screening , the case studies also show a disconnect between the Rule 34 medical examination and the production of a Rule 35 report as an outcome where it is appropriate. Because the Rule 34 examination and Rule 35 reporting have been decoupled (not because that is what the DCRs intended), there are then marked delays and waiting time between referral for a Rule 35 assessment and the resultant assessment being conducted. The delays of up to several weeks undermine the operation of this statutory safeguard against continued detention of those who may be vulnerable and particularly at risk of harm if they remain detained. The intention in the Rules and policy is for the Rule 35 assessment to be undertaken as part of the Rule 34 medical examination within 24 hours of the person first entering detention and so that the individual's status as an Adult at Risk can be promptly considered and acknowledged, and consequential decisions on detention and substantive immigration matters reviewed in the light of this.

52. Examples of delay include: **D56**, a Chinese national with a history of torture resulting in numerous scars was referred for a Rule 35 assessment after disclosing a history of torture within his first week of detention. However, he faced a delay of 10 days before undergoing his Rule 35 assessment. In **MZA**, the Rule 34 / health screening / mental health review mechanism failed to trigger a Rule 35 assessment despite repeated disclosure of an account of torture to the nurses. He himself requested a Rule 35 report but it was only undertaken three weeks later. In **D735** a request for a Rule 35(3) report was made through his legal representatives (despite disclosing a history of torture at health screening) but did not get an appointment for 12 days.

(4) Refusal to prepare a R35(3) report

53. There is no limit in the Rules as to the number of Rule 35 assessments that a person can undergo during their immigration detention. However in several of the case studies, IRC

doctors have refused to conduct a Rule 35 assessment because there had been a previous assessment. In these cases, no or no adequate steps were taken to consider whether there had been a material change in circumstances or new disclosure not previously considered.

54. In some cases, the IS91 RA Part C form was completed instead. Whilst that form is sent to to the Home Office, it was held by Ouseley J in *R (Medical Justice and 7 Ors) v SSHD* [2017] EWHC 2461 (Admin) (at §166), the IS91 RA Part C *"is not a substitute"* for a Rule 35(3) report.

55. Moreover, there is no statutory or policy mechanism which obliges the Home Office to consider an IS91 RA Part C by reference to the key question of whether (a) the document shows that the individual is an Adult at Risk; and (b) the decision to detain should or can be maintained in the circumstances, applying the Adults at Risk statutory framework. Thus the refusal to carry out a Rule 35 assessment or complete a report to be notified to the Home Office means, critically, that the individual detainee, who is an Adult at Risk, is deprived of a crucial safeguard against his continued detention.

56. The other problem with the refusal to do a further Rule 35 report where a previous one exists is that it deprives healthcare and the Home Office decision-maker of the opportunity to identify and consider any new information about the person's mental state presentation. Therefore, even if at the time of the first Rule 35 report, the doctor took a view that there was no clinical concerns that the detained person may be at particular risk of harm in detention; the passage of time and prolonged detention may well lead to a different clinical conclusion. By refusing to consider a further Rule 35 report, the doctor in effect is shutting his mind to possible evidence of deterioration, and similarly the Home Office is then without further information about the ongoing impact of detention.

57. Thus, for example:

    a. **D1225**, an Afghan national who was already in receipt of a Rule 35(3) report completed when he was at Heathrow IRC before he was transferred to Brook House. He expressly requested that a further report be prepared on the basis of an error in the previous report. He also disclosed a new allegation of rape which he had not previously disclosed and therefore was not captured in the previous report.

Notwithstanding this, the GP (Dr. Oozeerally) refused to carry out a further Rule 35 assessment on the basis that one had already been on the same events. Instead, the doctor used the IS91 RA Part C form to inform the Home Office of the additional disclosure. The GP accordingly failed to investigate whether D1225 was suffering from any psychological symptoms or mental health concerns arising from this specific trauma and the extent to which the current detention was impacting upon him.

b. **MJ7771**, a Pakistani national was in receipt of a recent R35(3) report, which the Home Office had accepted was evidence that he was a victim of torture and an Adult at Risk (risk level not specified) but maintained his detention on the basis of removal within a reasonable period of time and an absence of evidence of deterioration in his mental health as a result of immigration detention. After transferring to Brook House, he was referred for a further Rule 35(3) assessment based on disclosure of a history of torture, but was feeling unwell and could not proceed with the Rule 35 assessment with the GP (Dr. Ooozeerally) on the first occasion. He reported difficulties breathing, chest pains and symptoms of a panic attack. During a mental health assessment a few days later, he disclosed a detailed account of torture and distressing psychological symptoms triggered by being locked in his room at the IRC. At the second appointment, he was told by the GP (Dr. Oozeerally) that the Rule 35 assessment would not be completed because he had previously already had one. There was no assessment or documentation of his mental health despite the symptoms recorded the previous day by the mental health nurse which were attributed to the torture history and linked to the experience of detention and despite these symptoms not having been addressed in his previous Rule 35 report. These symptoms may well bear on the question of impact of detention materially differently from the previous report, but without a Rule 35 report, that vital information is simply not put before the Home Office.

c. **D2077** is an Iranian national who had previously had a Rule 35(3) report whilst detained at Tinsley House in 2016. This report, which had resulted in his release from detention, recorded his extensive physical torture and consistent scarring, as well as his trauma-related psychological symptoms which were compounded by detention. On being re-detained at Brook House in mid-2017, D2077 was identified as

a victim of torture in his reception screening but no Rule 35(3) referral was made. Several days later, D2077 sewed his lips together and started to refuse food in protest at his detention. He informed healthcare that he had a previous Rule 35(3) report which confirmed he was tortured, however nothing was done. He repeatedly asked to see a GP for a further Rule 35 assessment. When he finally saw the GP (Dr. Oozeerally) several days later, his lips still sutured, he confirmed that the previous Rule 35 had resulted in his release and stated he was suffering from poor sleep, anxiety and nightmares, linked to traumatic memories brought on by detention. D2077 also reported that he had also been subjected to sexual torture, which he had not previously disclosed as he felt unable to do so with a female GP. Instead of completing an updated R35(3) report to address the additional disclosure, the GP submitted an IS91RA Part C form to the HO reporting his further disclosure, the fact he had sown his mouth shut and (very briefly) D2077 account of his current symptoms. Although the GP noted trauma-related symptoms (nightmares, poor sleep, anxiety), he did not address the impact of re-detention on D2077 mental state and the Part C records no clinical opinion by the doctor.

(5) <u>Defective Rule 35 assessments and reports</u>

58. Although the Rule 35(3) template, amended further to the introduction of the Adults at Risk statutory framework, directs doctors to focus not only on the documentation of scars indicative of torture but also to address mental health and psychological indicators of ill-treatment and the impact of detention, many of the Rule 35 reports reviewed in the case studies reveal serious failures to address these matters crucial to the identification of vulnerabilities putting the detainee at risk of harm if they remain detained. This correlates with a similar phenomenon noted in a review of all Rule 35(3) reports disclosed on the Relativity platform. Thus for example:

a. The Rule 35(3) report for **D13** (completed by Dr. Oozeerally) referred to having some sleep disturbance and nightmares arising from his history of torture but no recognition that these symptoms were likely to be trauma-related, and no consideration of how detention may impact on these trauma-related. The report recorded that there were no concerns over **D13**'s mental health, without any accompanying rationale or assessment of his extant symptoms. This was

notwithstanding **D13's** having been referred and accepted onto the Mental Health Team's caseload at the time. He also had an ACDT opened, having reported specific traumatic symptoms and suicidal ideation. The R35(3) report also failed to assess whether he was at risk of further deterioration and whether the period of detention would be likely to cause harm.

b. The Rule 35(3) report (produced by Dr. Oozeerally) in respect of **JS** noted that he had made multiple attempts at suicide in the past, and he was anti-depressants but does not consider information in the medical records referring to his suffering from current serious psychological symptoms and self-harm ideation since his admission to Brook House. Despite this, the R35(3) report, in the assessment' section simply recorded that he "appear to be suffering mental health issues", giving no particularity, and no view as to his nature or extent. The report recorded there had been no deterioration in his mental health since detention, despite previous healthcare records showing that he had gone from reporting no thoughts of self-harm to having such thoughts on a recurring basis, and feeling anxious and stressed due to detention. There is no indication that the impact of detention was explored with JS in the assessment and the report makes no comment on the likely impact of continued detention. A subsequent MLR, post-dating JS's time at Brook House, confirmed his clinical deterioration, advising he was unsuitable for further detention.

c. The Rule 35(3) report (completed by Dr. Oozeerally) for **D1525** noted to suffer from flashbacks, anxiety and fear but did not consider whether these indicate PTSD / trauma-related symptoms and the current and ongoing impact of detention on OA in the circumstances. A subsequent MLR assessment arranged by Medical Justice resulted in a psychiatric diagnosis of PTSD and the finding that continued detention was exacerbating his condition. He was released on bail on 1 August 2017, shortly following this assessment, having spent over three months at Brook House.

d. During his Rule 35(3) assessment, **D668** showed the GP (Dr. Chaudhury) various scars to his back and limbs. The Rule 35(3) simply recorded the scars 'may be' due to his account, without reference to an accompanying body-map or any clinical assessment of the consistency of the scarring with his claims. The Rule 35(3) report

also did not assess or document the psychological symptoms of **D668's** torture, despite his having been already assessed as suffering from long-standing PTSD symptoms in the community. No consideration was paid to the impact of further detention on his mental state. A subsequent PSU investigation into various complaints made by **D688's** concerning his time at Brook House criticised the 'concerning' omissions in the R35(3) report, finding that the GP failed to provide a clinical assessment of the scarring or the impact of continued detention. It was found that the GP should have completed this assessment, even if he considered there was no negative impact from detention, rather than leaving it to the Home Office to infer.

e. The Rule 35(3) report that **D523** received noted his history of torture and that the scarring to his arm 'may be due' to his account, finding his story consistent. However, the report failed to document or assess whether **D523** suffered from any psychological symptoms consequent to his torture, or the likely impact of current and continued detention. He subsequently was placed on ACDT further to a period of forced removal from association and an attempted suicide. He was later diagnosed as suffering from PTSD and drug-induced psychosis, having self-medicated using spice and cannabis to manage the impact of detention.

(6) <u>Failure to produce Rule 35(2) reports</u>

59. Rule 35(2) states that:

> *(2) The medical practitioner shall report to the manager on the case of any detained person he <u>suspects of</u> having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.*

60. As was highlighted in my first statement, Home Office data for Brook House shows that no Rule 35(2) report was made at all in 2017 in Brook House, or for the preceding year (2016) or the two years after (2018 and 2019). The data across IRCs also paints a dismal picture of a failure to use Rule 35(2) to raise suspicions of suicide intent and thereby leading to a review of the detention of vulnerable detainees. This has been a long-standing concern, in inspection reports, independently commissioned reports, and has

also been recorded in findings of fact made by the jury and coronial reports concerning inquests of detainees who had died in IRCs, discussesd in Emma Ginn's witness statement. This has also been confirmed in Medical Justice's case studies. It appears to me that the Rule 35(2) safeguard is so dysfunctional as to be stripped of any purpose in safeguarding vulnerable adults.

61. The consequence is that clinical investigations are also not conducted in any focused way on the significance of suicide intent, its underlying causes and no assessment is made of the impact of continued detention nor the impact of the use of ACDT, constant watch/monitoring and segregation in the CSU or Rule 40 on E Wing as a containment and not a treatment strategy. Dr. Bingham's witness statement addresses this further and the link between self-harming risks and the need to properly assess those risks in the context of suicide prevention, in line with NICE guidelines on self-harm.

62. In nearly half of the 28 case studies reviewed, the individual was put on ACDT monitoring because of known risks of or actual attempts at self-harm or suicide but in none of the cases was a Rule 35(2) report completed and notified to the Home Office. This is even so in cases where detainees are put on constant watch.

63. The evidence from the case studies and the Inquiry disclosure indicates that healthcare staff are unaware of their obligations under Rule 35(2). Alternatively, they wrongly believe that ACDT is the primary mechanism by which any self-harming behaviour or suicidality linked to mental health deterioration is to be managed, rather than a safeguard that should lead to review of detention under the AAR policy and an powerful indicator of harm. The case studies accord with what Mr. Shaw identified in his follow-up review ("Shaw 2") in which he noted very high numbers of ACDTs being opened between January 2016 and December 2017. This was particularly the case at Brook House which had 956 ACDTs open during this period. He noted the strain on the ACDT process given the numbers opened and the staff: see §§5.13, 5.15-5.16 of Shaw 2.

64. This approach shows the fundamental disconnect between the AAR policy framework and what happens on the ground in IRCs, and how this disconnect exposes detainees to real and immediate risks of suffering harm or ill-treatment by staff ill-equipped to deal with their complex needs .

65. It is not that ACDT is not an important internal mechanism at the IRC level to managing detainees who self-harm or express suicidal ideation. The problem is, as I have explained in my first witness statement, which is that an open ACDT does not result in any report to the Home Office of the vulnerabilities identified in the ACDT process, or a corresponding obligation on the part of the Home Office to address the individual's circumstances in the context of the AAR policy, the level of evidence of risk of harm caused by continued detention, and whether in the circumstances, the individual ought to be released.

66. The starkest examples from the case studies are the following:

a. **MZA**, who asked at the reception health screening for a razor or knife and disclosed recent self-harming by razor and biting. He was put on an ACDT. The next day, he saw a GP (Dr. Oozeerally) who recorded MZA as saying that when he hears keys jangling, it reminds him of past torture. Dr. Oozeerally also described MZA as "very flippant" about killing himself and that the only reason he had not done it was due to the lack of opportunity. However, and even despite the overt expressions of suicidal intention, no Rule 35(2) report was made in MZA's case. He was instead put on ACDT and subject to mental health reviews. During those mental health reviews he repeated disclosed continued self-harm and expressed a wish to be killed, and still no Rule 35(2) report was made.

b. **D1914** was admitted to Accident and Emergency after he severely harmed himself by cutting his arms and his neck with a razor and by taking an overdose of his heart medication. When he was returned to E wing on discharge from hospital, he was put on ACDT constant supervision. The medical records do not record any consideration of a Rule 35(2). Instead the records described the incident as "self-harm".

c. **D2077** notified the Home Office through his solicitors of his suicidal state prior to his re-detention, initially at Campsfield, and then at Brook House. He had previously taken an overdose, and had a history of self-harming by cutting his wrists. Further to transfer to Brook House, DS was placed on ACDT constant

supervision after sewing his lips together and starting to refuse food. The records noted questions asked as to whether he wanted to harm himself but no recognition that that was sufficient to have "suspicions" of suicidal intention for the purposes of a Rule 35(2) report, even if the intention was not established with any certainty.

(7) **ACDT used as a containment strategy and erroneously as a substitute for the Rule 35(2) safeguard**

67. Further to the points made above, it is important to recall what ACDT is actually for and the rationale behind the mechanism. ACDT is a process transposed from the prison custodial context. Very limited guidance is publicly available – in the form of Detention Services Order 06/2008, which simply states that the purpose of the ACDT process is to (i) identify detainees at risk of self-harm and / or suicide; and (ii) provide subsequent care and support for such detainees. However, the DSO gives very little information on how this process should work, who should to be involved in management and oversight of the process and more importantly, it is silent on the nature of clinical expertise and level of clinical input required to manage the process.

68. The DSO makes no reference to the AAR framework, does not recognise that a person put on ACDT may be an Adult at Risk particularly vulnerable to harm if detained or maintained in detention. It operates as an internal management tool and does not therefore direct ACDT reviews to address the question of the impact of detention on the detainee. Similarly, the AAR policy contains no provision by which information about vulnerabilities arising from the ACDT process is addressed as part of the decision-making on detention. Nor is the ACDT process connected at all with the Rule 35(2) process and therefore, it does not provide an evidential basis for informing decisions related to the detention of Adults at Risk. There is a consultation currently ongoing on amendments to the DSO on ACDT, which Medical Justice is responding to. The proposed draft that has been circulated does not adderss the flaws outlined above, and does not indicate that the Home Office has understood the problems with the ACDT mechanism.

69. Furthermore, and in practice, the case studies below illustrate that the ACDT process appears to have been operated with no or little clinical care input at the relevant time in Brook House. In reality, as the case studies show, the ACDT process operated as a crude

containment tool, transposed from the prison context without any appreciation or recognition that the two contexts are entirely different:

a. Prisoners are in custody for the duration of their sentence. Immigration detention, on the other hand, is discretionary and there is always the possibility of release (as opposed to containment and continued detention) and considering the impact of detention and risks associated with detention therefor needs to be a fundamental part of responding to risks of suicide and self-harm. The ACDT process, in use in the prison context, cannot therefore be transposed into the immigration detention context without understanding the fundamental difference between the two custodial settings.
b. The ACDT process also cannot be bluntly read across and must take into account the particular complex needs of immigration detainees which are frequently underpinned by histories of torture, serious ill-treatment and trauma-related mental illness.
c. ACDT supervision and monitoring is carried out by custody officers with no clinical expertise.
d. The ACDT process is not clinically led. Mental health assessments are not always carried out; the underlying cause of the self-harming and suicidal ideations very frequently arises from a mental illness which may be connected to a history of torture or serious ill-treatment but this is not identified or explored.
e. The ACDT process does not require concerns about ongoing suicidal risks and self-harm (especially in constant watch cases) to be notified to the Home Office. Even if concerns are notified, there is no corresponding obligation on the Home Office to consider this information and ask itself the crucial question as to the suitability of continued detention.

70. The ACDT process is also frequently accompanied by Rule 40 removal from association and segregation. (See further analysis below) ACDT and removal from association is associated with actual and risk of use of force to implement it. Case studies analysing this are in Dr. Rachel Bingham's witness statement.

(8) <u>Failure to produce Rule 35(1) reports</u>

71. Rule 35(1) states that:

35.—(1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.

72. Despite numerous of the case studies reviewed documenting detainees' mental state deteriorating – shown by disturbed behaviour, recurring food refusal, suicidal ideation and self-harming, and direct disclosure by detainees of not coping with detention – only one detainee (D1914) received a Rule 35(1) report. On a review of the Rule 35 reports on the Inquiry's disclosure platform, we were only able to identify two additional Rule 35(1)s - D24 and D801 (who is a CP).

73. In **MZA**, for example, the medical records are littered with references to his wishing to kill himself, recurring self-harm and biting, and prolonged food refusal. A Rule 35(3) report completed by the GP (Dr. Ooozeerally) noted that he "seems low in mood and prolonged detention may have a negative impact on his health" but concludes, without any explanation that there were no major concerns regarding his mental health. This conclusion is difficult to reconcile with the medical records which repeatedly raise concerns about his active expressions of suicidal intentions, and reported trauma symptoms which were not further explored by healthcare staff. In response to the Rule 35(3), even the Home Office sent a query to healthcare on when continued detention "would result in significant harm." The records available to us do not indicate any response from healthcare or subsequent consideration of a possible Rule 35(1) report.

74. Medical records repeatedly noted **D13**'s disclosure of suicidal thoughts, being low in mood but no assessment was carried out into these apparent trauma-related symptoms and the Rule 35(3) did not consider the impact of detention on his mental health. That failure was in fact a reason why the Home Office maintained his detention in response to a Rule 35(3). Even after D13 reported thoughts of cutting his throat and hanging himself due to nightmares, flashbacks and ongoing detention, there was no assessment or consideration of possible PTSD or of the impact of detention on his health, in circumstances where this had not previously been alerted to the Home Office. The development of worsening trauma-related symptoms and thoughts of killing himself were clearly new information that would have highly relevant to whether detention was now injuriously affecting his health.

75. A concern Medical Justice has is that although Rule 35(1) requires the clinician to consider "*the **likelihood** of a detainee's health being injuriously affected by continued detention*", GPs appear not to understand that this does not require them to evidence actual harm or predict when harm is going to occur. GPs do not appear to properly understand what they are meant to consider when asked to express a view of the likely impact of detention on the detainee. This is also shown in the way that the AAR evidential levels of risk are applied, with Level 3 (the highest level of risk, and the highest level of protection) not afforded to people unless the doctor has identified actual harm.

76. In many of the Rule 35 reports we reviewed from the Inquiry disclosure refer repeatedly to the absence of psychosis and thus no concern about deterioration in mental health if the detainee remains in detention. This is problematic because it suggests that only psychosis would mean that the detainee would be likely to be injuriously affected by detention. Dr. Bingham explains her witness statement, this misunderstands what a Rule 35(1) asks a doctor to do, and importantly misses trauma symptoms that show potential PTSD which could be worsened by continued detention or conditions of detention. It also inadvertently raises the threshold of what is to be treated as constituting likely injury to a person's health, and perpetuates as "*wait and see*" approach that undermines the precautionary approach required under Rule 35. As is explained by Dr. Bingham in her witness statement, if a detainee reaches the point of presenting with psychosis, the injury may already have occurred.

77. That said, in circumstances where even Rule 35(3) reports fail to grapple with the impact of detention, it is, in a sense, unsurprising that Rule 35(1) reports are not being considered and are rarely issued. But that cannot justify the failure of the safeguard to operate. Rather, it demands proper consideration of how to remedy the recurring failure – identified in these case studies and ICIBI, HMIP and other objective reports to identify the most vulnerable and severely unwell detained persons.

(9) Inability of the Rule 35 process to properly identify indicators of trafficking and modern slavery

78. None of the three limbs of Rule 35 of the Detention Centre Rules are tailored to addressing indicators of human trafficking and modern slavery. Whilst human trafficking

is a crime which can involve physical or psychological violence, it can similarly leave no scars or marks. It is also well established that victims of trafficking and modern slavery often do not recognise that they are victims, do not understand what trafficking or modern slavery means, or are mistrusting of authorities (particularly those who detain them, and replicate the situation of modern slavery). The Home Office's *Modern Slavery Act 2015 Statutory Guidance* recognises this, and accepts that victim identification does not depend on victim self-disclosure or their overt identification of themselves as victims.

79. Thus for victims of trafficking and modern slavery, it is all the more important that the key statutory safeguards to identifying Adults at Risk, and notifying them to the Home Office for consideration of the impact of continued detention. However, the Rule 35 safeguard – operated to focus on the documentation of physical scarring – is incapable of promptly and competently identify those Adults at Risk who may be victims of human trafficking or modern slavery. See for example:

a. **D2567**: he disclosed a history of torture and exploitation by smugglers in Turkey and attempts to commit suicide and self-harm as a result. But the Rule 35 report that was eventually completed did not address the key indicators of trafficking. There was no flag for a referral to the National Referral Mechanism for him to be identified as a victim of trafficking.

b. **MJ8030** who was held in a house in the UK and forced to work to pay off an alleged debt. He had previously suffered serious ill-treatment as a child at the hands of his father and his uncle. The Rule 35(3) assessment did not address the indicators of trafficking or recognise that his description of forced labour gave rise to a credible suspicion of human trafficking and modern slavery in the form of forced labour. He was subsequently identified as a victim of trafficking.

(10) Defective Rule 35(3) Responses and Misapplication of Adults at Risk policy

80. As discussed in my first witness statement, the AAR statutory guidance is intended to operate on the basis of a strong presumption in favour of liberty, that presumption strengthening where there is professional evidence confirming the individual's status as an Adult at Risk. The AAR Casework Guidance accepts that Rule 35(3) reports are professional evidence that an individual is at risk of harm but treats it as default evidence

of Level 2 risk rather than Level 3. It is Medical Justice's view that this fundamentlly undermines the utility of a Rule 35(3) reports which were previously sufficient to trigger a very high threshold of "*very exceptional circumstances*" to justify continued detention under EIG 55.10.

81. This is compounded by persistent failures of IRC GPs to identify impact of continued detention in Rule 35(3) reports, leading the Home Office not to release in the absence of clinical views being expressed about this. This approach by the Home Office departs from previous long standing policy and the clinical evidence that recognises that it is inherent in being an Adult at Risk with professional evidence of risk (in the form of a Rule 35 report) that the person is already someone particularly vulnerable to harm if they remain in detention. The AAR policy, consistent with the obligations in Article 3 ECHR, is intended to be precautionary, and not predicated on a "*wait and see*" approach requiring actual harm to occur rather than to act upon the professional evidence of particular risk of harm.

82. The further major problem arises from the way in which the AAR policies direct a balancing exercise to be carried out by reference to immigration factors that may be said to displace the presumption against detention in a case of an Adult at Risk with Level 2 and Level 3 evidence. This approach significantly reduced the protections in the previous policy under EIG 55.10, which set a high threshold of "very exceptional circumstances" to justify continued detention. As explained in my first witness statement, section 59 of the Immigration Act 2016 and the issue of an AAR Statutory Guidance were intended by Parliament to strengthen (not dilute) the protections for vulnerable people in detention in light of the acceptance of recommendations made in Shaw 1. The statistics set out in my first statement, in combination with the case studies above, demonstrate how the actual formulation of the AAR policy and its application in practice by the Home Office did not and has not met that objective.

(11) Application of the Adults at Risk policy failing to secure release

83. Almost no Rule 35(3) resulted in release in the case studies reviewed by Medical Justice, even though in almost all of the case studies, the Rule 35(3) was accepted as professional evidence that the person was an Adult at Risk Level 2. The Home Office response to the

Rule 35(3) reports was to maintain detention and to treat immigration factors as the overriding considerations when balancing them against the vulnerability of the detainee to risk of harm.

84. The case studies reviewed by Medical Justice corroborate the statistic that I set out in my first witness statement about the low release rates of Rule 35(3) reports. Together they confirm a long-standing experience and concern that we have had since the implementation of the AAR Policy in 2016, that is that the strength of the presumption against detention for victims of torture /trauma and or with serious mental illness was and has been diluted by the terms of the Adults at Risk policy and its application in practice by fundamentally shifting the balancing exercise in favour of immigration enforcement rather than protection of vulnerable people.

(12) <u>Rule 40</u>

85. Rule 40 provides that:

> *(1) Where it appears necessary in the interests of security or safety that a detained person should not associate with other detained persons, either generally or for particular purposes, the Secretary of State (in the case of a contracted-out detention centre) or the manager (in the case of a directly managed detention centre) may arrange for the detained person's removal from association accordingly.*
>
> ...
>
> *(3) A detained person shall not be removed under this rule for a period of more than 24 hours without the authority of the Secretary of State.*
>
> *(4) An authority under paragraph (3) shall be for a period not exceeding 14 days.*
>
> *(5) Notice of removal from association under this rule shall be given without delay to a member of the visiting committee, the medical practitioner and the manager of religious affairs.*
>
> *(6) Where a detained person has been removed from association he shall be given written reasons for such removal within 2 hours of that removal.*
>
> *(7) The manager may arrange at his discretion for such a detained person as aforesaid to resume association with other detained persons, and shall do so if in any case the medical practitioner so advises on medical grounds.*

86. Rule 40 is in effect authority to isolate and segregate; it is a punitive measure that can have very severe negative consequences on the mental health of the person subjected to it. As explained in Dr. Bingham's witness statement, this rule is not designed or intended

to be used for the purposes of clinical care and lacks the safeguards that would apply to seclusion in a mental health context. It known from litigation in the cases of *R (MA and BB) v Secretary of State for the Home Department* [2019] EWHC 1523 (Admin) that E Wing was used by Brook House as a de facto form of the Rule 40 segregation.

87. It is also clear from Medical Justice's review of documents made available by the Inquiry on the use of Rule 40, that Rule 40 and E Wing was actually used as a crude containment strategy to deal with vulnerable detainees with mental health and self-harm issues, well beyond what the Rule is intended to do. Dr. Bingham's statement addresses concerns about this practice from a clinical perspective.

D. Medical Justice's Reaction to the BBC Panorama Documentary

88. When the BBC Panorama documentary aired, exposing repeated incidents of violence, use of force against detainees and verbal abuse and racism directed at detainees, it was disturbing to watch but we were not surprised this occurred, although some aspects such as the strangling of a detainee captured real-time on the footage – were utterly shocking to watch.

89. As Ms Ginn has explained, concerns about the use of force in IRCs had been present from when Medical Justice first began. Based on accounts given by our clients, we had suspected for some time that the conditions of detention at Brook House were poor and the relationship between detainees and detention custody officers were poor. In the casework team, we would sometimes get calls from clients telling us that an officer wanted to kill them. Threats of violence do not leave any trace. These types of incidents are rarely recorded if at all. So it was always difficult for us to know whether the client was purely experiencing subjective fear and possibly paranoid thoughts or whether an actual direct threat was made against them.

90. We were aware that force was used, often in removing a detainee into Care and Separation Unit under Rule 40 or to effect removal with escorts. But until the Panorama documentary was aired, we did not fully understand know why force appeared to have been used in such a routine manner, and we also did not appreciate just how violent, antagonistic and hostile officers felt about detainees or the level of racism present.

91. I cannot remember seeing Rules 40 or 42 reports or Use of Force incident forms included in medical records when we obtain these for clients in preparation for their MLRs. Sometimes we would see reference to Rule 40 removal from association being used in the medical records but with no or little information as to why it was used, whether or what clinical considerations were given before such action was taken. Often, we only learn of incidents of segregation, removal from association or use of force because our client or his legal representative tells us about it.

92. It is often difficult for us to document incidents of use of force and injuries caused by such incidents. This is because it is dependent on a referral being received by us almost immediately after the incident has occurred and us having capacity to allocate a doctor, on an urgent basis, to visit the IRC to document injuries. The longer the passage of time between the incident and being alerted to it, the harder it is to do a proper report on the use of force, because the physical signs will often have faded and there is then limited value to the report.

93. However, what was obvious to us about the Brook House culture at the time was that there was little concern for the welfare of our clients. I say this because on the occasions we had become aware of force being used, they were circumstances where it was or ought to be obvious that it would have been damaging to the client. We feared that there was little regard for detainee lives or welfare at Brook House, but it was still shocking to have it confirmed in the documentary footage when the Panorama programme was aired.

94. Casual incidents of verbal abuse, harassment or bullying reported to us by detainees are also seldom recorded. In the course of preparing the case reviews, we noted in our records that one of former clients, DX had given us a description of his experiences of staff culture, incidents of abuse and use of force and detention condition conditions and atmosphere at the time. Prior to transferring to Brook House, DX was subject to an enforced removal where a waist restraint belt was used. The removal did not go ahead, but the Home Office did not release him further to a challenge to his detention and removal and instead transferred him from Colnbrook IRC to Brook House. At the time of his detention at Brook House, he was in a relationship with a British woman, had lived with her for many years and was a stepfather to her three children. The experience of enforced removal with restraints was distressing, and DX stopped eating. He told us

that no one cared that he stopped eating. DX told us at the time that a detention centre officer called him a bad name and did not care whether he ate or not. Unbeknownst to us at the time, this was also captured on the BBC Panorama documentary with the detention centre officer recorded as saying *"He is a penis. If he eats or does not eat, it doesn't matter"*, although these derogatory comments were not recorded in the medical or detention centre records.

95. DX told us more recently in the preparation of his case study that he remembered feeling like staff would look at detainees *"as if you were a dog. If you asked them for anything it was as if you were fighting them ... I heard lots of bad language from guards at Brook House. If a person answered back, 4-5 guards would take you to the solidary room. Guards would always say things to you like 'Why are you here? Why didn't you go back to your country?'"* DX has since been granted refugee status.

E. Medical Justice's experience of Brook House post-Panorama

96. The entrenched failure of the Home Office to meaningfully engage with the various findings and recommendations made by the systemic reviews into immigration detention, detailed in my first witness statement and that of Emma Ginn, is reflected, if not magnified, in respect of the position at Brook House. Despite this being the very site of the abuses and ill-treatment uncovered in the Panorama documentary, Medical Justice has found little evidence to suggest that the specific conditions, policies and practices operating at the IRC have materially improved since then.

97. G4S, the contractor whose staff was captured on footage inflicting abhorrent physical, verbal and racist abuse on detainees, had its contract extended until 2020. G4S' contract was due to end in 2018, and the Home Office had been running a tender process for the new contract, but cancelled it on 4 May 2018, 8 months after the Panorama documentary was aired. It sought to explain that this was to await the outcome of the Lampard review and the Home Office Professional Standards Unit's investigation. The reasoning was hard to understand given the tender process had already started (unless it was intended that G4S would get the contract again). That decision was, in our view, reckless and callous in the circumstances where there was clear and incontrovertible evidence captured on footage of ill-treatment of vulnerable detainees. The consequence of that decision was that detainees had to continue to endure under the management of G4S at

Brook House. It also meant no real consequence occurred of any significance to G4S as an organisation save for a handful of frontline staff being sacked. As far as I am aware no leadership has been sanctioned by the Home Office to demonstrate how abhorrent this treatment was and to send the clearest message that it would not be tolerated.

98. I am shocked to read the assertion by Mr. Phil Riley on behalf of the Home Office (para 7, HOM03320005_0004) that there had been no indication that the abuses in question were inevitable. I do not understand how he could make that assertion given the information that was already available to the Home Office.

99. Mr. Riley's focus on the few members of staff who were captured on camera committing particularly awful and abusive acts misses the point that serious structural issues allowed this to happen, including a culture of racism and dehumanisation as well as a dysfunctional system of policies and operation of policies that failed to make sure that vulnerable people do not end up in detention, and if they do, they are identified promptly and removed. This is how past revelations of abuse have been explained and unsurprisingly it hasn't solved the problem.

100. The warning signs are plenty about abuse going on not only at Brook House but at other IRCs and of the fact that if you do not look for it, you would not necessarily know. There had been four previous undercover reports from Yarl's Wood and Oakington in 2005 and then Yarl's Wood (again) and Harmondsworth in 2015, all of which exposed abuse committed by contractors at IRCs; and racism in Yarl's Wood and Oakington. Whilst the early undercover reports were deemed, at the time, not to represent a structural issue, they clearly demonstrated that there was a risk that such abuse happens and can remain hidden to outsiders unless you specifically look for it. That is shown by the fact that the abuse and racism only got drawn into the light by journalists going undercover.

101. Moreover, the inquest into the death of Jimmy Mubenga, which Emma Ginn discusses in her witness statement, also revealed pervasive racisim with G4S. The coronial report produced by Assistant Coroner Karon Monaghan Q.C in 2013 found that texts exchanged by G4S detention custody officers involved in the attempted removal of Mr. Mubenga showed not only evidence of a couple of "rotten apples" but "rather seemed to evidence a more pervasive racism within G4S. Recommendations had been made by the Assistant

Coroner for the Home Office to introduce detailed and specific measures to ensure contractors address culutural and staffing issues and review the performance indicators and requirements in contracts entered with G4S and other contractors.

102. It is not acceptable for Mr. Riley to suggest that because the Home Office has no power to discipline individual G4S employees limits what the Home Office can and should do. The responsibility for ensuring a safe detention environment, if this system is to be used as part of the immigration control regime, must be with the Home Office as the overarching public body designed by Parliament to manage the regime on behalf of the state. The abdication of overall responsibility is what allows abuse to recur.

103. Mr. Riley's apparent confidence that whatever failings there may have been have been successfully mitigated is not grounded in evidence and and is contradicted by continued warnings made by independent oversight bodies (ICIBI, HMIP, IMB), and Parlaimentary Committees (Home Affairs Select Committee and the Joint Committee on Human Rights) of persistent failure in the immigration enforcement structure and culture to safeguards against harming vulnerable people by the use of detention and the failure to remove those detained from that environment.

104. Since 2017, independent oversight bodies, including the HMIP and the Independent Monitoring Board have also continued to be critical of the arrangements and operation at Brook House in respect of the detention and conditions of detention of vulnerable detainees. Those reports starkly highlight the inertia on the part of the Home Office and its contractors to bring about real change to policy and practice on the use of detention powers against vulnerable detainees and the safeguarding of those who are detained. The Home Affairs Select Committee and the Joint Committee on Human Rights also launched their own investigations into what happened in Brook House, and extended these inquiries to look at the immigration detention as a whole, finding that the dysfunction and deficiencies do not exist only at the local IRC level but are pervasive throughout the structure and operation of detention policies and disdainful institutional attitudes toward deatined people and people liable to be detained.

105. In my first statement I have already highlighted the criticisms made by Independent Chief Inspector of Borders and Immigration in respect of the macro AAR policy. In the section

below, I wish to draw the Inquiry specifically to the recurring critique of Brook House post-2017 by the HMIP and IMB.

106. Their critique of continued failed safeguards accords with Medical Justice's experience of Brook House since 2017. We have continued to see many of the same issues, including detainees whose mental health was deteriorating in detention not being identified, safeguards failing, and detention being maintained with the result of vulnerable people suffering harm as a result of continued detention. We have continued to encounter force and segregation being routinely used at Brook House on clients with known mental illness and other vulnerabilities apparently without consideration of the likely effects on their health and the legitimacy and danger of use of force on clinically vulnerable people. We have sought to illustrate through five case studies that we have been able to summarise with our clients' consent. The full case studies, and a summary of key thematic problems shown by the cases, are annexed to this witness statement at **Annex 2**.

107. The apparent improvements described by Mr. Riley still allowed a significant number of vulnerable people to be detained at Brook House in 2020, high levels of self-harm and use of force to manage these risks, with the situation in the IRC escalating to such a point of crisis that the IMB described the arrangements and operatio as amounting to inhuhmae treatment, which only subsided because of a Covid-19 outbreak in December 2020. In May 2021 Brook House was again filled with vulnerable detained people who had arrived from small boats into Kent. Mr. Riley's "ambitious reform" clearly has not addressed the underlying problems creating this crisis.

108. In our view ultimately the Home Office is responsible for ensuring that the safeguards it has created to meet its duty of care and positive obligation under Articles 2 and 3 ECHR are effective and that detainees do not suffer abuse while in their custody. However, since the |Panorama documentary, we have not seen significant changes made to safeguards to ensure they work effectively. Despite the gravity of the failures exposed by Panorama, Mr. Riley's evidence shows rather depressingly that the Home Office is still not sufficiently interested in the welfare of detainees and has continued to priorities removals over welfare.

Healthcare

109. There remains significant problems with understaffing of the healthcare unit. The 2017 IMB report[1] for Brook House identified the issue of staffing within both primary healthcare and mental health team as a 'chronic' problem, with positions very hard to fill and often plugged by agency staff (§8.6). The subsequent IMB reports for Brook House for 2018[2] and 2019[3] continued to find healthcare provision problematic: as of 2018 with 30% of the nursing team filled by agency nurses (§8.5). Healthcare staffing levels was further raised in the 2020 IMB report[4] as a central concern, with an ongoing dependency on agency staff (§6.19).

110. This strain on healthcare resources was intensified by the use of Brook House, from mid-2020 onwards, as the sole base for a compressed Dublin Charter flight programme, resulting in the influx of a particularly vulnerable detainee cohort of small boat asylum seekers, many of whom suffered from histories of torture and trauma and arrived without medical records.

111. The IMB came to the stark and grave conclusion that the circumstances in Brook House at the time of the Charter flight programme, in late 2020, amounted to inhumane treatment of the whole detainee population (§3.1). This reflected the '*extremely stretched*' capacity of healthcare in attending to the complex needs of this new population, including responding to the increased levels of self-harm, ACDTs and R35 requests.

112. The high levels of mental distress and anxiety within the IRC at this time was further intensified by the nature of the compacted Charter programme being run by the Home Office, with detainees 'bumped' onto another flight in a short period with little notice. The IMB raised the need for additional mental health resources with the Home Office, however no further staff were added (§6.2).

113. What the IMB documented accords with Medical Justice's experience at the time. Referrals to us from Brook House increased sharply in August 2020 (while referrals from other centres remained low) and were very high until mid-December, when a Covid-19

[1] IMB Annual report on Brook House: for reporting Year 2017, published 2018.
[2] Ibid, for reporting Year 2018, published June 2019.
[3] Ibid, for reporting Year 2019, published June 2020.
[4] Ibid, for reporting year 2020, published June 2021.

outbreak in Brook House forced several wings into isolation. The majority of detainees referred to us during this period were asylum seekers who had crossed the channel in small boats between spring and autumn 2020. The main nationalities were Iranian, Sudanese, Syrian, Yemeni and Eritrean. A very high proportion were survivors of torture in their country of origin with many having additionally experienced trafficking and ill-treatment during their journeys to the UK. The vast majority self-referred to Medical Justice or were referred by fellow detainees as they did not have legal representation. Rates of PTSD and depression were high and suicide attempts and self-harm incidents very common. We are aware from healthcare records and some client accounts that force was being used often to manage self-harm incidents. However in many cases, clients did not tell us about the use of force; many were so distressed about their psychological symptoms, their situation in detention and their threatened removal, that the use of force did not appear to be the primary issue on their mind. (This also reflected our experience in 2017.)

114. The already inadequate mechanisms for detecting vulnerabilities were further reduced as a result of the increased numbers of vulnerable people. Many did not have a proper screening interview to identify any vulnerabilities relevant to the decision to detain and to remove because the Home Office operated an unlawful policy of abridging screening and excluding from the interview crucial questions that could have revealed vulnerabilities relevant to detention such as histories of torture or trafficking. No questions were asked of the detainee as to why they came to the UK, whether there was any reason why they should not be detained and how they had come to the UK.

115. The waiting list for Rule 35 reports at that time was several weeks at Brook House, resulting in many detainees not having an assessment before their scheduled Removal Directions to inform the decision to remove or the decision to continue detaining pending removal.

116. To add to all of the above challenges, language barriers posed a significant obstacle to clients being able to access healthcare. Before the Pandemic, the healthcare at Brook House operated a daily walk-in nurse triage clinic, allowing detainees to attend healthcare and see a nurse. This stopped during the Pandemic and instead detainees have since been required to complete a written 'Healthcare Request Form', explaining their health

complaint in writing in English. Those clients who are not able to write in English are therefore forced to reveal their medical issues to fellow detained persons or detention custody officers so that they can help them complete the form. Sometimes detainees receive an appointment in response to completing a form. At other times, they simply receive a written response, in English, scribbled at the end of the form, without any clinical contact. We frequently encountered clients who did not understand what healthcare's response was.

117. Several clients have told me that they have completed a form about their mental health problems and were simply advised to use the gym and that hence they believed that the healthcare team had no interest in treating their mental health problems. On reviewing the forms, I found that that detainee had written (or rather have had an officer or fellow detainee write for them) that they cannot sleep and require sleeping tablets. The response received in writing was that they cannot receive sleeping tablets, should complete a sleep diary, use the gym and practice good sleep hygiene. If, instead of this written process in English, there had been a consultation with the client using an interpreter, that would have been an opportunity to explore why they cannot sleep and to assess their mental health.

118. The case study of **HRB** starkly illustrate some of these issues identified above and the callousness with which the Home Office and its contractors dealt with extremely vulnerable detainees, even when they had been accepted to be Adults at Risk Level 3: HRB is a survivor of torture from Iran. Unlike many of the people detained in 2020, he had arrived in the UK earlier and had already been detained twice. On the first occasion, he was released from immigration detention because he had suffered a serious deterioration in his mental state and had attempted suicide previously on at least two occasions. An interim MLR by a Medical Justice clinician had diagnosed him with PTSD and Severe Depression and he had been accepted as an AAR level 3 by the Home Office. Even so, he was re-detained at Brook House IRC in January 2020. He self-harmed and was maintained on ACDT. He was assessed by the IRC mental health team as presenting with a depressive disorder and Complex PTSD and at very high risk of suicide, with detention precipitating his trauma-related symptoms. This was confirmed in a further MLR prepared by Dr Eileen Walsh, a consultant psychologist, dated 31 January 2020, which advised that HRB was unfit for detention. He was released a second time in

February 2020. Further to release, HRB received intensive support from the Crisis Team and his GP whilst in the community.

119. Despite knowing HRB's clear vulnerabilities and accepting he was an Adult at Risk Level 3, the Home Office nevertheless detained him a third time in November 2020 and put him in Brook House again.

120. Upon being re-detained, HRB started to hyperventilate and complained of chest pains. He was subsequently admitted to hospital for assessment and was diagnosed with Anxiety Disorder. Following his discharge later that day, HRB started banging his head and stated he wanted to kill himself. According to Home Office GCID records, force was used to effect his transfer to Brook House from hospital. The subsequent reception screening failed to identify HRB's serious mental health issues, with the attendant entry in the medical records simply noting that he has "*health issues but only his Dr understands*" and that there were "*no issues*" with his mental state presentation. In respect of his hospital admission earlier that day, the nurse simply recorded that there were "*no issues*", despite observing that HRB appeared to be suffering "*body jerks*" during the screening and reported having pain all over his body.

121. HRB continued to deteriorate during his detention at Brook House IRC. He continued to self-harm, heard the noise of people crying and voices in his head and refused food, first because he could not keep anything down, and later because he said he wanted to die. No Rule 35 (1), |(2) or (3) reports were completed. Despite the Gatekeeper having only 'reluctantly' authorised his detention and advised he should be released if his scheduled removal failed, he was not released when, on 1 December, his removal directions were deferred. He remained in detention until 9 December 2020.

Training

122. Allied to the above, another concern that threads through these reports is the lack of mental health training for staff. A recommendation made in the 2017 IMB report for the provision of advanced mental health training to G4S custodial staff was not taken up, with the Board repeating this recommendation in its 2018 report. This was reiterated in the Lampard review, in November 2018, which made the same recommendation on specialist mental health training, observing that the proposed roll-out of mental health

first-aid training within initial training, and for operational staff on a one-off basis, was insufficient for staff on E wing who required more specialised mental health training (§§8.108-8.110).

123. However, it does not seem that these repeat recommendations were heeded by G4S. The 2019 HMIP report on Brook House[5] fails to identify the provision of specialist mental health training, noting only the inclusion of 'first aid' mental health awareness training for officers (§2.71). The limited knowledge and resources of Brook House custodial, in respect of knowing how to identify and manage mentally unwell detainees, continues to remain a significant concern for Medical Justice.

Failure to identify and treat mental health problems and associated impact of detention

124. Our experience of Brook House since 2017 revealed a continued casual attitude toward detainees presenting symptoms of serious mental health. Take the case study of **AK**. At an Adult at Risk meeting, although AK had already been diagnosed with severe depression and PTSD, was on constant observation reporting psychotic symptoms, staff reported to the Home Office that AK was not engaging with them. It was not said that this was because he was severely unwell. Instead, it was said that *"they believe this might be a personality issue rather than mental"*, a conclusion that bore no semblance with what was recorded in the medical records themselves.

125. We also continue to be concerned that healthcare staff at Brook House IRC do not screen for PTSD and frequently appear to miss PTSD in mental state examinations, even when the client has reported having experienced extremely traumatic events including torture or is reporting typical symptoms. Instead healthcare records frequently refer to 'no psychosis or severe depression', making no mention of trauma symptoms. Dr. Bingham discusses the clinical concerns with this flawed approach in her witness statement.

126. This again can be illustrated by **AK**'s case. It was apparent from the medical records that from early on in his detention, he was noted to have difficulties sleeping, feeling stressed, hearing voices, and suicidal. He made three Healthcare requests on 6,7, and 8 July 2021 requesting a doctor's appointment for his sleeping issues and need for mental health

[5] HMIP report of unannounced inspection of Brook House: 20 May -7 June 2019, 24 September 2019.

medication. He also said he had thoughts of self-harm. He did not get a GP appointment as a result. He told a mental health nurse on 8 July 2017 that he was hearing voices. having intermittent suicidal thoughts, having difficulties sleeping and feeling low. Despite these clear trauma-related symptoms, the nurse concluded he had no signs of mental illness. He was not screened for PTSD. The following day an ACDT was opened.

127. In the meantime AK's mental health continued to deteriorate, and he continued to report feeling very depressed and having suicidal thoughts. He was advised to use coping strategies and practice 'mindfulness'. In August 2021, a month into his detention, he was prescribed antidepressants by a GP, but despite AK attributing his mental health problems to his history of torture, the GP failed to assess him for a potential PTSD diagnosis.

128. A Rule 35 report, completed in August 2021, noted his account of torture including sexual mistreatment The GP expressed "*concerns about (AK's) mental health*", including his thoughts of self-harm and advised that he be monitored closely, but concluded that his health needs could be met in the IRC without any consideration of the clinical picture recorded in the medical records. The report did not consider whether he had suffered a mental health deterioration or the likelihood he would suffer further deterioration if he remained in detention. In response, detention was maintained by the Home Office.

129. AK continued to report distressing psychological symptoms. He self-harmed and reported suicidal intent. He was assessed as being at 'high suicide risk' and placed on constant watch. His mental state deteriorated to the point of food refusal. A mental health nurse review in September 2021 noted that *"he was "bearly [sic] able to talk, his lips where [sic] dry and his tongue was crusted, he was tearful and stated he wanted to die".*

130. It took nearly 2 months before AK was finally diagnosed by an IRC psychiatrist on 3 September 2021 as presenting with likely PTSD. But no Rule 35(1) was raised. Even after AK sent a healthcare request for help because he had auditory hallucinations and subsequently told the mental health nurse and a Home Office official, he wanted to die, no Rule 35(1) or (2) report was raised, and no consideration was given to reviewing his detention.

131. Similarly **RMA**, an Iraqi national and victim of torture, who was detained at Brook House from August to December 2021, does not appear to have had any substantive mental health assessment or psychiatric input during his time at Brook House. This was despite him having reported a history of torture, self-harming, reporting he could not sleep and was hearing voices in his room at night, having nightmares and flashbacks and feeling there was someone in his room strangling him. He only received a diagnosis after Medical Justice arranged for RMA to be assessed by an independent clinician who recorded a diagnosis of depression and trauma symptoms likely meeting the diagnostic criteria for PTSD.

Adults at Risk

132. As discussed in my first witness statement, the ICIBI's two annual reports on the AAR, published in 2020 and 2021, identified a fundamental disjunct between the AAR policy, which is statutory and intended purpose to protect vulnerable detainees from likely harm in detention, and the internal policies that custodial staff appeared to prefer to operate under, but which do not reflect the statutory minimum standards or safeguards.

133. The HMIP and IMB both found this disconnect between internal contractual policy and the AAR policy was profound at Brook House, and the AAR safeguards failed to function effective in the way Parliament intended them to on the ground.

134. The disproportionate numbers of vulnerable detainees designated as AAR Level 2 was raised by the HMIP in its 2019 report, finding that as of mid-2019 some 46 detainees - 19% of the population - were categorised as AAR, with 30 of the 42 at Level 2. Comparatively only 16 were designated as Level 1 and none as AAR Level 3. Further, from November 2018-April 2019, the HMIP found that, whilst Brook House had held 423 recognised Adults at Risk, only 7 were designated at AAR Level 3.

135. The arrangements at Brook House were not adequately capturing dynamic changes in vulnerability. This was raised in the 2019 IMB report, which cited two cases where detainees who were identified as AAR L1 were not re-designated even after they self-harmed and were placed on ACDT constant watch. The Board advised that the Home Office must ensure that the AAR framework was better adapted to meet the needs of detainees in so far as it was currently based on levels of evidence, rather than need, with

little movement between designated levels. It also recommended that the HO review the various safeguarding processes (i.e AAR, ACDT and Rule 35) for consistency and to ensure they provide a holistic approach to assessing vulnerability. The Home Office was also advised to impose a requirement for the systematic and ongoing review of AAR and other vulnerable detainees, to monitor the effect of continued detention on their wellbeing.

136. Other than inviting the ICIBI to carry out an annual review of the AAR policy, we are not aware of what informed steps have been taken to enact change at a local level at Brook House. The fact of a sharp increase in the number of vulnerable detainees being held at Brook House from mid-2020 onward rather show that no steps, or at least, no effective steps have been taken.

137. For example, the 2020 IMB report for Brook House noted a failure to carry out any sufficient screening for vulnerabilities for many of the asylum-seekers who arrived by small boats. Risk indicators of torture, human trafficking and modern slavery were not identified at health screening or induction. Even where at risk indicators were identified in the early days of detention, there was a delay in considering the impact of these risk factors on decisions to maintain detention and the safeguards that need to be put in place under the AAR framework. Moreover, the Board found that the rapid moves between IRCs and the compressed charter timelines further undermined the ability to carry out AAR assessments of vulnerability. The IMB repeated its three recommendations in relation to the review of the AAR process as made previously in 2019, supplemented by a further recommendation that the Home Office review its systems to ensure that vulnerabilities i.e. modern slavery, R35 claims, are identified and assessed at the earliest stages.

138. Each of the five case studies that I have annexed to this witness statement show clear deterioration suffered by the clients from being detained. In both **AS**'s and **HRB**'s cases, they were detained at Brook House despite the Home Office finding each of them to be an adult at risk Level 3. In **AK**'s case, despite concerns by the GP and mental health nurse that his mental health had deteriorated, no Rule 35(1) was ever raised to alert the Home Office to the fact that his health had already been injuriously harmed by detention and was likely to continue being so harmed. An attempted suicide did not prompt healthcare to consider a Rule 35(1) in respect of **FS** or the Home Office to address its

mind to that evidencing a deterioration in his health from being detained. He was only released further to a Medical Justice clinical letter raising concerns about the severity of FS' mental ill health and his being unfit for detention. FS was so unwell on release that he attempted suicide by jumping in front of a train and had to be sectioned under the MHA 1983 for urgent assessment and treatment.

139. These examples demonstrate not only a failure in the Rule 35(1) safeguard but a failure to apply the correct threshold of not detaining individual who clearly have been and continue to be harmed by detention save in very exceptional circumstances.

Rule 35

140. The HMIP and IMB both repeated findings that have been made repeated by both oversight bodies and in Mr. Shaw's two review as to the inability of the Rule 35 safeguard to operate effectively to identify and secure the release of vulnerable persons at risk in detention. As outlined in my first statement, these problems identified were not new and had repeatedly been drawn to the attention of the Home Office and its contractors at Brook House but with no effect.

141. In 2017, the IMB found that only 30% of those who received a R35 assessment at Brook House were released by the Home Office following consideration of the report. This rate decreased in 2018 to 16.6%, with a large number of detainees deemed to be Adult at Risk Level 2 remaining in detention on the basis of asserted immigration factors. Whilst the release rate went back up to 25%, the IMB raised further ongoing concerns as to the efficacy of the Rule 35 process in its 2019 report. The Board noted that 45% of those shown as AAR Level 2 at the end of January 2020 had their torture claims accepted by a Rule 35. Further, that at least 17 victims of torture have been in continued detention for over 12 weeks after their Rule 35 was accepted from July 2019-February 2020; 5 of them for over 24 weeks. In a similar vein, the HMIP report for Brook House in 2019 noted that from October 2018-March 2019, of the 94 R35 reports submitted, only 14% of these reports led to the detainee's release.

142. The IMB 2019 report for Brook House noted that the lack of transparency in the Rule 35 process and low release rate continued to raise serious concerns over whether the process protecting cohort of vulnerable detainees. As of September 2019, the IMB stopped

receiving data from the Home Office on the number of detainees released in view of Rule 35 claims. The IMB recommended the Home Office review its R35 processes so as to reduce the number of victims of torture detained, to provide greater transparency over the Rule 35 decision-making process and numbers of victims of torture detained after Rule 35 reports.

143. This recommendation was left unactioned by the time of the IMB's 2020 Report, which reported a dramatic increase in the number of R35 reports. Nearly half of the detained population Brook House in late 2020 had a history of past torture which required investigation under the Rule 35 process. They were all detained, regardless of their vulnerabilities, as part of the Home Office's Charter flight programme. This resulted in a significant backlog in Rule 35 assessments in late 2020 as GP resources were overwhelmed, with a Rule 35 waiting time of 21 days in mid-August 2020. The IMB found that this backlog contributed to heightening levels of anxiety and unease amongst an already vulnerable population of detainees.

144. Most concerning, the IMB found that the delays, coupled with the compressed Charter removals, meant some detainees were removed before they had seen a GP for their Rule 35 assessment. As for the Rule 35 reports which were produced, a significant number were accepted by the Home Office, with 49% of detainees on the AAR log having their torture claims accepted (in October 2020) and moved to AAR Level 2/3. An average of 32% of those detainees with accepted claims were released. The IMB was unable to show whether this reflected an improvement of the safeguard.

145. It is Medical Justice's view that this information exposes the number of vulnerable detainees who were wrongfully detained when they should not have been. The Home Affairs Select Committee's detention inquiry report (published in March 2018) had already criticised for routinely flouting its own policies which should have prevented unlawful detention and harm of vulnerable detainees by relying excessively on purported immigration factors of non-compliance to seek to justify the detention of people who should not be detained under the AAR policy. (see §§9 and 38 of the conclusion section) The HASC condemned this *"shockingly cavalier"* attitude that the Home Office took to deprivation of liberty and the violation of individuals' fundamental rights, but the high release rates seen in late 2020 at Brook House of torture victims with Rule 35 reports

confirms just how little reflection has been given to this very serious condemnation and no apparent action.

146. The underusage of Rules 35(1) and 35(2) were repeated in the several reports by the HMIP and IMB, and that accords with the data published by the Home Office in its quarterly statistics and that obtained by Medical Justice received through FOIA requests, and analysed in my first witness statement, and illustrated by the case studies at **Annex 2**.

147. The HMIP in its 2019 report questioned the absence of any Rule 35(2) reports in circumstances where Brook House had reported a high incidence of suicidal ideation and self-harm in that period. HMIP recommended that GPs must submit a R35(2) report to the HO in call cases of suspected suicidal ideation. This was also repeated by the IMB in its 2019 report. The IMB said in its 2020 report that the non-existence of Rule 35(2) reports was hard to reconcile with the consistently high incidence of self-harming/suicidal ideation at Brook House, reflecting the high levels of vulnerability amongst the small boat asylum-seekers subject to the charter flight programme when their vulnerabilities ought to have rendered them unsuitable for detention under the AAR policy.

148. The HMIP (as well as the HASC) identified a serious gap in the reporting mechanism for those who qualify as an Adult at Risk but are not victims of torture. There was a distinct and recurring lack of clinical reasoning in reports that record mental health symptoms but fail to consider whether they are symptoms indicative of PTSD. Vulnerable detainees with PTSD were routinely not picked up and reported via the Rule 35 mechanisms. This systemic gap was compounded by the under-use of the R35(1) mechanism.

149. The HASC had urged the R35 processes to be reviewed to ensure that all vulnerable groups as per UNHCR detention guidelines were effectively identified, and set a deadline for the review by the end of June 2019. This has not been done nearly 3 years on, and in fact the recommendation of a review was made as long ago as 2016 by Mr. Shaw in his first report when he found then that Rule 35 was not functioning. He took the view that what was required was an alternative mechanism given how entrenched the problems were with the Rule 35 mechanism, not only in respect of the way it operated but because of the entire loss of trust in the process on the part of the Home Office, the GPs and

stakeholders. Mr. Shaw repeated his strong recommendation for an alternative mechanism in his second report two years later in 2018. The ICIBI has also picked up on the same recommendations and repeated it in the two annual reviews that have been published thus far in 2020 and 2021.

150. Since then there have been two proposals for changes to Rule 35:

151. In 2019 the Home Office consulted on proposed amendments to the Detention Centre Rules. The cover letter to the consultations stated *"As a part of this, we would like to particularly draw your attention to draft rule 35 of the replacement Rules. This is, as it stands, largely unchanged in comparison with the equivalent from the 2001 Rules, save for widening the scope of those who can make reports under the rule, and an updated definition of the term "torture" for the purposes of the rule. We would, however, particularly welcome your suggestions on any further amendments that could be made to rule 35, including in relation to the range of vulnerabilities reflected in the rule."*

152. While 35 had been left largely unchanged, it was proposed to downgrade Rule 34 so that a member of the healthcare team (instead of GP) could conduct the examination and it did not need to be a mental and physical examination. Medical Justice submitted a response, but no further steps have been taken since by the Home Office. In our view downgrading Rule 34 is a retrograde step, and does not address the long-standing problems with the Rule 35 process, because the failure to carry out Rule 34 examinations is not only a failure in itself to identify immediate medical needs, but a significant missed opportunity for concerns about torture and other serious ill-treatment to be identified and reported to the Home Office promptly.

153. Further AAR reform proposals were circulated by Ian Cheeseman in August 2020. Those did suggest widening reporting under Rule 35 to 'the full range of vulnerabilities covered in the AAR'. Together with this it was proposed that evidence levels 1, 2 and 3 would be replaced by risk levels indicating 'low, medium and high' risk of suffering harm in detention. The Rule 35 (1) (2) and (3) would be replaced by a single form focused on assessing the likelihood of the person being harmed by detention. The proposal provided by Mr. Cheeseman gives little detail about how this would work. However, we have already seen how the current risk levels in the AAR policy do not work protectively and

in practice weaken the strong presumption against detention save in very exceptional circumstances. We cannot see, on first blush, how changing risk levels from levels 1, 2 and 3 to low, medium and high would improve matters. It is still predicated on the concept that you can be an adult at risk but not promptly recognised as being at very much risk of harm in detention. That is still significantly weaker than the old category-based approach under EIG 55.10, which Mr. Shaw recommended to strengthen, not to scrap entirely. Moreover, section 59 of the Immigration Act 2016 talks about adults at risk as being all who are at particular risk of harm in detention; it did not envisage gradients of risks that mean that some adults at risk would not be acknowledged as being harmed by detention.

154. This proposal continues the current problematic requirement to demonstrate likely deterioration in detention to achieve Level 3 (or high risk if that change is brought about). That approach only encourages a 'wait and see' approach by which detention is maintained until harm has already occurred and can thus be documented. Increasing the focus on evidence of specific harm, in our view, would be likely to further encourage that 'wait and see' approach.

155. These proposals were discussed at a meeting with NGOs in August 2020 but then put on hold pending the Nationality and Borders Bill, which is currently going through parliament. The only proposals which were taken forward in the meantime were proposals which had the effect of limiting the protection from detention available to victims of trafficking and of imposing additional requirements on external medico-legal reports. These are discussed in my first witness statement.

156. In these circumstances, as matters stand, there continues to be an ongoing and persistent failure to address the obvious and well-documented failing in the Rule 35 process and the Adults at Risk process in the face of sustained findings from all quarters for over a decade that these safeguards have not been operating effectively causing vulnerable people to be harmed.

157. Where changes to policy were made in response to recommendations, these have at times been designed in such a way as to negate the intended effect of the recommendation. When Stephen Shaw recommended that the 'satisfactory management' provision be

removed from the policy on detaining those with serious mental or physical illness, the provision was removed but replaced with a process which by requiring evidence of likely deterioration, effectively expanded the provision to apply to all indicators of risk. We fear that similarly the changes to the DCRs proposed in 2020, while inviting suggestions on strengthening the reporting obligation under Rule 35, would in fact weaken the main mechanism by which detainees ought to be promptly identified for a referral for a Rule 35 report.

158. The failure to address these long-standing problems is perhaps the starkest illustration of the HO resistance and inertia in response to calls for change,that has, in our view, provided fertile ground for the abuses documented in the Panorama programme to occur.

Self-harm and suicide prevention

159. Even in the absence of Rule 35(2) reports being raised, it is not difficult to see from the high numbers of ACDTs opened that a significant number of highly vulnerable people who self-harm and are pose suicide risks continued to be detained at Brook House, managed crudely by a process not designed with clinical input in mind or with any obligation on the Home Office and the healthcare unit to grapple with the fundamental question as to whether the detainee should continue to be detained in the circumstances.

160. The 2017 IMB report noted that on average 42 ACDTs were opening on a monthly basis that year, with 151 reported episodes of self-harm, statistics; this was the same the year before. Mr. Shaw noted that Brook House had the highest numbers of ACDT opened for the two years. This was not, however, an indication of vulnerable detainees being kept safe. As the Lampard review for Brook House noted, staffing shortages and pressures seriously impacted on the ability of detainee staff to attend to vulnerable detainees at risk of self-harm. Further, and in our experience given the ACDT process involved little if any clinical input, it is used, at best, as a containment strategy, as the case studies above demonstrate.

161. This has changed little since 2017. The 2019 HMIP report for Brook House noted a significant increase in self-harm instances, doubling the average in 2016, when the detainee population was higher then. At least 15% of the average monthly detained population was on an ACDT; 40% of detainees surveyed stated that they expressed

regular self-harm and suicidal ideations. Amongst those subject to ACDT, a high proportion was subject to constant watch. The 2018 IMB report noted 103 cases of constant watch, involving 85 detainees. The HMIP 2019 report noted that, as of mid-2019, there had been 95 constant supervision cases in the past six months alone.

162. The 2020 IMB BH report finds as a 'significant concern' the dramatic increase in levels of self-harm and suicide ideation in late 2020. This significant increase was directly linked to the higher level of vulnerability of the small-boat detainee population and intensive Charter flight programme in place at BH from mid-2020 onwards. As of August 2020, the IMB noted that acts of self-harm constituted 30% of the population and ACDTs over 40%. A 'disturbing' number of detainees were placed on constant watch, 23 detainees out of 80 detainees in the detention centre. Cases were noted of vulnerable detainees who had self-harmed being removed directly on fights: e.g. a detainee being taken directly to plane after hospital for treatment of injuries. At least 26 detainees were removed on charter flights on open ACDTs. The Board raised serious concern that, despite the scale of self-harm and suicidal threats, no R35(2) reports were issued throughout August-December 2020 (§4.4).

163. The ICIBI, in its second annual review, published in 2021, thought that a possible cause for the high numbers of ACDTs, non-existent use of Rule 35(2) and the absence of any action to seek the release of detainees on ACDT may be the underlying staff culture of disbelief around self-harm and the perception among detention centre staff that detainees were "faking it" and seeking to use self-harm to avoid removal. The same had been observed by Mr. Shaw in his second report, and by the IMB in its 2020 report. The IMB said the issues with staffing culture had not improved even with the handover of the detention contract from G4S to Serco, citing examples of staff expressing *"desensitised"* views about detainee and attitudes towards self-harm and food and fluids refusal, which *'lean towards a culture of disbelief'*. Detention custody officers were noted as still referencing self-harm as mechanism to avoid removal.

164. The evidence in the reports, the statistics on ACDTs and high proportion of detainees self-harming show starkly the unacceptable extent to which Brook House has remained an IRC with a highly vulnerable detained population, suffering high levels of mental distress self-harm and suicide risk. The entire disconnect of the ACDT process from the

statutory safeguards under the AAR is extremely concerning as this level of significant vulnerability ought to pose serious questions about the justification for continued detention.

165. **FS** is a stark example illustrating these practices. He is an Albanian national and victim of torture who has now been recognised as a refugee. He was detained in Brook House in December 2019. It was known at the outset that he had previously attempted suicide by an overdose but the health screening nevertheless stated that FS did not present with any mental health or self-harm issues. When he commenced a period of food and fluid refusal on or around 3 January 2020, he was moved to E-wing and monitored but no clinical assessment was carried out to investigate the triggers for the food and fluid refusal. FS' legal representatives made repeat submissions to the Home Office that he was unsuitable for continued detention, stating his mental health was deteriorating, and he was suffering rapid weight loss from his ongoing food refusal. Particular concern was raised over FS' imminent risk of suicide. Healthcare failed to action these concerns.

166. On 8 January 2020, FS attempted to hang himself with a ligature from the TV bracket. An emergency response was called and FS was cut down. He refused to engage with staff about the incident, only stating that he could not sleep. FS was consequently placed on ACDT constant supervision. This serious act of suicidality failed to prompt an urgent mental health assessment the same day. Nor does it appear from the available records that, throughout FS' time at Brook House, a report was issued under R35(1) or R35(2) despite his heightened risk of suicide and worsening clinical state.

167. On 9 January 2020, FS had his first RMN review, reporting traumatic flashbacks and active suicidal ideation, poor sleep and headaches. FS was referred for review by a psychiatrist. Healthcare informed the Home Office of FS' statement of suicidal intent, by way of email the same day, confirming he remained on ACDT constant supervision. Still no Rule 35(2) report was completed and the underlying causes and triggers of his suicide attempt and food refusal not explored by healthcare.

168. FS was assessed by a psychiatrist on 10 January 2020. He reported that his mood had deteriorated significantly since being detained and that he struggled with suicidal thoughts. He also reported suffering from persistent headaches, loss of appetite and poor

sleep. His serious recent suicide attempt was noted. FS was diagnosed with a depressive episode and prescribed Mirtazapine. But no Rule 35(2) was raised.

169. On 13 January 2020, Medical Justice contacted Healthcare to relay concerns that FS was feeling seriously unwell, and that he stated he *"needed to go to the hospital before it's too late"* as he was *"nearly finished"*. In an ACDT review that day, FS complained that he was not being helped by healthcare and would kill himself if his pain was not addressed. No action was taken in response to these concerns other than to keep him on constant supervision.

170. Medical Justice arranged for FS to be assessed by an independent clinician (Dr Bourdillon-Schicker) on 21 January 2020. FS reported regular suicidal ideation and that he had self-harmed the day before, by cutting his wrist, though had not informed staff. Dr Bourdillon-Schicker assessed FS to have severe depression, anxiety and PTSD with a high risk of suicide and self-harm. He wrote to healthcare, immediately following the assessment, to advise of his concerns. Dr Bourdillon-Shicker concluded, in his subsequent MLR dated 6 February 2020, that FS was unfit for detention, which had precipitated a deterioration in his mental health condition.

171. FS was finally released on 23 January 2020. The day of his release, FS attempted suicide by trying to jump in front of a train. He was admitted as an informal patient to a secure mental health ward the following day and was subsequently detained there, under Section 2, on 22 February 2020. He was discharged from the unit on 14 March 2020.

Use of Force:

172. The IMB and HMIP continue to document the ongoing high incidence of use of force at Brook House after 2017 as an ongoing serious concern. Whilst the IMB noted in their 2018 report that the overall number of use of force incidents had decreased from 2017, namely down to 257 incidents from 334, it was found this was still higher '*by a significant margin*' than in the years prior to 2017 (§4.8). This concern was reiterated the following year, the IMB observing in its 2019 report that, whilst the number of incidents was lower than the previous two years, it remained significantly higher than in the 2015-2016 period. The Board even indicated that, when calculated with reference to the average number of incidents per detainee, the use of force was comparable if not higher than in 2018 (§4.11). In its 2019 report, HMIP similarly raised concerns over the increased use of force since

its previous inspection in late 2016 and the lack of any clear analysis for the reasons (§1.57-1.58). It was further noted that the rate remained higher than at other IRCs, including those with a similar detainee population. HMIP recommended that an 'in-depth' review of use of force be conducted to ensure that incidents were minimised in line with the level used in other IRCs (§1.70).

173. The prevalence of use of force remained a serious concern for the IMB's 2020 report on Brook House, even after successive previous years of criticisms. The Board found that, whilst the number of incidents continued to fall, a higher proportion of the detained population was subject to a use of force in 2020 (17% per month) than in 2019 (7%). Perhaps the more shocking finding made by the IMB's 2020 report is that the use of force rate was higher as compared to 2019 both in the first and second half of 2020, so even after a transfer from G4S to a new contractor, Serco, and even after a significant reduction in the overall size of the detained population following the onset of the Covid-19 pandemic.

174. Even more concerning was the documented increase in the use of force to prevent self-harm in 2020; 37% of the overall incidents attributed to this reason, compared to 9% in 2019. This is coincident with the high levels of self-harm in the new detainee population of small-boat asylum seekers at the IRC as of mid-2020. These numbers, 17% of detainees at Brook House having been subject to the use of force with 37% of those incidents having been to prevent self-harm, is profoundly concerning. The use of force is not in any way a therapeutic intervention and, as my colleague Dr Bingham explains in her statement, should only be used exceptionally for the health and safety of the detainee. Every incident requiring the use of force to prevent self-harming should be viewed as failing in the systems to protect the safety and welfare of the detainee. Such a high incident rate reflects a continued laissez faire attitude to the use of violence against the most vulnerable at their most vulnerable (when they are self-harming)

175. The casual attitude to the use of force and its normalisation is exposed further by the reported frequent use of handcuffs for hospital escorts. The IMB found in their 2018 report that handcuffs were used on some 89.2% of these escorts, with the effect that some detainees were deterred from attend clinical appointments (§4.9). The IMB recommended that G4S reconsider its risk assessments for the use of restraint on escorted visits. This

recommendation was however repeated the following year, with the IMB finding that that use of handcuffs remained high, still being used in 66% of escorts (§4.12). HMIP raised similar concerns over the disproportionate use of handcuffs in their 2019 report on Brook House. There was little evidence that this pattern had improved by 2020, with the IMB finding that, from April-August 2020, nearly all the few escorted moves were handcuffed (§5.1).

R40/R42

176. The appearance of a fall in instances of R40 Removal from Association at Brook House since 2017 has to be qualified by the finding of the HMIP in its 2019 report that the overall rate of segregation remained higher than in other IRCs. Similarly, whilst the IMB found in its 2020 report that the use of the R40 mechanism continued to decrease that year to 160 instances (i.e. from 187 in 2019), the proportion of detainees subject to R40 was significantly higher, given the total detained population was less than half that in 2019. The IMB also raised concerns, in its 2018 report, over the significant increase in the average length of time spent on R40, amounting to 59.25 hours in 2018 as compared to 32 hours in 2017. By the point of the 2020 IMB report, whilst the average time on R40 from May-December 2020 was just under 36 hours, still higher than in 2017, with one detainee maintained on R40 for 12 consecutive days.

177. The multi-purpose use of E wing was also raised by the IMB in its 2018 and 2019 reports, with respect to its potential impact on vulnerable detainees. The IMB also observed in its 2018 report the increased use of E wing for those placed under R40, used as part of a 'phased re-integration' back into residential wings. Concerns were also raised as to the apparent use of E wing for de facto removal from association, with detainees accommodated on E wing who restricted without full free association yet not being subject to the formal R40 safeguards. It is unclear however if this pattern related to mentally unwell or otherwise vulnerable detainees and no recommendation was made on this basis. The 2020 IMB report also raised concerns over the 'pre-emptive' use of R40, specifically in relation to the simultaneous use of R40 on 45 detainees to manage removals for a Jamaican charter flight in Feb 2020.

178. In RMA's case, he had been under the care of the mental health team, had self-harmed by banging his head against the wall and was placed on an ACDT for a period of time. He

reported feeling low and anxious, having difficulty sleeping, hearing voices in his room at night, and feeling as though someone was strangling him, nightmares and flashbacks. On 23 November 2021, Medical Justice informed Healthcare that RMA had stated he would self-harm as he was locked in his room without electricity after refusing to move to a different wing. It appears that RMA was then subject to a planned C&R intervention to relocate him to CSU, under R40, later that day. RMA injured his wrist during the use of force removal, requiring review by the GP. The basis for his Removal from Association is unclear, and appears to be linked to his refusal to share a room. No advice was sought from healthcare as to medical concerns about the appropriateness of using restraints or forcing him into segregation in view of what was already known about his serious mental health issues and ongoing ACDT monitoring.

F. CONCLUSION

179. In conclusion, many of the structural or institutional failings underlying the abuse shown in the Panorama documentary have been evident for many years and have been repeatedly reported in various reviews, court cases, inspection reports and NGO reports. We have been attempting over many years to push for action to be taken to address these recalcitrant failings. However, it appears to us that those with responsibility within the Home Office have lacked the will to learn lessons and effect substantive change. It appears to us that the Home Office has consistently prioritised removals over protecting the safety, health and welfare of detainees.

180. The abuse shown in the Panorama documentary was shocking, but does not appear to have changed this underlying dynamic and systemic issues outlined in my 2 statements remain the same. There have been changes in contractors, but that does not address the underlying issues, because these issues are systemic and require meaningful action to be taken by the Home Office.

181. There has already been four major reviews into the operation of immigration detention in the past decade: the Tavistock Review (2014), the Joint Inquiry into the Use of Immigration Detention by the APPG on Migration and APPG on Refugees (2015), and Mr. Shaw's two reviews (2016 and 2018), the findings of which are summarised in my first witness statement. All of these reviews identified a systematic overreliance on

immigration detention, too many vulnerable people detained for too long, inadequate healthcare provisions and a failure of existing safeguards. The reviews found shortcomings in both the identification of vulnerable people and in the policies designed to protect them, but they have not brought about clear, positive and long-term change to the arrangements and operation of the immigration detention estate. As Mr. Shaw said to the HASC, *"potential for abusive behaviours is ever-present .. in closed institutions."*

182. As the HASC found in its immigration detention inquiry, prompted by the broadcast of the Panorama documentary:

a. there are *"serious problems"* with *"every element"* of the immigration and detention policy and process, which led to people being wrongfully detained, held in detention whilst vulnerable and detained for too long. (§1, conclusion)
b. the fact that more than half of the people being detained over a year were simply released again raises important questions over whether the power to detain is being used appropriately. (§3, conclusion)
c. there is doubt as to the accuracy of Home Office information about the approach to the decision to detain. Whilst the HASC accepts it is the intention only to detain people where there are public protection reasons to do so, in practice, too many asylum seekers are being detained who may not need to be and inappropriate decisions are being made to lock people up. (§8, conclusion)
d. Home Office policies which should prevent unlawful detention and harm of vulnerable people are regularly flouted or interpreted and applied in a way so that people are being detained unlawfully. The most vulnerable detainees including victims of torture are not being afforded the necessary protection. Detainees are held despite serious risk to their life. (§§9, 38, conclusion)
e. Senior Home Office officials have overridden independent review panel decisions to release vulnerable detainees, and continued detention without any justification, raising serious issues as to the point of these independent review panels. (§172, main report)
f. Detention decisions give excessive and unjustifiable weight to immigration history of non-compliance with immigration authorities. This creates a barrier to the release of some of the most vulnerable detainees. It is unacceptable to detainees'

fundamental human rights to be forced to languish in immigration detention. (§192, main report)

g. the Home Office's failure to collate basic, transparent information about the numbers of people who are wrongfully detained shows a "shockingly cavalier" attitude to the deprivation of liberty and the protection of people's basic rights. (§9, conclusion). The lack of face to face contact between the detention decision-maker and the detainee, and the entirely paper-based exercise, *"contributes to the cavalier attitude towards detention decisions"*. (§11, conclusion)

h. the Home Office is failing to properly capture detainee vulnerability in the early days of an individual's detention. It is crucially important that this is done in order to enable potential release. (§14, conclusion)

i. The AAR policy is not only failing to protect vulnerable people but, by introducing a requirement for individuals to provide evidence of the level of their vulnerability risk in detention, had significantly lowered the threshold for Home Office caseworkers to maintain detention of those most at risk. (§20, conclusion) It has not only failed to mitigate the harmful impact of detention on vulnerable people but has failed to deliver a reduction of the number of vulnerable people in detention. (§20, conclusion)

j. the Rule 35 process is plagued with too many long delays, sets too high an evidential burden, and that internal review panel recommendations to release are being overturned by senior Home Office officials. (§26, conclusion) The Home Office needs to review the Rule 35 process *"to ensure that no further injustices take place on the immigration detention estate."* (§29, conclusion)

k. Decisions to maintain detention are life changing for the most vulnerable people in detention. If there is no prospect of imminent removal, then people should not be detained. (§34, conclusion) Failure to do so will *"only compound detainees' frustration and may lead to self-harm and violence in immigration removal centres."* (§35, conclusion)

l. A detention time limit is long overdue as lengthy immigration detention is unnecessary, inhumane and causes harm. The indefinite nature of detention traumatises those who are being held and means no pressure is put on the Home Office and immigration system to make swift decisions on individuals' cases. (§§46-47, conclusion)

m. abhorrent abuse of the kind that took place in Brook House will remain hidden unless the Home Office takes immediate steps to ensure all IRCs have robust and effective whistleblowing procedures in place which IRC staff and detainees can use with complete confidence. (§59, conclusion)

n. Formal oversight mechanisms currently in place are clearly not working to ensure effective, safe and human management of IRCs. Accountability for serious misconduct does not only rest with contractors, but ultimately with the Home Office. (§62, conclusion) The evidence received by the HASC shows that Home Office has *"utterly failed"* in its responsibilities to oversee and monitor safe and humane detention conditions. (§63, conclusion)

183. Based on our experience since 2005 of working with detained people and engaging with the Home Office and other public oversight bodies on the use of immigration detention, Medical Justice does not consider that the Home Office has shown itself capable of operating a safe and humane detention system. It is no surprise that the HASC as well as the Joint Committee on Human Rights have both identified the need to significantly curtail the power to detain as a response to the systemic, pervasive and recurring problems with the detention system and its treatment of people, particularly those with vulnerabilities. Ms. Ginn's statement sets out Medical Justice's suggestions to the Inquiry for change. The suggestions require a radical rethink of the use of immigration detention and can only be effective if it is able to counter the government's policy and rhetoric of a 'hostile environment" which criminalises and dehumanises migrants, dispel the culture of disbelief within the Home Office, and diligently supervises the use of outsourcing and privatisation of services.

Statement of Truth

I believe that the facts stated in this statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

I am content for this witness statement to form part of the evidence before the Brook House Inquiry and to be published on the Inquiry's website.

Signature

Theresa Schleicher

Date: 3 February 2022

ANNEX 1

Medical Justice 2017 Case-Studies

(1) MZA **Home Office reference: A1233558**

Detention at Brook House from 17.07.2017 to 21.09.2017. Released from Immigration Detention on 15.11.2017 (from Harmondsworth)

Key issues arising from this case study:

- Detention Gatekeeper failed to apply Adults at Risk ("AAR") policy. Evidence of PTSD and adverse impact of detention, only assessed as AAR L2, and detention maintained.
- No Rule 34 Detention Centre Rules 2001 ("DCR") examination within 24 hours or at all.
- No Rule 35 DCR assessment of mental health, self-harm and torture made.
- Known mental health issues, including specific self-harming incidents and placed on ACDT but no Rule 35(2) DCR issued.
- Disclosure at ACDT / Mental health assessment of torture, including rape and the impact of detention owing to hearing keys, voices to kill himself and no Rule 35(1) or (2) DCR report issued.
- Food refusal on an ongoing basis but not treated as an issue of self-harm and investigated or a Rule 35 DCR assessment made.
- No proper consideration of impact of detention on MA in light of known PTSD diagnosis. Medical Justice report after transfer to Tinsley House was first time review of fitness to fly, but no review of fitness for detention.
- When Rule 35(3) issued after significant delay did not result in release
- Experienced degrading conditions of detention including lock in overcrowded cell.
- Witnessed officer misconduct

MZA's views about his experience of detention

Detention Environment/ Conditions:

- D wing was v bad. B wing was ok. Manager kept telling me will be moved and I said I didn't want to move anywhere. I felt secure there and if I was moved I feared my life would be in danger."
- "I was put in room with 3 or 4 others. We had no privacy, even to use the toilet."
- "They would lock you in all night. You lose sense of self in there. You cannot go to toilet in room as everyone can see you. No privacy and v bad place. BH was the worst."
- "In BH problems with 'spicey'. I saw lots of people smoking. They would then fall down and go to hospital. Bodyguards were v harsh to people who were ill because of taking the drug.
- I didn't know about spice until in BH. It felt more like a prison than a DC.
- I think the detainees from prison were selling spice and detainees get money from outside to pay for it. I wondered how spice got into the DC. I think guards brought it in but didn't see it happen. People selling it had no visitors so think must be guards that brought it in."

- "People had psychological problems – could not distinguish between love and hate. Many in detention had problems. I saw lot of fighting between detainees themselves. I did not feel safe. The fights always instigated by people from prison. They tried to involve me in the arguments but I had English so I could get out of the situation."
- "I think they should separate people from prison from people seeking asylum. It was the people from prison who were taking and selling the drugs."

Mistreatment/abuse:

- "I saw the tv programme, whatever was on the film happened all the time".
- "I was taken [from Brook House] to the airport to be removed [on 27/7/17]. I was racially abused that day. I speak some English so I could understand what people were saying. When I was brought back to the detention centre [after the failed removal], the guards were being racist. There was a person who seemed to be a manager or in authority. He said to the guards who were taking me "Why did you bring him back and not send him to his country? Why did you bring him here?" He seemed angry and had a red face. I didn't know his name. Other guards didn't reply.
- But some guards were ok. Not all were bad."

Use of Force:

- "It was normal to see guards being violent. If you were being disruptive they would send you to another camp. You could not do anything against the guards.
- I did not see direct assaults by guards on detainees. It would happen late at night and when locked in your room so no one would see. The assaults were mostly when people were taken [from the detention centre] to the airport. A friend was taken to airport and when he came back he had bruising on arms.
- The assaults would not happen with punches and kicks. The guards hurt your arms and put your body in tight positions.
- They wanted to send me to Turkey. 3 or 4 guards took me [from my room] downstairs late at night. They held my legs and arms and gagged me to take me to downstairs area. Then in the morning many guards forced me to leave the centre and took me by force to the airport. They twisted my arms, held my arms and legs to cause bruising. I had been told my ticket was cancelled and the guards knew that but they still took me. When I didn't get on the flight they took me to another DC. I think a saw a medic there."

Segregation/ Removal from Association:

- "When I had ticket [for removal], I was put in a room on my own for 24 hours and under observation. Guards were watching me all the time and taking notes about me."

ACDT:

- "Lots of time I wanted to end my life in detention."
- "I hurt myself when I was in detention."[1]
- I saw friend of mine hurt himself – he was immediately taken to another wing and I never saw him again. This was generally what happened if a person self-harmed. No chance to ask them how they were doing, if they were ok. They were just moved on."

[1] Medical records from IRC show that he did this by biting himself on the arm and using a razor when he could get access to one.

- "My child was born when I was in detention and I did not see until he was two months old. … Once my son came into world I had to stop thinking about committing suicide. It was hard as I had no right to visit my child – wife came to visit with our baby when I was in detention centre."

Food refusals

- "28 days of not eating – no one asked why I was not eating. They took body readings only, no conversation."

Complaints:

- "I spoke to HO after the programme to give them some information about what happen in BH.
- I was in a detention centre and I was told I had a visitor. It was a man and a woman, I think they said they were from a police – they spoke to me and took notes. They had interpreter. I told them about spice and how bad BH was."

Chronology	
Date	**Document and information**
17.07.2017	**Detained on reporting at Becket House**. (2 previous periods of detention in 2009 and 2014). Prior to be detained, HO had report from treating psychologist (dated 16.01.2017) in community stating that he suffered from "severe PTSD" due to torture and had "intrusive nightmares". Detention Gatekeeper decides to treat him as an AAR L2 under the AAR policy but decides to detain on basis of removal directions set for 27.07.2017. Aman solicitors write to HO to make representations about his self-harm risk, evidence as to his treatment for PTSD and requesting a Rule 35 report.
	Health Screening by mental health nurse. Notes thoughts of self harm and suicidal ideation. Asked for knife or razor and discloses recent self-harm by razor and biting self. Scars observed. Put on ACDT and referred to mental health. GP appointment booked.
18.07.2017	**GP appointment (Dr. Oozeerally).** Notes mental health problems started 3 years ago. When he hears keys, reminds him of the past and bites self to relief stress. "Very flippant" about killing himself and states he had not done it due to lack of opportunity. Put on 2 hourly observations for ACDT. *This is not a Rule 34 as it does not involve a full physical and mental health examination. The GP appointment does not result in a Rule 35(1) or Rule 35(2) or consideration of suitability for continued detention.*
24.07.2017	**Food refusal** (Day 1). Complaints that he does not have medication that he had previously been given.
	Mental health assessment. States he cannot breathe and that he is seeing someone in the room, telling him to die together. Also discloses that in Turkey he was raped in

	prison and tortured every night. Showed a scar in his pubic area. Advises that a Rule 35 will be booked. Arranges mental health review on 28.07.2017. *No Rule 35 ends up being booked prior to planned removal on 27.07.2017. Later request made by him on 09.08.2017.*
25.07.2017	**Food refusal** (Day 2)
	GP appointment Medication review.
	ACDT review. Used friend as an interpreter. No interpreter provided by healthcare. Expressed discomfort after witnesses detainees fighting. Expressed a wish to be killed as not coping. Worried about removal on 27.07.2017 and fearing being killed on return to Turkey. ACDT hourly observations recommended. Transfer to E wing next day in advance of flight.
26.07.2017	**HO decision to maintain Removal Directions for next day**. Application for stay on removal refused by Upper Tribunal.
	ACDT Review. Food refusal (Day 2). States he felt like a bomb and would rather kill himself. Decision made to be removed to E wing "in order to promote his safety. Put on constant supervision.
27.07.2017	**Failed removal.** Returned to Brook House. Tascor report by IS91RA Part C states: "captain refused boarding due to missing documents, flight over sold, families and kid, and potential physical/verbal disruption". Remains on ACDT
	Mental health review. Notes bruises on oth upper arms from biting self. Given medication for sleep. ACDT on 3 hourly.
01.08.2017	**Mental health review**. Feeling stressed and self-harming by biting to relief stress. Notes no evidence of psychosis.
02.08.2017	**Food refusal** (ongoing).
04.08.2017	**ACDT review.** Consideration of move to room to share with friend so he will feel safer. ACDT observations remain in place.
08.07.2017	**ACDT review.** Continued food refusal (Day 7). Complains that medical appointments had been cancelled because of failed removal. *Given ongoing food refusal, no consideration of this as a self-harm issue given the consistent expressions of suicidal ideation. No consideration of Rule 35(2).*
09.08.2017	**MZA requests Rule 35**.
11.08.2017	**ACDT review**. Food refusal (Day 10) No consideration of this as a self-harm / Rule 35(2) issue.
12.08.2017	**Starts to eat and drink.**

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14.08.2017	**Removal directions set for 03.09.2017**
21.08.2017	**Rule 35(3) by Dr. Oozeerally.** Torture by police on 3x in prison. Hit, beaten, dragged down stairs at night and raped. Broke his thumb by slamming thumb in the door (abnormal nail on left thumb) and hit is left foot with object (abnormal nail on left big toe.) Hit him in chest with metal object (scars present in sternal region). Thrown down some stairs and suffered injury to right scapular. Multiple scars on scalp from being hit whilst blindfolded. Given electric shocks. Had disclosed this to Medical Justice already. Had counselling for 2 years. Difficulty sleeping and gets nightmares. Nightmares worse at night when cell is shut as relate to torture experienced. Clinical view: "His scars are consistent with his account. His account is consistent with torture and he presents such evidence as a vulnerable adult. He seems low in mood and prolonged detention may have a negative impact on his health though currently no major concerns regarding his mental health."
23/8/17	**CID**: HO query to Healthcare on whether detention to 05.09.2017 would result in "significant harm".
26.08.2017	**Food refusal** (Day 1). Complains he has not been seen by dentist and that he needed treatment.
29.08.2017	**Further submissions received**. GCID states "nothing new that have previously been considered" – notes there is an outstanding Rule 35 and acceptance of AAR L2.
31.08.2017	**GCID** note records Rule 35 response sent to Brook House IRC – response maintains detention due primarily to imminence of removal – RDs set for 3/9/17
02.09.2017	**Judicial review claim (No 2) issued.**
03.09.2017	**GCID**: Tascor say that they cannot escort him to removal as they are 1 escort down and "due to the subject previous behaviour and medical history it wouldn't be safe for the team to attempt pickup"
06.09.2017	**Food refusal** (Day 12).
08.09.2017	**Requests temporary release** to see wife in hospital
17.09.2017	**Sees Medical Justice doctor**
21.09.2017	**27 day food refuser**.
22.09.2017	**Moves to Tinsley House**
05.10.2017	**Removal Directions set for 01.11.2017.**

Annex 1

18.10.2017	**Medical Justice report from Amy Chisholm** (Clinical Psychologist): Diagnoses complex PTSD. Notes moderate risk of suicide and "mental health is being significantly negatively impacted by his detention" with keys and doors banging triggering deterioration and flashbacks. Recommends that he should see psychiatrist. Does not believe fit to fl.
29.10.2017	**Home Office to Tinsley House healthcare** asking for fitness to fly to be re-examined
30.10.2017	**Tinsley House healthcare confirm fitness to fly.** Further submissions refused.
31.10.2017	**Judicial review. Interim relief refused on 31.10.2017**. (Goldman Bailey)
01.11.2017	**Transfer to Harmondsworth**
	Injunction granted on deportation.
02.11.2017	**Further submissions made in line with injunction directions.**
15.11.2017	**Released** after Director of IE authorises release. HO agree to withdraw asylum element of decision on fresh claim to reconsider.

(2) DX

Home Office reference: A1179939
Port Reference: DEU/300921
IFB reference: IFB03/013845/G
CRO number: 159536/07D

Detained at Brook House from 29.05.17 – 06.07.17

Key issues arising from this case study

- No medical examination after use of force used on enforced removal prior to transfer to Brook House even though DX arrived with open ACDT and complained about an assault sustained during an attempted removal.
- No documentation by Brook House of the use of force, even though GP examination identified bruising.
- No Rule 34 Detention Centre Rules 2001 ("DCR") examination within 24 hours of arrival at Brook House or at all.
- Despite expressions of self-harm / suicidal ideation, there was no mental health assessment. No Rule 35 assessment. ACDT process did not include clinician input. No Rule 35(2) DCR was completed.
- DX was not treated as Adult at Risk by reason of expression of self-harm / suicidal ideation or open ACDT.
- No monitoring of DX mental state during detention, despite open ACDT, expression of suicide / self-harm. Medical Justice casework notes record DX distress, including a note of food refusal and lack of interest by others in this shortly before ACDT process was closed.
- DX is the detainee on the Panorama programme footage referenced by a member of Brook House staff stating *"He's a penis. If he eats or does not eat, it doesn't matter."*
- No effort by Brook House healthcare to comply with R33(9) DCR to ensure clinical information that arose in detention was available to DX's GP in the community when he was released.
- Disclosure of the HO file shows that in November 2017 the Home Office and Government Legal Department did not consider that raising an allegation of being a victim of assault at Brook House was a barrier to removal from the UK.

Immigration History

DX is Iraqi and entered the UK, aged 22 in 2003. DX has a complex history of applications for leave in the UK. At the time of his detention at Brook House, he was appeal rights exhausted and he had resisted removal to Iraq. He was subsequently granted refugee status on 28.10.19.

He had experienced a prior detention from 26.09.2007 to 28.07.2008 further to a conviction for Sensitive/Irrelevant and a recommendation for deportation. This was his only criminal offence. He complied with reporting on release from immigration detention and his tag was removed on 21.9.10. He was recognised as low risk to the public prior to his detention in 2017.

Prior to being detained at Brook House, he had been detained from 27.03.2017 at Morton Hall, and then Colnbrook from 04.04.2017 and then back to Morton Hall on 06.04.2017 before transferring to Brook House on 29.05.2017.

He was re-detained less than two months after release from Brook House and detained at Morton Hall from 30.08.2017 to 01.09.2017. When re-detained, he was assessed as at risk of self-harm and referred to the Mental Health Team. He was also assessed as AAR level 2 due to risk of self-harm.

He was then released and re-detained again for a fourth period of detention from 15.11.2017 to 04.12.2017 at Morton Hall and then Colnbrook.

At the time of detention, DX was in a relationship with a British woman (since 08.2010). He was a stepfather to her three children and they lived together as a family from 12.2010. His partner was unable to regularly visit him in detention in 2017 as for the majority of this time as he was located some distance from their home.

DX account of his experience of Brook House

Staff culture / use of derogatory or discriminatory words / bullying

- "Staff would look at you as if you were a dog. If you asked them for anything it was as if you were fighting them. In Brook House the only ok people were the journalist (Callum Tully) and an Arab lady (I don't know her name.) I heard lots of bad language from guards at Brook House. If a person answered back, 4-5 guards would take you to the solitary room. Guards would always say thing to you like "Why are you here? Why didn't you go back to your country?"

Use of Force

- During the enforced removal I was in a waist restraint belt and handcuffs when taken to Heathrow: "I was kept in the van until the plane was ready. There were 5 men and a doctor. The assault happened when just inside the airport. I was in the corridor, on the stairs near the plan. The guards told me I must shut up for 10 minutes. I asked why are you putting me on the airplane? When I resisted them on the stairs they were holding my shoulder and hands. One person pushed me back up the stairs. Two guards grabbed my shoulders and put their hands on my neck. I felt faint and I thought they were taking me to hell. They put their hands on my neck and I could not breathe. They pushed me on the stairs up towards the airplane. One person put his hand on my mouth and kept telling me not to shout. I bit him and he put his hand over my mouth again.
- They moved me to the airplane and I said to the airline staff 'they are going to kidnap me. I showed them my handcuffs which were hidden under a white covering on my wrist and said 'they are going to take me to hell.' The airline staff would not let me on the plane (it had other passengers on it.)
- I was not seen by a doctor [at Brook House] after this assault. They would not let Name Irrelevant [partner] visit me. My solicitor sent someone to see me. I had bruising to my shoulder."

Food refusal / self-harming

- "Lots of people did hunger strikes because they don't care about us in detention. I am a normal person but they gave you no respect.
- Staff knew I was on hunger strike but did not care. One person said "He's a penis. If he eats or does not eat, it doesn't matter." (This was however not recorded on the IRC health records but was recorded by Medical Justice.)

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Impact of detention
• "Many nights I wake up and think about detention." "I often have dreams when I am in the solitary room, am taken [from the Detention Centre] to the airport. I have dreams about the guards hurting me, bursting into my room in detention and then I wake up."

Chronology	
Date	**Document and information**
24.03.17	**Decision to detain on reporting** on 27.03.17. Detention for purposes of Documentation Interview for Iraqi nationals.
27.03.17	**Detained on reporting (GCID)**: Assessed as low risk of absconding. Not AAR. Anticipated he would be released shortly after the interview, subject to compliance.
	Transferred to Morton Hall
04.04.17	**Transferred to Colnbrook**
06.04.17	**Transferred to Morton Hall**.
27.04.17	**Removal directions set for 06.05.2017.**
03.05.17	**Fresh claim made by Duncan Lewis**. Requests cancellation of removal directions.
05.05.17	**Placed in segregation to effect removal.** Medical records note he became "volatile and angry".
05.05.17	**Transferred to Colnbrook**. Removal directions deferred after further representations
25.05.17	**Fresh claim refused.** Limited notice Removal Directions for 29.05.17 served.
	IS 91RA Part C (Colnbrook). ACDT opened because of threat of cutting his neck further to refusal of fresh claim and issuing of removal directions.
28.5.17	**Decision to use escorted removal for 29.05.17.**
29.05.17	**Segregation for planned removal** following threats to harm himself if deported.
29.05.17	**Removal aborted.** DX was put in waist restraint belt but still resisted removal.
	Transferred to Brook House on an open ACDT.
	IS91 RA Part C from TASCOR: Resisted removal whilst in waist restraint belt.
	Health screening: ACDT opened. States he will be better off dead. Disclosed his biting escorts and escorts throwing him in the toilet. Notes red marks on his left arm. States he does not want single room as fear of dark and need light on 24 hours a day.

30.05.17	**GP Appointment (Dr Oozeerally)**: notes *"very upset about enforced removal."* Notes bruises to both biceps consistent with application of pressure - 3 circular scars on one bicep and 4 on the other. Also bruising to his wrist. Notes complaint of difficulty sleeping as well. Plan: Adv simple analgesia (pain medication). No photographic evidence taken.
01.06.17	**GCID**: **Seen for pre-departure induction**
	GCID: Scheduled removal on 10.06.2017 not to be disclosed "in light of subs disruptive behaviour". Existing Limited Notice of Removal Window valid until 25.06.2017.
2.6.17	**Pre-action protocol letter** challenging detention, removal and deportation. Refers to DX relationship with his partner and her children.
	MJ database entry: DX tells caseworker he has not been eating since 3pm yesterday and no one has asked him about this. He has bruises on both arms. Can't sleep at night, in pain, thinking too much. Feels he can't go back to Iraq."
05.06.17	**ACDT Form closed.** No details of the reasons.
	Removal Directions cancelled
07.06.17	**Judicial review lodged.**
14.06.17	**Home Office response to Pre-Action**, refusing submissions and refuses to defer removal.
19.06.17	**Detention reviewed and maintained** on basis of high absconding risk. Notes outstanding judicial review.
20.06.17	**Detention approved by case progression panel**: ETD in place, although expired on 10.06.17 can be revalidated quickly. Factor in favour of release is non-expedited suspensive judicial review but JR can be expedited.
29.06.17	DX **submits transfer request to move to Morton Hall.**
06.07.17	**Released from detention**: Immigration bail granted by First-Tier Tribunal and

(3) D735 **Home Office reference: 7801475**

Detention at Brook House from 10.06.2017 to 23.08.2017.

Key issues arising from this case study

- Detention authorised at outset notwithstanding being an Adult at Risk Level 2. Had a history of self-harm already when detained and a known history of depression and a current prescription of anti-depressants. He disclosed a history of self-harm when detained.
- No Rule 34 Detention Centre Rules 2001 ("DCR") assessment undertaken at all in that there was no full assessment of physical and mental health. No identification of his history of torture to prompt a Rule 35 report.
- Rule 35(3) DCR report only obtained when advised by his immigration representatives to directly request this. Then there was a significant delay of 12 days before the appointment was scheduled.
- Rule 35 assessment did not include consideration of mental health symptoms and risk of suicide or self-harm. Did not consider impact of detention.

  Despite barriers to removal, including outstanding Judicial Review proceedings, detention maintained for Adult at Risk L2 where no removal directions could be issued, no ETD was available.
- Had an asthma attack in detention after not accessing medication.
- Difficulties accessing anti-depressants.
- Repeated detention reviews maintained detention on basis that although Adult at Risk, he can be "effectively managed" in detention by healthcare when that is not a threshold for maintaining detention. Previous policy had "satisfactory management" but this was heavily criticised by Stephen Shaw with a clear recommendation that this threshold was removed and is not included in the AAR policy.
- On HJ's account, bullying, and violence was routine within Brook House.

Immigration history

HJ came to the UK in 2005 and had his first contact with the Home Office on 24.06.09 when he applied to marry; the application was subsequently withdrawn. He was recorded as overstaying in March 2014, and was unsuccessful in his asylum claims, made in May 2014, May 2015 and March 2017. At the time of his detention on 09.06.2017, he was Appeal Rights Exhausted.

Information about vulnerability before detention

Letter from GP dated 11.5.16 had been provided to the Home Office which stated HJ had suffered a head injury in Bangladesh and was feeling depressed and had been started on a course of anti-depressant medication.

HJ's account of his experience at Brook House

Conditions of Detention / Wing culture

- C wing was frightening place. Found the place had an aggressive feeling. I often saw people fighting and shouting. I also got used to seeing people who seemed to have taken drugs as they were acting strangely.

- There was one incident where a big group getting frustrated as the door was not being opened. There were many angry people collecting near the door. It is hard to see everything that has happened and I was in the middle of this. People went to get things from their rooms to throw. I could see some people got hurt, their faces and heads were bleeding. Guards gave medical treatment and took people to healthcare. I escaped as I did not get hurt and did not need to see a doctor. I can't remember the date this happened. Whilst this was happening I thought I might have a heart attack, I was so frightened. Afterwards I kept thinking about it and I could not sleep, I kept remembering what happened and how dangerous it was.

Use of derogatory / abusive / discriminatory language / bullying

- I got used to guards disrespecting me and saying things sarcastically like 'Do you think this is your house?' if you asked about anything. It is hard to remember each time a guard acted in this way as it happened so often. I soon decided that I did not want to approach the guards for anything or have any contact with them.

- I would just try and stay in my room as much as possible. I started to feel desperate and frustrated but there was nothing I could do. I lost my appetite, and I could not sleep.

- I think there were two times when guards came to my cell without any warning. They would tell me that I had to pack my things and go to another detention centre.

- The first time this happened it was early in the morning, I was not expecting to be told to move. I said to the guards that I would need contact my solicitor. The guards did not touch me or try and make me move. I was crying, I did not know what would happen next. It was a very bad moment. They said 'Ok. You won't move today.'

- Another day guards came into my room unexpectedly and said 'Tidy up, you are leaving.' I said 'I am not going.' My voice was not angry when I spoke to them. When I said this they then just left me alone.

Clinical care issues:

- I would go to get my medication and it would not be there. Staff would tell you to come back again tomorrow. This meant I missed my asthma medication and antidepressants several times. I did not know what to do when this happened.

- If there had been an interpreter I think it would have been easier to speak to the doctors and to explain I was feeling very bad. At times I felt suicidal. I can't remember the medical staff asking me about how I was feeling. I did not have enough English to explain my problems more deeply.

- I remember my Rule 35 appointment. I could not tell the doctor I was feeling suicidal. I had seen what happened to people they thought were mentally ill. The guards would take them and lock them in a jail cell; a separate room on their own, to calm them down. I was worried this would happen to me if I said how bad I was feeling.

- I had difficulties with my asthma at Brook House. There was a night when this got worse. I felt I could not breathe and my medication had run out. My roommate used the emergency button in the cell as he was worried about me. Someone from healthcare came and they gave me emergency medication. The fear that the asthma would come back and I had no medication to manage this was another reason to feel worried, but there was nothing I could do.

Use of force / self-harm

- I saw guards restraining detainees on the floor and using handcuffs so often it is hard to remember individual times. When I was in my room I could often hear people shouting outside, things like 'I have a solicitor' and I would hear the sounds of a struggle, but could not see exactly what was happening. This often happened during the night.
- So many times I saw people being angry with the guards shouting or fighting them but I did not know what had caused the situation. I would just see the pushing or hear the yelling. When this happened, it was frightening and if I was not already in my room, I would try to get away.
- There was one incident when I was really worried that things had gone too far with the guards. He was a young Algerian guy, a boy, I am not sure about his name. He used to cut people's hair and they would pay him what they could afford. One day, I cannot remember the date or even which wing this happened, but he jumped onto the netting. I think he was trying to kill himself. People were watching and I thought he would get hurt by jumping. The officers took him off the net and held him on the floor. They held him with his face down and his body up, it seemed a long time. There were several guards, one held the boy's neck and another two held him down on his back with their knees. They handcuffed him and told him to calm down, but the boy could not move. I was worried he could not breathe as he was silent. After he was handcuffed the guards moved the boy to his feet. Then he started shouting and swearing. He kept repeating "I don't want to be here. I want to leave." Guards did not say anything in reply they just moved him away.[2]
- But the most upsetting sight at Brook House was when I saw a person who had been hurting himself. I do not know the date of this incident or the name of the person. He was a middle-aged man. I think this happened when I was in C Wing. I do have a strong memory that the person would not leave his room. When the guards took him he was screaming and shouting. I don't remember that the guards said anything to him. It was shocking to see him covered in blood. I think he had cut himself with a razor many times on his neck and hands. I think he had to go to hospital for treatment. He came back to detention covered in bandages. I was shaken to see someone in this state, so desperate. At the end of the day, he was going through the same thing as me. He could not accept being jailed in a building and no one had helped him. It was shocking to see him hurt himself and it made me worry as I was in the same situation. At times I wondered if I would end up the same way. I can still see the way that he looked with so many injuries.[3]

Complaints / barriers to complaining :

- There was no one to complain to. The staff were so rude and dismissive you could not speak to them directly about their behaviour.
- I did try to make a written complaint. I think I said something like 'Services are bad' but I am not sure about the words I used. I didn't have fluent English so I could not explain things in detail, but I wanted people to know there were problems at Brook House. There was a letterbox for complaints so I used that. I did not get a response. I think I gave my name on the form, but again I am not sure.

Impact of detention

- If I am asked now about the guards I can see them in front of my eyes. I have started shaking when thinking about them and remembering their behaviour. It makes my heart beat fast. Sometimes it gives me pain in my chest to think about this period of my life. I become down thinking about my time detention, but although I am upset, I know I must cope.

[2] This person is referred to by the Inquiry as D275.
[3] This person is referred to by the Inquiry as D1914.

- I dream about detention and my time at Brook House. I hear thumping of cell doors, shouting and people screaming things like 'I have a case pending' as a guard forcefully takes them away. I always remember seeing the person who was covered in blood when he hurt himself.

Chronology of documentary information	
Date	Document and information
09.06.2017	**Encountered at immigration raid at a restaurant.** Transferred to Bromley Police Station. Noted to be on anti-depressants and had inhaler for asthma. He had medication for both conditions when taken into custody. Disclosed he had self-harmed by cutting his arm 7/8 months prior. Recognised as an AAR L2 as a result. Detention authorised based on basis of the risk of absconding and notice of removal served with removal directions after 15.6.2017 for a 3 month window.
10.06.2017	**Transferred to Brook House IRC.**
	Health screening at 3.01 am. Discloses a history of torture and self harm. States he has a depressive illness requiring prescription medication (citalopram) and asthma. Notes history of self-harm, shows cuts on arms. Advised to contact Healthcare if need another Rule 35. Referred to an RMN for a mental health assessment.
	Detention approved by gatekeeper due to high risk of absconding and refusal to accept voluntary departure. No evidence detention would be harmful to health.
11.06.2017	**GP appointment (Dr. Husein)**. Medication review. Anti-depressant medication is prescribed. *Not a Rule 34 assessment as not a full physical and mental state examination despite disclosure of past self-harm and pre-existing depression and medication for it.*
13.06.2017	**Nurse appointment**. Notes history of depression. Noisy cell. Having difficulty eating.
14.06.2017	**Judicial review issued and served on Home Office**
	Request made for TA
15.06.2017	**7 day review of detention.** Awaiting ETD. Notes pending JR.
	HJ refused to sign ETD form
16.06.2017	**Detention review**. Maintains detention in the light of refusal to cooperate with ETD, JR to be suitable for expedition. Previously absconded.
	Complained he had not received medication for three days. Fasting for Ramadan. Complained of coldness in hands. Arrange to have medication at night.
17.06.2017	**Discharged from mental health caseload** for non-attendance at appointment three times.
19.06.2017	**Request Rule 35.** Stated he has injuries sustained to his head and back in Bangladesh during political violence in Bangladesh.

	Request for a travel document to High Commission of Bangladesh.
20.06.2017	**GP appointment**. Shows dental appointment and requests rebooking. Anti depressant medication to be provided in the evening due to Ramadan.
22.06.2017	**Detention reviewed and maintained**. Accepted to be AAR Level 2 because of prescription medication. No concerns that asthma / depression means not effectively managed in detention.
22.06.2017	**Request for TA with sureties**
23.06.2017	**Further request for TA** raising complaints about delay with access to medication
	Judicial Review served on Home Office
26.06.2017	**Refused to leave Brook House for Colnbrook for ETD interview** with Bangladeshi authorities on 29.06.2017.
29.06.2017	**TA refused**
01.07.2017	**Rule 35 appointment** with Dr Oozeerally Records brief account of torture and details significant scarring. Notes his account of depression and attempted suicide last year. On antidepressants. Anxious about being deported. GP accepts he may be a victim of torture and that he gives a detailed and credible account of torture and has scars very consistent with this. But states he does not present with serious mental health issues and is on medication. Appears stable in respect of his mental health currently."
02.07.2017 (sent 04.07.2017)	**Home Office response to Rule 35 report**. Accepts HJ may be AAR L2 but detention maintained because was encountered when working illegally and had not complied with reporting conditions in the past. Detention pending resolution of outstanding judicial review. Removal possible in 7 weeks (5 week for court decision and further 2 weeks to arrange removal. Further, although AAR, doctor has not indicated that a period of detention is likely to worsen your symptoms."
04.07.2017	**Detention reviewed and maintained** with immigration factors outweighing presumption. No concerns raised by IRC healthcare that his conditions cannot be effectively managed in detention.
05.07.2017	**Acknowledgment of Service lodged**
06.07.2017	**Detention reviewed and maintained** reliant on same reasons.
10.07.2017	**Risk assessment completed concerning escort to dental hospital**. Long cuffs advised.

Annex 1

26.07.2017	**GP Appointment** as ran out of asthma medication. " Mentions worsening symptoms at night but spends (sic) like having panic"
27.07.2017	**Asthmatic attack.** Complain of shortness of breath and difficulties breathing.
28.07.2017	**Request for TA**. Removal was not imminent given pending judicial review. Also set out concerns about HJ's medical treatment in detention regarding lack of access to asthma medication, suffering an asthma attack in detention when he could not access this.
03.08.2017	**Detention review and detention maintained** reliant on same reasons.
03.08.2017	**Request for TA**. HJ's representatives raise a complaint about level of healthcare concerning his asthma.
04.08.2017	**Detention review and detention maintained** as JR outcome expected imminently. HJ can be referred for scheduled ETD interview and document can be completed within 2 weeks from interview.
05.08.2017	**Section 4(1)(c) bail address offered for purposes of bail.**
15.08.2017	**Request for TA** due to judicial review claim
	Case progression panel approve continuing detention. AAR L2 but with expedited judicial review
16.08.2017	GP appointment. Complains of worsening asthma symptoms. Prescribed medication. Seen by RGN on wing at 23.42 due to worsening asthma symptoms, noted asthma inhaler had run out . Requested sleeping tablets, encouraged to try sleep relaxation techniques.
23.08.2017	**Released from detention due to timescale of judicial review.**

(4) CBT **Home Office ref: T3016799**
Port ref: ASC/ 4878584

Detained at Brook House from 18.03.2017 to 03.07.2017. Was detained from 07.03.2017 at Morton Hall IRC.

Key issues arising from this case study

- No Rule 34 assessment at Brook House.
- Rule 35 assessment only carried out 2 weeks after he first entered into immigration detention, even though he disclosed torture at a health screening when he was first detained on 7 March 2017 at Morton Hall. Even after disclosing a history of torture again at health screening at Brook House, a Rule 35(3) only carried out four days later.
- Repeated records of CBT being flat in mood, having depression and PTSD symptoms. But no psychiatric input and his PTSD was not recognised by healthcare staff at Brook House. No consideration of impact of detention on depression or PTSD.
- Inadequate / lack of clinician care for mental health, with management only via medication and group interventions that were inappropriate to address CBT's symptoms of mental illness. No consideration of the fact that CBT's PTSD could not be adequately treated in detention.
- RMN reviews focused on whether CBT had psychotic symptoms and ignored all symptoms of impact of detention on PTSD including intensity of flashbacks, nightmares, inability to sleep.
- No feedback from healthcare to HO on the ongoing trauma symptoms and his increasing difficulties in coping with impact of detention.
- No consideration of Rule 35(1) and whether continued detention was harmful.
- Rule 35(3) did not result in release focus on immigration factors being a 'trump card' not treated as unsuitable detention despite AAR Level 2.
- Home Office failure to identify information concerning vulnerability from earlier asylum proceedings and to apply this to detention decisions

Immigration History

CBT is Cameroonian and arrived in UK on student visa in 2014. His asylum claim, made in July 2015, raised a history of torture and that he had been prescribed anti-depressant medication after arrival in the UK. He became appeal rights exhausted in February 2017. He had no criminal offending history and was compliant with reporting requirements.

CBT's appeal bundle included GP medical records setting out a diagnosis of PTSD in July 2016, as well as anxiety and depression in March 2016. Records refer to CBT's symptoms of nightmares, anxiety, panic attacks, low mood and set out a regular prescription of antidepressant medication (sertraline) and a referral to counselling.

CBT was granted refugee status on 30 September 2019. He has an outstanding civil claim for unlawful detention.

CBT's account of his experience of Brook House

Use of Force

- It was a "bad time" when a person was to be deported. The DC would be locked down. It often happened early morning when you were sleeping.
- Saw a Nigerian detainee being restrained in a type of cling film as part of an attempted removal. "The officers beat him to make him walk" so that he would leave.

Drugs use

- Lots of people took spice. I was not sleeping and I was told that spice would help me sleep so I smoked some. It made me ill. It was normal to see other people taking spice and being ill because of it.

Self-harm / suicide

- Saw an Iranian man who wanted to commit suicide. He threw himself off the landing and the only reason he didn't die was there was a fine net that you could not see that stopped him.

Clinical care

- Had to queue for a very long time for medication. Sometimes I would not get the medication for the day. People would get frustrated.

Impact on CBT

- Brook House "was a very traumatic place. It was not easy to spend one night there. It was a nightmare. It was the worst place to be if you were depressed. I would not want my worst enemy to be there. I had panic attacks and could not leave my cell."
- "It was like a jungle. It was a very tense atmosphere. People were always on edge and all I could do was keep quiet."

Chronology	
Date	Document and information
07.03.2017	**Dawn raid (6.36am) at accommodation**. Taken to Wirral Police Station. CBT states he has "suicidal thoughts." Treated as Adult at Risk level 1. No regard to known mental ill-health.
	Detention Gatekeeper Referral: Removability assessed as low, risk of harm to the public as medium and harm matrix score was C. Removal said to be imminent.
08.03.2017	**Detained at Morton Hall IRC.**
08.03.2017	**Reception health assessment (12.23am)**: Discloses history of depression, prescription of antidepressants and self-harm with an elastic band 6 months ago. Gives account of torture history. Referred to mental health team.
	GP assessment (not Rule 34): Notes depression diagnosis for 3 years, anti depressant prescriptions. Notes he presents as flat, poor eye contact. Recommends MHT appointment.

11.03.2017	**Removal Directions issued for 17.03.2017.**
13.03.2017	**Medical record**: CBT found on the floor, conscious and alert with no signs of being affected by drugs. Plan: officers to monitor CBT
14.03.2017	**Medical record**: Notes CBT disclosure of "occasional thoughts of self harm". Wears an elastic band on his wrist at these times and snaps it against his skin to help manage thoughts.
14.03.2017	**Further submissions for a fresh claim.**
16.03.2017	**Further submissions refused.**
17.03.2017	**Judicial review lodged challenging removal.**
	Injunction granted against removal.
18.03.2017	**Transferred to Brook House from Morton Hall in early hours.**
	Health screening (03.08am): Discloses torture in Cameroon, poor eye contact, claims has self-harmed by banging his head on wall but no current thoughts of self harm. Notes some degree of PTSD and treatment (counselling) in the community.
20.03.2017	**RMN appointment**: "Flat in affect with poor eye contact. Was only able to engage superficially." Again discloses account of torture. Notes need for GP pre-Rule 35 appointment on 22.03.2017.
21.03.2017	**Food refusal**. Nurse review. Raises torture claim again. Notes low mood. CBT discloses that in December 2016 self harmed by banging head over the wall in his home.
22.03.2017	**GP appointment (Dr. Oozeerally)**. Review of medication.
	Rule 35(3) assessment Tortured in Cameroon 2010, 2011 by Police because of sexual orientation on two occasions. (1) 2 weeks in police station. Beaten on 3 occasions. Made to sit with leg resting but extended, hit to the legs with metal. Beaten with metal rod to the arms and a wooden ruler. This lasted for approximately 10 minutes. (2) 2 months in police station: Beaten 2-3X a week) and then on one occasion in the night plastic bag was melted and dripped onto his skin. Presents with low mood and poor sleep. Low mood and nightmares of being chased by police for 2 years. Referred to mental health and medicated. Notes currently refusing food. Scars: notes numerous scars on anterior shins and linear and hyperpigmented more circular scars on forearms. CBT explains some of these scars related to rituals and also vaccine scars.

	Accepts account of torture. Notes CBT states mental health declined recently. May be because of detention and lack of medication or therapy.
25.03.2017	**RMN Review**. Notes medication prescribed but not collected. Notes poor sleep and ongoing nightmares. Notes withdrawn in IRC and no socialising with deatinees. Notes past self-harm but no current thoughts and denies suicidal ideation. Mental health referral form completed but limited information included (stated CBT was in Wing B)
28.03.2017	**Further submissions for a fresh claim made.**
	Rule 35 Report re-sent to Home Office,
29.03.2017	**Permission refused in judicial review.**
	Response to Rule 35: Accepts account meets definition of torture, Adult at Risk Level 2 but maintains detention to ensure compliance with enforced removal. Acknowledges that there are pending further submissions.
	Further submission refused.
30.03.2017	**Further judicial review challenge.**
01.04.2017	**Mental Health Review (nurse):** Appears claom and settled and sleep improved from medication. Plan: Review to continue. To attend group activities and maintain a structured day. To remain compliant with his prescribed medication."
03.04.2017	**Attends Emotional Health Group for stress management.** noted as appearing "anxious and distressed."
04.04.2017	**HO to IRC healthcare re medical escort advice.**
07.04.2017	**Medical Justice appointment in IRC. (Dr. Steen)**
10.04.2017	**Permission refused in judicial review.**
12.04.2017	**IRC healthcare to HO stating CBT would not require a medical escort**
21.04.2017	**RMN Review after several missed appoitments**: Notes poor eye contact and limited engagement. Presents as low in mood. Not been taking his prescribed medication. Should continue to attend emotional health group,
24.04.2017	**Attended emotional health group:** Reports flashbacks at night disturbing sleep. Reports just barely coping. Advised to seek input from healthcare.

28.04.2017	**RMN Review**. Mood has dropped since last review. Flat and blunted in affect. Down cast in presentation. Discussed possibility of an increase in his medication. Continues to busy himself during the day with church, classes and gym. Flashbacks becoming more intrusive and unable to return to sleep afterwards, despite using grounding techniques taught.
28.04.2017	**GP increased medication as requested by RMN**. No face to face assessment.
05.05.2017	**RMN Review**: Improved mood although still having flashbacks. Said his appetite is poor , but tries to eat and drink. No suicidal thought or self harm ideation was reported.
09.05.2017	**GCID**: No legal barriers to removal. CBT on sleeping tablet and risk of self-harm so medic escort is required. Past disruption of removal. Notes AAR Level 2. Three escorts deemed appropriate.
10.05.2017	**Medical Justice Medico-Legal Report completed (Dr Iona Steen)** Referenced CBT's emotional response when recounting history of torture. Level of distress required a pause in the assessment. Diagnosed CBT with PTSD with possible auditory hallucinations, as well as a mild to moderate depressive episode. Assessed as at low risk of self harm and suicide. Very detailed description of scarring, with conclusion that this was "highly consistent" with his history of torture. Considered at risk of further deterioration due to being detained and loss of his social network in the community. Forced return would lead significant risk of further deterioration. Assessed CBT as unfit for detention as incarceration was having a re-traumatising effect on his mental health. Considered CBT needed psychological intervention for PTSD and that medication should not be first line treatment for depression without accompanying psychological intervention. Recognised that a stable setting and long term security would be needed to engage with psychological therapy.
11.05.2017	**Removal directions set for 01.07.2017** with escorts and medic
12.05.2017	**RMN Review**: Complains still have difficulty sleeping, No suicidal thought or self harm ideation reported. Plan to attend emotional health group and to return to healthcare if sleep concerns continue
15.05.2017	**Emotional Health Group**. States that he experienced heart palpitations. Physical symptoms of stress were discussed.
20.05.2017	**RMN Review**. Notes he "continues to present as flat in mood,"
22.05.2017	**Attends Emotional Health Group.**

23.05.2017	**RMN Review**: Mood continues to appear flat. Increase in Mirtazapine to 30mg has not helped. Feeling pressure because of his present situation and not knowing what is happening with his case. Said he has no thoughts of self harm or suicidal ideation.
24.05.2017	**GP Review:** Notes mood is flat and has avertive gaze. But n o psychotic features or poverty of movement. Mirtazapine increased to 45 mg
29.05.2017	**RMN Review**: Shows report from Medical Justice (10.05.2017). Denies any thoughts of self harm or suicidal ideation.
05.06.2017	**Emotional Health Group**: Still waking up and experiencing flashbacks. Trying the relaxation exercises and they helped for a couple of minutes but then distressing thoughts would return. Appeared more distressed than he has done in previous groups. Expressed his frustration of impact of not knowing when he will be released and how that is also affecting him.
12.06.2017	**Emotional Health Group**: Stated he was still having difficulty relaxing.
17.06.2017	**RMN Review**: Finds it difficult to talk about what he describes as trauma and asked if he could see a specialist. Has been talking to the Samaritans on phone as he finds this easier because he is not face to face. NOTES his anxiety and low mood are connected to him being held here in detention and fear of what will happen if he has to return to his own country. Although anxious, no evidence of psychotic symptoms or content in his speech. Denies thought of self harm or suicidal ideation.
25.06.2017	RMN review: Still very worried about being held here in detention. No evidence of any psychotic symptoms or content in his speech. Denies any thoughts of self harm or suicidal ideation at this time.
26.06.2017	**Further submissions on a fresh claim submitted.**
	Duncan Lewis provides HO with Medical Justice MLR (from 10.05.2017) and request Temporary Admission.
27.6.2017	**Healthcare Enquiry to IRC Brook House**: CBT claims to have suicidal thoughts/ PTSD. Solicitors have raised concerns and have asked for an assessment on CBT. Case added to complex case log." **Healthcare Response**: He is already under our mental health team he was seen on 25/6/17 fully assessed and has another appointment on 29/06/17"
	Removal Directions cancelled for 01.07.2017
28.06.2017	**Further submissions amount to a fresh claim**. Notes PTSD diagnosis and MLR from Medical Justice states detention is detrimental to his health. Previous Rule 35 accepted victim of torture. **Consider as Adult at Risk Level 3. Release recommended**

29.06.2017	**RMN Review**: No evidence of any psychotic symptoms or content in his speech and denies any thoughts of self harm at the moment. Had elastic bands around his wrist which we discussed. Taught this approach when he was in hospital to keep him focussed when he starts to get anxious and worried about situations and also stops him from self harming
03.07.2017	**CBT released from immigration detention**

(5) D1318

1. D1318 is a Pakistan national with serious limb injuries attributed to torture by the Taliban. He suffered from pain in both feet due to deformity; he had no toes on either foot. He could not walk with shoes, had reduced mobility, requiring a wheelchair / crutches to walk.

2. D1318 was detained at Brook House IRC between 4 and 28 August 2017. He was then transferred to Harmondsworth and subsequently released on 31 August 2017.

3. His physical disability and account of torture was disclosed at the reception screening on 4 August 2017. It noted his need to be on the ground floor.

4. D1318 did not have a Rule 34 examination[4], only a GP appointment when he was prescribed ibuprofen for the foot pain and advised to bring him walking stick from home. A form for "Provision of Services for the Disabled" was completed on the same day indicating that D1318 had a disability, but there is nothing in the records accessible to Medical Justice to indicate what services were provided. No walking aid – whether a wheelchair or crutches – were given to him. At the start of the detention, he was put in a wing where he had to climb stairs which was difficult owing to his disability. No adjustments were made to accommodate his disability.

5. A request was made on 7 August 2017 for crutches as D1318 was unsteady on his feet. He is seen by a GP again on 8 August who recommended a referral to psychotherapy as crutches could not be given to him without a physiotherapy assessment. The GP voiced concern on how to manage D1318 pending the assessment. A physiotherapy referral was made on 11 August 2017. In the meantime, only paracetamol and ibuprofen was given. He was unable to walk properly and was at risk of falling without a walking aid. D1318 reported not being able to sleep because of pain in his feet, and he resorted, against advice to wrapping a plastic bag to ease the pain.

6. On 11 August 2017, D1318 fell in the shower. He is prescribed naproxen for pain relief.

7. On 13 and 14 August there was concern that D1318 was taking too much medication for his pain and his Naproxen is taken off him

8. On 17 August 2017 D1318 was taken to a physiotherapy appointment in Crawley and was given crutches. No further treatment plan was put in place. The only other treatment was pain management via analgesics – he was prescribed codeine.

[4] Rule 34 provides that "Every detained person shall be given a physical and mental examination by the medical practitioner (or another registered medical practitioner in accordance with rules 33(7) or (10)) within 24 hours of his admission to the detention centre."

9. No R35 assessment was undertaken during the month-long detention at Brook House despite his account of torture and his obvious disability which was not and could not be adequately treated and accommodated in Brook House.

10. D1318 wrote directly to the Home Office on 8 August 2017 to request his release given the impact of detention on his physical condition. The response was that he had been referred to a physiotherapist. No consideration was given to release. He was also referred to Medical Justice by another NGO to assist in obtaining the necessary clinical support.

(6) MJ8375

1. MJ8375 is an Indian national with a history of torture, trauma-related mental health issues and a history of self-harming and past suicide attempts.

2. MJ8375 was detained at Brook House IRC between 5 August 2017 and 19 September 2017.

3. MJ8375 was not asked questions about his mental health or about whether he had experienced past torture in the reception screening. There was no Rule 34 examination within 24 hours of his being detained at Brook House – when seen by the GP the consultation was focused on his physical health. He had an initial GP appointment but that did not involve a full physical or mental state examination.

4. A mental health referral was requested on 11 August 2017 after MJ8375 disclosed that he had previously been hospitalised for mental health issues. This was carried out on 13 August by a mental health nurse (MHN). Recommendation was made for him to attend the Emotional Health Group. He had a mental health review on 19 August and was encouraged to engage in activities and referred to RAPT/Forward for stress management support. He continued to attend regular appointments with the mental health nurses.

5. On 16 August 2017 MJ8375 made a claim for asylum which meant he could not be removed until it was finally determined.

6. MJ8375 requested a Rule 35 report on 12 August 2017. But the R35(3) assessment did not then take place until 26 August 2017. The Rule 35 noted that he was also sexually assaulted by police officers. A large scar to the left triceps was noted as well as multiple other scars on both wrists as well as above the eyebrows and scars on his left foot and left knee. He disclosed having tried to commit suicide on multiple occasions and suffering from poor sleep. The Rule 35(3) conclude that "*he may be a victim of torture and does appear to be suffering from mental health issues. ... the presentation is consistent with his account*." The Rule 35(3) however stated that there was no deterioration in his mental health. This is inconsistent with the IRC medical records which recorded that JS was suffering from anxiety and stress as a result of being detained and required regular emotional health group sessions.

7. In the R35(3) response, it was accepted that MJ8375's account met the definition of independent evidence of torture and that he was an Adult at Risk Level 2 but detention was maintained on the erroneous basis that he was not at risk of harm if detention continued and because it was considered that it was highly unlikely that he would be removable unless detained. It was also said that there was no evidence from healthcare that MJ8375 was not unfit or unsuitable for detention.

8. An ACDT was opened on 19 September 2017, when he was moved to the Heathrow IRCs on a precautionary basis in view of his history of self-harm.

(7) D1225

1. D1225 is an Afghan national with a history of torture. Detention medical records indicate a previous period of detention in IRC Haslar in 2015. D1225 was detained from around 6 December 2016, at first at The Verne and then Heathrow IRCs before transferring to Brook House.

2. A history of torture was disclosed when D1225 was first detained at the Verne on 6 December 2016 during a reception screening. The screening noted visible scars above the right eye and in the scalp line attributed to beating by the Taliban. The screening identified a need for a Rule 35 assessment. This was, however, not done at The Verne before he was transferred to Heathrow IRC on 14 December 2016. A Rule 35(3) assessment was carried out at Heathrow IRC and a report issued on 30 December 2016 with a conclusion that D1225 may be a victim of torture.

3. D1225 had legal representatives during detention and had obtained a Medico-Legal Report ("MLR") on 17 February 2017. This concluded that D1225 suffered from depression and chronic PTSD and that continued detention was having a detrimental effect on his mental state. This report was provided to the Home Office on 14 March 2017. It is not clear whether the Home Office considered this or responded to it but his detention was maintained.

4. On 18 March 2017, D1225 was transferred to Brook House. There is nothing to indicate that the MLR was ever provided to Brook House.

5. An ACDT was opened owing to suicidal ideation. He also requested another Rule 35 report but it was not undertaken. D1225 made another request on 28 and 29 March 2017. The GP declined to do a further Rule 35 assessment even though D1225 disclosed new allegations of sexual assault not previously disclosed and that he was having difficulties sleeping. Instead, the GP stated that the Home Office would be informed by way of the Part C IS91A.

6. Although D1225 was on ACDT, he was not referred for a mental health assessment and support until 31 March 2017. He was prescribed anti-depressant medication and had input from a mental health nurse, but not a psychiatrist.

7. From 19 to 20 June 2017, D1225 was removed from association under Rule 40 following an altercation with another detainee. The Form DCF1 stated this was necessary to "maintain the safety and security of the centre." It made no reference to his mental ill-health.

(8) D13

1. D13 is a Sri Lankan national with a history of torture. He was detained at Dungavel IRC; a Rule 35(3) assessment and report completed there on 9 March 2017 recorded scars, chronic back pain, sleep disturbances and nightmares attributed to the torture. The GP found in Rule 35(3) report that the history was given in a credible manner and he was tearful during his account of abuse. On 16 March 2017 the Home Office found that the Rule 35(3) was not independent supporting evidence of torture as it was a self-reporting account and adverse credibility findings had previously been made against him in refusing his fresh claim application.

2. On 24 March 2017, D13 was transferred to Brook House IRC. No Rule 34 medical examination within 24 hours was undertaken. No Rule 35 referral was made. A "Provision of Services for the Disabled" was completed on 24 March 2017 to indicate he has a "*physical, sensory or mental impairment which*

has a long term and substantial effect on their ability to carry out normal day to day activities." It does not note the nature of this disability recognised in D13 or what services were provided.

3. A GP appointment took place on 25 March 2017 but it was not a physical and mental state examination in accordance with Rule 34 and no such R34 compliant assessment appears to have been undertaken during his detention at Brook House.

4. D13 subsequently repeated his torture claim to healthcare staff, on four separate occasions, on 5 April, 10 April, 19 April, and 20 April 2017, until a referral for a R35(3) assessment was finally made. A R35(3) report was issued on 27 April 2017 and again found that he may be a victim of torture but the GP stated that he was unable to comment on his mental health, without having carried out any assessment, and thus was unable to advise on the psychological sequalae of his torture or the likely impact of ongoing detention on his mental state. The Home Office, in a response to the R35(3) dated 28 April 2017, accepted D13 was an Adult at Risk Level 2, but maintained detention on the basis that there was insufficient information provided as to his psychiatric / mental ill-health, previous adverse credibility, and imminence of removal. The Response did not conclude with any request to the IRC healthcare for further information about the nature and extent D13's mental ill-health.

5. Medical records indicate that D13 repeatedly disclosed suicidal thoughts, being low in mood, difficulty sleeping and having nightmares about events that happened to him in Sri Lanka. On 20 April he reports he had thoughts of cutting his throat and hanging himself due to nightmares, flashbacks and his current situation. He was seen by the Mental Health Team but no assessment for PTSD was undertaken despite presenting with a range of trauma-related symptoms, and reporting a history of torture. No consideration was given as to the likely impact of detention on his health and whether a Rule 35(1) report would be indicated. No Rule 35(2) report was issued. Instead, D13 was put on ACDT monitoring from at least some time in mid-April 2017. Although he also refused food several times, there was no investigation into the underlying cause of this.

6. On 19 May 2017, D13 appears to have been removed from association on transfer to E-Wing.

(9) D745

1. D745 is a Sri Lankan national with a history of detention and torture by the authorities. In or about February 2017 prior to his detention, he had submitted a Medico-Legal Report by a consultant psychiatrist to the Home Office which diagnosed him with PTSD together with psychotic depression which made it difficult for him to function or express himself. He was on anti-depressants but the MLR concluded that he also required psychotherapy via EMDR or CBT. The MLR also raised concerns about his capacity to be questioned and to give a coherent verbal account of himself.

2. D745 was detained for two days in The Verne from 16 March 2017 before being transferred to Brook House on 18 May 2017. He was in Brook House until 14 June 2017 when he was released from immigration detention. There is no evidence that the MLR was made available by the Home Office to the Verne or to Brook House

3. At his reception screening, D745 reported a history of torture, including being beaten with a stick and cut with a knife on his left lower leg. He informed the healthcare assistant that he had mental health issues and was on anti-depressants and that he had tried to commit suicide in the past by overdosing.

4. D745 did not however have a full physical and mental state examination within 24 hours or at all under Rule 34. The MLR submitted in February 2017 was not provided to IRC healthcare and therefore the diagnosis of PTSD, psychotic depression and anxiety were not known to the IRC Healthcare.

5. Brook House IRC Healthcare was aware of his prescription for anti-depressant medication, but no referral was made to the MHT for assessment and treatment of his mental health. He was only given a continued prescription of antidepressants.

6. According to records disclosed in Relativity, D745 appears to have been subject to a Rule 40 and put in the Care and Segregation Unit in the E-Wing sometime during the relevant period for the Inquiry but the date of this is unclear. There is no Form DCF1 disclosed in Relativity. It is not clear whether one was ever completed.

7. On 26 May 2017, D745 asked for a Rule 35 assessment at an appointment with the IRC Healthcare.

8. A Rule 35(3) assessment was carried out on 31 May 2017 which noted scarring to the left knee, right axilla and right foot and deformity to the right small finger as well as multiple scars to the legs. The Rule 35 could not be completed on that day because D745 became very tearful. No consideration was given to a mental health referral. A Rule 35(3) report was then completed on 7 June 2017 which concluded that his scarring was consistent with his account of torture. But the Rule 35 did not assess or document the psychological symptoms of the torture, or the impact of further detention on his mental state. In the R35(3) response, the Home Office accepted D745 was an Adult at Risk Level 2 due to the evidence of torture, but maintained detention because it was said that there was no evidence that a period of detention was likely to cause harm to him and that removal was imminent.

9. D745's removal was however not effected during this period of detention and he was in fact released on 14 June 2017.

(10) MJ7771

1. MJ7771 is a Pakistani national. He was at Brook House from 9 April 2017 to 4 June 2017.

2. At the time of his detention at Brook House on 9 April 2017, he was subject to a Notice of a Removal Window. He had previously had a Rule 35(3) report issued whilst he was detained at Colnbrook IRC. It was accepted by the Home Office that he was a victim of torture and thus an Adult at Risk, although the risk level was not identified. The Home Office however decided to maintain MJ7771's detention on the basis that there was no evidence that a period of detention was likely to worsen his symptoms, he was an overstayer, and his removal was within a reasonable time frame of 8 weeks. However, as the chronology thereafter showed, no removal was effected in that period. It is not clear the basis for the assessment of an 8 week timeframe.

3. MJ7771 was transferred from Colnbrook to Dungavel and then to Brook House on 9 April 2017. When at Brook House, he again reported his history of torture based on his sexual orientation, and that he suffered from depression in his reception screening on 9 April 2017. He was referred to the Mental Health Team in the light of the medication he brought with him to detention. MJ7771 did not receive a Rule 34 medical examination within 24 hours. The GP assessment he had on 10 April 2017 was solely focused on his rectal bleeding and a routine GP appointment was advised.

4. On 12 April 2017, MJ7771 attended a Rule 35(3) DCR assessment but it was recorded that he was too unwell to proceed. He discussed his difficulties with breathing, chest pains, and his anxieties. The doctor recorded his impression of anxiety and panic attacks. MJ7771 was prescribed promethazine Sensitive/Irrelevant There is no record of any mental health input as a result. When he presented a week later, on 18 April 2017 for a Rule 35 assessment, he was advised that a second one would not be undertaken. No Rule 35(3) was issued.

5. Input from the mental health team did not take place until later. He only had one RMN review (on 17 April 2017). During that review, he disclosed to the nurse that he had been raped, had objects tied to his genitalia and those being pulled whilst he was tied up. He also disclosed bleeding from his bottom since the rape. He said he could not cope with detention when the door was locked at night as it reminded him of the torture. He reported flashbacks and nightmares and difficulty breathing whenever the door is locked. His issues were attributed to low mood only. No assessment for PTSD was carried out and there was no consideration of the impact of detention on his mental health. The client did not receive any mental health input thereafter. He had no psychiatric assessment. He was referred to the mental health team again on 23 April 2017 but there was no response to this referral by the time he was transferred.

6. On 4 June 2017, MJ7771 was transferred to Tinsley House and on 7 June 2017 he was released.

(11) MJ8035

1. MJ8035 was a national of Poland. He was diagnosed with depression and psychosis. He had spent a month as an inpatient at in St Bernard's psychiatric Hospital in or about 2015. MJ8035 was alcohol dependant and had been drinking since the age of 15.

2. MJ8035 completed a short custodial sentence of Sensitive/Irrelevant at HMP Wormwood Scrubs, and was then transferred to Brook House on 26 April 2017. He remained there until 22 August 2017.

3. Whilst at HMP Wormwood Scrubs, had had a mental health assessment and had been diagnosed with depression, alcohol dependence syndrome and noted to have mental and behavioural disorders due to use of alcohol. He had disclosed a history of self-harm but no active self-harm or suicidal ideation. He also had a history of substance misuse. He had a mental health plan and was undergoing alcohol detoxification.

4. At the reception screening at Brook House, conducted by a healthcare assistant, MJ8035 said he suffered from depression, that he was on medication for this, and that he had previously received psychiatric treatment. No referral was made to the Mental Health Team at this stage.

5. On 27 April 2017, MJ8035 had a GP appointment, but this was not a full Rule 34 physical and mental state examination. PU never received a Rule 34 medical examination. This GP appointment noted his self-reporting of ongoing mental health issues and his request for anti-psychotic medication and medication for digestive issues, which were prescribed to him. No MHT referral was made.

6. MJ8035 saw a nurse a month later on 24 May 2017, during which he reported feeling depressed, low in mood, wanting to hurt himself and having to fight the feeling of hurting himself. He also raised concerns that this prescribed medication was not effective. ACDT was to be opened and concerns raised with C-Wing. Referral was then made to the RMN.

7. Despite his disclosure of self-harming thoughts, no consideration was given to a Rule 35(2) report. No referral was made for a GP appointment to this effect or otherwise.

8. On 26 May 2017, a further RMN review noted that he reported hearing voices, and his mood and presentation was observed to be flat, he was referred for a medication review only by a psychiatrist. On 29 May 2017, MJ8035 continued to disclose hearing voices, but these were distant and he said he knew

they were not real. He was managing to cope with any thoughts of self-harm and the ACDT was downgraded to observations once every 4 hours and one conversation a day.

9. On 1 June 2017, MJ8035 saw Dr. Belda, an IRC psychiatrist. He disclosed a family history of being adopted and an environment of domestic violence. He also disclosed a history of self-harm and attempted suicide, as well as mood swings and hearing voices. The psychiatrist diagnosed him with an Emotionally Unstable Personality Disorder, Impulsive type. He was also suspected to have ADHD. His anti-psychotic medication was changed to olanzapine and he was issued with a questionnaire for ADHD. No Rule 35 DCR report was issued or considered.

10. On 8 July 2017, MJ8035 was again seen by the psychiatrist. A diagnosis of ADHD was made and medication started for this. His antipsychotic medication was stopped.

11. MJ8035 was detained at Brook House until 22 August 2017 when he was released further to a pre-action letter from Bhatt Murphy.

(12) D2567

1. D2567 is an Iraqi national who was detained on arrival on 30 March 2017. He disclosed psychological problems and a history of sexual assault, torture and exploitation / trafficking by agents in Turkey but no NRM referral appeared to have been made further to such disclosure by the Home Office.

2. D2567 was detained a Brook House IRC on the 2 April 2017. At his reception screening, conducted in the early hours (1.36 am), he disclosed being tortured in Turkey by smugglers, suffering from depression, and self-harming ideation and attempts. Scars were observed on his arm. He was referred to an RMN.

3. No R34 DCR examination within 24 hours of being detained at the IRC was undertaken or otherwise.

4. He self-harmed on the first night in detention. An ACDT was opened with constant observations and he was again referred to the Mental Health Team for review. However, no Rule 35 assessment was undertaken. No Rule 35(2) report was made.

5. D2567 was seen by a GP on 5 April 2017 and disclosed a history of torture and attempting suicide. This was not a Rule 34 physical or mental health assessment. He was prescribed antidepressant medication. He was advised to come back to the GP once he has seen the Mental Health Team. No Rule 35(3) assessment was carried out then.

6. D2567 was not reviewed by the MHT until his sixth day at Brook House (7 April 2017), despite reporting ongoing suicidal ideation, problems sleeping, low mood and anger. No referral was made for a psychiatric assessment. ACDT was downgraded to hourly observations on 10 April 2017.

7. D2567 had to request a Rule 35 assessment himself, which was carried out on 13 April 2017. The R35(3) report confirmed that he appeared vulnerable and had difficulties sleeping, displayed symptoms of depression and general low mood. He appeared credible and the GP indicated a strong likelihood of torture and deterioration in detention, indicated by his self-harming

8. D2567 was released further to the Rule 35(3) report on 13 April 2017.

(13) D1525

1. D1525 is a Nigerian national with a history of serious ill-treatment and violence on account of his sexuality. He had been detained at the Verne two years earlier. He was arrested and detained at Brook House on 27 April 2017, and subject to a Notice of a Removal Window. He was subsequently released on 1 August 2017.

2. There was no record of him being asked whether he had a history of torture in his reception screening. Nor was a Rule 34 examination carried out.

3. On 2 May 2017, he disclosed to a nurse that he was kidnapped, beaten and had scars on his back and left arm and that he suffered flashbacks. A referral was made for him to be assessed under Rule 35. He was also booked to be referred to a mental health nurse.

4. The Rule 35 assessment took place the next day. It recorded his account of being attacked with canes, sticks and iron rods. The report noted large scars on his arms, legs and face. He was noted to suffer from flashbacks, anxiety and fear. A Rule 35(3) report was issued which concluded that he may be a victim of torture, but the GP did not carry out an assessment of his mental state to consider whether his psychological symptoms were corroborative of his torture and the current or likely impact of detention on his mental state.

5. Similarly, the mental health nurse did not carry out a mental state examination or consider the nature and extent of his trauma-related symptoms, the impact of detention on his mental health and treatment. He was offered a referral to the Emotional Health Group.

6. In a Rule 35 response dated 4 May 2017, the Home Office accepted that the Rule 35(3) report constituted evidence of torture and that he was an Adult at Risk Level 2. However detention was maintained on the basis that he was appeal rights exhausted, and despite pending further submissions, it was said that, if rejected, removal would be imminent.

7. The further submissions were rejected whilst D1525 was detained. Judicial review proceedings were lodged to seek an injunction against his removal. A further set of submissions were made in support of a fresh claim, which were also rejected.

8. D1525 was under the Mental Health Team for over 2 months, but received only 1 mental health nurse review. He was then discharged from the Mental Health Team. After that, Medical Justice arranged for him to be assessed by an independent psychiatrist, who diagnosed him with PTSD and recommended his release, advising that continued detention was exacerbating his condition. He was released on bail on 1 August 2017, shortly following this assessment, having spent over three months at Brook House.

(14) MJ7977

1. MJ7977 is an Afghan national with a history of torture who presented with active self-harming ideation. He was appeal rights exhausted at the point in time he was arrested and detained at Brook House on 12 April 2017. A Notice of Removal Window was served on him a week after he was detained.

2. He was transferred to Brook House from a police cell where he had been detained for more than 30 hours. At the reception screening, he told the nurse he wanted to see a mental health nurse and that he can often become angry. He also reported that he had hit himself whilst in the police cell. No ACDT was opened at this stage. No questions were asked in screening as to whether he had a history of torture. He missed his GP appointment on the first day. It was recorded that he did not understand why the appointment was booked and had not been explained the purpose of a Rule 34 examination.

3. MJ7977 self-harmed during his first night in detention by cutting his upper arm and his chest. He reported he could not remember having cut himself. He reported a history of banging his head on the wall when he cannot cope. He was referred to the Mental health nurse, and placed on ACDT constant supervision. No referral for a Rule 35 assessment was made and no consideration of a Rule 35(2) report was recorded. During his ACDT review, the morning after he stated that his 'life is shit', but that he did not want to kill himself, just self-harmed to relieve stress. His observation level was decreased to half hourly. He was seen by the GP later that day who noted he was on E wing. His wounds from cutting were still bleeding and described as 'deep incision'.

4. On 16 April 2017, he had another ACDT review and RMN review. He described getting 'strange thoughts' that made him feel like he was going crazy and leading him to self-harm, especially during the night. No mental state examination was carried out and no psychiatric assessment was made. Instead he was told to use an elastic band technique each time he had self-harm thoughts and to speak to a wing staff member. On 19 April 2017, he reported feeling more settled and using the elastic band method each time he has thoughts of self-harm. He was moved from the E Wing to another wing and his ACDT was closed.

5. An ACDT was reopened a week after on 26 April 2017 after he self-harmed by cutting. A mental state examination was carried out by a nurse, but no diagnosis was given. He reported feeling some relief from self-harming. He was shown breathing and relaxation exercises with a plan for mental health nurse support to continue. No further mental state assessment was carried out. There was again no consideration of a Rule 35(2) report or the impact of detention.

6. He had a further mental health review on 19 May when he reported not being able to sleep because of bad dreams and feeling scared and becoming afraid whenever he hears a noise. He disclosed that he had been self-harming by banging his head or biting his hand but had avoided cutting. On 23 May 2017 he had a GP appointment and was prescribed antidepressant medication. It does not appear that any assessment for PTSD was done or the impact of detention on his health considered.

7. He also faced a serious delay in being referred for a R35(3) assessment, with a referral triggered three weeks into his detention on 9 May 2017 and after he expressly disclosed his history of torture. No Rule 35 assessment had taken place by 26 May 2017, the last entry on the available medical records.

8. According to the IRC records, he was also subject to an unknown period of R40 removal from association, the week after being taken off his second period of ACDT. There is no documented assessment in the medical records or HO Authorisation Form DCF1[5] of the appropriateness of this restriction in view of his mental vulnerabilities, nor of the safeguarding measures implemented.

(15) MJ8071

1. MJ8071 is an Algerian national who had several criminal convictions for Sensitive/Irrelevant He had a history of serious mental health issues, including schizophrenia and self-harm. He also had a history of substance misuse and the records indicated that he was suffering an opiate withdrawal in prison during a custodial sentence completed in December 2016. He was detained under immigration powers first at The Verne and then at Brook House from 26 March 2017.

2. The reception screening noted his history of mental ill-health, self-harming, depression and drug induced psychotic episodes. None of this prompted a referral to the Mental Health Team or a Rule 35 assessment.

[5] His cipher is unknown so Relativity could not be checked for documentation.

3. Although MJ8071 saw a GP on 27 March 2017, this was not a Rule 34 full physical and mental health examination. It was a review of medication. A further GP appointment on 31 March 2017 was also a review of medication.

4. MJ8071 self-harmed around 7 / 8 April 2017, making a cut to his forearm that required emergency treatment at A&E. Despite this incident, no referral was made to the Mental Health Team. An ACDT was opened, but no records of any ACDT reviews appear in the healthcare records. It is not clear whether any clinical input was provided in any ACDT reviews. The ACDT was closed on 12 April 2017 again, appearing to be without any clinical input. No referral was made for a Rule 35 assessment and no Rule 35(2) report was issued.

5. MJ8071 does not appear to have received any input from the mental health team during the several months he was at Brook House and was not referred to a psychiatrist.

6. He was removed from association to the Care and Separation Unit in the E-Wing. It is unclear why or for how long.

(16) MJ8266

1. MJ8266 is an Indian national who was an overstayer when he was encountered on 6 June 2017 working. He was detained at Brook House on that day. Whilst in detention he claimed asylum.

2. MJ8266 had a history of torture with related mental health issues. He did not receive a R34 examination within 24 hours of his admission, with the attendant entry in his medical records erroneously stating that no referral was required as he did not have any medical issues. The reception screening stated that SS denied being tortured outside the UK. There is no information in the medical records to explain what he was told about the significance of the information.

3. On 22 June 2017, he requested a R35(3) assessment. Whilst the medical records note the need for him to be booked for an assessment, no referral was initiated. The R35(3) assessment appears on the face of the medical records to have remained outstanding two weeks later, when he was transferred to another IRC.

4. A Rule 35(3) report that was later completed led the Home Office to accept that MJ8266 was an Adult at Risk with Level 2 evidence of torture, but detention was maintained.

(17) D56

1. D56 is a Chinese national with a history of torture.

2. He was detained at Brook House from 31 July 2017. His release date is unknown.

3. His reception screening assessment did not record a history of torture. He did not receive a Rule 34 assessment within 24 hours or otherwise.

4. He directly raised his history of torture with Healthcare several days into his admission. This prompted a R35(3) referral. He showed the nurse scars which he said were caused by being beaten on the head by the butt of a gun. He presented as tearful and also said he suffered from headaches. He faced a subsequent wait of 10 days between this referral being made and undergoing the R35 assessment.

5. The Rule 35(3) report issued on 15 August 2017 noted that he was beaten, handcuffed, hit with guns batons and fists. He showed the GP a number of scars on his ankles, on his head and the back of his hands. It was said that he had no mental health issues but it was observed that he said he could not sleep and had recurring headaches which were affecting his sleep. No assessment of his mental health was carried out. The report concluded that his scars were very consistent with his account of torture but that there were no current concerns regarding his ongoing detention. It is not known what the response was to it but he continued to be detained.

6. D56 reported to healthcare that he was not eating due to stress. He requested to see a psychiatrist on 15 September 2017 and was referred to the MHT for assessment. He reported suicidal thoughts on 17 September 2021. He was also placed on an ACDT. He resumed eating on 21 September 2017.

7. On 22 September he was seen by the GP and reported thinking there was something wrong mentally, mentioning feeling depressed and being tearful. He was prescribed antidepressants. He had his mental health assessment with a mental health nurse that same day. The Mental Health assessment concluded that there were no psychotic systems, no thoughts of self-harm and no suicidal ideation and that his mood was related to being detained. His ACDT was closed. No Rule 35(2) report was issued.

(18) MJ7963

1. MJ7963 is a Bangladeshi national who was an overstayer and was arrested and detained when encountered at a restaurant on 28 March 2017. He was detained at Brook House IRC. He was not asked about a history of torture during his reception screening.

2. He was seen by a GP when he arrived at Brook House. This was not a Rule 34 compliant physical and mental state examination. However, the GP did note that he suffered from stress, lack of sleep and headaches. No referral was made to the Mental Health Team. He was not prescribed medication until 6 April 2017 when he reported to a GP again that he was not able to sleep. He was recorded as saying he was not depressed, more anxious. He was prescribed Promethazine hydrochloride.

3. It was only following his transfer to another IRC (Harmondsworth) on 17 April 2017 that he received mental health support from an RMN. He was also not identified as a victim of torture throughout his time at Brook House.

4. A R35(3) report was issued on 28 April 2017 by a GP at Harmondsworth. That report concluded that he was a victim of torture. He was accepted to be an Adult at Risk Level 2 in a Rule 35 response dated 3 May 2017. However his detention was maintained based on immigration factors.

(19) MJ8176

1. MJ8176 is a Sri Lankan national with a history of torture and a diagnosis of PTSD and depression. He was under mental health care prior to detention and had regular psychiatric assessments. He was prescribed Quetiapine, an antipsychotic medication, mirtazapine, an antidepressant and zopiclone, a sleeping pill. His GP records appear on the Systm1 records provided by Brook House, so would have been available to the IRC healthcare team.

2. MJ8176 was detained at Brook House from 13 July 2017 on reporting.

3. On being detained, a mental health assessment was carried out. He disclosed that he had been taken to a hospital for mental health problems and that he was visited by doctors when he was discharged from hospital. He was prescribed sleeping tablets. It was assessed that he had depression. He reported that he could not cope with being at Brook House because it reminded him of his experience in prison in Sri Lanka, where he was tortured. It was noted that he was on food refusal and that he was reluctant to leave his room and required encouragement to attend the appointment. A referral was made to the Mental Health Team with arrangements for a psychiatrist to see him. A Rule 35 appointment was also booked for 8 days later. He was put on an ACDT from the outset. A GP prescribed him Quetiapine and Mirtazapine in the meantime. There was no consideration by the GP at this point as to the impact of detention on his health.

4. On 20 July 2017, he was seen by a psychiatrist. His account of torture was recorded. He described having intrusive memories, high emotional arousal, severe anxiety and dysphoric mood. He also expressly reported that detention was exacerbating his past trauma. A diagnosis of PTSD was confirmed.

5. Despite these clinical factors, no report appears to have been prepared under R35 during this period (the medical records only cover the first few weeks of his detention).

(20) MJ7875

1. MJ7875 was detained at Brook House in March 2017. He was refusing food and fluids for a minimum of six days and was subject to the FFR monitoring process. He was entirely unresponsive to staff's efforts to engage him.

2. Medical Justice was contacted and made aware of concerns within the IRC from the referrer, as to MJ7875's worsening physical state. He was subject to an independent mental capacity assessment by a Medical Justice clinician (Dr. Steen) on 7 April 2017. He was assessed as being seriously unwell, presenting as significantly underweight and dehydrated. It was unclear what the motivation for his food refusal was given his non-responsiveness. He was also assessed as potentially lacking capacity to consent to medical treatment. It was advised that he required immediate admission to hospital for re-feeding and clinical monitoring to prevent the risk of fatal complications arising. These concerns were relayed urgently to the IRC Healthcare on 7 April 2017. They were separately related to the Home Office by Medical Justice on 8 April 2017.

3. It was advised that MJ7875 would require further assessment in relation to his capacity and the possible causes of his presentation. Medical Justice did not have access to his records. It is accordingly unclear how his condition was permitted to deteriorate to the point at which Medical Justice intervened. It does not appear, from the clinician's assessment, that Healthcare had taken any prior or substantial steps to assess his capacity to refuse medical treatment. Effective food refusal monitoring ought to have alerted Healthcare to the serious and imminent risks to his health and his potential unfitness for continued detention well before the intervention of external clinicians. Medical Justice referred MJ7875 to a solicitor for legal representation, and made a safeguarding referral on his behalf to the local Adult safeguarding Team. It is not known when he was subsequently released from detention.

(21) MJ8074

Annex 1

1. MJ8074 is a Nigerian national who had a history of serious ill-treatment and violence on account of his sexuality. He was initially detained at Dungavel on 16 February 2017, before being transferred to Colnbrook on 27 March 2017. The medical records indicate that MJ8074 did not receive a reception screening upon his arrival at Colnbrook as he was placed immediately in Rule 40 segregation for three days. MJ8074 was transferred to Brook House on 24 May 2017. He was released on 21 July 2017.

2. MJ8074 had a R35(3) assessment whilst at Colnbrook, on 24 April 2017, which recorded his account of being attacked with knives, sticks and bottles by his family members as a child. Scars to MJ8074's forehead and limbs were found consistent with his account, the report concluding that MJ8074 may be a victim of torture. However, the GP failed to undertake a mental assessment of MJ8074 or to consider the impact of ongoing detention, summarily recording that he had no physical or mental health issues.

3. Detention was maintained by the Home Office in the R35(3) response, notwithstanding acceptance of MJ8074 being an Adult at Risk Level 2, on the basis that it was necessary to effect his removal (anticipated within the next four weeks) and his failure to leave the UK voluntarily even though he had good compliance with reporting. A subsequent fresh claim refusal found that the R35 was not independent supporting evidence of MJ8074's torture as it was premised on his self-reporting account and failed to establish the causative mechanism of the scarring.

4. At Brook House, on 24 May 2017, MJ8074 was identified as a victim of torture in his reception screening. He was however discharged from the R35 case-load the following day without assessment on the basis that he already had a R35(3) report. Several days later, MJ8074 expressly asked for a further R35 assessment, as the previous report had failed to record two of his scars. This was refused even though further material information ought to have resulted in an updated R35(3) report or, at the very least, communication to the Home Office by way of a IS91 RA Part C.

5. MJ8074 did not receive any mental health input whilst at Brook House. This was not asked at his reception screening. Nor were MJ8074's medical records from Colnbrook seemingly reviewed, which recorded his prior assessment for insomnia and referral for RMN review (though never actioned), having reported symptoms of stress, poor sleep and palpitations.

6. He did not have a Rule 34 medical examination. The records indicated he missed GP appointments although no reasons were recorded. Whilst at Colnbrook, in early July 2017, he had reported suffering from stress-related sleeping issues. He asked Brook House Healthcare for a re-prescription of the sleeping medication. This was not provided.

7. Healthcare attended to MJ8074 in an emergency response on 18 June 2017 following a vomiting episode. He reported that he had smoked a cigarette he had been given and was unsure whether it had been mixed with illicit substances. This was retrospectively recorded in the medical notes as a possible NPS episode. Several days later MJ8074 had a further vomiting episode and disclosed having vomited for the past three weeks after eating. He was prescribed gastric medication, though was not formally assessed by a GP in relation to his physical presentation.

8. Medical Justice arranged for MJ8074 to be assessed by an independent psychiatrist (Dr Jane Mounty) whilst at Brook House. The MLR, which was produced following his release from detention, diagnosed MJ8074 with a Mixed Bipolar Disorder and PTSD, advising he required long-term specialised psychiatric treatment and commencement on mood-stabilising medication. It opined that MJ8074 may also have a possible diagnosis of Mild Neurocognitive Disorder with behavioural disturbance, arising from his history of torture, which required further neurological investigation. The MLR advised that any further period of detention would precipitate a worsening of MJ8074's PTSD and mood disorder.

(22) D668

1. D668 is a national from the Ivory Coast and a victim of torture with mental health issues. He was initially detained at The Verne on 18 May 2017, before being transferred to Brook House on 28 June 2017. He was released on 4 October 2017. D668 was assessed as suffering from symptoms of depression and PTSD whilst in the community. He had also previously self-harmed by punching a wall, resulting in a wrist injury.

2. During his prior detention at The Verne, D668 disclosed his history of torture and self-harming during his reception screening, though a R35(3) referral was not made until a week later (following a delayed R34 examination). No subsequent R35(3) assessment was conducted, as the medical records state D668 struggled to collect his memories during the appointment and needed more time to reflect on his experiences.

3. No R35(3) referral was made upon D668's admission to Brook House on 28 June 2017, despite disclosing he was a victim of torture in his reception screening. His mental health issues and self-harming history were not identified.

4. D668 did not receive a Rule 34 examination whilst at Brook House. The first GP appointment he attended, on 30 June 2017, did not involve a mental state assessment; nor did the GP identify the need for a R35(3) referral consequent to his disclosure of torture. A referral was only made some two weeks later, after D668 expressly requested that a R35(3) report be prepared.

5. The subsequent R35 assessment, on 24 July 2017, took place nearly a month into D668's detention at Brook House. The R35(3) report recorded D668's account of being beaten by state agents on several occasions, resulting in his loss of consciousness and hospital admission. D668 showed the GP various scars to his back and limbs. The report recorded the scars 'may be' due to D668's account, without reference to an accompanying body-map or any clinical assessment of the consistency of the scarring with his claims. The Rule 35 did not assess or document the psychological symptoms of D668's torture, or the impact of further detention on his mental state.

6. Detention was maintained by way of the Home Office R35(3) response, notwithstanding the acceptance of D668 being an Adult at Risk Level 2, because it was found that the GP had failed to indicate that a period of detention would cause him harm and that his removal was likely to take place within a reasonable time frame of 12 weeks. It was noted that no body map had been included in the R35(3) report. No request was made by the Home Office for further information from the GP as to D668's mental state or the impact of detention.

7. D668 was prescribed Mirtazapine in a GP review on 28 July 2017, after reporting he was suffering from depression and sleeping problems. He was reviewed several times by a mental health triage nurse in late July 2017, reporting that he was unable to sleep because of traumatic flashbacks, as well as related stress and anxiety. D668 did not however undergo a full mental health assessment until over 5 weeks into his detention at Brook House, on 6 August 2017. He stated his flashbacks were triggered by his detention and that he sometimes thought about harming himself to see if immigration would pay attention to him. D668 was advised simply to continue with regular RMN support and attend Emotional Health Groups.

8. D668 continued to report ongoing sleep disturbances and flashbacks in the following months. He also disclosed intermittent suicidal ideation. In an RMN review in late September 2017 it was observed that D668 may have anxiety relating to being locked in at night and he was advised to ask for a transfer to Tinsley House. The medical records do not indicate that D668 was placed on an ACDT whilst at Brook House. Nor that he was assessed for a report under R35(1) or R35(2) despite his serious trauma-related

symptoms and suicidal ideation. He was not referred for specialist review by a psychiatrist throughout his detention.

9. D668 was released from Brook House on temporary admission on 4 October 2017. A subsequent MLR, prepared on behalf of the Helen Bamber Foundation diagnosed D668 with PTSD and major depressive episode. The MLR advised that he required a significant period of specific trauma focused therapy to assist with his recovery.

10. Following his release, the PSU undertook an investigation into various complaints made by D668 concerning his treatment in detention. The final report, produced on 21 February 2018, upheld 4 out of 11 of his allegations.

11. The PSU found that that IRC staff had failed to take appropriate investigative action in response to D668's complaint that a detainee had thrown water over him in August 2017, and after he reported that his property had been stolen in late September 2017. There was no documentary evidence to indicate that these incidents were recorded or responded to. It was also found that a DCO had spoken to D668 very rudely during evening lock-up. Further, that he had received no response from G4S after making a complaint to the care officer that he felt unsafe, the officers dismissing the complaint out of hand and providing no feedback. The PSU observed that this failure to provide support was in the context of, and notwithstanding, D668's recognised status as an Adult at Risk. Recommendations were made concerning G4S policy compliance with complaints handling. The PSU noted that some G4S staff may have committed disciplinary offences in view of these findings, however no further action appears to have been taken on the basis that staff were operating in a 'difficult' climate at the time in light of the recent *Panorama* documentary.

12. D668 complained that staff had failed to follow up a further incident of bullying, when he had been pushed by another detainee. He also alleged that he had been treated rudely by G4S staff prior to and following a failed charter removal. The PSU declined to uphold these allegations, preferring the evidence of the officers involved who denied having witnessed or partaken in the incidents.

13. D668 also alleged that he had been subject to excessive force during a visits search on 24 August 2017 by a DCO who he claimed was known to hold racist attitudes. This allegation was similarly found unsubstantiated, the PSU finding that the documentary evidence suggested the DCO had not likely been working on Visits that day, but that, in any event, the general search process the DCO described (despite having no recollection of the alleged search) was in accordance with policy. It was noted that there had been a previous PSU investigation, in 2017, into the alleged use of excessive force by this officer, and several internal G4S investigations concerning complaints of racist abuse, which were unsubstantiated.

14. The report declined to uphold D668's complaint that he had been treated dismissively by a nurse on two occasions, who denied him access to the waiting room and asked for his medical details in front of other detainees. The nurse described by D668 was not identified, though the PSU endorsed the evidence of another nurse on duty who stated that the prescribed process for the open clinic would have been followed on both occasions.

15. The PSU also investigated a complaint by D668 concerning the inadequate sanitation conditions in Brook House. Specifically, that he had to use a toilet in his shared room during lock-up, which was not private and caused him great distress and humiliation. He claimed this was exacerbated by the poor ventilation, the windows being fastened shut. The PSU found that the toilet was separated from the room by a curtain, though some of these curtains had been previously missing. It was accepted that the toilet arrangements could '*cause discomfort and be unpleasant*' to detainees, though the Home Office accepted this as an '*operating norm*'. Somewhat equivocally, the PSU found the complaint

unsubstantiated, though escalated the issue for consideration within the wider Home Office review into Brook House accommodation facilities which was underway at the time.

16. A further complaint in respect of the preparation of the R35(3) report was rejected on the specific basis alleged, namely that IRC officers had instructed healthcare to not complete a full assessment. The PSU report however identified 'concerning' omissions in the R35 process. The GP had not fully completed the R35 report, failing to provide a clinical assessment of the scars he observed or the impact of current and continued detention. It was found that the GP should have completed this assessment, even if he considered there was no negative impact from detention, rather than leaving it to the Home Office to infer. Concerns were also raised that the Home Office had not queried this missing information with the GP, instead proceeding on its own assumption that no comment meant there was no impact. In view of the GP's evidence that there was a lack of clarity over who was responsible, between IRC clinicians and Home Office caseworkers, for assessing the impact of detention, the PSU recommended that the R35(3) policy be reviewed and clarified between the Home Office and NHS England.

(23) D2077

1. D2077 is an Iranian national who was a victim of physical and sexual torture. He was detained at Campsfield House on 31 March 2017, before being transferred to Brook House on 6 April 2017. Prior to this period of detention D2077 received counselling and intensive primary care support for depression and anxiety. He took a drug overdose in late 2016 and self-harmed by cutting his wrists.

2. D2077 had been previously detained for a short period at Tinsley House in June 2016, where he received a R35(3) report. This recorded D2077's history of extensive mistreatment by the Iranian police and his numerous lacerations which were considered consistent with his account. The report found that his trauma had resulted in memory loss, severe headaches, and flashbacks which were compounded by detention. In reliance on this report, the Home Office released D2077 from detention on 23 June 2016.

3. D2077 was re-detained upon reporting at Campsfield House, despite his legal representatives writing to the Home Office to emphasise his unsuitability for detention in view of his suicidal state and previous R35(3). D2077' history of torture was subsequently identified in his reception screening at Brook House on 6 April 2017, however no R35(3) referral was made at this stage. He reported suffering from depression and headaches. His past attempted overdose and self-harming history were recorded.

4. D2077 received a R34 examination, however this did not comprise a full mental or physical health assessment. The GP summarily recorded D2077' history of depression and maintained him on the anti-depressant and beta-blocker medication he was admitted with, pending review by the MHT. D2077 was allowed to keep this medication in-possession, despite his recorded history of overdose.

5. D2077 was placed on ACDT constant supervision and relocated to E wing on 9 April 2017, a matter of days into his detention at Brook House, after he sewed his lips together and started refusing food. In an initial RMN review, D2077's medication was taken away from him, though no medication review was conducted. Similarly, no mental state examination was carried out, nor questions asked as to his food/fluid intake or suicidal intent. Between 11-12 April 2017 it appears D2077 was refusing both food and fluids and was commenced on FFR monitoring. During this period, he asked healthcare twice for a R35(3) assessment, though no referral was made.

6. In a subsequent GP review, D2077 was assessed as presenting with no signs of mental disorder, despite expressly reporting that he had sewn his lips together as an expression of his ongoing depression and anxiety. He stated that the experience of detention brought on traumatic memories from his Iranian imprisonment. D2077 reported that he had also been subjected to sexual torture during this time,

however had not disclosed this in his original R35 assessment as the GP was female. The GP submitted a IS91 RA Part C in respect of this additional disclosure of torture, rather than completing an updated R35(3) report.

7. D2077 consented to having his stiches removed on 12 April 2017. No R35(1) or R35(2) report was prepared throughout this admission at Brook House, despite his signs of serious psychological deterioration. D2077 did not receive a full mental state examination to consider the nature and extent of his trauma-related symptoms, or the impact of detention on his mental health and treatment. Nor was any referral made for review by a psychiatrist.

8. Medical Justice arranged for D2077 to be assessed by a consultant psychiatrist (Dr Fatema Ibrahimi) on 16 April 2017. The subsequent MLR concluded that D2077 had PTSD and a recurrent depressive disorder. It advised that D2077 was unsuitable for immigration detention, which seriously exacerbated his mental health condition and increased his risk of suicide. D2077 required access to regular psychiatric input and specialist trauma-based therapy which was not available or clinically appropriate within the detention setting. D2077 was released on temporary admission on 20 April 2017, in advance of his scheduled bail hearing that day.

(24) MJ7791

1. MJ7791 is a Sri Lankan national and victim of torture. Prior to his detention, he had a history of mental health issues, with a previous diagnosis of adjustment disorder of mixed anxiety and depressive reaction. He attempted suicide by overdosing on paracetamol in 2012. He was detained at Brook House on 1 March 2017 after being arrested. He was released on bail on 6 June 2017.

2. MJ7791 was not asked questions about whether he had experienced past torture in his reception screening. The screening also recorded that he had no mental health or self-harm issues, despite his relevant history. In his subsequent GP examination, he reported feeling depressed, tearful, and unable to sleep. He was commenced on Mirtazapine and it was advised he required review by the MHT, however he was not subsequently assessed by an RMN until two weeks later.

3. A week into his detention, on 7 March 2017, MJ7791 reported to healthcare his history of torture. The medical records indicate that a Rule 35(3) assessment, or pre-assessment, was conducted the following day, though no R35 report or Home Office response (if such were produced) has yet been seen on the material available. The accompanying entry in the medical records notes MJ7791's account of being beaten and burnt by state officials on account of his LTTE affiliations. The GP recorded that MJ7791 had extensive scarring to his face and to his forearms consistent with the burn injuries described. It was noted that MJ7791 reported suffering from depression and had difficulties sleeping because of his intrusive memories. The GP's attendant entry in the medical records however fails to document whether MJ7791's psychological symptoms were corroborative of his torture or the impact of continued detention on his mental state.

4. A mental state examination was conducted by an RMN on 15 March 2017, in which MJ7791 presented as tearful and reported a loss of sleep and appetite. He stated he would rather kill himself than return to Sri Lanka. No diagnosis was made, with recommendation only for follow-up MHT support. In a further RMN review in late March 2017, MJ7791 reported ongoing nightmares and stated that he would hang himself from the second floor if he were returned. MJ7791 was advised to practice 'grounding' techniques and sleep hygiene. No mental state assessment was conducted. No ACDT was opened in relation to his ongoing suicidal ideation nor concerns raised under R35(2). He later started to suffer from episodes of breathlessness and heart pains which were considered anxiety-related. From the material available (with the medical records only covering the first month of his detention at Brook House), it

does not appear that MJ7791 was referred for review by a psychiatrist, despite his serious psychological symptoms.

(25) D1914

1. D1914 is a Romanian national, who suffered from a serious heart condition and related heart attacks. At the time of his detention, he had already undergone a double coronary bypass and was awaiting a cardiac catheter. D1914 also had a history of self-harming and suicidal ideation. He was detained at Brook House on 29 March 2017, after being served with notice of his liability to deportation.

2. During his reception screening, D1914's clinical history concerning his heart condition was noted, as well as his previous self-harming. The GP appointment D1914 attended the following day as recorded in the medical notes was not a Rule 34 compliant examination, entailing only a review of his medication. In a further GP review on 13 April 2017, it was noted that D1914 was due to undergo a cardiac catheter ablation on 17 August 2017. Again it was not a Rule 34 examination.

3. D1914 was placed on an ACDT from 11-12 April 2017 after stating that he would die in detention. D1914 submitted a complaint on 13 April 2017 to G4S about his 'bullying' treatment by a GP who was ignoring his medical concerns. The Clinical Lead responded on 21 April 2017 stating that the GP was concerned about his health needs and would like to meet with him. No findings were made as to the alleged treatment.

4. On 18 April 2017 D1914 was admitted to A&E after an abnormal ECG. On his return to Brook House the following day, the GP confirmed his fitness to fly and for continued detention. On 20 April 2017, a chronic heart disease care plan was created. In the following weeks, D1914 reported suffering from intermittent chest pain and palpitations, as well as related stress and anxiety.

5. D1914 was placed on a Supported Living Plan for his clinical vulnerability on or around 9 May 2017, over a month into his detention. Early in the morning of 17 May 2017 he was re-admitted to hospital by ambulance and treated for Deep Vein Thrombosis.

6. On 27 May 2017 D1914 was subject to a C&R relocation from C to E Wing in advance of his charter removal the following day. The 8-man C&R team was briefed by DCM Steve Dix about D1914's significant self-harm and medical issues. It was confirmed that the GP had assessed him that morning as fit to fly, provided there was a medical escort, and authorised the use of reasonable related force. DCOs Pashcali, Tulley and Webb made up the primary C&R team. On entry he was seen to hold his chest and collapse on the bed, requiring review by healthcare who confirmed the transfer could continue. Arm locks and then handcuffs were applied after he dropped to the ground and refused to stand back up.

7. During this C&R incident, DCO Tulley recorded an exchange with DCO Webb wherein he advised Tulley to hit D1914 with the shield "*anywhere between the knee and the throat... just keep fucking going*" and to *'hit him with the big gun''*. This was partly captured in the *Panorama* footage. DCO Webb was subsequently issued with a verbal warning following a G4S disciplinary investigation.

8. On 28 May 2017, D1914 was returned to Brook House after his removal failed, the airline refusing to take him due to his heart condition. Following his relocation to E wing, he was placed on R40 segregation and ACDT constant observations due to suicide threats he had made during the transfer. A nurse noted that he had not sustained any injuries, however the ACDT assessment the following day records that he was sore and required treatment for his C&R injuries. The assessment also records that he stated that the force used was excessive and that he wanted to make a complaint, however no follow-up action is documented.

9. ACDT observations were subsequently reduced to hourly on his return to E wing. D1914 was relocated back to C wing the following day. This second ACDT was closed on 3 June 2017.

10. On 5 July 2017, D1914 was admitted to A&E after he severely self-harmed, by cutting his arms and his neck with a razor and taking an overdose of his heart medication, in response to his bail request being refused. He was returned to E wing later that day, where he was placed on ACDT constant observations until 7 July 2017. The Home Office was notified of this serious self-harm attempt by way of a Part C update. No concerns were raised as to D1914's deteriorating mental and physical state by way of a report under R35(1) or R35(2) at this stage.

11. On 8 July 2017 D1914 was assessed as suffering from a likely anxiety attack after he presented hyperventilating and tearful, with high stress levels. On 10 July 2017 he was re-admitted to hospital with chest pains. D1914 subsequently made a superficial cut to this left arm on 12 July 2017. A GP submitted a IS91 RA Part C to the Home Office the following day, stating that D1914 was at increased risk of cardiac problems from ongoing detention. Again, no R35(1) report was issued at this time.

12. It was only on 17 July 2017, nearly 4 months into D1914's detention, that a Rule 35(1) report was prepared. It stated that his condition had worsened throughout detention and that the stress of detention may trigger events leading to another cardiac arrest. It was advised that D1914 be released to reduce the risk of further harm.

13. Despite D1914's clear indicators of mental vulnerability, allied to his physical health problems, he was not referred for a mental health assessment until 19 July 2017. He reported to the RMN problems sleeping and that he would die in Brook House on account of his heart condition. D1914 continued to report ongoing chest pains and related stress throughout that month. He was finally released on temporary admission on 8 August 2017.

(26) D523

14. D523 is an Afghan national with a history of torture. As a child he was violently attacked and taken captive by the Taliban. He was detained at Brook House on 27 February 2017, being Appeal Rights Exhausted at the time. It appears he was released on or around 8 May 2017. He has subsequently diagnosed with Paranoid Schizophrenia, Psychosis, PTSD and a severe depressive episode.

15. During his reception screening at Brook House in the early morning (02:59) of 27 February 2017, the nurse recorded that D523 had no medical issues, save for that he smoked cannabis daily. There is no reference in the medical records to indicate that D523 was asked whether he was a victim of torture. D523 was referred to the substance misuse team, and a cannabis use care plan was created. AK later informed healthcare he was smoking Spice and cannabis every night.

16. It appears that D523 failed to attend his GP appointment later on 27 February 2017. This initial GP review was not however re-arranged, resulting in him not being seen for a full physical and mental state examination under Rule 34 during his time at Brook House.

17. On 2 March 2017, D523 disclosed his history of torture to healthcare, stating he had sustained a 'hot scar' mark to his left arm. He was referred for a R35(3) assessment on 3 March 2017, in which his history of capture and attack by the Taliban was noted, as well as the round scar to his left arm. However, the GP erroneously advised D523 that the Home Office was already aware of his account of torture, as this had been previously considered in the context of his asylum claim refusal. D523 was advised to speak to the Home Office and to come back if he needed to "*re-examine rule 35*". A Rule 35(3) report

was not accordingly prepared on this occasion, as the GP appears to have been under the mistaken view that a Rule 35 report wasn't necessary if the Home Office had previously rejected a detainee's account of torture within the asylum process.

18. On 10 March 2017, the same GP saw D523 again and this time produced a Rule 35(3) report. The GP noted AK's history of torture and that the scarring to his arm may be due to his account. The Rule 35 did not however assess whether D523 had psychological symptoms from his torture, or the likely impact of ongoing detention. Detention was maintained by way of a Home Office response dated 14 March 2017 which, whilst accepting D523 was an Adult at Risk, relied on his previous history of absconding and the fact that the GP had not indicated that detention would have an adverse impact on D523's health. It appears that the Home Office did not seek clarification from the GP on these issues before providing the response.

19. D523 was removed from association under Rule 40 on four occasions whilst at Brook House. The first period, on 20 March 2017, was due to an alleged altercation with another detainee, the second, on 25 March 2017, in response to D523 allegedly jumping on the C wing netting and the third on 7-8 April 2017, after D523 allegedly refused lock up and threatened a staff member.

20. During his third period in CSU, on 8 April 2017, D523 attempted to ligature by tying a plastic bag around his neck. The reason attributed in the IRC records was that he was unhappy about being on R40. Healthcare attended and no physical injuries were noted, though AK reported difficulties breathing. D523 was subsequently placed on an ACDT. It appears that a delayed CSU health screening was conducted later that day which, notwithstanding his recent act of self-harm and healthcare noting that he was on ACDT, confirmed there were no clinical reasons against his continued Rule 40 removal.

21. D523 was placed back on Rule 40 on 14 April 2017 after his alleged involvement in a protest on D wing. He was relocated to CSU by force, with wrist locks and then handcuffs applied, after he reportedly refused to walk compliantly. Healthcare was not informed of this use of force until the following day. D523 was taken off Rule 40 and moved to E wing on 17 April 2017.

22. D523 did not receive any RMN support whilst at Brook House. There was no apparent consideration given to whether, in view of his history of torture and serious self-harming episode, he may suffer from underlying mental health issues. He was only offered an RMN review belatedly on 6 May 2017, several days before his release, in response to his reported difficulties sleeping. He declined the referral at this late stage.

(27) D390

1. D390 is a Nigerian national and victim of torture, who has a history of depression, anxiety and insomnia. He served a previous custodial sentence, during which he received some 1:1 mental health support and underwent physiotherapy to address an injury to his hand which he sustained as a child in a knife attack. D390 was detained at Brook House from 15 May 2017 to 5 June 2017.

2. D390 was transferred to Brook House after the expiry of his criminal sentence. A nurse noted in his reception screening that he self-reported a history of PTSD and depression and that he had previously been prescribed Mirtazapine and Amitriptyline. D390 reported that he suffered from testicular swelling. No questions are recorded to have been asked about whether he had experienced past torture. He was referred for review by a mental health nurse and a GP appointment was made.

3. The subsequent GP consultation on 16 May 2017 does not appear to have been a Rule 34-compliant assessment. Whilst the GP recorded D390's complaints of swelling to his legs and testicles, there is no

record that the Doctor conducted a physical examination. It was also noted that D390 had previously been on Mirtazapine for his insomnia and Amitriptyline, however there is no documented mental state examination. D390 was only re-prescribed Amitriptyline at this stage. It was only on 18 May 2017, when D390 was seen by another GP, that he was prescribed Mirtazapine, along with medication for a possible testicular infection following examination.

4. On 30 May 2017, D390 had an appointment with a mental health nurse, where his history of torture was first noted. He was frustrated and tearful, reporting he had suffered from depression since his violent attack as a child. No R35(1) or R35(3) referral was made at this stage, nor was further RMN support considered necessary. During D390 attendance at an Emotional Health Group on 5 June 2017, D390 queried why he should take medication in the IRC, stating that prison was preferable as at least there he knew when he would be released. He stated he had suffered from insomnia for the past 15 years.

5. His roommate later disclosed, in his evidence for his related unlawful detention claim, an episode at Brook House in the early morning when D390 had stated running around their room, hitting the walls, and saying things that didn't make sense. His roommate says that he repeatedly called the emergency line for 30 minutes, but no officers attended. This incident is not referenced in D390's medical records.

6. D390 was forcefully removed from his room on 5 June 2017 to effect his transfer to Harmondsworth. This was a planned C&R intervention, on the basis of his alleged non-compliance, despite his not showing any active resistance, having no such history, and having informed staff he could not move as he had an upcoming bail hearing. It is recorded that D390 was subjected to the application of shield force, inverted wrist holds and locks (a short clip of the officers before they entered the room was shown on the *Panorama* footage). Whilst two nurses attended the incident, there are no references in the medical records or Use of Force paperwork to suggest that consideration was given to whether the use or extent of force was appropriate in light of his mental health issues. D390 reports injuries a result of this incident, though this was not recorded in the contemporaneous records.

7. Despite expressly reporting his history of torture to healthcare, no Rule 35(3) report was prepared whilst D390 was at Brook House. Following his transfer to Harmondsworth, a Rule 35(3) report was produced on 21 June 2017, five weeks into his IRC detention. This documented his history of gang-related torture in Nigeria and his resultant scarring, as well as his symptoms of anxiety, insomnia, panic attacks, and flashbacks which were considered consistent with the clinical findings. The report did not consider the impact of current or continued detention on his mental state. This is also what a Rule 35(1) would be expected to address, but one was not completed until October 2017.

8. D390 received therapy from an IRC psychologist whilst at Harmondsworth. In response to an express request for clarification of his mental health condition, the clinical psychologist wrote to the Home Office confirming that he presented with symptoms consistent with anxiety and PTSD, that he was on an ACDT for active suicidal ideation, and that his symptoms would likely deteriorate in detention. Notwithstanding this, the Home Office maintained D390's detention in a delayed R35(3) response, on 7 August 2017, on the basis of his immigration history and criminal record. It was emphasised that he did not yet have any formal diagnosis and the R35 report had not indicated that ongoing detention would cause harm.

9. A subsequent R35(1) report, prepared by a Consultant Psychiatrist on 2 October 2017, recorded his further disclosure of sexual and physical abuse a child. He was diagnosed with PTSD and severe depression with psychotic symptoms, the report advising that the stress of detention was causing a major deterioration in his mental health, to the point at which D390 was a high risk of suicide and was experiencing auditory hallucinations. By way of a delayed response dated 18 October 2017, the Home Office recognised that D390 was a Level 3 Adult at Risk, however maintained detention on the basis

that the R35(1) report did not specify that ongoing detention would injuriously impact him in a matter of weeks or days. It was also averred that D390's removal could be enforced within a reasonable timescale, despite his having only recently submitted an appeal against his human rights claim refusal.

10. D390 was finally released from detention on immigration bail on 24 October 2017.

(28) MJ8030

1. MJ8030 is an Indian national. He is a victim of both torture and trafficking. He was violently attacked as a child, sustaining a head injury for which he required surgery. During the course of MJ8030's journey to the UK, when still a child, he experienced sexual abuse. On arrival, he was kept in domestic servitude and forced to work for several years. MJ8030 was initially detained at Campsfield on 3 June 2016 following a custodial sentence for Sensitive/Irrelevant He was transferred to Brook House on 7 January 2017. He remained there until 18 September 2017.

2. Whilst in Campsfield a Rule 35(3) report was prepared on 24 August 2016. It noted that MJ8030 had sustained a head injury from a sword attack as a child, for which he had surgery and was hospitalised. He stated he still took pain relief for his injuries. It was noted that his brother had been killed, and father injured, in the attack. Scarring to the back of MJ8030's head was documented in an accompanying body-map. The GP however failed to address whether MJ8030's scarring was clinically consistent with his account or any other rationale for why he considered he may be a victim of torture. He also failed to assess whether MJ8030 had any psychological symptoms from his torture and whether ongoing detention would be injurious to his health. In a very delayed response dated 4 November 2016, the Home Office maintained MJ8030's detention, stating that the Rule 35(3) report was not independent evidence of torture as it simply relied on MJ8030's self-reported account, the GP failing to provide a 'full and detailed' assessment as to whether he had had been tortured.

3. On 15 November 2016 MJ8030 requested a further R35(3) appointment with another GP as he considered there were errors in the extant report and he had not been given the opportunity to provide further details about his past torture. MJ8030 was however booked in to see the same GP, who wrote to the Home Office on 18 November 2016 providing further details of MJ8030's history of torture and indicating further scars to his legs and stomach on an updated body-map. The letter also stated that MSK had suffered memory loss from the attack and ongoing depression. However, the GP still failed to comment on the clinical consistency of MJ8030's psychological and/or physical symptoms with his account, or the impact of continued detention. The Home Office subsequently wrote to healthcare requesting an explanation as to the 'unacceptable' omissions in the previous body-map. The GP responded stating that the additional injuries had not been apparent in the initial R35 assessment, but that he had no reason to disbelieve MJ8030's attribution of the injuries to his reported attack. Again, he failed to provide any clinical opinion as to whether MJ8030 was a victim of torture. It appears that further clarification was sought by the Home Office. No response by the Home Office to the second R35(3) report has yet been identified on the available records.

4. In MJ8030's reception screening at Brook House, on 7 January 2017, it was recorded that he had undergone brain surgery when a child and still suffered from related pain. The nurse noted that he had received a previous Rule 35(3) report in relation to this injury. No mental health issues were identified, despite the medical records confirming MJ8030 was on anti-depressants.

5. MJ8030 attended a GP review on 8 January 2017 where his head injury and medication was discussed. However, whilst he was maintained on anti-depressant medication, there was no assessment of MJ8030's mental state or the possible psychological symptoms he suffered consequent to his torture.

This was not a Rule 34 examination. He did not have a Rule 34 examination during his time at Brook House.

6. On 19 January 2017 MJ8030 provided healthcare with a letter from the Campsfield GP requesting that a further R35(3) be prepared as he had supplementary information and 'new body maps'. MJ8030 was accordingly booked in for a 'Rule 35 pre-assessment' on 23 January 2017, where his history of torture and resultant scarring was noted. However, in his subsequent R35(3) appointment on 31 January 2017, the GP refused to produce a further Rule 35(3) report on the basis that one had already been prepared and responded to, notwithstanding the omissions in this original report.

7. MJ8030 repeated his request for a further R35(3) report on 15 February 2017, stating that he had further information that was not included in the previous report. The GP again refused this request, noting that he had spoken to the Home Office caseworker, who advised that he had received a reply to the second report and MJ8030 was not to attend for a further R35(3). Healthcare continued to refuse MJ8030's repeat requests for a R35, despite his stating he had more to add in terms of his memory problems.

8. In a GP review in late March 2017, it was noted that MJ8030 had a longstanding cough and had occasionally produced blood, and an associated pain to his left side. After vomiting blood on 1 July 2017, MJ8030 was referred for an x-ray and for specialist investigation.

9. MJ8030 also disclosed to the GP that he had thoughts about hitting his head against a wall. He was referred for review by the MHT, subsequently attending his first RMN review on 19 April 2017, some four months into his time at Brook House. He reported intermittent poor sleep, which he attributed to chronic pain from a brain injury he received after being tortured. MJ8030 stated he be sometimes banged his head against the wall, precipitated by the pain in his head, having last done this two weeks ago. He reported feeling frustrated at being in detention, stating that the previous R35(3) reports were wrong. There was no review of MJ8030's anti-depressant medication at this time or subsequently. MJ8030 was discharged from the MHT case-load on 14 May 2017 after failing to attend subsequent appointments.

10. Despite his clear indicators, detention staff at Brook House did not identify MJ8030 as requiring a referral to the National Referral Mechanism as a potential victim of trafficking. It was not until 15 June 2017 that he was referred into the NRM by the Salvation Army, whom MJ8030 had been referred to by Bail for Immigration Detainees. On 28 June 2017 the Home Office made a positive reasonable grounds decision. MJ8030 subsequently received a positive conclusive grounds decision on 23 August 2017.

11. Medical Justice arranged for MJ8030 to be assessed by an independent clinician (Dr Iona Steen) whilst at Brook House on 19 July 2017. The subsequent MLR, produced following MJ8030's release, documented numerous scars across his body (contrary to the previous R35s) which were found overall to be highly consistent with his history of torture. The report concluded that MJ8030 was suffering from a depressive episode and trauma-related symptoms which appeared to have worsened in detention. It was advised he was not fit to be detained.

12. MJ8030 was released from detention on 18 September 2017. Following his release, he received a further MLR, which confirmed his extant diagnoses and opined that his depression and trauma-related symptoms had been exacerbated by his period of immigration detention. It was advised that he lacked capacity to engage in legal proceedings.

ANNEX 2

Medical Justice Post-2017 Case-Studies

(1) AS

1. AS is an Indian national who is a victim of torture and trafficking. He sustained a serious head wound during a violent attack as a child and suffered sexual abuse during his journey to the UK. AS has a history of epilepsy, depression, and related substance misuse. He was subject to intermittent periods of immigration detention between 2016-2019.

2. On 16 February 2021, AS was re-detained initially at Colnbrook and then Harmondsworth IRC pending deportation. . He received psychological therapy and psychiatric input whilst at Harmondsworth and was placed on an ACDT after evincing suicidal ideation. On 13 April 2021, a Part C was raised in mid April 2021 stating that AS had threatened to self-harm. On 15 April 2021, Healthcare advised that AS's mental state was likely to deteriorate with continued detention but did not raise a Rule 35(1). The Home Office treated the information from IRC healthcare as constituting AAR Level 3 evidence.

3. Notwithstanding this, AS was transferred to Brook House on 12 June 2021. At the time, he was someone with no barriers to removal but there was no Emergency Travel Document to effect removal; one would take at least 3-6 months, According to a Home Office bail summary. AS remained at Brook House until 3 December 2021 when he was released.

4. The reception screening on 12 June 2021 recorded that AS had been transferred to Brook House on an open ACDT and had previously attempted to self-ligature. He reported that he had a history of epilepsy and was prescribed Sertraline for his mental health problems. The record of the screening does not indicate that AS was asked whether he was a victim of torture.

5. AS was subject to a mental health assessment on 13 June 2021. During this assessment he disclosed that he had been tortured when he was 13 / 14 but that the Home Office had not accepted his Rule previous 35(3). He reported that he was not feeling well as he had not received his anti-depressant medication as it was not sent with him when he was transferred to Brook House. It was noted that AS appeared 'low in mood', but not presenting with psychotic symptoms. AS had received several R35(3) reports at previous IRCs raising

concerns that he may be a victim of torture. The most R35(3) assessment, dated 26 February 2021, recorded that AS had scarring to his scalp and lower legs, and significant mental health symptoms, consistent with his account of torture. Whilst the Home Office accepted AS was an AAR L2 as a result of that report, detention was maintained on the basis of his imminent removal and absconding risk. No further referral was made for a Rule 35(3) assessment following disclosure at this mental health assessment.

6. At a a GP appointment review later that day, a view appeared to have been taken that as he had previous Rule 35(3) reports, no further report would be made. The review concluded with a plan to arrange a further GP appointment if or when concerns arose.

7. On 14 June 2021, two days after his arrival at Brook House, AS was re-prescribed Sertraline, On 25 June 2021 his Sertraline was increased and he was referred to the Mental Health Team.

8. In a follow-up MHT review on 26 June 2021, AS reported that he was suffering from flashbacks and nightmares, which were exacerbated by night-time lock-up. . He was noted to look very tired and his eye where red and sore. AS was referred for review by the GP. The GP appointment took place the following day but consisted only of a medication review with the outcome being to continue with the current medication. The trauma symptoms elicited by the nurse the previous day were not explored and the impact of detention and whether a Rule 35(1) or (3) would be indicated, were not considered. AS continued to report ongoing difficulties with his sleep, and being 'fed up' with his situation, when reviewed again by the MHT several days later. The GP re-prescribed Promethazine for AS' sleeping issues at this point, but without meeting AS for an appointment.

9. On 5 July the Home Office sent an enquiry to healthcare asking whether AS continues to be fit for detention. A GP at Brook House healthcare responded stating that he was 'on medication for allergies (hay fever), athma, gastro-osephalageal reflux and low mood. None of these conditions pose a cause for concern. His mental health is stable and he is supported by the mental health team'.

10. In a subsequent RMN review on 6 July 2021, AS requested that his anti-depressant medication be changed and his sleeping medication be re-prescribed. He disclosed that his mood was 'very low' and felt as if something was 'haunting him'him' and that as he was

brushing his teeth when he felt as if someone pushed him from behind. In response he 'was helped to acknowledge that out minds/imaginations sometimes sway'. The mental health nurse recorded that AS presented with no symptoms of depression, and raised his possible discharge from the MHT and concern about drug-seeking behaviour.

11. During a subsequent GP appointment it was agreed to change his anti depressant medcation from Setraline to Mirtazapine, an antidepressant that can help with sleep. He was not re-prescribed Promethazine over a month later.

12. Medical Justice arranged for AS to be assessed remotely by a Medical Justice GP, Dr Thelma Thomas, in June 2021. Following her initial assessment, on 18 June 2021, Dr Thomas sent an urgent letter to Brook House Healthcare, advising that AS presented with serious trauma-related symptoms which required prompt assessment and rendered him unfit for detention. Dr Thomas also advised that AS' epilepsy, which was possibly related to the head injury he sustained from his past torture, required further assessment and referral for neurological investigation. Having received no response, Medical Justice chased this up with Healthcare again in late June 2021, though still heard nothing. The final MLR, which was provided to Healthcare in early August 2021, diagnosed AS with depression and symproms highly suggestive of PTSD and advised that AS required a full psychiatric and scarring assessment within the community.

13. It does not appear that Healthcare took any steps to consider or action Dr Thomas' findings. On 18 August 2021 the Home Office contacted healthcare specifically regarding Dr Thomas' report stating *' we trust that you will take note of this information and take any required action (...)'*. And asking whether healthcare had any concerns that AS may be struggling to cope with detention. The response was by a GP at Brook House was *'No' 'Not apparent from records'* without any further explanation. It was also claimed that there was no record of Dr Thomas raising her concerns directly with Healthcare, despite her recent urgent memorandum, receipt of which was confirmed by the Healthcare team to Medical Justice.

14. AS continued to report poor sleep and low mood in health reviews throughout July-August 2021. He also complained that the anti-depressants prescribed did not work and asked for an increase of the dosage. inc In a GP review on 27 August 2021, AS reported suffering from traumatic flashbacks and ongoing low mood, even following the change of his anti-

depressant medication. A belated referral was made for neurological review of AS' epilepsy, although no appointment was received during the time covered by the records available to us (up to 23 September). AS was also referred to the MHT for review for possible PTSD, however there is no evidence to indicate that this in fact took place. In the subsequent MHT review AS attended, on 29 August 2021, he was advised simply to pursue more activities outside of his cell. No substantive assessment of the nature and extent of AS' trauma-related symptoms was conducted. Nor, despite the findings of the recent MLR, was AS referred for by a psychiatrist at Brook House during the time covered by the healthcare records available to us (up to 23 September 2021)..

15. AS was removed from association on two occasions whilst at Brook House. He was first placed on Rule 40 on 27 July 2021, after jumping onto the suicide netting in protest of being unfairly treated by a specific detention custody officer. AS was removed to Care and Segregation Unit again on 15 August 2021 after he allegedly threw a fax machine at a DCO. The available evidence indicates that AS was placed on an ACDT after this incident as he had stated he wanted to take his own life. The ACDT appears to have been closed later that day, when he was taken off R40.

16. We do not know whether force wes used to transfer him to segregation.

17. On 2 September 2021, a medical record entry noted AS hitting at the Healthcare door, asking for a doctor who had apparently completed a Rule 35 assessment and found that he was fit for detention. The report was not included in the disclosed medical records and there was no other entry referring to the Rule 35 report, which limb it was made under, and what its purpose was. In protest at his ongoing detention, AS commenced a period of food refusal from around 5 to 14 September 2021. He was placed on constant supervision throughout this period. AS reported feeling depressed and having no interest in anything. No substantive assessment was undertaken by the MHT to determine the motivation for his food refusal or underlying mental health needs.

18. He was released from detention on 3 December 2021.

(2) FS

1. FS is an Albanian national who is a victim of torture. Prior to detention, he had a history of depression and suicidality, having attempted to overdose in 2017. FS was first detained at Tinsley House, for around a month, in January 2018, after becoming Appeal Rights Exhausted. He was subsequently re-detained at Brook House on 26 December 2019, making asylum representations shortly thereafter.

2. In his reception screening early on 27 December 2019 (00:13) it was noted that FS had previously taken an overdose and been prescribed depression medication. Despite this, it was recorded that FS did not present with any mental health or self-harm issues. FS was not asked questions about whether he had experienced past torture in his reception screening.

3. FS did not receive a Rule 34 examination whilst at Brook House. He saw a GP on the day he was screened but this merely involved the GP recording that FS felt stressed and had previously been prescribed anti-depressants. He was not given a physical and mental state examination and no questions were asked to elicit whether he had a history of past torture. FS' medication needs were also not assessed even though he had told the GP he was previously on anti-depressants. He was referred to the MHT for review. FS reported to Healthcare the following day that he was having difficulties sleeping and repeated his previous prescription for anti-depressant medication. He also requested a R35(3) report, with a referral accordingly made.

4. In the subsequent R35(3) assessment with the GP (Dr. Oozeerally), on 2 January 2020, FS disclosed his history of being physically abused, beaten up, threatened and taunted by other students at school over a whole year, about four years ago. The other students would pull his trousers down, whilst he was restrained, and threatened to put a stick up his anus on account of his sexuality. He said he had no residual scarring from the abuse, although had thoughts of ending his life and suffered from difficulties sleeping. He also mentioned having previously received therapy and medication in the community. The GP observed that FS was coherent, and presented with no psychotic features and noted that he had already been referred to the Mental Health Team but that no rule 35(3) would be raised.

5. In an IS.91RA Part C, Dr. Oozeerally explained that a Rule 35(3) was not going to be completed because FS "*has not (sic) supporting evidence for this*". This is even though there is no requirement for evidential proof and the GP did not consider the possibility of physical abuse not leaving any scars. There was no consideration of whether and to what extent FS' psychological symptoms were consistent with his reported mistreatment.

6. The medical records indicate that FS commenced a period of food and fluid refusal on or around 3 January 2020. He was moved to E wing and remained subject to food and fluid monitoring until around 16 January 2020 if not later (the medical records relating to the final week of detention are missing). He disengaged with mental health services from time to time during that period.

7. FS' legal representatives made repeat submissions to the Home Office that he was unsuitable for continued detention, stating his mental health was deteriorating, and he was suffering rapid weight loss from his ongoing food refusal. Particular concern was raised over FS' imminent risk of suicide. Healthcare failed to action these concerns. On 8 January 2020, FS attempted to hang himself with a ligature from the TV bracket. An emergency response was called and FS was cut down. He refused to engage with staff about the incident, only stating that he could not sleep. FS was consequently placed on ACDT constant supervision. This serious act of suicidality failed to prompt a report was issued under R35(1) or R35(2) despite it being evidence of his worsening clinical state.

8. In an ACDT review on 8 January 2020, FS repeated that he was having issues sleeping and suffered from intermittent suicidal ideation. He confirmed that prior to detention he had been prescribed medication for his depression and had received talking therapy. FS was advised in response to pursue more activities. In an ACDT review the next day (9 January 2020), FS continued to state that he felt depressed and would try to kill himself if he got the chance. No clinical assessment was undertaken to investigate the triggers for his suicide attempt, or his ongoing food refusal.

9. On 9 January 2020, FS also had his first RMN review, nearly two weeks into his detention. He reported that he suffered from traumatic flashbacks and active suicidal ideation. FS also reported that he was struggling to eat or sleep and that his head hurt. FS was referred for review by a psychiatrist. Healthcare informed the Home Office of FS' statement of suicidal

intent, by way of email the same day, confirming he remained on ACDT constant supervision.

10. Medical Justice contacted Healthcare that day to express concerns about FS' reported ongoing suidal ideation, poor sleep and his saying he did not have the necessary medication and was "going mad". The charity confirmed FS had been previously prescribed medication for his low mood and sleeping. Later the same day, in a GP review, FS requested that he be prescribed medication, stating that he had previously received anti-depressants. He was recorded as presenting as *"sad fed up frustrated"* and *"asking for a solution"*. The GP did not undertake medication review or prescribe medication and stated that FS' mental health would be reviewed by the mental health team the next day.

11. On the night of 9 January 2020 FS tried to tie a further ligature around his neck but was intercepted by staff. FS was also observed punching and headbutting the wall. This failed to prompt an urgent mental state examination.

12. A further R35(3) assessment was conducted on 9 January 2020 by a different GP (Dr. Al-Maliki) at the request of FS' legal representatives. The medical records do not contain a copy of the report but there is a medical record entry describing the content of the report. The resultant report recorded FS' account of physical abuse by other students at school on account of his sexuality, including one occasion when his cousin was hospitalised after sustaining serious injuries trying to protect him. It appears that the GP concluded, without any explanation, that FS' claim did not amount to torture but rather constituted assault and abuse. He consequently failed to assess FS' underlying psychological symptoms or the impact of continued detention. The Home Office R35(3) response, dated 13 January 2020, similarly found that FS' account did not meet the definition of torture, though accepted that he still engaged AAR L2. It was noted that FS had outstanding representations and did not pose a public protection risk. Detention was however maintained on the basis that there was no indication that FS' medical needs could not be met in detention, notwithstanding that the Home Office was expressly aware of FS' acute mental vulnerability and suicidal ideation.

13. FS was finally assessed by a psychiatrist on 10 January 2020. He reported that his mood had deteriorated significantly since being detained and that he struggled with suicidal thoughts. He also reported suffering from persistent headaches, loss of appetite and poor sleep. His

serious recent suicide attempt was noted. FS was diagnosed with a depressive episode and prescribed Mirtazapine. This was medication that he had asked for when he was first detained, 14 days earlier. FS did not receive any further psychiatric input or review throughout the remainder of his time at Brook House, only intermittent RMN welfare checks.

14. On 11 January 2020, FS was assessed by healthcare after he reported suffering from migraines and blurred vision. He was prescribed painkillers and advised to increase his food intake. FS continued to report ongoing headaches in the following days, requesting stronger analgesia and stating that he was *'dying'*.

15. On 13 January 2020, Medical Justice contacted Healthcare to relay concerns that AS was feeling seriously unwell, and that he stated he *"needed to go to the hospital before it's too late"* as he was *"nearly finished"*. In an ACDT review that day, FS complained that he was not being helped by healthcare and would kill himself if his pain was not addressed. No action was taken in response to these concerns other than to keep him on constant supervision.

16. In a healthcare review on 15 January 2020, FS continued to report ongoing headaches, dizziness and loss of appetite. He also stated that he felt depressed, and that the Mirtazapine was not working. He complained of poor sleep, nightmares and trembles. In a GP review later than day, FS was kept on Mirtazapine and advised to take pain relief. Again, there was no assessment of his acute clinical presentation. There was no consideration as to whether detention was likely to be injurious to his health given the recurrning problems and ineffectiveness of medication and ACDT.

17. Medical Justice arranged for FS to be assessed by an independent clinician (Dr Bourdillon-Schicker) on 21 January 2020. FS reported regular suicidal ideation and that he had self-harmed the day before, by cutting his wrist, though had not informed staff. Dr Bourdillon-Schicker assessed FS to have severe depression, anxiety and PTSD with a high risk of suicide and self-harm. He appears to have written directly to Healthcare, immediately following the assessment, to advise of his concerns. Dr Bourdillon-Shicker concluded, in his subsequent MLR dated 6 February 2020, that FS was unfit for detention, which had precipitated a deterioration in his mental health condition.

18. FS was finally released on 23 January 2020. The day of his release, FS attempted suicide by trying to jump in front of a train. He was admitted as an informal patient to a secure mental health ward the following day and was subsequently detained there, under Section 2, on 22 February 2020. He was discharged from the unit on 14 March 2020.

(3) RMA

1. RMA is an Iraqi national and victim of torture. He was detained at Brook House on 24 August 2021, having become Appeal Rights Exhausted. Several sets of further submissions were made, and rejected, by the Home Office during his detention. RMA was granted immigration bail on 7 December 2021 and released shortly after.

2. RMA was not asked questions about whether he had experienced past torture in his reception screening on 24 August 2021. The screening also recorded that RMA had no mental health or self-harm issues. It appears that RMA failed to attend his GP appointment later on 25 August 2021. This initial GP review was not however re-arranged, resulting in RMA not receiving a Rule 34 complaint assessment during his time at Brook House.

3. RMA was first reviewed by Healthcare on 7 September 2021, after reporting severe head pain. His observations were taken, and he was assessed as suffering from stress-related headaches linked to his immigration case. Healthcare was subsequently informed that, prior to their attendance, RMA had self-harmed by banging his head against the wall. He was placed on an ACDT, which remained open until 26 September 2021. RMA was also referred for review by the MHT.

4. RMA was not assessed by an RMN until 11 September 2021. During this initial assessment, he reported feeling routinely hopeless, anxious and having difficulty sleeping. Despite his depressive symptoms, no mental health issues were identified, nor was consideration given to RMA's medication needs. RMA was reviewed again by an RMN on 14 September 2021, when he was still noted to be low in mood with ongoing headaches. Again, no potential diagnoses were considered or medication prescribed.

5. A belated referral for a Rule 35(3) assessment was made on 10 September 2021, over two weeks into his detention. The Rule 35 assessment, carried out the next day, recorded RMA's account of being attacked and stabbed due to his religion. Scars were noted to his scalp and face. The report recorded that RMA had been referred to the MHT after self-harming. RMA

reported feeling hopeless and was suffering from regular headaches and poor sleep. The GP assessed that RMA's scarring was overall consistent with his claim, though failed to identify or assess whether the psychological symptoms were corroborative of RMA's torture. The report concluded that ongoing detention "*may deepen anxiety or mood difficulties without mental health support*". No separate Rule 35(1) was raised. The Home Office R35(3) Response, dated 14 September 2021, is not on file, however it appears that detention was maintained notwithstanding that it was accepted the report constituted AAR Level 3 evidence.

6. RMA complained of ongoing headaches and generalised pain throughout his detention, requiring frequent pain relief. It does not however appear that RMA received a full clinical assessment in relation to these concerns, nor consideration of the possible nexus with the head injury he had sustained from his past torture.

7. The first documented ACDT review in the medical records took place on 16 September 2021, some five days after RMA had self-harmed. I was said that he presented with no signs of depression or anxiety.

8. On 21 September 2021, RMA reported in a MHT follow-up that he was not sleeping and was hearing voices in his room at night. These serious psychological symptoms were not identified or assessed as suggesting an underlying mental illness. The RMN instead recorded that RMA presented with no signs of psychosis or thought disorder and did not consider whetehr the symptoms could be trauma-related. The following day RMA repeated, to the same RMN, that he was suffering from nightmares and felt that there was someone in his room strangling him. He stated that he did not know if he was going to harm himself. The RMN stated on this occasion that RMA presented with signs of PTSD, and discussed his case with the GP who prescribed an antidepressant, Mirtazapine. .

9. The GP however did not conduct a mental state examination to assess whether RMA's symptoms were consistent with a depressive or trauma-related disorder and did not consider the need for psychotherapy or the likely impact of detention on RMA's health given his trauma symptoms. Similarly, no mental state review was conducted when RMA informed a nurse, on 28 September 2021, that he was suffering from traumatic flashbacks. Despite his acute psychological presentation, it does not appear that RMA was subject to a substantive

mental health assessment throughout his time at Brook House, nor did he receive input from a psychiatrist.

10. RMA underwent a short period of food refusal in early November 2021. No consideration was given to whether and to what extent this was connected with or caused by his trauma-related symptoms.

11. On 23 November 2021, Medical Justice informed Healthcare that RMA stated he would self-harm as he was locked in his room without electricity. It appears that RMA was subject to a planned C&R intervention to relocate him to CSU, under R40, later that day. RMA injured his wrist during the use of force removal, requiring review by the GP. The basis for his Removal from Association is unclear, though appears to be linked to his refusal to share a room. No advice was sought from healthcare as to medical concerns about the appropriateness of using restraints or forcing him into segregation in view of what was already known about his serious mental health issues and ongoing ACDT monitoring.

12. Medical Justice arranged for RMA to be assessed by an independent clinician (Dr Kathryn Allinson) whilst at Brook House on 2 December 2021. Dr Allison wrote to Healthcare the same day to confirm that RMA presented with depression and symptoms consistent with PTSD, which required further assessment. She also advised that he required review by a GP for his ongoing headaches. The preliminary MLR, dated 7 December 2021, recorded a diagnosis of depression and trauma symptoms likely meeting the diagnostic criteria for PTSD and that RMA had reported suicidal thoughts and self-harmed on several occasions whilst in detention, including by hitting his head against the wall. Dr Allison advised that continued detention would lead to a further deterioration of RMA's mental condition and an attendant increase in suicidal risk.

(4) <u>AK</u>

1. AK is an Indian national who is a victim of physical and sexual torture. He arrived in the UK on a student visa in late 2017, subsequently overstaying after his leave expired. He was encountered on 4 July 2021 during an enforcement visit and served with notice of liability for removal. AK was detained at Brook House later that day. Shortly thereafter he was served with Removal Directions set for 21 July 2021 but these were cancelled further to a claim for asylum being made.

2. AK was detained at Brook House for two and half months, released on 4 October 2021 further to judicial review proceedings being issued. He suffered a marked decline in his mental state during this period, compounded by the failure of Healthcare to recognise and treat his long-standing PTSD symptoms.

3. On being detained, he was subject to a health screening and a GP assessment but no questions were asked to explore whether he had a history of past torture. He did not have a physical and mental statement examination as required under Rule 34. The GP only noted his reporting anxieties and poor sleep but said he "appears well". No MHT referral was initiated or medication review undertaken.

4. In the days following this, AK's medical records noted his having difficulties sleeping, feeling stressed, hearing voices, and suicidal. On 6 July 2021, AK issued a Healthcare request form on 6 July 2021, asking to see a Doctor urgently in respect of his sleeping issues and need for mental health medication. This failed to prompt any clinical response. AK submitted further Healthcare requests on 7 and 8 July 2021, stating that his mental health was worsening and he was having thoughts of self-harm. It is to be noted that AK sent a total of 14 Healthcare requests in his first 30 days in detention.

5. On 8 July 2021, AK was referred for a mental state assessment. He disclosed to the RMN that he was hearing voices and having intermittent suicidal thoughts. KA also reported, in the mental health screening questionnaire, feeling routinely low in mood, anxious and having difficulties sleeping. Despite his recorded symptoms, the RMN erroneously concluded that AK did not present with any signs of mental illness. The plan was recorded for ongoing RMN support, with a referral for psychiatric review if AK's condition deteriorated.

6. An ACDT was opened on 9 July 2021 in response to AK's self-harm ideation. The Home Office was informed via an IS.91RA Part C received on 12 July 2021. There is no evidence of an urgent mental state examination or ACDT review being carried out at this stage, in order to identify and assess any clinical triggers for KA's suicidal ideation.

7. AK submitted further Healthcare request forms on 12 and 14 July 2021, asking to be seen by a Doctor as there had been no improvement in his mental health. He repeated his need

for medication for his stress and sleep issues. AK was informed in response that he would be reviewed by a GP in a week.

8. On 14 July 2021, AK was served removal directions to be effected on 21 July 2021. On 17 July 2021, his immigration solicitors informed the Home Office that AK wished to claim asylum on the basis of his being a Tamil, having a well-founded fear of persecution in India as a result of his support and involvement with the LTTE, and having a history of detention and torture (including rape and sexual abuse) by the Indian authorities. He required an assessment under Rule 35(3). Jein Solicitors stated that in the light of his traumatic past, it would not be appropriate to interview AK in respect of his asylum claim in detention; steps were being taken to refer him for assessment with Medical Justice and Freedom from Torture and he should be released on bail to his friend's address.

9. On 18 July 2021, the Home Office recorded AK's asylum claim and cancelled the removal directions due for 21 July 2021. Although AK was booked for a Rule 35(3) report, this was postponed because he had to isolate for suspected contact with a confirmed Covid-19 case at Brook House.

10. In the meantime, the medication records showed continued self-harm, suicidal ideation, ongoing ACDT monitoring and referrals being made to the Mental Health Team as a result. On 15 July 2021, he told an RMN that he felt depressed and anxious, and wanted to self-harm because he was not sleeping. The RMN assessed him to pose moderate risk of suicide and was *"very concerned about (AK's) welfare"*. That day a GP prescribed him with Promethazine Hydrochloride, a sedating antihistamine which can be used as a sleeping aid. It does not however appear that AK was assessed in person by the GP. For reasons that are difficult to understand from the records, the ACDT was closed the next day even though he had been assessed as a moderate suicide risk the day before and his underlying mental health needs remained untreated. On 17 July 2021, an emergency response was called after AK presented with shortness of breath and anxiety.

11. On 22 July 2021 AK recorded, in a Healthcare request form, that he needed to see a Doctor as he had run out of his sleeping medication. He submitted a further request the following day. Healthcare responded that he had only recently finished his medication and would not be prescribed more.

12. AK was referred for review by the GP on 29 July 2021, after reporting via a Healthcare request feeling depressed and suffering from suicidal thoughts. In the subsequent GP review, KA confirmed his ongoing psychological symptoms and intermittent self-harm ideation. He was noted to present as low in mood and was "*considering starting medication*". No mental health diagnosis was considered. Nor were AK's medication needs reviewed, including his repeat request to be re-prescribed Promethazine. AK was simply advised of coping strategies and referred back to the MHT. Whilst the GP noted that AK was awaiting a R35 appointment, no concern was raised over the delay in progressing this referral.

13. AK's legal representatives issued a pre-action letter to the Home Office on 31 July 2021, challenging his detention and the inclusion of his asylum claim into a fast-track process owing to hims mental ill-health, his being unfit to be interviewed in detention and steps being taken to obtain an MLR to address his scarring and psychiatric state. They also complained of the failure to conduct a R35 assessment.

14. That same day, AK submitted a further Healthcare request, underlining that he was a victim of torture who was suffering from suicidal ideation and depression. He reiterated his need for sleeping medication. These concerns were repeated in a RMN welfare check on 1 August 2021, and in another Healthcare request issued several days after. An accompanying entry in the medical records notes that custodial staff had been informed of AK's suicidal ideation and would "*act accordingly*". There is however no record of AK being placed on an ACDT at this stage. There was no evidence any consideration of a Rule 35(2) report.

15. In an RMN review on 4 August 2021 AK asked again for sleeping medication and stated he "*needs help with his mental health problems*". AK was simply advised to practice 'mindfulness' in response. In a GP review the following day, he was advised that Healthcare could not prescribe him with sleeping pills, though no apparent consideration was given to re-prescribing him Promethazine. AK was noted to present only with "*circumstantial sleep and anxiety issues*". Again, no mental health diagnosis was considered, nor his need for supporting medication.

16. It was not until 6 August 2021 – over a month into his detention at Brook House - that AK was finally prescribed anti-depressant medication (Sensitive/Irrelevant) in a GP review. AK reported having suicidal thoughts at night, along with a history of self-harm. There is

reference in the medical records to AK being on an ACDT again by this point, though it is unclear when this was opened. Despite AK attributing his depression and anxiety to his history of torture, the GP failed to assess him for a potential PTSD diagnosis.

17. On 7 August 2021, a R35(3) assessment was completed; this was a delay of some 22 days from when AK first raised his claim of torture. The resultant R35(3) report recorded AK's account of torture including sexual mistreatment when detained in police custody and documented scars on his body. The GP considerd AK *"credible and has some visible scars that may be consistent"* with his account. The GP expressed "*concerns about (AK's) mental health*", including his thoughts of self-harm and advised that he be monitored closely, but concluded that AK's health needs could be met in the IRC without any consideration of the clinical picture recorded in the medical records. The report did not address the issue of whether his mental health had deteriorated since he was first detained or whether it was likely to do so if he remained in detention.

18. On 8 August 2021, AK was moved from 2-hourly observations to constant observations under ACDT after being found to have made a superficial cut to his lower arm. The ACDT review that day noted that he was self-harming as an attempt to end his life. He said this was triggered by thoughts about his past experiences of torture coming back to him whilst in detention. He was assessed as *"high suicide risk"* and observed to present as *"emotionally distressed"*. No Rule 35(2) however was raised. An IS91 RA Part C was raised instead.

19. On 10 August 2021, AK was notified that his substantive asylum interview would take place on 18 August 2021. This was subsequently changed to 24 August 2021. He applied to the Home Office for immigration bail, putting forward a release address with his friend, and £2,000 as a financial condition. This was refused on 19 August 2021, reliance being placed on an assertion that he was unlikely to comply with bail conditions owing to his past non-ocmplaince, absence of family ties, and late asylum claim, said to be made to frustrate removal. No consideration was paid to AK being an Adult at Risk with at least Level 2 (but arguably Level 3) evidence of risk.

20. In the mean time, on 10 August 2021, the Home Office provided a response to the Rule 35(3) by accepting the doctor's view that AK may have been a victim of torture, agreeing to treat him as an Adult at Risk Level 2 on this basis but maintained his detention on the basis of his past non-compliance with immigration laws. The response did not address at all

or properly the threshold for AAR Level 3, particularly as the Home Office was already aware of AK's high suicide rates and his intention to kill himself.

21. On 12 August 2021 the GP responded to a Home Office's Healthcare enquiry, confirming its view that AK was not fit to be interviewed *"until his mood improves in the near future"*. He was however re-assessed as fit to be interviewed on 15 August 2021, despite no indication in the medical records that his mental health had improved over the three days.

22. On 19 August 2021, AK's immigration solicitors produced an MLR from Dr Saleh Dhumad, a consultant psychiatrist, who concluded that AK met the diagnostic criteria for Severe Depressive Episode and Post-Traumatic Stress Disorder ("PTSD"), and that he had a moderate risk of suicide which was likely to become significant in the context of removal. Dr. Dhumad considered that AK did not receive the necessary treatment in detention, including trauma-focussed Cognitive Behavioural Therapy and medication, and that he was very likely to suffer a serious deterioration in his mental health if he remained detained. Dr. Dhumad considered that he was unfit for formal interview whilst in detention and was unfit to fly.

23. On 24 August 2021, the Home Office maintained AK's detention, stating that limited weight would be given to Dr. Dhumand's MLR because of asserted technical breaches of the purported standards for MLRs contained the AAR Casework Guidance. This was said to include a failure to set out the limitation of remote assessments, to raise concerns about the Claimant's mental health with the IRC healthcare immediately, to consider the availability of primary healthcare in detention and the absence of a statement of assurance that the MLR met the purported standards set out in the casework guidance. The Defendant maintained that the Claimant's health was managed in detention, and there was no substantial evidence of detention causing a deterioration and he was fit to be interviewed on 25 August 2021.

24. The response did not address at all or properly the threshold for Adults at Risk ("AAR") Level 3, relying on Dr. Musalam's view that the Claimant's health needs could be met in the IRC without considering the medical records, which noted his being at "high suicide risk" and his being elevated to constant ACDT suicide watch, from 2-hourly observations, which clearly indicated a deterioration in his mental state.

25. Late on 24 August 2021, AK self-harmed by cutting his arm with a razor. No urgent mental state examination was documented. AK was placed on constant supervision, and stated that "*he just want to die* [sic]". He repeated his request for sleeping medication. He was not referred for review by the GP nor psychiatric assessment. Concerns over AK's acute condition were not raised via a report under R35(1) or R35(2) at this stage. He was simply advised to pursue more activities.

26. In an ACDT review on 27 August 2017 KA requested a razor to kill himself with. There was observed to be no positive change in his presentation. He remained on constant watch. Despite this, and his recent MLR diagnoses, the RMN assessed that he presented with no signs of severe depression and re-assessed him as moderate risk of suicide. Again no Rule 35(1) or (2) was raised.

27. AK underwent a period of food refusal from around 27 August-1 September 2021, during which he appears to have refused to engage with staff observations. In an RMN review on 1 September 2021, it was recorded that he was "*bearly* [sic] *able to talk, his lips where* [sic] *dry and his tongue was crusted*". He presented as tearful and stated he wanted to die. It was only at this stage, some two months into his detention at Brook House, that KA was referred for review by a psychiatrist.

28. AK was assessed by the psychiatrist, on 3 September 2021, as presenting with likely PTSD. This is the first and only mention of PTSD within AK's medical records, despite having presented with indicators of a trauma-related disorder from early on in his detention, and despite Dr. Dhumad having diagnosed him to have PTSD. AK's dosage of Mirtazapine was increased.

29. In a GP review on 5 September 2021, AK reported ongoing self-harm thoughts which he was "*unable to control.....and may act impulsively*". He stated that being locked up exacerbated his traumatic memories of his past mistreatment. AK was at this stage re-prescribed Promethazine to aid his sleeping issues, over a month after he had initially requested this. He was also commenced on a new anti-depressant medication, Sertraline, after complaining of physical side-effects from Mirtazapine.

30. Medical Justice separately arranged for AK to be assessed by its clinical advisor, Dr Rachel Bingham, on 16 September 2021. Dr Bingham cut short the appointment as she considered

that KA was too unwell to undergo a full medico-legal (including scarring) assessment. She immediately raised her concerns with Healthcare, both in person and by way of a summary letter, as to AK's serious condition. She confirmed that AK presented with ongoing symptoms of PTSD and depression and reported hearing voices. He presented as at high risk of suicide, having stated he would cut his throat with a razor blade. She assessed AK as unfit for detention and for interview. It was advised that Healthcare arrange a psychiatric assessment and liaise with the Home Office over his fitness for detention, however there is no evidence to indicate that these steps were taken.

31. AK suffered a further steep deterioration in his mental state in mid-September 2021. On 14 September 2021, he submitted a Healthcare request stating that he continued to suffer from flashbacks and nightmares, and could *"hear voices very strongly"*. He presented with a raised heart rate in a clinical review several days later, on 16 September 2021, stating he was *"hearing voices in his head shouting HELP ME HELP ME"*. He was placed back on ACDT constant supervision the same day, following Dr Bingham's assessment. AK subsequently refused to engage with Healthcare and commenced a further period of food refusal. In a Food and Fluid interview on 20 September 2021, attended by the Home Office, he stated that he wanted to die. In an RMN review on 21 September 2021, AK reported that police were coming into his cell at the night. He repeated this ideation in a review on 28 September 2021. Despite this, it was consistently recorded that AK did not present with any signs of psychosis or thought disorder.

32. AK was discussed in an AAR meeting on 22 September 2021. The accompanying entry in the GCID records notes that IRC staff raised concerns regarding AK's state, which they wanted to be brought to the attention of his caseworker. AK was not reportedly engaging with IRC staff or the Home Office. It was however recorded that *"they believe this might be a personality issue rather than mental"*. The same day, AK's solicitors wrote to the Home Office in proposed challenge to his ongoing detention on account of his serious clinical vulnerability.

33. On 27 September 2021, the Home Office provided its response to Dr Bingham's preliminary letter to Healthcare. The various criticisms levelled by the Home Office were premised on the incorrect treatment of this letter as an MLR, rather than an urgent communication. Dr Bingham wrote to the Home Office to correct this position. Her resultant MLR, produced on 1 October 2021, confirmed AK's diagnoses of PTSD and a Severe Depressive Episode

and that detention was causing a serious deterioration in his mental state. This was subsequently provided to the Home Office for consideration.

34. On 4 October 2021, AK was released from detention further to judicial review proceedings having been issued on 1 October 2021.

(5) HRB

1. HRB is an Iranian national and victim of physical and sexual torture. He has a long-standing history of serious mental health issues and suicidality. HRB has been subject to recurrent periods of immigration detention since 2019. Prior to detention at Brook House from 23 November 2020 to 9 December 2020, HRB was detained for two earlier periods, from 20 August 2019 to 26 September 2019, and 22 January 2020 to 10 February 2020.

2. HRB suffered a serious deterioration in his mental state during his two periods of detention prior to Brook House. He attempted suicide whilst detained at Colnbrook, in late 2019 on at least two occasions and was subject to constant watch in the Care and Separation unit of that IRC. An interim MLR prepared by a Medical Justice clinician (Dr Thelma Thomas), in September 2019, diagnosed HRB with PTSD and Severe Depression and advised that he was unfit for detention. The Home Office accepted that he was an AAR Level 3. When he was re-detained in January 2020, that status had not changed. HRB continued to self-harm and was maintained on an ACDT during this second period of detention. He was assessed by the IRC healthcare MHT as presenting with a depressive disorder and Complex PTSD and at very high risk of suicide, with detention precipitating his trauma-related symptoms. This was also confirmed in an MLR prepared by Dr Eileen Walsh, a consultant psychologist, dated 31 January 2020, which advised that HRB was unfit for detention. Following his release from detention on 10 February 2020, HRB received intensive support from the Crisis Team and his GP whilst in the community.

3. In November 2020 when HRB was re-detained at Brook House, despite being recognised as an AAR L3, the Deteniton Gatekeeper authorised detention "*reluctantly*", on the basis of his imminent removal, despite being "*extremely concerned over his fragile mental health state*". It was requested that HRB receive close monitoring during his detention and "*proper welfare and medical support*". It was also requested that he be released immediately if his removal,

scheduled for 8 December 2020, failed. However, despite his removal directions being subsequently deferred, on 1 December 2020, HRB's detention was maintained until 9 December 2020.

4. Upon being re-detained on 23 November 2020, HRB started to hyperventilate and complained of chest pains. He was subsequently admitted to hospital for assessment and was diagnosed with Anxiety Disorder. Following his discharge later that day, HRB started banging his head and stated he wanted to kill himself. The GCID records indicate force was used to effect his transfer to Brook House.

5. The subsequent reception screening at Brook House later on 23 November 2020 failed to identify HRB's serious mental health issues, with the attendant entry in the medical records simply noting that he has *"health issues but only his Dr understands"* and that there were *"no issues"* with his mental state presentation. It was inconsistently recorded that HRB both had, and had not, received medication for his mental health problems, despite it being noted that he was admitted with Mirtazapine. Similarly, whilst HRB disclosed thoughts of self-harm, the nurse wrongly recorded that he had no recent history self-harm or attempted suicide or whilst in detention. In respect of his hospital admission earlier that day, the nurse simply recorded that there were *"no issues"*, despite observing that HRB appeared to be suffering *"body jerks"* during the screening and reported having pain all over his body. Referrals for review by the GP and RMN were subsequently made.

6. Despite his history of torture being identified during the screening reception, HRB was not referred for a R35(3) assessment throughout his several weeks' detention at Brook House.

7. In his first GP review on 24 November 2020 HRB reported suffering from significant stress and poor sleep. He was observed to present as *"very tired like he was falling asleep"*. He also reported having regular panic attacks, during which his mouth *"became locked"* and at times his heart went *"numb"*. HRB confirmed he had ongoing chest pains following his clinical episode the day before. This assessment was not however Rule 34 compliant, the GP failing to carry out a mental state examination in order to confirm HRB's underlying mental health conditions and to assess the nexus between his psychological and physical symptoms. In the absence of any related review of his medication needs, HRB was simply maintained on Mirtazapine. Further, whilst it was noted that HRB required an ECG, no referral was initiated.

8. On 25 November 2020 HRB self-harmed by banging his head against the wall. He was placed on ACDT constant watch. HRB was reviewed by a primary healthcare nurse, who noted that he presented as stressed, pointing to his head and saying *"it's getting louder"*. He also reported that he had not eaten since the day before and had not slept for days. Notwithstanding his concerning presentation, no mental state examination was conducted and he was assessed as low risk of suicide. An IS.91RA Part C was submitted to the Home Office, confirming that HRB was on constant watch and heard voices in his head. It does not appear that the Home Office responded to this Part C.

9. In an ACDT review the following day, 26 November 2020, HRB hearing the sound of people crying and voices telling him 'bad things' including to commit suicide, which were intensified by his high stress level. He confirmed he was not eating as he couldn't keep food down. HRB reiterated that detention was not good for his condition. Again, no mental state examination was conducted. It was noted that an RMN appointment was booked for 30 November 2020, though there is no entry in the records to indicate this took place.

10. In a subsequent GP review on 26 November 2020 HRB reported increasing abdominal pain and vomiting. He was prescribed medication for suspected gastritis. HRB also reiterated that he was suffering from headaches and hearing voices, however this failed to prompt a mental state examination or referral for psychiatric review.

11. The first reference in the medical records to HRB being subject to formal Food and Fluid ('FFR') monitoring is on 27 November 2020, several days since he had stopped eating. He submitted a healthcare request the same day to see a GP as he was continuing to vomit when taking his medication. It appears that HRB continued on minimal food intake throughout his several weeks' detention. Despite reporting visible weight loss during this period, there is no reference in the medical records to any weight measurements being taken since his admission.

12. On 28 November 2020 HRB was served with his removal directions by a Home Office engagement officer. The GCID notes record that, in response, HRB stated that *"he might not be alive for the flight so we will see"*.

13. HRB self-harmed again on 29 November 2020 by banging his head against a drain pipe. Despite this being HRB's second act of self-harm, in the space of four days, whilst on constant watch, this failed to prompt an urgent mental state examination. It appears that HRB remained

on constant watch for the several weeks he was at Brook House. During this period, and notwithstanding his serious clinical deterioration, no report was issued under Rule 35(1) or R35(2) to raise concerns over his fitness for detention.

14. In an ACDT review on 29 November 2020 HRB repeated that he continued to hear voices. He stated that he was afraid, and that "*sometimes he cannot control himself*". He reiterated that he did not understand why the Home Office had re-detained him, given that he was an Adult at Risk Level 3. He stated he would rather die than be returned to Belgium. Notwithstanding his acute presentation, the RMN in attendance erroneously recorded that no symptoms of depression were noted or reported. By way of support, HRB was merely advised to stay 'hopeful' and pursue activities.

15. In a further GP review on 29 November 2020, HRB reported that he had suffered from hearing voices, telling him to kill himself, and depression, for the past 15 months. He confirmed that he had not eaten for 7 days and that, whilst initially motivated by feeling physically unwell, he was now continuing this because he wanted to die. He stated that his medication was not helping and his mental health had deteriorated in detention. It was recorded that HRB had *"declined hospital input"*, seemingly in relation to his ongoing food refusal.

16. The GP referred HRB for urgent review by the MHT. There was however no assessment of HRB's underlying mental health diagnoses, treatment needs or impact of detentionin light of his worsening trauma-related symptoms. The GP also used the incorrect mechanism of a form IS.91RA Part C, rather than a report under R35(1) and/or R35(2), to inform the Home Office of concerns as to HRB's vulnerability. He recorded therein that HRB was not eating, evincing suicidal ideation and hallucinations, and felt that his mental health was worsening.

17. HRB's physical observations were taken later on 29 November 2020, after complaining of nausea and vomiting. He was noted to present as anxious and very stressed. He was reviewed by a nurse again, later that night, after he continued to report nausea and vomiting.

18. A first response was called on 30 November 2020, after HRB started banging his head on the floor. Force was used to stop him further self-harming, consequent to which he complained of wrist pain, with red marks noted to his left wrist. In a healthcare check that evening, HRB continued to report stomach pain and nausea. He also reiterated he was "*in lots of stress and hearing voices*" and refused to take his Mirtazapine.

19. An emergency healthcare response was called overnight on 1 December 2020, after HRB was found shaking and complaining of ongoing stomach pain. He had a high pulse and was hyperventilating. Later that day, HRB reported still feeling unwell and vomiting. No further clinical action was taken at this stage to investigate his serious physical symptoms.

20. As of 1 December 2020, some nine days into his detention, HRB had still not received a detailed mental health assessment by the MHT, nor been referred for psychiatric review. This was notwithstanding that he had been referred for RMN review in his reception screening, with a further task for urgent review sent by the GP several days later. The only mental health support HRB had received by this stage comprised intermittent welfare checks, which failed to identify his serious mental health needs and attendant deterioration in detention. Medical Justice does not have healthcare records after 1 December 2020.

21. Medical Justice subsequently arranged for HRB to be assessed by an independent clinician (Dr Elizabeth Clark) on 1 December 2020. The resultant interim MLR, dated 8 December 2020, confirmed HRB's clinical presentation of PTSD, severe depression and anxiety with some psychotic features. His mental state was found to have significantly worsened since his re-detention and he was assessed at risk of suicide and physical harm through his continued reduced food intake. HRB was noted to report having attempted suicide by self-strangulation several days earlier, though there is no reference to this in the medical records. Dr Clark advised that he was unfit for detention and required release to re-engage with CMHT support.

22. HRB was subsequently released on bail on 9 December 2020.

Annex 2

Summary of Key Thematic Issues arising from the Medical Justice Post-2017 Case Studies

(1) AS

- Misapplication of the AAR policy: AS admitted to Brook House, and his detention maintained, despite having been categorised as an AAR L3 by the Home Office at his previous IRC.
- Failure to initiate a Rule 35(3) further to reception screening: AS not asked questions about whether he had a history of torture in his screening.
- Failure to complete a R35(3) report: on the basis that he had received previous Rule 35(3) reports whilst at other IRCs.
- Failure to produce a Rule 35(1) report: despite AS' serious trauma-related symptoms and receipt of an MLR advising he was unfit for detention.
- Failure in mental health provision: ongoing failure to recognise and assess his serious mental health issues and refer for psychiatric assessment for possible PTSD, even in the face of an MLR expressly advising this; repeated communications to Home Office that AS fit for detention and no concerns.
- Use of ACDT monitoring, including constant supervision, as an isolated containment strategy with no therapeutic purpose.
- Use of Rule 40 as a containment strategy to manage mental illness.
- Failure to treat prolonged period of Food and Fluid period as an issue of self-harm and/or manifestation of mental distress

(2) FS

- Failure to conduct a Rule 34 mental and physical examination.
- Failure to initiate a Rule 35(3) further to reception screening: FS not asked questions about whether he had a history of torture in his screening.
- Initial refusal to prepare a Rule 35(3) report: refused on the misconceived basis that there must be physical proof of scarring to prompt a report, with no consideration of FS' psychological symptoms.
- Subsequent defective R35(3) report: unsupported conclusion that account did not constitute torture but rather abuse/assault, failure to consider FS' psychological symptoms and impact of detention.
- Defective R35(3) response: misapplication of the AAR policy in maintaining detention despite accepting FS as a Level 2 Adult at Risk with a barrier to removal.
- Failure in mental health provision: serious delay in referring FS for psychiatric assessment and prescribing anti-depressant medication; overall failure to identify and treat his ongoing PTSD symptoms.
- Failure in physical healthcare provision: failure to investigate and provide appropriate treatment for FS' complaints of ongoing headaches and dizziness.
- Failure to produce a Rule 35(1) report: despite FS' worsening mental and physical state, suicidality and prolonged food refusal.
- Failure to produce a Rule 35(2) report: despite FS' repeat ligature attempts, self-harming and ongoing ACDT monitoring.
- Use of ACDT monitoring, including constant supervision, as an isolated containment strategy with no therapeutic purpose.
- Failure to treat prolonged period of Food and Fluid Refusal period as an issue of self-harm and/or manifestation of mental distress.

(3) RMA

- Failure to initiate a Rule 35(3) further to reception screening: RMA not asked questions about whether he had a history of torture in his screening.
- Failure to conduct a Rule 34 mental and physical examination.
- Defective R35(3) report: failed to assess possible psychological symptoms of torture.
- Defective R35(3) response: records indicate that detention was maintained, despite accepting RMA was a Level 3 Adult at Risk.
- Failure to produce a Rule 35(1) report: notwithstanding RMA's trauma-related symptoms, ACDT monitoring and the R35(3) opinion that ongoing detention may worsen mental health symptoms.
- Failure in mental health provision: failure to assess RMA's serious trauma-related symptoms and to refer for psychiatric assessment or psychological treatment; serious delay in prescription of anti-depressant medication.
- Failure in physical healthcare provision: failure to investigate or provide appropriate treatment for RMA's persistent complaints of head and generalised pain.
- Use of ACDT monitoring as an isolated containment strategy with no therapeutic purpose.
- Use of Rule 40 as a containment strategy to manage mental illness.
- Use of force to remove RMA to CSU pursuant to the use of R40 as a containment strategy.
- Failure to treat prolonged period of Food and Fluid Refusal period as an issue of self-harm and/or manifestation of mental distress.

(4) AK

- Failure to conduct a Rule 34 mental and physical examination
- Failure to initiate a Rule 35(3) referral further to reception screening: AK not asked questions about whether he had a history of torture in his screening.
- Delay in conducting R35(3) assessment: not completed until 22 days from when AK first raised R35 claim.
- Defective R35(3) report: assessed that AK's mental health concerns could be managed in IRC without considering evidence of serious clinical decline in medical records; failure to consider impact of ongoing detention.
- Defective R35(3) response: maintained detention despite accepting AAR L2 for non-compliance reasons; failure to consider/apply AAR L3 to the clinical concerns raised in the report and prior notice of AK's high suicide risk.
- Failure to produce a Rule 35(1) report: despite the acute decline in AK's mental state, high suicide risk, and advice from two external clinicians that he was unfit for detention.
- Failure in mental health provision: failure to recognise and treat AK's PTSD symptoms even on receipt of MLR confirming diagnosis; delayed referral for psychiatric assessment; failure to refer for psychotherapy; serious delay in prescription of anti-depressant medication.
- Failure to produce a Rule 35(2) report: despite AK's recurrent suicidal ideation, self-harming and ongoing ACDT monitoring and being graded as a high suicide risk by IRC healthcare and MLR.
- Misapplication of the AAR framework: Home Office failed to address/apply AAR L3 to MLR diagnosing AK with PTSD and advising that ongoing detention would cause a serious deterioration in his mental health.

- Use of ACDT monitoring as an isolated containment strategy with no therapeutic purpose.
- Failure to treat two periods of Food and Fluid Refusal period as an issue of self-harm/mental distress.

(5) HRB

- Misapplication of the AAR policy: HRB admitted to Brook House, and his detention maintained, despite Home Office categorisation as AAR L3 and 'extreme' concerns over mental health.
- Failure to initiate a Rule 35(3) further to reception screening: HRB not referred for R35(3) report throughout detention, despite his history of torture being identified in his screening.
- Failure to conduct a Rule 34 mental and physical examination.
- Failure to produce a Rule 35(1) report: despite the serious decline in HRB's mental and physical state, self-harming and prolonged food refusal; IS.91RA Part C wrongly issued.
- Failure in mental health provision: failure to identify and assess HRB's PTSD/psychotic symptoms; failure to refer for psychiatric assessment; failure to review medication or refer for psychotherapy.
- Failure in physical healthcare provision: failure to investigate or provide appropriate treatment for HRB's persistent symptoms of abdominal pain and vomiting and worsening clinical state from food refusal.
- Failure to produce a Rule 35(2) report: despite HRB's recurrent acts of self-harming whilst on ACDT constant watch.
- Failure to treat prolonged period of Food and Fluid Refusal as an issue of self-harm/mental distress.
- Use of force to prevent HRB self-harming.
- Use of ACDT monitoring, including constant watch, as an isolated containment strategy with no therapeutic purpose.

Independent Monitoring Boards

Annual Report of the Independent Monitoring Board at Brook House IRC

For reporting year 1 January – 31 December 2020

Published May 2021

national preventive mechanism

Contents

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 detainees
- 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 detainee that causes them concern as it affects that person's continued detention
- visit detainees who are removed from association, in temporary confinement or subject to special control or restraint
- report on any aspect of a detainee'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 detainee 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 detainees and to make recommendations for the prevention of ill-treatment. The Independent Monitoring Board (IMB) is part of the United Kingdom's National Preventive Mechanism.

2. Description of the establishment

Brook House opened in 2009 as a purpose-built IRC for adult males. 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 448, but the centre usually operates at no greater than 358 (80%) capacity and this was reduced to 209 (47%) for most of 2020 due to COVID-19 pandemic restrictions.

Once again, and mainly due to the impact of the pandemic this year, detainee numbers were lower than in previous years. The average month-end detainee population was 95 in 2020, with a low of four in December. By comparison, the average month-end populations in 2019 and 2018 were 242 and 292, respectively.

Serco Ltd ('Serco') took on a new contract for running the centre and Tinsley House IRC for the Home Office on 21 May, after expiry of G4S's contract. Serco also took over the provision of catering, cleaning and running a shop for detainees – previously done by Aramark as a subcontractor of G4S. G4S and Aramark staff were transferred to Serco under the Transfer of Undertakings (Protection of Employment) regulations (TUPE).

NHS England commissions G4S Health Services Ltd ('G4S Health') to provide medical services. This contract remains in place, although it will expire on 31 August 2021 and a new tender process is currently under way. A small healthcare centre provides 24-hour cover, but not inpatient treatment. G4S Health provides primary mental healthcare and Elysium Healthcare is subcontracted to provide secondary mental health services. The Forward Trust provides psychosocial substance misuse services.

The Samaritans, Gatwick Detainee Welfare Group (GDWG), the Bail for Immigration Detainees (BID) charity, the Red Cross, Migrant Welfare and Music in Detention provide support to detainees – although all had to discontinue on-site visits for most of 2020 due to pandemic restrictions.

The Home Office has two teams on site. One covers contract compliance by G4S and Serco, while the other, the detainee engagement team (DET), liaises between detainees and their case workers.

Her Majesty's Inspectorate of Prisons (HMIP) undertook a short scrutiny visit of Brook House and three other IRCs in May 2020 to assess aspects of their responses to the pandemic. HMIP also visited the centre as part of its inspections of charter flights in the second half of 2020.

In September 2017, BBC 'Panorama' aired a programme showing mistreatment of detainees in Brook House. A public inquiry, chaired by Kate Eves, has been set up to investigate. The inquiry is not expected to start taking evidence from witnesses before November 2021.

3. Executive summary

3.1 Background to the report

Three events each had a significant impact on detainees at Brook House in 2020: the COVID-19 pandemic, Serco taking on the contract to operate the centre from 21 May and the Home Office running a compressed programme of charter flights to European countries in the latter part of the year.

- Impact of the pandemic – as the wider community was subject to restrictions following the March national lockdown, so too was the centre, its detainees and staff. In particular, throughout most of 2020 there was less free association and mixing off the wings; accommodation moved to single occupancy; and in-person social and legal visits were stopped or restricted. In addition, pressure on temporary accommodation provided by the government often meant long delays for some detainees between being granted bail and their release. The centre was declared a pandemic outbreak site in December, leading to the release or transfer of all detainees.
- Change of contract provider from G4S to Serco – the most noticeable change to date has been a welcome increase in the number of staff.
- Charter flights to European countries – from late July, the centre's detainee population shifted to detainees who had arrived in the UK after crossing the Channel in small boats. The Home Office used Brook House as the base for its plans to remove these detainees to European Union (EU) countries party to the Dublin Convention before 31 December 2020.
- The combination of the compressed nature of the charter flight programme, with Brook House as its sole base for Dublin Convention flights, and the fundamental changes in the centre's population and nationalities, their different vulnerabilities and their needs, put the centre's systems, detainees and staff under great stress and raised some serious concerns for the Board. Most notably, there was a dramatic increase in levels of self-harm and suicidal ideation, deficiencies in the induction process and increased needs for legal support and Detention Centre Rule 35 assessments.

The issues are discussed in detail in the different sections of this annual report.

3.2 Main judgements

How safe is the IRC?

- The Board's view is that, due to circumstances related to the Dublin Convention charter programme, in the latter months of 2020 Brook House was not a safe place for vulnerable detainees who had crossed the Channel in small boats (see section 4).
- This is evidenced by the high levels of self-harm and suicidal ideation in that time (see section 4.2).

How fairly and humanely are detainees treated?

From our monitoring and observations, the Board's view is that detainees are generally treated humanely at Brook House. However:

- The Board's view is that circumstances in Brook House related to the Dublin Convention charter programme amounted to inhumane treatment of the whole detainee population by the Home Office in the latter months of 2020 (see section 4).
- Large numbers of detainees were detained for removal but were later released, having been exposed to the harmful effects of detention in the interim: 53% of those detained in 2020 were released, with the level rising to 72% between August and December, when the charter programme was being run (see section 7.2).
- Some detainees who were granted bail were then not released for a considerable time due to a lack of suitable accommodation, which the government is required to provide (see section 7.4).

How well are detainees' health and wellbeing needs met?

- There do not appear to have been any formal arrangements in place for briefing receiving authorities about the vulnerabilities or needs of the most vulnerable detainees removed to EU countries (see section 4.2).
- There were serious delays in access to Rule 35 assessments during August through December (see sections 4.4 and 6.3).

How well are detainees prepared for return or release?

- Detainees were not given advance information about what would happen to them in receiving countries if they were removed under the Dublin Convention (section 7.4).

3.3 Recommendations

TO THE MINISTER

- Introduce a time limit for immigration detention (repeated from 2018 and 2019).

TO HOME OFFICE IMMIGRATION ENFORCEMENT

- Review systems and processes in the detention journey, to ensure that vulnerabilities such as age, modern slavery and Rule 35 torture claims are identified and assessed at earliest stages (see section 4.1).
- The Board repeats all of its recommendations from 2019 relating to reviews of adults at risk; and assessment, care in detention and teamwork (ACDT) and Rule 35 policies and processes (sections 4.2 and 4.4).

- There should be a requirement for systematic and ongoing review of vulnerable detainees, to monitor the effect of continued detention on their wellbeing (see sections 4.2, 4.4, 6.3 and 7.2, and repeated from 2019).
- Review arrangements for the provision of suitable accommodation for detainees granted bail to reduce waiting times (see section 7.4).

TO THE DIRECTOR/CENTRE MANAGER

- Ensure that inductions for new arrivals are consistent in delivery and content, and backed up by written information in the languages of detainees in the centre (see section 4.1).
- Continue assessments for escorted visits, to see if the use of handcuffs can be reduced further (see section 5.1, and repeated from 2019).
- The Board recognises early improvements made but is of the view that more needs to be done in the offer and consistent delivery of a wide programme of organised and purposeful activities for detainees (see sections 6.5 and 6.6).
- Design and deliver a range of vocational training to prepare detainees for their release (see section 7.1).

TO NHS ENGLAND

- Keep staff recruitment and retention as a priority (see section 6.2, and repeated from 2018 and 2019).
- There should be a requirement for systematic and ongoing review of vulnerable detainees, to monitor the effect of continued detention on their wellbeing (see sections 4.2, 4.4, 6.3 and 7.2).

3.4 Progress since the last report

- The Board welcomes the increase in staffing numbers evident since Serco took on a contract to run the centre on 21 May. The adoption of other recommendations, such as the delivery of purposeful activities and vocational training for detainees, may follow from this but it is too soon to tell, and these recommendations are repeated.
- The Board also welcomes investment made by Serco in the information technology (IT) system used by detainees, the opening of education rooms on weekends and the fixing of defects in rooms for detainees with disabilities.

Evidence sections 4 – 7

4. Safety

Overview

Section 3.1 above summarises the shift in the second half of the year to a population of almost exclusively detainees who had crossed the Channel on small boats and who were later held at Brook House pending removal under the Dublin Convention. 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. Section 4 therefore focuses heavily on this part of the year and on the safety of this group of detainees.

The Board's view is that some systems at Brook House or in the Home Office detention estate did not adapt quickly enough to the needs of this population. Issues we observed included:

- Induction and related information provision were ad hoc and inadequate.
- Interpretation was not always readily available.
- There were difficulties in maintaining access to solicitors.
- There was a failure to identify vulnerabilities such as age and torture claims at an early stage.
- There were serious delays in access to Rule 35 assessments.
- Mobile phones were confiscated by the Home Office, sometimes resulting in loss of family contact.
- There were problems in Home Office communication to detainees about changes in their removal plans.
- The healthcare service was over-stretched.
- There was an absence of information for detainees being removed to EU countries about what would happen on arrival.

These issues are considered in detail below or in sections 5, 6 and 7.

To Board members, detainees often seemed fearful and anxious about their removal and what might await them; they were sometimes bewildered about their detention, and they were also affected by the hopelessness and anxiety of those around them. This was the environment in which the compressed Dublin Convention programme of removals was run by the Home Office.

The seriousness of this situation was evidenced in statistics of self-harm and suicide concern so striking that the Board and the IMB charter flight monitoring team jointly wrote to the Home Office minister for immigration compliance and courts on 2 October.[1] The Board expressed the view that circumstances in the centre amounted

[1] https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2020/12/Letter-to-Minister-Charter-Flights-EU-Impact.pdf

to inhumane treatment of the whole detainee population, and this was repeated in evidence submitted by IMBs in November to the home affairs select committee inquiry into Channel crossings, migration and asylum-seeking routes through the EU.[2]

As has been made clear in the letter to the minister and to the home affairs select committee, our criticisms are not of staff treatment of detainees, but rather of the circumstances in the centre.

4.1 Reception and induction

The Board is concerned about apparent failures in identifying risk and vulnerabilities at different stages in the overall Home Office detention system. Many detainees brought to Brook House for removal on Dublin Convention charters did not have age disputes, national referral mechanism (NRM) claims of modern slavery or trafficking, or Rule 35 torture claims identified or assessed before reaching the centre, and often this did not occur until some time after arrival. Yet, many of these detainees would already have been in Home Office care from their arrival in Kent, sometimes through a short-term holding facility such as Yarl's Wood, and then the reception process at Brook House.

It is the Board's view that, as the IMBs noted in their evidence to the home affairs select committee, rapid moves between facilities and the compressed timelines and processes for removal for the Dublin Convention charters meant that there was sometimes insufficient time for any one centre to carry out thorough assessments of risk and vulnerability.

The Board's reports on induction processes at the beginning of the year were positive, with a system in place that we felt worked well. There was a dedicated induction wing for new arrivals, the induction took place at a time allowing all new arrivals on the induction wing to participate, and it involved a good mix of representation from different departments.

Later in 2020, however, the Board observed a number of problems with the induction process. Following pandemic guidance from Public Health England, wing arrangements were changed so that new arrivals were accommodated together, remaining in a 'bubble' (or a 'reverse cohort') for a 14-day quarantine, and the designated arrivals wing rotated.

Inductions became ad hoc and were no longer delivered by specialists trained in inductions. Moreover, the process could be very confusing, with an enormous amount of information delivered to perhaps a single detainee, sometimes immediately on arrival following a long journey and having gone through the reception process. In addition, the quality of the induction could vary from officer to officer, and not all officers were familiar with providing them.

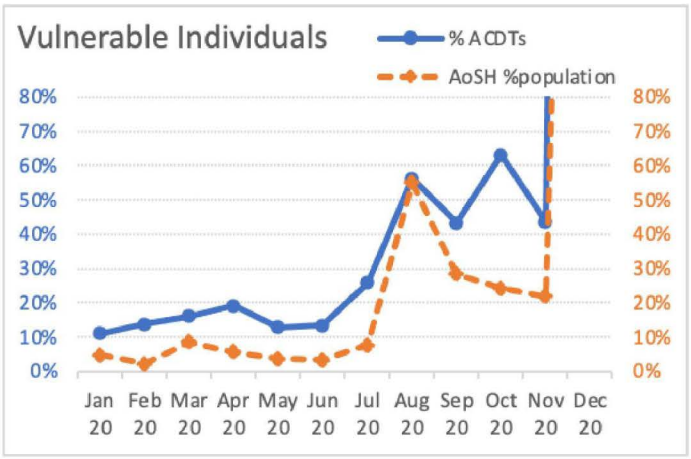
The Board's view is that there is a lot of information to absorb on arrival, and that induction should be supported, as it has been in the past, with written information, available in multiple languages. At the time of writing, Serco has now introduced a multi-language handout or booklet for new arrivals.

[2] https://committees.parliament.uk/writtenevidence/14811/pdf/ and https://committees.parliament.uk/writtenevidence/18348/pdf/

Given the shift in population to predominantly detainees who had crossed the Channel in small boats, the Board is concerned that induction processes were not more rapidly adapted. Typically, approximately half of the centre's population have previous experience of a prison environment in the UK and are likely to find a detention setting somewhat familiar. Former prisoners and people brought to the centre from the community have both usually been in the UK longer and may have a better command of English and understanding of their rights, and of the country's systems. This new population, however, was not accustomed to UK institutions and had limited spoken English (see also section 5.5).

4.2 Suicide and self-harm

While Brook House is accustomed to distress among detainees, the substantial number of cases of self-harm and threats of suicide by detainees in the latter part of 2020 has been a major concern for the Board and everyone in the centre. This is clearly illustrated in the chart below, which shows the considerable increase in the proportion of ACDTs and acts of self-harm in the centre from August onwards.[3]



ACDTs are used to monitor the welfare of detainees when there is a concern that they are at risk, typically of suicide or self-harm or from a medical condition. Summary information prepared by the Serco safer community team for the months of August to December showed that out of 205 ACDTs, 51 were opened on the basis of actual self-harm, 64 on the threat of self-harm and 59 on the basis of suicidal thoughts.

Statistics from the second half of the year show a strong correlation of increased incidence of ACDTs, acts of self-harm and suicidal ideation with the change in population and the concentrated charter flight programme. Incidents of self-harm increased sharply in August and only reduced in December, with the wind-down of charter flights and subsequent release of most detainees.

[3] This shows acts of self-harm and ACDT plans as percentages of the population at month-ends. The chart includes December 2020, during which the number of ACDTs and acts of self-harm were lower than in previous months (at 42 and 18, respectively), but because the month-end population was very small (four men), the percentages are off the scale.

It is the Board's view that the significant increase in self-harm and suicide risk is directly linked to the higher level of vulnerability of the small-boat population and the intensive programme of Dublin Convention charter flights.

The response to serious incidents of self-harm and threats of suicide was often constant supervision by officers to prevent further harm. The table below shows numbers of detainees placed on constant supervision in the months of the charter programme.

Month	Average daily population[4]	Number of detainees on constant supervision during the month
August	93	32
September	115	33
October	107	31
November	122	34
December	80	23

In writing this report, the Board struggles to convey how disturbing these numbers of detainees on constant supervision are. Concern about a detainee's state of mind must be very high indeed to justify assigning staff to watch them at all times. Moreover, these are only the most extreme cases; more detainees were, at the same time, on hourly, overnight or less frequent watch.

The numbers were so high that one member of the mental health team said that he was spending almost all his time on constant supervision reviews, and struggled to find time to provide other care. In September, the Board asked the Home Office if there would be provision for extra mental health resource which could allow focus on preventative measures to alleviate stress and anxiety. The response was that healthcare staff had not requested any additional resource.

In addition, the highly visible nature of these constant supervisions, which took place on all wings, itself contributes to an increase in anxiety in the centre. They serve as a constant reminder to other detainees – and staff – of the levels of despair that detainees were suffering.

The statistics are distressing, and so too was the Board's experience of monitoring in the latter part of 2020. On our visits to the centre and from conversations with detainees and staff during that time, we felt that there was usually an atmosphere of tension, fear and despair pervasive among detainees, and great stress on staff caring for them. On frequent occasions, Board members heard detainees in ACDT reviews say plainly that they would kill themselves if served removal directions. In conversations, we heard detainees talk of being subject to racism, homelessness and hunger in the countries to which they were to be removed.

Triggers for self-harm incidents and threats of suicide that the Board has observed over the course of the year include bad news, poor information flow about immigration cases and last-minute changes to removal plans (see also section 5.1).

The Board has been particularly concerned about detainees being removed while in a state of distress or injury following self-harm, which we feel is inhumane and puts them

[4] Average calculations made by the Board based on population numbers taken from Serco daily operations report.

at further risk. We have noted examples of a detainee being taken to a plane directly from having attended hospital for his injuries, another being removed after being stuck in the netting following what was believed by officers present to be a suicide or self-harm attempt, and another being presented for a charter flight bleeding from self-harm and in a state of partial undress.

From the Board's records, at least 26 detainees were removed on the charter flights while on ACDTs, and yet there appear to have been no formal arrangements in place for briefings to the receiving authorities about these most vulnerable of detainees, some of whom were on constant supervision when collected from Brook House.

As set out more fully below (see sections 5.4, 5.5, 5.6 and 6.1), the Board acknowledges the impact of this extremely challenging time not only on detainees, but also on Serco and healthcare staff working in the centre.

4.3 Violence and violence reduction

Trends in incidents of violence changed substantially in Brook House in 2020 from previous years. In 2020, there have been 45 recorded assaults on staff, as compared with 82 in the previous year, and 11 assaults on other detainees, as compared with 20 in 2019. This drop in numbers is welcome, but is likely to be attributable to the lower number of detainees and the different character of the detainee population, and a number of these incidents are attributable to a few particularly volatile individuals.

There have been eight fights recorded this year, compared with 24 in 2019, with seven taking place in the first three months of the year. These occurred prior to pandemic-related restrictions on movement and free association between detainees from different wings in the centre.

Serco introduced a new system to monitor bullying. However, there was no use of this system in 2020, and at the monthly safer community governance meeting in January 2021, staff acknowledged that it was not yet being used effectively. Serco has informed the Board that it does not believe that there have been any situations where the new process could have been used.

There was no survey of detainee safety in 2020.

4.4 Vulnerable detainees, safeguarding

In our annual report for 2019, the Board pressed for a review of adults at risk (AAR), ACDT and Rule 35 policy and procedure. In his response to our report, the minister for immigration compliance and the courts said that these were all under review and that the intention was to implement changes resulting from the reviews by the end of summer 2020. We are disappointed that the Home Office appears to have 'paused' these reviews. The concerns that led to our recommendation in 2019 have been heightened by our monitoring this year, and the Board still believes that a full review should be conducted.

Adults at Risk

In accordance with Detention Services Order (DSO) 08/2016 and the 'Adults at Risk in Immigration Detention' guidance of 6 March 2019 for Home Office staff, detainees at Brook House are logged as level 1, 2 or 3 AAR. In our report of 2019, the Board expressed concern about this system, noting that it did not adequately capture an individual's level of vulnerability or any deterioration in his situation. This was, in part, because the system's levels actually relate to the amount of evidence that the detainee is able to provide rather than their assessed level of vulnerability.

These issues were not resolved in 2020 and, indeed, were arguably worsened with the large numbers of detainees with vulnerable mental health status on ACDTs and self-harming, but not all being added to the AAR log. We noted last year that the system should make more recognition of the impact of continued detention on vulnerable detainees, but in two prolonged cases of detention this year (six and nine months, respectively), the Board saw no evidence that this was either factored into the existing assessment of these detainees' situations or that it triggered any additional assessment.

Given the characteristics of the population at Brook House in the second half of the year, it is perhaps unsurprising that a substantial number of detainees submitted claims of trafficking and modern slavery to the NRM. However, it took some time for these cases to be categorised as AAR by the Home Office. This was remedied only on 26 October, when these individuals began being routinely placed on level 1 and reviewed in the weekly multidisciplinary meeting. In the initial weeks after 26 October, 32 individuals were added to the log.

Rule 35 claims

A large proportion of the detainees who arrived at Brook House from early August made Rule 35 claims of torture. On occasions, nearly half of the detainees in the centre had a claim under Rule 35.[5]

For a while, the increase in Rule 35 claims overwhelmed the capacity for GP appointments, and the waiting time for a Rule 35 appointment lengthened. A Board duty member reported waiting times of 21 days in mid-August, and on 11 September 60 detainees were awaiting appointments. In September, the Home Office made provision for an additional 12 Rule 35 GP appointments per week, which brought the waiting time down; Board member rota reports indicate waits of about 16 days in early September, 12 days in October and five days or less in mid-November.

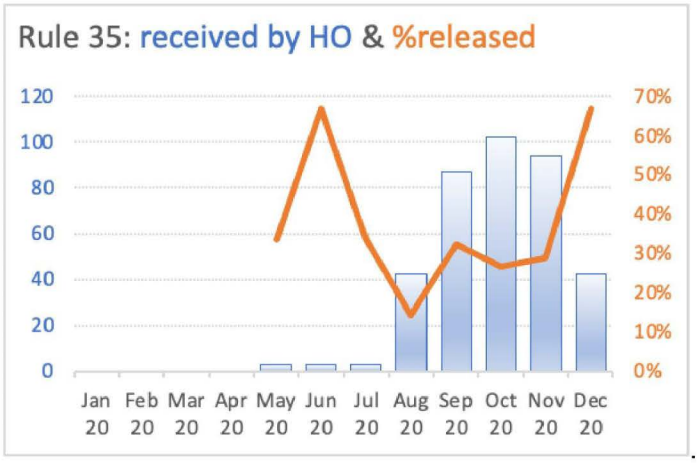
Given the frequency of charter flights and these long delays, there were instances of detainees being removed before they had seen the GP (for example, seven detainees removed on a charter to Spain on 3 September). In the Board's view, these backlogs and delays for appointments contributed to high levels of anxiety and unease among all detainees in the centre.

From early in October, the Home Office started to use a 'Red 3' form for collection of final representations from detainees on the manifest who might not by then have had a Rule 35 appointment. However, on an inspection on 13 October, HMIP was critical

[5] For example, on 22 September 48% (59 detainees) of the population had a claim under Rule 35, while on both 7 and 14 October and on 11 November 44% and 46% of the population, respectively, had claims.

of the practice as then in place, after which processes were strengthened by the Home Office. This form is reviewed by a Home Office central unit for charter flights, and this has led to some detainees being taken off the manifest, and to some releases.

The chart below[6] shows the dramatic increase in the number of reports from GPs received by the Home Office in the months when the charter programme was operating. By way of comparison, over the first nine months of 2019 (the period for which the Board had data), the Home Office received, on average, 17 Rule 35 reports per month – at a time when the average population was near twice that of this year.



Of detainees who were able to access a GP assessment before their flight, a significant number had their assessed claims accepted by the Home Office. For example, on 20 October, 49% of the detainees on the AAR log had had torture claims accepted by the Home Office and were moved up to AAR level 2 or level 3. The chart above also shows the average percentage of detainees who were released each month with accepted Rule 35 claims.

Under the Home Office's AAR framework, the higher the risk level, the stronger the presumption that a person should not be in detention, and an accepted Rule 35 claim implies a presumption against continued detention. In 2020, an average of 32% of detainees with an accepted Rule 35 report were released; for the remaining 68%, detention was maintained – although, in the end, all but four of these detainees were removed or released before the end of the year as the charter programme wound down. Given the substantial differences in the characteristics of detainees in 2020 and their much shorter average stay, it is difficult to judge whether the larger proportion released (32%) actually reflects a more appropriate application of the intention of Rule 35 than in recent years (when 25% were released in 2019 and 17% in 2018).

It is notable that, over August to December, 99.4% of Rule 35 GP assessment reports were made under Rule 35(3): where the detainee 'may have been the victim of torture'. Only two reports (0.6%) were made under Rule 35(1): 'likely to be injuriously affected by continued detention'; and none under Rule 35(2): 'suspect[ed] of having suicidal intentions'. The Board finds this puzzling, in the light of the scale of self-harm and suicide threats made by the population of Channel-crossing detainees resident during

[6] Drawn from monthly combined Home Office/Serco reports and from monthly Home Office Rule 35 database summaries.

this period. We cannot reconcile the evidence of frequent suicide ideation with there being absolutely no Rule 35(2) reports.

Age disputes

As set out in evidence from IMBs to the home affairs select committee's inquiry, the Board has been concerned, in the latter part of 2020, that a significant number of detainees have been identified as under-age only after their arrival at Brook House. Details are shown in the table below, prepared by the Serco safer community team, where it can be seen that the majority (70%) of the 20 age dispute cases between September and December were released to social services.

Month	Number of age disputes	Outcome
September	4	3 released to social services 1 maintained in detention
October	8	7 released to social services 1 maintained in detention
November	6	3 released to social services 3 maintained in detention
December	2	1 released to social services 1 maintained in detention

We note that, while the age of 18 has important legal implications, it is less important when looking more generally at an individual's vulnerability and safety. On several occasions, the vulnerability of individuals whose age dispute case was rejected has been recognised at Brook House by putting them on supported living plans, which we consider a good practice. The Board also commends the decision taken by the Home Office in the latter part of the year to give 'the benefit of the doubt' to age dispute cases who also made NRM claims, and treat them as minors.

Finally, the Board notes the beneficial impact of additional support provided by a Serco social worker based at Brook House this year, particularly in addressing concerns relating to age disputes, but also for supporting other vulnerable detainees.

Safeguarding governance

Safer community meetings run by Serco are held monthly, although the rhythm of these meetings and their documentation has been interrupted. A new assistant director of safeguarding was appointed on 20 September, and in the latter part of the year the meetings seem to be settling, and the Board finds them to be generally useful and productive.

The change of service provider has meant a welcome refresh of training, with a strong emphasis on safeguarding, and the Board has been pleased to see a ramping up of staff support, with more proactive measures to help them manage stress and vicarious trauma, which can have knock-on benefits for detainees.

4.5 Use of force

Set out below are the number of occasions when force was used in 2020, compared with recent years.

	2020	2019	2018
Total use of force incidents in year	197	223	257
Average month end detainee population	95	242	292

The number of incidents involving the use of force continued to fall. However, the prevalence of use of force in 2020 is double what it was in 2019 and 2018 when looked at by reference to the average proportion of detainees having force used on them each month. An average of about 17% of detainees had force used on them in each month in 2020, compared with between 7% and 8% in 2019 and 2018.

The Board is concerned by the increased prevalence of use of force this year, and our analysis of underlying data shows that it was higher in both the first half of 2020 and the latter part of the year, after the shift to a more vulnerable population.

The following is a summary of the reasons given by G4S/Serco for the use of force.

	Maintain good order	Protect third party[7]	Prevent self-harm	Other	Total use of force
2020	76 (39%)	35 (18%)	72 (37%)	14 (7%)	197
2019	132 (59%)	46 (21%)	20 (9%)	25 (11%)	223
2018	164 (64%)	38 (15%)	36 (14%)	19 (7%)	257

There is a noticeable increase in prevention of self-harm being given as the reason for use of force in 2020 compared with previous years and, at 37%, it was the main reason given this year. Looking at the underlying data, a monthly breakdown shows that this increase is coincident with the higher levels of self-harm and suicidal ideation seen among the small-boat population brought to the centre for removal on Dublin Convention charter flights (see also section 4.2).

The category 'Other' comprises use of force for self-protection and uses to prevent damage to property or escape.

[7] Protect third party includes use of force interventions to prevent assault on detainees by other detainees, or to protect third parties such as healthcare staff or contractors.

There has been a slight reduction in use of force to facilitate the removal of detainees. This is reported as a sub-set in the category 'Maintain good order':

2020	2019	2018
32 out of 197 (16%)	41 out of 223 (18%)	48 out of 257 (19%)

The monthly use of force governance meetings run by Serco are generally well attended by a multidisciplinary team, with representatives from the Home Office and healthcare team. The Board has a standing invitation, and a member usually attends.

Based on our observations, these meetings continue to be run in an open, transparent and constructive manner. The presentation at each meeting is informative, and a selection of film footages are reviewed, where lessons from both good and bad examples are discussed.

Under the terms of Serco's contract, a new procedure has been introduced to help monitor staff culture and mitigate risks of unfair treatment/force used on individuals: a review is to be conducted on any member of staff who has been involved in three or more uses of force within a three-month period, and where concerns are raised an internal investigation will follow.

The Board should be informed of all use of force incidents without delay (taken as within two hours). The Board believes that it is usually informed in a timely manner, but there were some rare occasions this year when incidents were only brought to the Board's attention after a longer period of time.

4.6 Substance misuse

There were 25 drug finds and 16 'hooch' finds during the course of the year, in comparison with 45 drug finds and 11 'hooch' finds in 2019, although we note that the population last year was about half that in 2019. In April, we noted continued evidence that drugs were coming into the centre despite the lack of visitors due to pandemic restrictions, but this decreased over the course of the year.

Substance misuse support is provided by the Forward Trust (see section 6.2)

5. Fair and humane treatment

5.1 Escorts, transport, transfers

The table below shows 'raw' data for the proportion of detainees handcuffed on escorts for hospital visits during 2020. An average of just over seven detainees per month were handcuffed on escorts.

2020	Total Escorts	Handcuffed
January	29	15
February	22	14
March	13	8
April	3	3
May	1	1
June	2	2
July	9	8
August	12	9
September	23	4
October	14	5
November	33	13
December	7	1

Due to the substantial changes in detainee population during 2020, it is difficult to draw conclusions from comparison with data for 2019 (when the monthly average of detainees handcuffed was nearly 20). However, during April to August 2020, virtually all the (few) escorted detainees were handcuffed in advance of the move. We are pleased to see that the proportion handcuffed from September has dropped.

There have been issues with information provision to detainees who were on the manifests for Dublin Convention charter flights, when delayed communication between caseworkers, the local DET and Serco officers has led to some detainees believing that they were to be removed, when in fact it had been known for a while that they would not be. This caused unnecessary distress and there were a few instances of detainees self-harming during this period.

In one instance, reported in the national press in August, force was used to take Mr A from his room and place him in a van to be taken to the airport – although his removal directions had been cancelled some time before. Mr A knew this, but the Home Office, Serco, and Mitie Care & Custody (Mitie), the immigration escort provider for the Home Office, had conflicting information.

Although there are now no more Dublin Convention flights, this potential issue of timeliness and clarity of communications is relevant for any future charter flights.

5.2 Accommodation, clothing, food

Accommodation at Brook House is in five wings over three floors, with connecting communal corridors where facilities such as healthcare, visits, welfare and educational and recreation activities are located. Pandemic restrictions have required G4S and Serco to be flexible in use of the wings – for example, to keep detainees segregated to reduce the risk of spreading COVID-19. In response to the pandemic, accommodation moved to single occupancy of rooms.

Early in 2019, the Board raised with the Home Office and G4S that water from the showers in rooms for disabled detainees would flood out into the room. This issue was not dealt with during 2019, nor as part of the 'dilapidation works' as G4S came to the end of its contract in May 2020. By the end of January 2021, a solution had been designed and tested, and installed in all three of these rooms.

Board members' rota reports have generally commented that the accommodation and facilities have been kept clean and in working order.

A food survey was conducted in early December. Thirty-eight responses were received, from the population of approximately 160 detainees at the time. Eighteen per cent thought the food was 'very bad' or 'bad', while 45% were 'happy' or 'very happy'. The survey respondents were overwhelmingly happy with the portion sizes (79%), the diversity of food offered (84%) and the approachability of the serving staff (84%).

From 21 May to the end of December, there have been four complaints against Serco about food (13% of the total of 32 complaints). All four were unsubstantiated. For comparison, during 2019, 14 complaints from a total of 156 (9%) were about food.

5.3 Separation

The care and separation unit is a small separate unit of six rooms at the end of E wing which is normally used for detainees who have been placed on either Rule 40 (removal from association) or Rule 42 (temporary confinement) of the Detention Centre Rules. Detainees on Rule 40 may be located on E wing as well.

Rule 40 separation has been used 160 times during 2020. While this appears to be a reduction from 187 instances last year, it should be noted that the average population during 2020 has been less than half that in 2019.[8]

Data on Rule 40 during the first part of 2020 (while the centre was run by G4S) was considerably distorted by its simultaneous use on 45 detainees to manage removals for a charter flight to Jamaica in February. This included detainees not scheduled to fly and detainees who were on the charter but had not given any indication that they would resist removal. While understanding the desire of both the Home Office and G4S to ensure that removals for the charter were conducted with the minimum of disruption, the Board questioned whether this pre-emptive use of Rule 40 was justified and unnecessarily inclusive. Both G4S and the Home Office acknowledged that there had been difficulties in communication and planning for the charter.

[8] 1 January to 20 May (contractor = G4S): average population at month end = 103.8.
21 May to 31 December (contractor = Serco): average population at month end = 85.0.
2019 January to December: average population at month end = 242.3.

	2020						
	21 May – 31 Dec	1 Jan – 20 May	**2019**	**2018**	**2017**	**2016**	**2015**
Rule 40 events	54	106	187	259	503	358	293
R40 events per 1,000 man-days in detention[9]	2.68	7.24	2.11				
Average time on Rule 40	35.3 hours		46.5 hours	59.3 hours	32.0 hours	34.8 hours	36.0 hours
Rule 42 events	3	3	3	12	2	14	37
Average time on Rule 42	<24 hours		4.2 hours	16.8 hours			

Apart from the instance relating to the Jamaica charter, the Board believes that Rule 40 and Rule 42 have generally been used appropriately, and for suitable lengths of time. Members have attended Rule 40 reviews when these have occurred during their visits; they have not reported any concerns with the way they were conducted other than occasional problems with the use of interpreters, and have on occasion praised the sensitivity with which the reviews were conducted.

While, from information available, the average time on Rule 40 (in the period since 21 May) has been a little under 36 hours, one individual was maintained on Rule 40 for a total of 12 consecutive days in November. This detainee had been violent during his initial reception, and later caused injury to a member of staff. Although scheduled for a charter removal, he was in fact taken into police custody.

5.4 Serco and Home Office relationships with detainees

Change of contract provider

Serco took over operation of Brook House on 21 May. The transition and settling-in period has been considerably affected by pandemic measures and the change in August to charter-only operation. Serco has made a number of changes to the management of the centre – for example, in running Brook House and Tinsley House IRCs together and restructuring the senior management team. From the Board's observations, the mechanics of changing operators did not have a negative impact on detainees.

There has been a substantial increase in staffing numbers as Serco has recruited and trained officers to meet their contractual commitments. This has inevitably led to significant proportions of inexperienced officers on duty – for example, by the end of the year some 50% of detainee custody officers and 23% of detention operations managers (DOMs) were newly recruited or promoted – but the Board has not noted inappropriate behaviour or difficulties caused by this to relationships with, and care for, detainees.

[9] Calculation made by the Board to show prevalence, using following formula: Number of R40 events * 1,000 / (days in period * average month-end population in period).

The previous low ratio of staff to detainees has been flagged as a key concern for the Board in our annual reports for the past three years, and we welcome the ongoing increase in staff numbers.

Changes to staff shift patterns has been a major source of discontent among some staff. Although hearing occasional negative comments from officers, the Board has not detected any impact on detainees.

Serco staff and detainee relationships

The Board's observation is that relationships between officers and the detainees appear generally positive. On numerous occasions throughout the year, Board members have recorded in rota reports observations of detainees being treated with dignity and respect, and we have witnessed good interactions and relationships. Members have also recorded examples of detainees telling us that they feel they are treated well. These observations must, however, be contrasted with the relatively high levels of formal complaints about staff behaviour (see below).

We have witnessed a few instances in which staff have expressed what appear to be desensitised points of view. This has included comments like, 'he can't be allowed to show that self-harm will stop deportation' (referring to a man who had just made a determined attempt to self-harm), or 'he's just spoilt' (referring to a man who was thought to be demanding). Although these are rare, the Board believes that DOMs and duty directors should send an immediate message when they are detected, particularly in light of historical problems with staff culture at Brook House.

The Board has also noted that attitudes of some staff towards self-harm and food and fluid refusals can at times lean towards a culture of disbelief – for example, sometimes referring to these as techniques for avoiding removal. While there is no evidence that these attitudes have had a negative impact on the care provided for detainees, it is the Board's view that self-harm and threats of suicide should be treated as signs of mental distress and treated with care and empathy. Again, we believe that any instances should be called out by DOMs and duty directors.

Soon after taking over operating the centre, Serco began a long-term programme of work around staff culture and developing a positive culture for all in the detention setting.

Complaints about staff behaviour

During the period of Serco's operation, since 21 May, 17 complaints have been made about staff behaviour (54% of the total of 31 complaints). Three of these complaints were dealt with by the Home Office professional standards unit (PSU). All three were for alleged assault: one was partially substantiated, another substantiated and one is ongoing.

Of the balance of 14 complaints about staff behaviour which were addressed by Serco, two related to alleged assault and the remainder to rudeness, unfair treatment and other unprofessional behaviour. Examples include complaints about the manner in which detainees have been spoken to, a complaint about loss of paid work and

complaints about an officer's appearance. Eleven of these 14 complaints have been completed, only one was partially upheld.[10]

The Board is not aware of any particular reason for the increased prevalence of complaints made about staff behaviour, and we will monitor this area in more detail in 2021.

In their response to a complaint made by a man about his treatment during an attempted removal, the PSU made recommendations about retraining a DOM involved in the incident, and being advised of their apparent confrontational and aggressive demeanour.

Home Office and detainee relationships

On 28 April, a serious incident was declared after over 20 detainees refused to lock up. Deep frustration about a lack of information from the Home Office about their cases and dissatisfaction with their continued detention appeared to be the key issues for the detainees involved.

Pandemic precautions have affected the Home Office's engagement with detainees. From September, DET engagement with detainees on reverse cohort wings was changed to being by telephone rather than face-to-face, until the detainees had completed their period of quarantine. In-person engagement with this cohort of detainees was resumed in visiting rooms after the fitting of COVID-19 protective screens in mid-December.

In late September, there was a pause in other face-to-face engagement as standard practice, after some new circumstances in the centre were identified as exposing DET staff to COVID-19 risks. After these were resolved in mid-December, there was a mix of telephone and in-person engagement with detainees.

On some occasions from September, these changes in work practices meant that Home Office staff would call in advance to a detainee to explain that removal directions were being served and that a Serco officer would bring the paperwork.

These practices are understandable for health and safety reasons, and the Board makes no criticism of individual DET members who were also subject to exceptional pressures caused by the pandemic and the charter programme. However, our focus is outcomes for detainees, and the Board raised concerns at the lack of Home Office personal contact on delivery of removal directions, which is an emotionally difficult time for most detainees. Serco and healthcare staff continued to have personal engagement with detainees throughout this period.

The Board also questioned the absence of Home Office personnel in ACDT or constant supervision reviews, being of the view that it would be fair and respectful to detainees to have a presence, given the impact of Home Office decisions on their lives. We have been told by the Home Office that it is the decision of the Serco manager to request Home Office presence if they wish, as their presence may have

[10] In 2019, by comparison, 44 (26%) of 156 complaints against G4S were about staff behaviour; four of these were upheld or partially upheld. During the period of G4S's operation to 21 May 2020, there were nine complaints made about staff 'misconduct', from a total of 26 complaints (35%).

the effect of causing more distress to detainees, and that Home Office staff will attend reviews if they can be available.

The Board's view is that Home Office attendance at these reviews would have the added benefit of providing a direct line of information back to caseworkers who are making decisions about the future of affected detainees.

The detainee voice

Overall, this year the Board has noted that there have been fewer opportunities for detainees to be consulted or engaged – for example, in detainee forums. Unlike in previous years, no survey was conducted of detainee perceptions of safety, and there has been a lack of detainee representation in meetings. Starting on 6 March, through the early months of the pandemic, there were 'COVID forums' involving detainees, which may have helped their understanding of the measures being put into place.

The Board hopes that, going forward, the resumption of detainee consultation and involvement will be prioritised, and welcomes Serco's reintroduction of detainee consultation forums late in the year.

5.5 Equality and diversity

The Dublin Convention charter flight programme led to a fundamental change in the make-up of the detainee population, with the main nationalities affected being Iranian, Iraqi, Kuwaiti, Sudanese, Syrian and Yemeni. These are nationalities not usually seen in significant numbers in the centre.

At times, there was a high demand for professional telephone interpreting for Arabic and Farsi speakers especially, combined with delays in getting interpreters on the line or poor-quality connections with the interpreting service. As a result, Serco staff with language skills were deployed – particularly on constant supervision and ACDT reviews. While the Board would usually recommend the use of independent interpreters, from our observations it helped detainees in these extremely stressful circumstances to have someone they were familiar with interpreting for them. The Board acknowledges the work done by Serco staff here, in circumstances which were often deeply distressing for detainees and the staff supporting them.

Serco has introduced translation tablets for simpler and more utilitarian communication. The Board welcomes this, but there have been issues due to weak Wi-Fi signals on the wings. Wi-Fi boosters were to be installed late in the year but the Board has not yet had the chance to see if this has improved things.

The Board welcomes the plans by Serco to separate safer community and equality/diversity governance meetings, with the first diversity governance meeting having been held in February 2021.

5.6 Faith and religious affairs

The first national lockdown of the pandemic led to the cancellation of faith services for four months from late March. Services resumed with distancing and other limits, consistent with those in the wider community. For the Muslim population, there was

some innovation aimed at maximising participation in Friday prayers: they were held outdoors in warmer months and then, as the weather changed later in the year, the three imams each went to different wings.

Meal arrangements for Ramadan seem to have gone smoothly last year, and special meals and celebrations were put on for detainees and staff for both Eid and Christmas.

The Board acknowledges the spiritual support and comfort provided by members of the religious affairs team to many of the detainees, particularly those who were on ACDTs with constant supervision.

5.7 Complaints

During the period from 21 May, 31 complaints were made against Serco. Three relating to staff behaviour were dealt with by the PSU (see section 5.4). Of the balance of 28 complaints, 24 have been completed, with three (13%) being upheld or partially upheld, 16 (66%) being unsubstantiated and the remaining five (21%) withdrawn.[11] Complaints relating to food and property are dealt with in sections 5.2 and 5.8, respectively.

The Board's view is that the small number of complaints is likely to be the result of a combination of reduced detainee numbers and the shift in population in the latter part of the year. From our observations, it was not clear that this group of detainees were as familiar with, or confident about, the complaints process.

The Board does not see replies to complaints made against the Home Office, or those made against either G4S healthcare or Mitie staff. Complaints related to healthcare are covered in more detail in section 6.1.

As in previous years, the Board's view is that complaints are generally taken seriously and thoroughly investigated, although we still have the reservations expressed in last year's annual report about the overall process and its inherent barriers to a detainee being able to make a case.

5.8 Property

There have been some issues with detainees' mobile phones being confiscated on arrival at Dover or property being left behind when detainees have been picked up by immigration enforcement staff from hostels or hotels. In some instances, this property appears to have gone missing or taken an inordinate time to arrive at Brook House. Detainees have been particularly distressed by the confiscation of their mobile phones, as this is sometimes the only place that they store family telephone numbers.

To have their property returned, detainees have been told to contact a Home Office email address or telephone number but they complain that the telephone is never picked up and emails are not answered. The Board can confirm that this is the case.

[11] For comparison, a total of 156 complaints were made against G4S in 2019. Twenty were upheld or partially upheld (13%), and four were withdrawn. Ten complaints were dealt with by the PSU, with one being partially upheld. During the period of G4S's operations to 21 May 2020, there were 54 complaints against them.

It is not reasonable or fair that detainees are expected to be calling and chasing – the Home Office should implement a system to relocate confiscated or lost property.

While the local DET was able to help in recovering and returning some mobile phones to their owners by year-end, at the time of writing it is not clear that Border Force has yet implemented a system to address the problem.

During the period of Serco's operation from 21 May, two complaints were made about missing property (6% of the total of 32 complaints). One was upheld and the other upheld but withdrawn. For comparison, in 2019 42 out of 156 complaints made were about property (27%) – lost, stolen, withheld or damaged.

6. Health and wellbeing

6.1 Healthcare: general

G4S Health is commissioned by NHS England to supply healthcare services. Healthcare staff are available 24 hours a day, seven days a week. There is no in-patient facility.

The facilities at the centre include two consultation rooms plus waiting area, a dedicated mental health interview room and two rooms within the centre's main arrivals area for preadmission screening. The Board's annual reports for 2018 and 2019 commented on the inadequate flooring in the consultation rooms. This was resolved in 2020.

From March 2020, restrictions in place around the centre changed the provision of healthcare services from a drop-in/triage/proactive arrangement to an appointment-based system, with medication being delivered to the wings rather than collected from the healthcare team. At the end of March, Tinsley House IRC was closed for detainees and this allowed G4S Health to consolidate its resources at Brook House. There were no significant issues in securing personal protective equipment for staff and detainees during the year. NHS England held supportive quarterly meetings during the pandemic which have been attended by representatives from the healthcare team, the Forward Trust, Home Office and Serco, and a member of the Board.

The already heavy demands on healthcare staff due to the pandemic were significantly increased from July onwards with the arrival of large numbers of very vulnerable detainees. High levels of both mental health and physical health issues appear to have been exacerbated by the stress and anxiety resulting from their detention in the centre and the prospect of removal to EU countries. In addition, many of these detainees presented at Brook House with no medical records, and detailed medical assessment of some conditions resulted in hospital appointments and delays in the prescription of appropriate medications.

Meeting the complex needs of this population included responding to emergency calls for incidents of self-harm, attending ACDT, constant supervision, and food and fluid refusal reviews, and responding to the huge increase in Rule 35 appointments and requests from solicitors for information. The result was a more reactive service based on the complex medical needs of this population, rather than a proactive and precautionary healthcare service.

There were 24 formal complaints received by the healthcare team during 2020, 15 related to medical care and two to staff attitude; none were upheld. While these are all much lower than numbers in 2019 (when 60 formal complaints were received, 28 relating to medical care and eight to staff attitudes), the average population in 2020 was much lower too.

Complaints are discussed at the quarterly quality meetings, which are attended by a member of the Board. The Board does not see healthcare complaints, but we understand that lessons learnt principally involve appropriate communication with detainees.

The Board received 13 healthcare-related applications from detainees last year, down from 19 in 2019, although, again, we note the lower population this year.

Despite the challenges presented by the pandemic, the Board considers that detainees were able to access an appropriate service for their physical health, equivalent to that available to the community during the year. The Board recognises the great pressures that healthcare staff were under in 2020, as was the case in the wider community, and acknowledges the services and support they provided to detainees.

6.2 Physical healthcare

All arriving detainees see a nurse at reception for an initial health screening within the first two hours of their detention and are offered an appointment with a GP within the first 24 hours, although not all choose to take this up.

With the onset of the pandemic, healthcare staff carried out a preliminary screening, in the transporting vehicle, of all new arrivals before they entered the centre. From late October, this preliminary screening was followed up with a lateral flow test for COVID-19. This test was not mandatory and, of the 290 tests offered before year-end, 82 were declined.

In March, consistent with changes in the wider community, detainees with underlying health conditions making them vulnerable to COVID-19 were advised that they should be located together in a separate quarantine wing. All 19 affected detainees declined, preferring to stay with a wider group of detainees than be more isolated. The Board understands that they signed acknowledgements of the advice given. There were no detainees in the centre who were required to 'shield' for COVID-19 reasons.

Isolation areas were established in case any detainees show symptoms of the virus. One detainee tested positive in April and although a further 22 were isolated at different times during the year because of symptoms, none proved positive until December. At that time, four detainees tested positive and most of the centre was put into outbreak status as a result. A significant number of Serco staff also tested positive in December.

Access to healthcare for a detainee is initially via a nurse, who, if necessary, will refer the patient on to a doctor. The waiting time to see a GP has generally been less than three days during the year and emergency appointments are always available. From March onwards, procedures were in place for nurses to visit the wings daily or staff could contact the healthcare team to arrange a medical appointment on behalf of a detainee.

Care that cannot be provided at the centre involves a visit to hospital. There were 133 off-site hospital appointments during the year, with two emergencies requiring an ambulance in the period from January to June, and nine emergencies from July to December. All hospital visits involve Serco staff acting as escorts.

Healthcare staffing levels continue to be a concern, but agency staff have been used to fill vacancies. We understand that recruitment efforts have continued throughout the year.

G4S Health's provision of 'wellman' clinics stopped from March and these were not restarted, which we understand is comparable to care in the community. Smoking cessation clinics stopped from March and, although they restarted in September, they stopped again from November due to pandemic restrictions.

The Forward Trust continued to provide psychosocial substance misuse services to detainees throughout the year by being present on the wings to support detainees individually, but groupwork ceased. Demand for their services appeared to drop significantly with the change in population.

Monthly visits to the centre by an optician stopped from March and could have restarted but their services were not required. Weekly visits by Boots the chemist, which focuses on long-term medication issues, did return from September but ceased when the centre went into outbreak status in December.

The Board is disappointed that the agreed provision of a mobile dental unit was delayed by the pandemic. We understand that the provision of a dental suite is covered under the new healthcare provider contract due to start on 1 September 2021.

6.3 Mental healthcare

G4S Health provides the primary mental healthcare and subcontract Elysium Healthcare to provide secondary care.

There are four registered mental health nurses on the team (3.6 full-time equivalents), and there is a mental health nurse on site seven days a week. Psychiatrists visited weekly and we are told that the waiting time for an appointment is a maximum of seven days.

Group talking therapy sessions were suspended in March but restarted in June and continued until the pandemic outbreak status in December.

The mental health team was extremely stretched in attending to the complex needs of the population and the Board questioned whether there should be additional resource, but no staff were added (see also section 4.2).

Given the recognition of the harmful effects of isolation on mental health in the wider community during the pandemic, the Board is disappointed that there was no additional funding or resource to focus on the impact of isolation on the mental health of detainees in detention in Brook House in 2020.

No detainees were placed under section 48 of the Mental Health Act in 2020.

There was a huge increase in the need for Rule 35 appointments from September. G4S Health and the Home Office responded to this by increasing available

appointments with the GPs from 14 to 26 per week from September. Despite the increase in appointments, there were still long delays and backlogs, contributing to high levels of anxiety in the centre (see also section 4.4).

G4S Health report that, during the period January to July, a total of 85 Rule 35 assessments were conducted, with a typical waiting time of three days. Forty-five were conducted in August, and then 85 in September, 112 in October, 101 in November and 49 in December.

6.4 Welfare and social care

The Board has found that the welfare team continues to be supportive and sympathetic to the needs of detainees. There have been times during the year when they have been extremely stretched but we are pleased to note that Serco has plans to boost the team by an additional 18 staff across both Brook House and Tinsley House in 2021.

The welfare team provided support to detainees in contacting their lawyers and other organisations, such as Gatwick Detainees Welfare Group (GDWG) and Bail for Immigration Detainees (BID). During the times of restricted movement around the centre, welfare staff made daily visits to each wing to meet newly arrived detainees, and attended induction sessions to ensure that detainees were aware of the assistance they could offer.

6.5 Exercise, time out of room

Under the terms of the new contract with Serco, from 1 October, unlocked time out of rooms was extended by two hours between 7am and 10pm each day. Pandemic restrictions required a rota system to be put in place to prevent association between detainees from different wings. This resulted in reduced access to usually free association areas such as the gym and some courtyards, and generally reduced opportunities for social interaction between detainees. Detainees were still given access to fresh air on yards directly connected to their wings, and a limited amount of gym equipment was provided on most wings during this time.

In our annual reports for 2018 and 2019, the Board has been critical of what we consider to be inadequate and inconsistently delivered programmes of organised and purposeful activities for detainees. It is too soon to assess whether Serco has made the necessary changes but there are positive signs, with an increase in the number of activities staff and investment in gym and other equipment, such as pool tables and football posts.

6.6 Soft skills

Art classes were suspended due to the pandemic but, after a request from detainees, the art room reopened on a restricted basis early in May. Staff ran ad hoc sessions on the wings when the centre was under further pandemic restrictions. The cultural kitchen, which has been extremely popular in recent years, was closed during most of the year from March, following pandemic guidance relating to the size and capacity of the room and concerns around the sharing of food prepared there.

7. Preparation for return or release

7.1 Activities including education and training

Pandemic social distancing restrictions introduced in March meant the suspension of classes and activities in the education rooms and closure of the library. Overall, in 2020 there was a major reduction in the range and frequency of scheduled education classes, although there was some adaptation, with some materials moved online and teachers running small informal classes on the wings.

The library remained closed until February 2021.

As has been the case for many years, the centre did not offer any vocational training programmes of note for detainees.

Access to IT rooms was continued through the year, although on a reduced basis from March. Internet access was made available on wings where detainees were required to remain while reverse cohorting.

These different arrangements for IT access, combined with small numbers in the centre, generally appeared to meet the needs of detainees. There was a noticeable drop in the use of the IT rooms with the shift in detainee population. It is not clear to the Board whether this was due to a lack of need or lack of information about the IT facilities on induction.

In our annual report for 2019, the Board's view was that the overall provision of IT for detainees was barely adequate, with difficulties in printing certain documents, slowness of internet connections and some websites unnecessarily blocked. The Board understands that Serco has made investment in both IT hardware and infrastructure, and we are told that there should no longer be long delays in dealing with requests to unblock sites. It is too soon to tell the impact of this, but it is welcome news.

7.2 Case management

Access to legal advice

Pandemic restrictions had an impact on in-person legal visits at different times in 2020 but, from our monitoring, there was generally no significant impact on the ability to get legal aid appointments – albeit usually remotely by telephone or Skype. COVID-19 protective screens were put up in some rooms in the visits area in July, but there was little uptake for on-site visits by solicitors (see also section 7.3).

BID ceased on-site surgeries from March but continued to provide a telephone service, and it had a high success rate in getting bail for the detainees it represented.

There was especially high demand for legal support from detainees brought in for Dublin Convention flights, and almost all seemed eligible for legal aid. In early September, a number of detainees refused to lock up for several hours, with one of their issues being about solicitors not returning calls. In response, the number of legal aid firms was increased, to provide appointments five days a week. Wait times for legal aid appointments were generally shorter than in previous years – often being available within 72 hours and sometimes the next day, although at one point in late November there was an 11-day wait.

Whether or not a detainee was removed on a charter often depended on work done by his lawyer, and, understandably, many detainees were very anxious about contacts. As well as the frustration and anxiety of detainees demonstrated by the incident in September, there were some informal complaints about problems with telephone connections, both for lawyers and detainees, in October and November.

Some detainees told us that they preferred to stay on their wings or yards, where they knew there was mobile reception, rather than risk going to other areas of the centre, in case they miss a call. There were also informal complaints about some calls not being returned by lawyers. The welfare team was regularly deployed to help detainees with their legal contacts.

Length of time in detention

Detention at Brook House is intended to be short term. Below is a snapshot on length of stay in the centre, from information provided by the Home Office.

	Jan 2020	July 2020	Nov 2020	Dec 2020
Total number of detainees at month end	197	78	161	4
Less than 1 week	85	32	39	0
1 week – 1 month	28	1	111	1
1 – 2 months	30	14	9	2
2 – 6 months	42	19	1	1
6 – 12 months	10	9	1	0
1 – 2 years	1	3	0	0
Over 2 years	1	0	0	0

The drop in total population by July 2020 was due to the large number of releases that the Home Office made after the onset of the pandemic meant that there was no reasonable prospect of removing detainees on international flights. Those who remained the longest were primarily time-served foreign national prisoners (TSFNOs) who the Home Office determined to be high risk to release, but by August only four TSFNOs remained and they were transferred to another IRC.

Detainees who remained often expressed frustration with the Home Office and what they regarded as unfairness about their continued detention when seeing so many other detainees released. There was a sense that detainees felt they had been left behind. This was exacerbated for those who were granted bail but then subjected to long delays before release while the Home Office found suitable accommodation for them (see also section 7.4).

The acceleration of releases after March due to the pandemic, and the high level of turnover of detainees for the Dublin Convention charter programme later in the year make it difficult to draw meaningful comparisons between figures for 2020 and those for earlier years.

Removal and release rates

In 2020, an average of 53% of all detainees leaving Brook House each month were released into the community, while an average of 39% were removed from the UK. The balance of 8% were transfers to other detention centres or to prisons. This release rate is even higher than in 2019 (44% monthly average) and, even allowing for increased releases in the first half of the year due to the pandemic, raises again the question of whether so many detainees should have been in detention at all. The only basis for detention should be to facilitate removal, and yet 53% of detainees leaving Brook House in 2020 were released rather than removed, and in the interim had been exposed to the potentially harmful effects of detention on their physical and mental health.

The question is even more pertinent in the period from August to December, when the Home Office ran its programme of Dublin Convention charter removals. In this time, releases actually rose to 72% of all leavers and the rate of removal dropped to 21%. From the Board's estimates, between August and December, over 600 detainees who were detained for varying lengths of time in Brook House to prepare them for removal from the UK were eventually released instead. This sits beside data for the same months which shows that significant numbers of detainees were either on constant supervision or ACDTs and with high levels of actual or threatened self-harm or suicide risk in circumstances of great stress and anxiety for all detainees in the centre.

Twenty-six flights were originally planned for the charter programme. Some of the flights had to be cancelled or were injuncted. The Board estimates that fewer than 120 detainees were removed from the centre under the Dublin Convention programme.

7.3 Family and other contact

Social visits were not permitted at different times in 2020 due to national lockdowns or local pandemic rules. From March, the Home Office gave an extra £10 per week phone credit to each detainee, to help with continued contact with family, solicitors and others.

From the Board's observations, both G4S and Serco made it a priority to give detainees access to the usual visits area rooms for use of Skype or Facetime, and a room was also set up on each wing by early September to allow video calls. There were connectivity issues with Skype from time to time, but the Board did not receive any complaints from detainees.

There was a significant drop in demand for social visits from August onwards, presumably because the population, consisting largely of detainees who had crossed the Channel on small boats, had fewer family and friends in the UK. GDWG suspended on-site visits in March but continued to provide telephone-based support for detainees. Throughout the year, the Board continued to recommend detainees to GDWG, including those who appeared affected by isolation.

While detainees could have telephone or video access in place of visits, the loss of in-person contact from social and legal visits, and from others such as BID, GDWG and other non-governmental organisations, is likely to have contributed to the sense of isolation and being left behind (see also section 7.2). There was also reduced contact

with other detainees due to pandemic restrictions, especially for socialising on the yards with those from other wings.

7.4 Planning for return or release

Home Office delays in finding suitable bail accommodation was a major source of frustration for larger than usual numbers of detainees from early April to August, when the last TSFNOs were transferred from the centre.

The situation was often worsened by the fact that a grant of bail could lapse after 28 days and, if accommodation had not been found, the detainee might have to make a fresh application and go through the process again. While recognising the 'competition' for accommodation during the pandemic, the Board noted a sense among the detainees that their Home Office caseworkers were not motivated to persist on their behalf. The local DET members regularly chased caseworkers for updates.

Many of the detainees affected were level 2 or 3 on the AAR log. For example, on 29 April, 12 detainees (nearly 20% of the centre's total population) were wating for bail accommodation and just under half of them were level 2 AAR. One man first granted bail in March was still waiting for accommodation in August, when he was transferred to another IRC.

There appeared to be a complete absence of meaningful information provided to detainees about what would happen to them in receiving countries if they were removed under the Dublin Convention charter programme. The Board's view is that this poor level of engagement by the Home Office exacerbated the anxieties and distress of detainees in the centre.

In early September, 28 detainees started refusing food after hearing from former detainees removed to Spain that they had just been left at the airport without any assistance from Spanish authorities and been told that they must leave Spain. Subsequent press reports showed the detainees to be homeless. As far as the Board is aware, the Home Office did not reply to a formal complaint by 23 detainees asking that their cases be considered in light of this. The next charter to Spain was injuncted.

8. The work of the IMB

The pandemic has had an impact on the Board's monitoring. While we were able to continue on-site visits in all but three weeks in 2020, we made fewer total visits than we typically would.

The Board adopted two wider IMB national initiatives to aid accessibility for detainees. In April, we introduced an email address and in May we added an 0800 telephone number voice message service. Only 12 calls were received for the Board on the 0800 voicemail and less than a handful of emails were received.

Despite repeated requests made to both Serco and the Home Office, the Board has not had access to the centre's database of detainee information (CMS) since 21 May. At the time of writing, steps are under way to give access. The Board has a right to access the records of the centre under Detention Centre Rule 63(3).

Effective from 1 January 2021, Brook House IMB and Tinsley House IMB have merged and will operate as a single Gatwick IRC IMB going forward. This will be the last report from the Brook House Board.

Board statistics

Recommended complement of Board members	12
Number of Board members at the start of the reporting period	9
Number of Board members at the end of the reporting period	9
Total number of visits to the establishment	123

Applications to the IMB

Code	Subject	Previous reporting year	Current reporting year
A	Accommodation, including laundry, showers	8	0
B	Use of force, removal from association	n/a	1
C	Equality	1	0
D	Purposeful activity, including education, paid work, training, library, other activities	5	0
E 1	Letters, faxes, visits, telephones, internet access	10	1
E 2	Finance, including detainees' centre accounts	2	0
F	Food and kitchens	1	1
G	Health, including physical, mental, social care	19	13
H 1	Property within centre	2	0
H 2	Property during transfer or in another establishment or location	4	3
I	Issues relating to detainees' immigration case, including access to legal advice	53	14
J	Staff/detainee conduct, including bullying	5	1
K	Escorts	1	1
L	Other	7	1
	Total number of applications	118	36