BROOK HOUSE INQUIRY

First Witness Statement of Deborah Coles

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 5 May 2021. I have been authorised by INQUEST, 3rd Floor, 89-93 Fonthill Road, London N4 3JH to provide this witness statement.

I, Deborah Coles, will say as follows:

Introduction

1. I am the Executive Director of INQUEST, a post I have held since February 2017. I previously acted as Co-Director for around twenty years and have worked for the charity since 1989. I sit on the cross-government Ministerial Board on Deaths in Custody, and I have a public appointment to the Independent Advisory Panel on Deaths in Custody. I was an advisor to the Harris Review into self-inflicted deaths in custody of 18-24 year olds, and was the special advisor to the Chair of the Independent Review of Deaths and Serious Incidents in Police Custody, set up by the then Home Secretary Rt Hon Theresa May MP in October 2015. This review was published in October 2017 making 100 evidence-based recommendations to prevent future deaths. I am also the author of a number of reports on the improvements needed to the oversight and implementation of lesson learning and accountability after deaths in custody and detention.[1]

2. During the relevant period of this Inquiry, 1 April 2017 to 31 August 2017 ("the relevant period"), my role as Director of INQUEST involved leading on our strategic policy, legal and parliamentary work.

[1] https://www.inquest.org.uk/learning-from-deaths-in-custody; https://www.inquest.org.uk/deaths-in-mental-health-detention

58. There are a number of general points I would make based on my experience in this area:

a. Self-inflicted death and self-harm risk is very prevalent amongst detained people and extremely dangerous. INQUEST have conducted extensive work on self-inflicted deaths of people in detention, including immigration detention. Many of the deaths of immigration detained people involve repeated "basic errors" by staff who are ignorant of the mental health risks associated with detention and the histories of trauma of many detained people. Indifference and lack of humanity is what underlines the care provided in immigration detention. Evidence at inquests repeatedly reveals systemic failures and failures to implement suicide prevention policies. Indifference and lack of humanity also underlines the standard of care provided in immigration detention. There have been examples of staff not taking suicidal thoughts seriously and/or believing that someone is malingering or manipulating to get attention. Such an attitude is reprehensible. People exhibiting these behaviours are always very, very distressed. A potential self-harm risk cannot be discounted, and certainly not without the most careful assessment.

b. Such assessments need to follow the guidance and instructions, which has been developed over many cases and following many inquests. That means properly identifying the triggers for such behaviour; properly care planning to reduce risk, with specific and timebound actions; and proper monitoring and ensuring safeguards are put in place.

c. Above all, however, what almost all people need is time and being listened to. That is necessary in order properly to gauge their risk. But it is also necessary to give them a sense of influence, and control, or support, so they do not harm themselves. Most suicide and self-harm is not stopped by watching someone and stopping them carrying out the physical mechanism of self-harm. It is stopped by encouraging the individual to believe that there is hope.

d. Information and support for other detained people following a death is also severely lacking. As set out above, following the death of Muhammad Shukat, his roommate was severely traumatised by having witnessed his death and the

neglect that led up to it. Yet he was placed in a single cell in the austere "Assessment and Integration Unit" and segregated from other detained people who may have offered support.

59. What emerges from the cases, examples of which I have given in this statement, are disturbing patterns across IRCs when it comes to the wider circumstances of deaths of detained people. Given what has been exposed by inquests and investigations in respect of harmful and unhealthy cultures and practices and the lack of dignity and respect afforded to detained people at other IRCs, I would be very surprised to learn that similar issues of concern did not exist at Brook House during the relevant period in 2017, and indeed now.

Oversight – IMB, PPO and HMIP

60. In the witness statement I gave to the High Court signed on 22 February 2019 I explained the limitations on the investigations conducted by the PPO and the effect of those constraints. I refer to paragraphs 11-25 of my earlier statement and confirm that the matters described there continue today.

61. As referred to above, in the case of Prince Fosu, the IMB acknowledged that steps needed to be taken to improve working culture, to encourage staff to challenge unacceptable conduct by other staff and to foster a stronger sense of professional responsibility.

62. In the case of Bai Bai Ahmed Kabia mentioned above, where at the inquest his death was found to have been preventable, the PPO initially discontinued their investigation and only resumed when Mr Kabia's family gave notice of Judicial Review proceedings. His family also had to challenge repeated decisions to refuse legal aid. If it had not been for the perseverance of his family and their legal team, the failings which led to Mr Kabia's death would not have been uncovered.

63. Our concern about HMIP is that their methodology and inspection approach is focused on the general, which is at the expense of identifying patterns or trends arising from individual cases and therefore it is not clear how they would ever identify a potential