**THE BROOK HOUSE INQUIRY**

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**STATEMENT**
**Of EMMA GINN**

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I Emma Ginn of Medical Justice, DPA will say as follows:

1. I am the Director of Medical Justice. In 2008 I became the first member of staff employed by the organisation as the Co-ordinator. I have always held the leadership role at Medical Justice and in 2018 my job-title transitioned to Director. I manage the day to day running of the organisation and have oversight of all the work undertaken including policy and research.

2. Although I am not a lawyer, it has been essential to my work for Medical Justice that I acquire a working knowledge of the law, policy and rules relating to immigration detention, I also have familiarity with some of the relevant cases concerning immigration detention, particularly cases in which Medical Justice have brought in its own name or played a part in as an intervenor or witness.

3. This statement is provided to the Brook House Inquiry for the purposes of outlining the nature of the work undertaken by Medical Justice which is most relevant to the Terms of Reference. In particular, I have sought to document the extensive efforts made by Medical Justice, and successive statutory bodies and reviews, to bring to the attention of the Home Office the serious concerns and systemic failures in the arrangement and operation of detention policy and safeguards for clinically vulnerable persons. The evidence upon which these concerns are based has been raised long before, and after, the material events at Brook House. I also detail the Home Office's response to these issues to date which, in the view of Medical Justice, is centrally characterised by their entrenched failure to implement effective remedial action to prevent the risk of serious harm to highly vulnerable detainees. I believe this is important context for understanding how and why grave mistreatment and abuse occurred at Brook House in 2017 and is critical to identify the effective remedial action to prevent, as far as possible, its re-occurrence.

## (1) About Medical Justice

4. Medical Justice is an independent charity[1] which was established in 2005 by a formerly detained person and the volunteer doctor who had assessed him in detention. It was granted charitable status in 2009.

5. Medical Justice is the only charity in the UK with a specific clinical remit to assess and assist people in immigration detention who present with physical or psychological sequelae of past torture or who have mental or physical health needs which have not been identified or are unmet within the immigration detention environment. It also monitors and investigates the adequacy or otherwise of healthcare provision in immigration detention and the effect of detention on the physical and mental health of detained persons.

6. Medical Justice employs 13 members of staff, including four caseworkers working directly with immigration detained persons, a specialist researcher, a parliamentary analyst, a policy researcher and a parliamentary manager. In addition, Medical Justice ensures that former clients who have experienced detention remain involved in its work. Three people with lived experience of detention are trustees of the Charity. Former detained persons also contribute to the training of the charity's volunteer doctors and interpreters.

7. The charity has been one of the leading organisations, with medical expertise, providing evidence and insight based upon its clinical casework to the Home Office through consultations and stakeholder forums, as well as to statutory bodies such as HM Inspector of Prisons ("HMIP") and the Independent Chief Inspector of Borders and Immigration ("ICIBI"). This includes both policy and operational matters pertaining to the treatment of mental illness, and health care in immigration detention. Medical Justice has been a member of the Refugee and Asylum Forum since 2015 and, since 2019, the Adults at Risk Forum, which provides input into the ICIBI inspection agenda and reports. We have also provided training and assistance to the Care Quality Commission ("CQC"), the independent regulator of health and social care since 2014, including in 2019 on Rule 35 of the Detention Centre Rules 2001. The CQC invited Medical Justice to be a part of its IRC Advisory Group. As a member of this closed group, Medical Justice was asked to provide input into the planning of a CQC thematic review of the management of women's healthcare needs in IRCs.

8. Medical Justice has established collaborative relationships with the key medical Royal Colleges, which draw on the broader spectrum of relevant clinical expertise and evidence on

[1] Charity Registration Number (1132072).

the adequacy of clinical and healthcare arrangements in immigration detention, the challenges faced by medical professionals and the impact on the treatment of detained persons. We have been an active participant in the Royal College of Psychiatrists' Working Group on the Mental Health of Asylum Seekers and Refugees since October 2012 and the Royal College of GP's Secure Environments Group since January 2014. In 2019, Medical Justice contributed to the Faculty of Forensic and Legal Medicine of the Royal College of Physicians ("FFLM")'s 'Quality Standards[2] for healthcare professionals working with victims of torture in detention'.

9. Medical justice also contributed to the British Medical Association's (BMA) seminal report on healthcare in detention: "*Locked up, Locked Out: Health and Human Rights in Immigration Detention*" (2017). This report addressed immigration detention policies and practices as they relate to health and explored the role of doctors in protecting and promoting the health-related human rights of detained individuals. The overall conclusion of the BMA was that:

> *"...the detention of people who have not been convicted of a criminal offence should be a measure of last resort. Detention should be reserved for individuals who pose a threat to public order or safety. Ultimately the use of detention should be phased out and replaced with alternate more humane means of monitoring individuals facing removal from the UK.*
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> *As long as the practice continues, however, we believe that there should be a clear limit on the length of time that people can be held in detention, with a presumption that they are held for the shortest possible time. The state must also meet its obligations to those it detains: detained individuals should not experience infringements of their health-related rights and must be able to access high-quality healthcare, commensurate with their needs. Where doctors are unable to meet their obligations to patients, systems and processes must be scrutinised and restructured."*[3]

We were invited to participate on the BMA's clinical expert panel following the publication of this report.

10. Medical Justice also provides clinical perspective and evidence to statutory bodies with oversight of immigration detention. We have assisted the HMIP at their request to provide clinical expertise and experience on longstanding concerns such as the deficiencies of Rule

[2] Faculty of Forensic and Legal Medicine (May 2019) Quality Standards for healthcare professionals working with victims of torture in detention.

[3] British Medical Association, "*Locked up,, Locked Out: Health and Human Rights in Immigration Detention*" (2017), pg.11.

35 of the Detention Centre Rules 2001 ("DCRs"). We have met with the HMIP on an ad-hoc basis since 2005, regularly raising issues for consideration by the inspector in his IRC inspections.

11. Medical Justice also utilises its clinical and casework evidence and experience, together with research and monitoring, to seek to effect longer term legal and policy reform in respect of the conditions and treatment of people in detention. This work has included providing evidence to Parliamentary Committees and briefings to Parliamentarians during the passage of immigration legislation, generally highlighting issues of significant concern or systemic failures in the arrangement and operation of detention safeguards for clinically vulnerable people and their healthcare. For example, the casework and research carried out by Medical Justice relating to the systemic failure in policy and abusive treatment of pregnant women in detention was instrumental to bringing about the introduction in the Immigration Act 2016 of a strict time and other limits on the detention powers as they apply to the detention of pregnant women. I discuss this further below.

12. Medical Justice is also the Secretariat for the All-Party Parliamentary Group ("APPG") on Immigration Detention. The APPG on Immigration Detention has held meetings on the operation of the Adults at Risk policy as well as on the Home Office's approach to processing small boat arrivals. In 2021, the APPG held an inquiry into quasi-detention in places such as the Napier and Penally barracks.[4]

**(2) The Work of Medical Justice: Background**

13. From inception, Medical Justice was supported by former detained persons, lawyers, volunteer doctors and visitors such as myself, who were concerned that there was a major problem with access to and the provision of healthcare in immigration detention. On visits to detained people at IRCs around the country, I recall noting high levels of mental distress and what may have been mental illness seeming to go untreated. I was also very worried about some individuals who had physical injuries such as bruising and others who were refusing food and fluids risking their health and, in some cases, even their lives. From the outside, it felt like an alarming picture, but it was very difficult to obtain reliable and corroborative information about what was actually happening within the IRCs.

14. As occurred in 2017 with the Brook House Panorama broadcast, it has largely been owing to

[4] APPG on Immigration Detention (December 2021) Report of the Inquiry into Quasi-Detention.

undercover reporting that many of our concerns about the conditions of detention and the reality of the experience of detained people were brought into the open. I was a visitor at Yarl's Wood IRC in 2003 when a Daily Mirror journalist went undercover there. The PPO Report on the Treatment of Detainees at Yarl's Wood IRC (2004)[5] subsequently recorded that, after 5 weeks of training as a detention centre officer ("DCO"), the undercover journalist reported on incidents of racism, including racial profiling[6], racially derogatory language[7], xenophobia,[8] and threats of violence[9] that he had witnessed. Around the same time Medical Justice made representations to HMIP who undertook an inspection of healthcare at Yarl's Wood IRC in 2006 and published the themed report *"Inquiry into the quality of healthcare at Yarl's Wood Immigration Removal Centre*". The report's findings, which were to become all too familiar, included that:

> "*....the healthcare service was not geared to meet the needs of those with serious health problems or the significant number of detainees held for longer periods for whom prolonged and uncertain detention was itself likely to be detrimental to their well being.....the delivery of healthcare was undermined by a lack of needs assessment, weak audit and clinical governance systems, inadequate staff training (particularly in relation to trauma) and insufficiently detailed policies and protocols, for example with regard to food refusal...mental health care provision was also insufficient....the inadequacy of healthcare systems in the IRC was compounded by the unresponsiveness of the IND to clinical concerns about an alleged history of torture or adverse medical consequences of continued detention. When clinical concerns were raised, the information was not systematically addressed or actioned. Nor was independent medical opinion sought or adhered to* [10]
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> ...
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> *There was no system to seek the opinion of an independent medical specialist and in some cases IND caseworkers, with no declared medical qualification,*

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[5] PPO (2004) Investigation into allegations of Racism, Abuse and Violence at Yarl's Wood Removal Centre.

[6] "*The Indians and Pakis are all right. But Jamaicans are drug-dealing pieces of s**t. Algerians are the slimiest bastards in the world - all of them. They're all terrorists, the ones we get any way. And the Chinese are evil little bastards",* PPO (2004) report of investigation into allegations of Racism, Abuse and Violence at Yarl's Wood Removal Centre at pg.10.

[7] "*'They're bitches in here. They're here for a reason.' On another occasion I was told: 'We have to watch out for incest. Its part of their culture. They'll stick it up anything.*' Ibid at pg.10.

[8] "*During another session on human rights, trainees were subjected to a right-wing rant. They were told: 'Now they (asylum seekers) are rowing over here in dinghies. Sink them that's what the navy should be doing.' and 'The ones who come here and don't stop crying really piss me off. I'm like "shut up!" they only do it to get attention." 'the scum of the scum.* "' Ibid pg.10.

[9] "*I listened with horror as a senior officer sadistically relished rumours they would soon be able to punch, kick and even head butt difficult inmates under new control and restraint plans by Home Secretary, David Blunkett for the centre. 'You are in there, you are hyper, you want to go for it. You're not allowed to hit them. Only blocking moves. But the blocking moves can hurt. They can break limbs. You will always defeat them, no matter how big they are. You will have more teams in the corridor behind them and you will take them out. It will be done.' A supervisor admitted some officers seemed to get a kick out of provoking detainees - giving them an excuse to use restraint techniques. He said, 'Control and restraint hurts. You will hurt them".* Ibid pg.12.

[10] HMIP, '*Inquiry into the quality of healthcare at Yarl's Wood Immigration Removal Centre: 20-24 February 2006",* Executive Summary, §§1.3-1.6.

*appeared to be making their own clinical judgements."*[11]

15. On 2 March 2005 the BBC programme *Detention Undercover: The Real Story*, was also broadcast, revealing what was later found by Stephen Shaw in a PPO Inquiry into allegations of racism and mistreatment of detainees at Oakington Reception Centre (2005)[12] what he called "*a sub-culture of abusive comment, casual racism, and contempt for decent values*" at Oakington IRC.[13] Oakington was billed as the most relaxed detention environment suitable for determination of claims for asylum under the Detained Fast Track ("DFT") procedure then in place. It seemed evident from the experiences recounted at other IRCs that these abusive practices were not limited to Oakington and were pervasive throughout immigration detention facilities.

16. It was apparent that there was a pressing need for an organisation that could facilitate access to independent medical expertise, to examine and provide reports on the physical and mental health of those detained and to provide some possibility of opening up these closed institutions to more external scrutiny so that better insight and information could be obtained on the reality of the practice and provision of healthcare and the welfare of detained persons within IRCs. Without independent corroboration, the claims made by detained people, including of mistreatment, could be and were simply ignored. Even then, the culture of disbelief and denial was deeply ingrained in all of aspects of Home Office practice. We had hoped (somewhat naively) that reports from clinical experts and professionals with direct access to detained persons could counter that.

17. Medical Justice's work has been informed from the outset by this context and has developed four main strands, namely: i) direct individual casework; ii) monitoring, research and investigations; iii) legal reform and policy and iv) strategic litigation. Through these core activities, over the past 17 years, Medical Justice has acquired a deep and detailed institutional knowledge of the policy and practice of the Home Office and its contractors, including in respect of the relevant period under investigation by the Inquiry. I draw on the organisation's experience over the years to inform what I say in this statement. Theresa Schleicher, Medical Justice's Casework Manager, and Dr. Rachel Bingham, our Clinical Advisor, have given evidence particular to our experiences of the period that is the subject of the Inquiry. We have

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[11] Ibid §3.14.
[12]PPO (July 2005) Inquiry into allegations of racism and mistreatment of detainees at Oakington immigration reception centre and while under escort.
[13]Ibid pp. 3,35,59,68-70 and 105.

also obtained the advice of a clinician with use of force expertise, Dr Brodie Paterson, to provide additional insight on the evidence in particular relating to institutional culture, use of force and segregation from a clinical perspective.

**(3) Medical Justice's Direct Casework**

18. Our clinicians make visits to both IRCs and prisons. Visits are arranged following referrals from charitable organisations, medical professionals, lawyers, detained people themselves, and occasionally by healthcare staff in IRCs. Our volunteer clinicians provide Medico-Legal Reports ("MLRs") to document individual experiences of torture and other cruel, inhuman or degrading treatment or punishment; injuries sustained by the excessive use of force, physical and mental illness, and to address the impact of continued detention on the health of detained persons. All of the charity's healthcare professionals are trained to complete MLRs to the high standards of the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("the Istanbul Protocol"). These reports are regularly relied upon in appeal hearings before the Immigration and Asylum Tribunals and also in public law cases in the higher courts.

19. In the 5 years prior to the pandemic, Medical Justice received 800-1000 referrals each year, across the UK's immigration detention estate, including prisons. Since its inception, it has arranged for more than 1,500 reports concerning immigration detained persons, and assisted thousands more. It is through its extensive casework and liaison with other clinical and care professionals that Medical Justice has had access to a wide spectrum of information concerning detention policy and practice, conditions of detention and treatment of clinically vulnerable detained persons. The charity's casework database has details of more than 8,000 immigration detained persons who it has assisted since 2009. It includes information on more than 1,000 clients who have been held in Brook House IRC since 2009.

20. My colleague Ms. Schleicher explains in her second witness statement ("TS2") the steps we took to identify former detained people who were at Brook House during the relevant period about the work of the Inquiry. This was a difficult process because of the prolonged delay between the Panorama broadcast and the establishment of the Inquiry. Despite the investigative duties under Article 3 ECHR, no effective steps appear to have been taken by the Home Office to trace and inform former detained people. There was no moratorium on removals, so it is highly likely that opportunities have been lost to obtain relevant evidence. We were, in the end, able to provide evidence relating to 28 cases of former detained people

who we had contact with during the relevant period. A detailed analysis of what those case studies show is set out in TS2 and Dr. Bingham's witness statement. I would invite the Inquiry to consider their analysis in detail. In brief, the findings confirm that long-standing systemic failures in detention policy and safeguards for clinically vulnerable people manifested in the operations and arrangements at Brook House IRC; with high numbers of detained people with serious and deteriorating mental illness, many displaying disturbed behaviour, self-harm and suicidal ideation and managed through containment, using constant monitoring (ACDT), formal and informal segregation, and restraint measures.

**(4) Monitoring, Research, Investigations and Publications**

21. Medical Justice draws on its casework database and experience to monitor and identify such patterns of concerning practice, particularly in relation to clinical and healthcare provision, in the detention and treatment of those in immigration detention. We have published significant research which documents recurring and systemic problems in the structure and operation of detention and immigration enforcement policies as they affect clinically vulnerable people. We have also documented the damaging and harmful effects of detention and conditions of detention on physical and mental health. Our research shows how immigration enforcement and detention policies operate in a manner which infringes the fundament rights of many individuals subject to the regime, by exposing them to actual or unacceptable risks of inhuman or degrading treatment contrary to Article 3 ECHR, and even contributing to deaths of people in immigration detention at IRCs and prisons.

22. Our research is directly relevant to the issues that the Inquiry has set out to investigate in its Terms of Reference at both a systemic and operational level. I set out the full list of these reports below, all of which are exhibited to this statement, and will address the themes and evidence that are most relevant to the Inquiry's investigation in this statement:

a. *Beyond Comprehension and Decency: A report on medical abuse in immigration detention* (2007);
b. *Outsourcing Abuse: state sanctioned violence during the detention and removal of asylum seekers* (2008);
c. *The Second Torture: The Immigration Detention of Torture Survivors* (2012);
d. *Mental Health in Immigration Detention* (2013);
e. *Expecting Change: The Case for Ending the Detention of Pregnant Women* (2013);
f. *Healthwatch and Immigration Removal Centres: Asylum Seekers in Detention Centres* (2014);

g. *Biased and Unjust: the immigration detention complaints process* (2014);

h. *A Secret Punishment: the Misuse of Segregation in Immigration Detention* (2015);

i. *Death in Immigration Detention 2000 - 2015* (2016).

23. The Inquiry will see from the topics of our research reports that a number of these relevant concerns are not new and are recurring failures in detention policies and practice which have been identified and have been known to the Home Office and its contractors often for years before the Panorama programme was broadcast in September 2017. The problem is that despite the warnings, the Home Office and its contractors (including G4S) have failed to address and rectify them. This has come at a costly and grave price of putting the fundamental rights and welfare of those detained under immigration powers in jeopardy.

24. I provide below a brief summary of the reports relevant to the operation of detention policy, safeguards and healthcare provision that are relevant to the Inquiry.

## (5) Summary of Medical Justice research prior to 2017

***Beyond Comprehension and Decency: A report on medical abuse in immigration detention (2007)***

25. This first report focused upon the detention of the vulnerable, including due to mental illness, a history of torture or serious physical illness. It identified failures to diagnose medical needs by detention healthcare and gave examples of detained persons subject to mistreatment in detention including assault, inappropriate use of handcuffs and the use of segregation. The report comprised an analysis of 56 medico-legal assessments conducted either in detention or shortly after release. The findings included 20 examples of independent medical assessments that had identified a history of torture. The report found that in each case there was a breach of Rules 34 or 35 DCR. The majority of these assessments diagnosed individuals with post-traumatic stress disorder ("PTSD") and recorded attempts at self-harm whilst detained. The conclusion we drew at that time in 2007 (10 years before Panorama) was that *"Unmet health needs are a major problem among immigration detainees, detention itself was frequently damaging to the health of detainees, sometimes profoundly so. Detention of torture survivors, children and those with physical or mental ill health were being held contrary to the Home Office's own policy."*

***Outsourcing Abuse: State Sanctioned violence during the detention and removal of asylum seekers (2008)***

26. This report[14] was based upon 48 case studies[15] of alleged assault in the period between January 2004 and June 2008 within the IRC estate, primarily in the context of escorted removal to and from the airport.[16] The report provided information concerning 48 case studies where consent from the detained person had been provided for their personal details and experiences to be formally documented. Medical Justice's assessment was that all of these case studies were examples of excessive force, even those where it may have started off as reasonable force. Most of the cases alleged excessive use of force in circumstances where the victim did not wish to do something or go somewhere. However, in many incidents the victim was not resisting or posing a risk to others. The most common form of injury recorded resulted from the inappropriate use of handcuffing, including swelling and cuts to the wrist, sometimes leading to long lasting nerve damage. Other injuries included bruising and swelling to the face and fractures to the wrists, ribs or ankles.[17] Often psychological consequences resulted, such as the onset or exacerbation of PTSD, panic attacks, suicidal feelings and depression.[18] Detainees gave accounts of guards or escorts using racist language.[19] Outsourcing Abuse also noted that many detainees faced barriers in lodging complaints in respect of their treatment, with resultant inadequacies in the limited number of investigations which did take place. [20] In analysing the evidence of harm presented to us, and in drawing our conclusions, we were mindful of the limitations of our data set and the difficulties we faced in documenting use of force with the limited resources available to us as volunteers. We published the report to draw attention to the disturbing trends we had identified and with the hope that a fuller, adequately resourced independent academic study would be undertaken into the issues to obtain greater and more rigorous detail. [21]

27. In November 2008, the Complaints Audit Committee ("CAC") reported that there were "*endemic and enlarging problems*" in misconduct investigations and "*indications of rising discontent and continuing failures*". The CAC stated that 79% of serious misconduct

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[14] It was jointly prepared with Birnberg Peirce and Partners Solicitors and the National Coalition of Anti-Deportation Campaigns of which I was one of the co-ordinators at the time.
[15] This followed a review of nearly 300 cases of alleged assaults that took place in detention or transit since January 2004. The data was collected from immigration solicitors, civil action solicitors, direct from victims, visitors to immigration detainees, media articles, airline passengers, hospital staff, independent doctors and journalists. Only 48 of these complainants however provided consent for their experiences to be used as case-studies.
[16] An earlier Medical Foundation Report in 2004: "Harm on Removal: Excessive Force against Failed Asylum Seekers" documented people being "*dragged along the ground, being kicked or kneed, being punched – including to the head and face, being elbowed, having the thumb forcibly bent back, pressure being applied to the angle of the jaw, pressure exerted on the neck, being sat on (thorax and abdomen), and assault to the genitals*", §3.2, pg.11.
[17] 'Outsourcing Abuse', pg.14, Tables 7 and 8 and pp. 21-46.
[18] Ibid, pg.14
[19] Ibid, pg.40: cases A4, B2, B6, D4, F1, F5 and F6.
[20] Ibid, 15-18
[21] 'Outsourcing abuse', pg 20.

complainants were not interviewed, that 65% of the responses were not defensible, and 27% took over 1 year.

28. The Home Office commissioned Baroness Nuala O'Loan DBE to conduct a review of the 'Outsourcing Abuse' report and to consider 29 of the cases referenced in which the UK Border Agency or HM Prison Service had already carried out an investigation.[22] This review was published in March 2010. Baroness O'Loan did not find evidence of systemic abuse in the cases she was able to review.[23] However, in the 29 cases in which complaints were made she identified 18 cases in which *"the investigations were not adequate, or there was no investigation"*.[24] Baroness O'Loan found that many of the use of force techniques described in 'Outsourcing Abuse' were lawful in so far as they were permitted Control and Restraint techniques, though went on to state that:

> *"Such use of force must, of course, also be necessary and proportionate. The same procedures are used for all categories of people: young, old, weak, strong, sick and well. Consideration of issues of proportionality and necessity in relation to the proposed use of force by means of Control and Restraint techniques cannot be identified in a number of the cases in this Review"*. [25]

29. The review also identified *"problems and confusion"* in relation to the use of handcuffs which needed to be addressed, noting that the use of handcuffs was commonly associated with injuries at varying levels within the cases examined.[26] In the conclusion to her report, Baroness O'Loan stated:

> *"There are among the Outsourcing Abuse cases a significant number of people who have self-harmed or attempted suicide. The evidence suggests that there may well be heightened levels of anxiety and illness among those detained. All these factors must also be further considered if there is to be a reduction in the number of occasions on which force is used, and an improvement in the way in which force is used. In particular, it is vitally important that every attempt is made to reach a situation in which force does not have to be used. I have made recommendations to address these issues."*[27]

30. Baroness O'Loan also concluded that there was *"inadequate management of the use of force*

[22] Report to the United Kingdom Border Agency on "Outsourcing Abuse", 12 March 2010: see terms of reference at pg.2.
[23] Ibid, Executive Summary at § 7.
[24] Ibid, Executive Summary at §3.
[25] Ibid, Executive Summary at §12.
[26] Ibid, Executive Summary at §8 & §13.
[27] Ibid, Conclusions at §16.

*by the private sector companies",* which resulted in "*failures properly to account for the use of force by recording fully the circumstances and justification for the use of force".* Further, training on the legal obligations concerning the use of force was not reflected in the "*bulk of the case papers"* she examined[28]. Finally, the review found that "*the investigation procedures and management prior to 2008 were not adequate to ensure that investigators conducted an investigation of the standard which should have been required*", going on to detail these failings and the extent of improvements made since[29].

31. In all Baroness O'Loan made 22 recommendations in respect of the management of removals and the complaints investigation processes, six of which related to the use of force and handcuffing, including "*a review of the control and restraint techniques and of the Guidance used to determine what improvements could be made. Such a review should encompass consideration of control and restraint training and the physical techniques used in mental health establishments*." The Home Office duly agreed to prepare a Service Improvement Plan, though it has not provided a copy to Medical Justice. Lin Homer, the Chief Executive of the UKBA at the time, perceived the 'Outsourcing Abuse' report "*as an attack on the reputation of our contractors*", rather than an attempt to raise serious concerns and secure proper investigation into them. However, notwithstanding this, she pledged her commitment on behalf of the Home Office, in response to the O'Loan review, "*to ensure we maintain robust systems of accountability to ensure that we root out any individual whose behaviour falls below the high standards we should rightly demand in this sensitive area. The public deserve nothing less."*[30]

***The Second Torture: The Immigration Detention of Torture Survivors (2012)***

32. This report addressed the failure of the safeguards in Rules 34 and 35 DCR to identify those who may be victims of torture. A review was undertaken of 50 Medical Justice clients who were subject to detention between May 2010 and May 2011 and for whom an MLR was completed. The review found that Rule 34 examinations either did not take place at all or were inadequate and Rule 35(3) did not operate effectively to lead to the release of those clients. The Home Office only released one of the clients after a Rule 35 report. Two had been removed and experienced further torture before returning to the UK. Deficiencies in the Home Office's responses to Rule 35(3) reports included the Home Office's failure to provide adequate reasons for continued detention and/or to accept the medical opinion provided by the

[28] Ibid, Executive Summary at §14
[29] Ibid, Executive Summary at §§17-22
[30] Ibid, Foreword.

IRC doctor and others.

33. Broader systems-level problems were also identified in the report, including a lack of knowledge and training of Home Office and healthcare staff, and the culture of disbelief that was ever present in the context of their consideration and conduct of the Rule 35 process. In the research sample, there were a high number of responses to Rule 35 reports that failed to engage with the facts and failed to even acknowledge evidence on the basis that the allegations had already been assessed and rejected. Medical Justice found a set of abusive annotations scrawled on one individual's asylum interview records by a Home Office official who described the individual who was crying as a "loser" who should go back to his home country. Attitudinal problems were also evidenced amongst IRC healthcare staff. The haphazard and careless Rule 35 reports suggested a *blasé* attitude towards the Rule 35 mechanism and detained people. This reflected criticism in some of the HMIP reports, with healthcare staff being described as "*brusque*"[31] and "*inappropriately abrupt*"[32]. It was exacerbated by poor quality healthcare in detention and a lack of accountability for flaws in the process.

34. We also noted that within the sample of 50 cases, six included a complaint of assault. The report set out difficulties with addressing concerns about the use of force; namely the reluctance of people in detention to raise the issue and when they did so, the complaints system was complex and ineffective.

35. The failures identified in the report echoed earlier criticism of the Rule 35 process identified by HMIP and other stakeholders, showed an inertia to bringing about positive changes and raised serious concerns about the conduct of audits of the safeguards and the Home Office's refusals and delays in publishing the outcomes. Medical Justice's analysis led it to conclude that the Rules 34 and 35(3) procedures were not fit for purpose.

***Mental Health in Immigration Detention (2013)***

36. This report identified mental illness as the most significant issue for people in immigration detention. Those detained had high levels of such illnesses with safeguards designed to prevent their detention proving to be ineffective. Detention caused exacerbation of mental disorders, sometimes to a degree requiring compulsory hospital treatment. The report found particular harm caused to people with trauma-related mental illness such as PTSD and that the

[31] HMIP, "*Report of an announced inspection of Harmondsworth Immigration Removal Centre (11-15 January 2010)*", 26 May 2010, H3.23, pg.13.
[32] HMIP, "*Report on an announced inspection of Tinsley House Immigration Removal Centre (7-11 February 2011),* 26 July 2011, §5.3.

current arrangements were not in keeping with modern clinical practice which required the use of the least restrictive treatment options. There were inadequacies in healthcare offered to people with a mental illness, compounded by insufficient training, unsatisfactory record systems and poor access to specialist referrals. The effect of the detention on those with a significant mental illness was also recognised as impacting on other people in detention exposed to behaviour and distress caused by such illness.

37. Medical Justice identified problems with IRC healthcare staff failing to identify and diagnose mental disorders, and staff having potentially dual loyalties. Medical Justice was also in receipt of documents from the Home Office characterising symptoms of illness as 'manipulative.' Treatment options were limited and there was an overreliance on psychoactive medication. Overall, diagnosis and treatment in detention were assessed as substandard.

38. At the time this report was published in 2013, it was evident that Rule 35 DCRs was not operating as an effective safeguard for those with mental illness, assessments were often not initiated by IRC doctors (under any of the three limbs of Rule 35), and even when completed, did not secure the individual's release as clinical judgment was overruled by Home Office caseworkers.

***Healthwatch and Immigration Removal Centres: Asylum Seekers in Detention Centres (2014)***

39. This report identified the conflict in IRC healthcare between a duty of care towards people in detention and the Home Office's imperative to enforce removal. The report documented examples of poor-quality primary care, inadequate clinical information systems in detention and that people in detention often complain of a culture of disbelief. Poor emergency care was recorded and again deficiencies in the care of people with a mental illness, which also applied to those lacking capacity, and the absence of independent advocacy in detention. Use of force was also raised in the report concerning the regular use of handcuffs at external medical appointments and a lack of examination and recording of the physical effect of the use of force.

***Death in Immigration Detention 2000 - 2015 (2016)***

40. This report was compiled in an effort to provide a systematic analysis of deaths in immigration detention because of a lack of published and accurate information from the Home Office. It documented 35 deaths during a 15-year period between 2000 and 2015. The analysis was based on publicly available information such as Prison and Probation Ombudsman reports, inquest findings and other less formal sources of information such as media reports and data

from families and people in detention. What I believe is significant for the Inquiry is that this report identified failures in health screening, in Rule 34 examinations and the Rule 35 process, the use of restraints on dying detained persons, poor notification practices, systemic failures in healthcare provision, the detention of individuals unfit to be detained (p. 32), and shortcomings in emergency responses as factors contributing to the deaths.

41. I have read the witness statement of Deborah Coles on behalf of INQUEST[33] and agree that the overall numbers of deaths in immigration detention are alarming. I believe that it is of significance for the Inquiry that inquest juries have made findings of the same recurring systemic failures contributing to these tragic deaths. In 2017, the year the Panorama programme was broadcast, there were a total of 11 deaths in IRCs and prisons of people subject to immigration detention.

**(6) Medical Justice's Contribution to Inquiries and Reviews**

42. In addition to publishing our own reports and research, Medical Justice has regularly shared the results of its monitoring, investigations and reports through the submission of detailed evidence to Government-led and independent inquiries and reviews. Medical Justice's evidence has, over time, sought to highlight how the same problems in the detention and treatment of clinically vulnerable people are recurring contrary to long-standing Home Office policy and without any effective remedial action, and how routine detention of vulnerable people for prolonged periods has consequential and lasting adverse impacts on their mental and physical health. Key investigations we have contributed to before 2017 included:

a. Report To the United Kingdom Border Agency on "Outsourcing Abuse" by Baroness Nuala O'Loan DBE (March 2010);
b. Joint Committee on Human Rights call for evidence on human rights judgments (2013);
c. Home Office's Consultation: Immigration Detention of Persons with Mental Health Problems (2014);
d. Tavistock Institute's Review of Mental Health Issues in Immigration Removal Centres (2015);
e. APPG Refugees and APPG Migration Joint Inquiry Report into the Use of Immigration Detention in the UK (2015);

[33] INQ000037.

f. Independent investigation into concerns about Yarl's Wood immigration removal centre, Kate Lampard (2016);

g. Stephen Shaw's Review into the Welfare in Detention of Wulnerable Persons (2016);

h. Universal Periodic Review Shadow Civil Society Report initiated by the British Institute of Human Rights (2016);

i. Joint Committee on Human Rights Inquiry into Mental Health and Deaths in Prison (Feb 2017)

43. This material has contributed to the sustained critical findings by these numerous investigations and reviews, in particular Stephen Shaw's 2016 review into the welfare of vulnerable people in immigration detention ("Shaw 1").[34] Mr. Shaw's review confirmed the systemic problems identified by Medical Justice and many other bodies and NGOs in the sector and relied upon them to make 62 recommendations. His findings and those arising from the Tavistock review and the APPG Joint Inquiry into Immigration Detention are summarised in Ms. Schleicher's first witness statement ("TS1") at §§96-106 and 114-122.

44. This review of past material critical of the Home Office's detention policies and practices is highly relevant context which shows that, by the time of the Panorama programme, there was already a well-established body of findings and cogent evidence recording Home Office recurring non-compliance with its own detention policies and safeguarding for vulnerable people in detention, going as far back as 2005 (and no doubt earlier), and criticising the absence of real change in practice being effected to prevent a repeat of mistreatment, abuse and neglect in immigration detention.

45. I believe that this reflects one of the key experiences of Medical Justice over the years, operating prior to 2017 (and which continues), that there is, within the Home Office, an ingrained attitude and culture that makes it resistant to really listen, to accept its failings, to take on board recommendations for change, and importantly, to make the necessary changes required or the commitment to make any changes effective and durable. In our experience, the Home Office has proved unwilling to put the rights and welfare of individuals subject to immigration control above its enforcement priorities of removal and administrative convenience. It very much feels like the Home Office sees itself in some kind of war of attrition so that even if concessions are forced to be made following, for example, a court

[34]Shaw. S (January 2016) Review into the Welfare in Detention of Vulnerable Persons (a report to the Home Office).

ruling or the Shaw report and a step forward appears to have been achieved, it will be followed by two steps backwards in new policy or practice. Even where policy changes in principle are an advancement, the practices of the Home Office and its contractors on the ground frequently do not change or quickly regress. It is difficult to know exactly why this is the case, but based on our experiences, it appears to be a combination of political pressures dictating removal as the overriding priority, a case-hardened institutional culture and ultimately, I regret to say, at times a callous or at least reckless indifference to the experience of people in detention and the harmful effects of detention. I have long ago come to the conclusion that institutionally, the Home Office simply does not care, or does not care enough, about the welfare of people in detention to make it a priority and to act to ensure the effective protection of their rights.

46. I would identify the Home Office responses to the first Shaw review as the best recent example of this in two important ways:

    a. First, in seeking to actually reduce the protection for vulnerable detained persons by narrowing the definition of torture for the purpose of Rule 35 despite the Court having previously rejected this approach as unlawful and contrary to the clinical evidence in the case of *EO*[35] and in doing so, weakening the protection against harm in detention for torture victims under the Adults at Risk ("AAR") Policy.

    b. Second, and again whilst purporting to have accepted the need to improve protections for vulnerable detained people, the AAR policy was formulated in such a way that it, in fact, significantly weakened them, by no longer treating a Rule 35(3) report as sufficient to secure release, introducing additional requirements for professional evidence of harm caused by detention to attract the strongest presumption against detention and even then, recasting the balance in favour of "immigration factors" by removing the threshold of *"very exceptional circumstances"*.

47. These problems were evident in the early drafts of the AAR statutory guidance, and despite Medical Justice (and others) raising concerns that, formulated in this way, it would lead more vulnerable people being detained for longer and *"does not provide the safeguards needed to avoid future Article 3 breaches"*[36] the Home Office went ahead and implemented these regressive changes anyway.

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[35] *EO & Ors, R (on the application of) v Secretary of State for the Home Department* [2013] EWHC 1236 (Admin).
[36] *Putting Adults at Risk*, pg.7.

48. I would also say that this disposition has been reflected in some of our direct communications with the Home Office through formal consultations and participation in stakeholder forums.

## (7) Medical Justice's direct engagement with the Home Office

### (i) Consultation

49. Our experience of consultations with the Home Office is that this is very much a formalistic process with a real sense of just going through the motions. Often, we are given very little notice of the consultation and a truncated timetable is imposed for our representations on complex and lengthy documents. Our representations and evidence are frequently treated dismissively and disregarded.

50. The consultation process is also not inclusive or transparent. There have been a number of instances of expert organisations that were initially excluded from consultations by the Home Office and documents circulated under embargo so we cannot seek input from the excluded expert organisations such as the EHRC, BMA and Royal Colleges.

51. Routinely, it is our experience that the Home Office fails to engage stakeholders in discussions on policy changes until the very last minute, when it is apparent that the policy had clearly been months in the making. The Home Office is reluctant to share the evidential basis (if there is one) for their proposed changes, which makes it hard sometimes to understand the rationale for the proposed changes.

52. We have often found face to face meetings called by the Home Office, purportedly to engage and have a discussion with stakeholders, to be antagonistic rather than constructive. These are generally not conducted with an open mind and the officials appear to be largely closed to our concerns. They have tended to be dismissive of the gravity and urgency of the situation. These face to face meetings also feel like an attempt on the Home Office's part to go through the motions and show that they have met with stakeholders, even if the meetings feel like they proceed on the basis that the implementation of the policy, as proposed by the Home Office, was already a foregone conclusion.

53. Good examples of this are the (i) extensive and repeated (and largely pointless) consultations on Rules 34 and 35 processes, which have taken place from time to time over the years (as described by Ms. Schleicher in TS1) and (ii) the draft documents that became the Adults at Risk policies in 2016. As explained by Ms. Schleicher, Medical Justice made detailed

representations raising their concerns about how the AAR draft policies did not reflect the Government's public commitment (in response to Shaw 1) to enhance and strengthen safeguards for preventing vulnerable detained persons from suffering harm in detention, and appeared to dilute the existing safeguards. This was most starkly illustrated by the Home Office's proposed reversion to a narrow definition of torture, which as discussed above and in Ms. Schleicher's first witness statement, had already been struck down by the court in the *EO* judgment. It took Medical Justice bringing litigation by way of judicial review to strike down the narrow definition again. The Judge, in allowing our challenge in R (*Medical Justice) v SSHD* [2017] EWHC 2461 (Admin), noted this about the grounds upon which he ruled the policy unlawful: *"Medical Justice made much the same points as it did in these proceedings during the consultation"* but these concerns were disregarded by the Home Office, as they had been on the Rule 34 and 35 processes for many years.

54. This approach of the Home Office's consultations has not changed, and the most recent rounds of consultation on the AAR policy and other proposed reform to detention safeguards related to incapacitated adults have been conducted in much the same manner, as explained by Ms. Schleicher in TS1 at §§177-201.

**(ii) <u>No Evidence Base for Policy</u>**

55. One of the major drawbacks and frustrations with this approach is that the Home Office fails to engage and develop policies based on evidence including established clinical research and literature. Professor Cornelius Katona has explained in detail in his statement why the policies and practices adopted do not take into account or are at odds with the clinical evidence and consensus contained in Position Statements of the Royal Colleges and reports issued by the BMA.

56. One stark example was the adoption in August 2010 of the notion that detained persons' mental illness could be satisfactorily managed in detention, therefore permitting the detention of this category of extremely unwell detained person. This policy approach was retained until the AAR policy was introduced in 2016, further to criticisms made by Stephen Shaw (at §§4.35-4.36, Shaw 1) that "satisfactory management" of mental illness was an ill-defined and meaningless phrase with no foundation in clinical practice. Moreover, it had no regard to the clinical research that showed that people with pre-existing mental illness were predisposed to

being damaged by detention itself.[37] However, it is our experience that even though the actual phrase "satisfactory management" has been removed from the AAR policy, in practice, it is still being relied upon in practice in responses to Rule 35 reports, and in the overall approach of the AAR policy. This is clear from the requirement to show predictable likelihood of being harmed by detention, despite already demonstrating and being accepted to have mental ill health, a history of torture or other forms of severe ill-treatment.

57. Another example was the definition of torture introduced with the AAR policy and the distinction between state and non-state torture as relevant to the risk of harm in detention. As stated above and explained in detail in Ms. Schleicher's TS1 (§§62-66, 134-137), the Court found in both *EO* and *Medical Justice* that this distinction lacked any evidential basis and was contrary to the established medical evidence.

58. Similarly, there have been criticisms by the ICIBI[38] about the external MLR standards that were introduced in May 2021 (explained at §§186-196 of Ms Schleicher's TS1). The ICIBI queried what evidence these standards have been based upon, as they do not bear any correlation to accepted international standards and clinical practice such as the Istanbul Protocol.[39]

59. This cavalier approach to the formulation of policy is also reflected in the Home Office's attitude to its important public sector equality duty, now under the s 149 of the Equality Act 2010. This duty is intended to be integral to policy making to ensure that the needs of protected groups such as those with a disability arising from mental or physical illness are considered and any discriminatory impact of the policy proposal is identified and assessed. But the duty is repeatedly disregarded by the Home Office. The Home Office, for example, was found to have failed to comply with this duty in 2010 in respect of the satisfactory management caveat in detention policy (*R (HA (Nigeria) v SSHD* [2012] EWHC 979 (Admin))[40] and this was not remedied for a number of years. The Court also found that the approach taken to the discharge of the public sector equality duty to be flawed in *Medical Justice* because of the substantive flaws in the adoption of a narrow torture definition in the AAR policy. A further example relevant to Brook House was when the Home Office breached the public sector equality duty when it agreed with G4S to increase capacity by

[37] See Professor Bosworth's literature review annexed to Shaw 1. See also the Royal College of Psychiatrists' three position statements annexed to the witness statement of Professor Katona.
[38] ICIBI, Second annual inspection of 'Adults at risk in immigration detention: July 2020 – March 2021 (October 2021).
[39] Ibid at §3.11.
[40] See further §§76-79 of TS1.

adding 60 three-man rooms (*R (Hussein and Rahman) v Secretary of State for the Home Department* [2018] EWHC 213 (Admin)).

**(iii) Stakeholder Meetings**

60. Over the years Medical Justice has also been involved in stakeholder forums convened by the Home Office, including between 2008 and 2013 the Detention User Group's (DUG) medical sub-group. This was convened by Simon Barrett and also attended by Phil Schoenenberger. Here, again, many of the concerns raised were batted off or simply ignored. Their attitude at times was even dismissive. When we asked at various meetings for Home Office statistics, we were told they were not collated. There appeared to be no real interest in monitoring what was happening in IRCs even in respect of self-harm and deaths. It was said that the British public didn't want Home Office officials spending their time collating statistics and this was treated as a sufficient rebuff to our concerns.

61. Even where our concerns could not be dismissed, it did not lead to any action. As long ago as 2010, Simon Barrett accepted at a DUG meeting (12 January 2010), that there was a "*disconnect*" between the people filling in the Rule 35 forms (i.e., the medical professionals) and those assessing whether this would lead to a decision to release (i.e. the UKBA officials with responsibility for decisions to detain). This "*disconnect*" meant that the numbers released from detention as a result of a Rule 35 report was relatively small. Simon Barrett undertook to take up the "*disconnect*" with colleagues to try and get a common understanding on Rule 35. This was also recorded in the minutes on 25 January 2010: "*There is also agreement now by UKBA that there is a disconnection between the purpose doctors have in mind when completing rule 35 reports and the way they are then used by caseworkers when considering whether to maintain detention…*".

62. Nothing ever really came of this. The Inquiry will be aware, from the general statistics, confirmed by our analysis of the Brook House cases studies, that it is has been a persistent trend that low numbers of people are released from detention as a result of a Rule 35 report.[41] The same fundamental *disconnect* has continued ever since. It was documented in Stephen Shaw's first review in evidence from the BMA at §§4.113-4.116 and in his conclusion that "*put bluntly…the Home Office does not trust the mechanisms it has created to support its own policy*" (§4.118).

[41] See §§144-154 of Ms. Schleicher's first witness statement.

63. In November 2011, two of the Article 3 cases S and BA were raised by both Medical Justice and BID with Simon Barratt. It was stressed how critical the Court had been of the Home Office and its contractors and that the findings were very serious. Mr Barratt and other senior officials present said they had no knowledge of the cases. It was noted as an action point for "*Simon Barratt to check the details of the Article 3 European Convention on Human and to confirm how lessons learned from such cases are disseminated to UKBA staff*". At the following meeting on 15 January 2012, Mr Barratt stated that he had not had time to read the judgments and did not know whether any lessons needed learning. It was again noted as an action point. There was no follow up on this.

64. The DUG group was disbanded in 2013 and subsumed into the National Asylum Stakeholder Forum's ("NASF") detention sub-group which is co-chaired by the Home Office and an NGO, currently Detention Action. It meets once a quarter. It is a frustrating experience. When we highlight the terrible harm being done to some individuals to the Home Office officials in attendance, they show little outward concern or humanity. Instead, they are defensive and certainly do not show an inclination to follow up and investigate the concerns for themselves. We were told in one NASF meeting that the Home Office cannot consider our representations and the evidence of *"such generality"* on one issue but at the same time said they could not consider our evidence on a related issue because it was of *"such granularity"*. Ultimately, our experience has been and continues to be that there is very little connection between the NASF and the reality of Home Office policy implementation and practice. I would say these meetings operate in a kind of parallel universe to the realities that individuals who contact Medical Justice from detention experience.

65. In both contexts of consultation and stakeholder forums we have been met with what I can only describe as institutional inertia on part of Home Office to engage with our concerns, backed by case examples, of problems with the key safeguards in detention policy and rules, the provision of adequate clinical care, and the link between these practices and overall deterioration and mismanagement of the mental health of vulnerable people in detention. On these topics, I do not believe there has been a will to hear or address the concerns and take seriously the information being provided to them. At best, what we have experienced has been lip service and at worst cynical disinterest. In light of what was exposed by the Panorama undercover reporting at Brook House about the grave mistreatment of obviously mentally ill and vulnerable detained persons who, if the safeguards had worked, should

probably not have been in detention at all, these attempts at constructive engagement seem now like something of a charade.

**(iv) Strategic Litigation**

66. The Home Office resistance to constructive engagement at a policy level, to receiving and acting upon evidence of problems in the arrangements and operation of detention policies and practice and taking effective remedial action has led Medical Justice to pursue legal challenges to these Home Office policies and practices in the courts as a last resort. We have done so by bringing proceedings for judicial review in our own name, or by assisting the Court as an Intervener or providing witness evidence. The claims that we have brought or contributed to have concerned the following recurring themes:

a. Unlawful removal policy which denied detained people effective access to justice in challenging removal[42];

b. Failure to ensure compliance with Rules 34 and 35 DCRs and the correct interpretation of torture for the purposes of Rule 35[43];

c. Failure to lawfully and properly apply detention policy in respect of those with serious mental illness;[44]

d. Detention and conditions of detention which subjected individuals to ill-treatment in breach of Article 3 ECHR [45];

e. Absence of safeguards to facilitate identification of mental incapacity and facilitate detained people to participate in decisions concerning detention and segregation[46].

**(8) Home Office Response to Legal Action**

67. I believe that aspects of the Home Office response to litigation give some further insight when trying to understand why these problems have remained so intractable. Our experience is that, despite successful court rulings on these issues, the Home Office often appears to never really accept the outcomes and has sought to reargue their position at a later date, e.g. the definition of torture under the DCRs and the AAR Policy (*EO* and then *Medical Justice*) and the removal window policy (our litigation in 2010 and then 2019), or to not remedy the

[42] *R (Medical Justice) v SSHD* [2010] EWHC 1925 (Admin) (26 July 2010) and *R (FB* (Afghanistan)) v SSHD; *R (Medical Justice) v SSHD* [2020] EWCA Civ 1338.
[43] *EO* and *Medical Justice* [2017] EWHC 2461 (Admin).
[44] *O v SSHD* [2016] UKSC 19 and *R (Das) v SSHD* [2014] EWCA Civ 45
[45] *R (S) v SSHD* [2011] EWHC 2120 (Admin), *R (BA) v SSHD* [2011] EWHC 2748 (Admin), *R (HA) v SSHD* [2012] EWHC 979(Admin), *R (MD) v SSHD* [2014] EWHC 2249 (Admin).
[46] *VC v SSHD* [2018] EWCA Civ 57and *R (ASK) v SSHD* [2019] EWCA Civ 1239.

deficits identified by the courts in earlier cases requiring repeated further litigation e.g. regarding Rules 34/35, Article 3 ill-treatment (7 cases relating to detention between 2010 and 2016) and mental capacity, namely *VC* in 2018 (one of the 7 cases in which an Article 3 ECHR finding was made) and *ASK* in 2019.

68. In our view, based on our experience, this reflects the absence of a culture of responsibility, accountability and lesson learning within the Home Office for unlawful policies, practice or decisions even where there have been such serious consequences of mentally ill people being subject to treatment in breach of Article 3 ECHR.[47] In the case of BA[48] for example, the Director of Criminality and Detention at UKBA, Mr David Wood, on two occasions refused to release BA when his condition had deteriorated to such a point that the Court concluded detention was subjecting him to inhuman or degrading treatment and he was on the verge of death. Mr Schoenenberger, then Deputy Director of UKBA stated in an email, in words that the Judge described as "chilling": "*we will discuss the RRT as there will be significant press interest if he does subsequently pass away. We have made sure that healthcare are keeping good and accurate details of his care and this record will be available to the PPO should he die*". Mr Schoenenberger authorised the transfer of HA[49] from Brook House to Harmondsworth immediately before a HMIP inspection and into segregation. This was an aspect of the treatment found to be degrading by the Court.

69. Senior civil servants responsible for detention policy and policy implementation have remained in post over many years. This includes officials such as Hugh Ind[50] Ian Cheeseman, Phil Schoenenberger[51] and Simon Barrett[52]. As far as we are aware, adverse court rulings do not lead to real consequences at a senior level within the Home Office for significant policy failures.

**(i) <u>Accountability of Senior Officials</u>**

70. Mr Cheeseman, for example, was responsible for the Home Office response to the Shaw reviews and the formulation of the Adults at Risk policy including the unlawful definition of torture. The implementation of that torture definition led to a significant number of highly

[47] See the list of cases reviewed by Jeremy Johnson QC and summarised in Professor Katona's witness statement.
[48] *R(BA) v Secretary of State for the Home Department* [2011] EWHC 2748.
[49] *R(HA) v Secretary of State for the Home Department* [2012] EWHC 979 (Admin).
[50] Senior Director for Returns and Detention Operations (2013-2016) promoted to Director General, Immigration Enforcement (2016-2018).
[51] Mr Shoenenberger was Head of DEPMU in 2008 and an Assistant Director of Detention Services until approximately 2018.
[52] Assistant Director Detention Service Policy Unit.

vulnerable people being wrongly detained and not being able to access the Rule 35 safeguard, until the High Court suspended the definition on an interim basis pending our challenge. The Court criticised that policy for redrawing the policy in favour of immigration factors over welfare of vulnerable detained people. Despite findings as to failings in the AAR policy by Mr Shaw and the ICIBI, urgent steps have not yet been taken to remedy it despite numerous strong and repeated recommendations to do so.

71. Another stark example is the DFT policy operated at Oakington IRC and referred to above in connection with Mr. Shaw's investigation and resultant finding of a sub-culture of abuse and racism. Since then, the DFT's operation had been subject to repeated litigation for more than a decade until it was eventually found to have been operating unlawfully as systemically unfair and unjust by the Courts.[53] It was only after further litigation in 2015[54] that the process was finally suspended because of an unacceptable risk of unfairness to vulnerable people in detention.

72. The DFT's lawful and fair operation depended upon effective health screening on entry and identification, through the Rule 34/35 process, of those unsuitable to be detained in the DFT due to vulnerability such as a history of torture or trafficking or mental illness. Despite those safeguards being described in evidence by a senior civil servant, Mr Ian Martin, then the deputy director of the Immigration and Nationality Directorate, as of "*paramount*"[55] importance, it transpired from early on when the rules were first implemented in 2001, that the Home Office and its contractor GSL had not in fact even contracted and provided funding for the Rule 34/35 examination to take place.[56] The Court in *D and K* (2006) consequently found "*a persistent and sustained failure*" to comply with the Rules between 2001 and December 2005. Yet even in the face of this finding, the situation continued to operate in this hugely problematic way with the acquiescence of the Contract Compliance Manager, in spite of concerns raised by the HMIP, the Independent Monitoring Board ("IMB") and Refugee Council. Furthermore, as a result of Mr Martin informing the healthcare provider that doctors were not to express any opinion on the account of torture, the Rule 35(3) process operated unlawfully in a manner that fundamentally defeated its purpose.

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[53] *Saadi v SSHD* [2002] 1 WLR 3131, *Saadi v UK* (2008) EHRR 17, *R (Refugee Legal Centre) v SSHD* [2004] EWHC 684 (Admin); *JB (Jamaica) v SSHD* [2013] EWCA Civ 666; *R (Detention Action) v SSHD* [2014] EWHC 2245 (Admin).
[54] *R (JM and Ors) v SSHD* [2015] EWHC 2331 (Admin).
[55] *Saadi* at [§15] and [§18]; *D and K v SSHD* [2006] EWHC 980 at [§42].
[56] *D and K* at [§§65-69] and [§71].

73. The highly critical findings in *D and K* did not lead to change throughout and up until the suspension of the DFT in 2015. The Rules 34 / 35 process is still beset with the persistent defects in its operation and practice, despite it being central to the effectiveness or otherwise of the AAR policy. A failure to hold any official to account for such serious sustained breaches of legal obligations must at least play a part in the fact that they have continued to endure for so long and in the face of widespread and repeated objection. It is also of importance for the future because the Government is seeking to introduce a detained fast-track process through the current Nationality and Borders Bill at a time when the failures in screening and Rule 34/35 remain very much present and challenging. If these persistent defects are left as they are and the DFT is reintroduced, this is very likely to see even higher levels of vulnerable people including mentally ill people in detention than in Brook House in 2017, with the added intense pressure of a compressed fast-track detention and removal procedure. This makes it even more critical for the Inquiry's recommendation on the Rule 34/35 processes to identify the change that can end this systems failure and address an important factor in the conditions that contributed to the desensitisation, toxic culture and abuse in Brook House by significantly reducing the numbers of people with serious and complex needs in detention.

**(ii) <u>Individual Decision-Makers</u>**

74. Similarly, we are not aware of what, if any, consequences there have been for individual decision-makers when their decisions to detain or maintain detention have been found by the Court or even accepted by the Home Office to have been unlawful. There had been a significant number of such unlawful detention cases before 2017 (and since). But we do not know whether and what systems operate within the Home Office to ensure that the findings of the court, or concessions made by the Home Office, are fed back to individual decision-makers and their line managers and action taken to address such individuals' responsibility and accountability, including through disciplinary action. We also do not know what steps are taken to ensure there is individual and corporate learning to ensure such errors are not repeated if a common issue is identified. The latter is important as a part of any effective oversight or monitoring to prevent the unlawful exercise of detention and removal powers. The repeated individual challenges to unlawful detention strongly suggest that caseworkers, their managers and senior officials do not have any real knowledge and understanding of when and why individual decisions are held to be unlawful or conceded to be so. Even when the Home Office concedes cases in the course of litigation, they seldom provide any clear

indication of acknowledgment of what actually went wrong. The Joint Committee on Human Rights in its 2019 Investigation expressed concern about the use of confidentiality orders on settlement in detention related cases because it undermines responsibility and accountability.

**(iii) Contractors**

75. Not only does it appear that there are no real consequences for Home Office officials, there also appears to have been no contractual consequences for G4S including for grave failures amounting to Article 3 ill-treatment.

76. Reverend Nathan Ward, a G4S Director for the Gatwick IRCs, has explained in his evidence to this Inquiry that, until the first Shaw review in 2016, he was not aware of any of the cases in which the court had found a breach of Article 3 ECHR even though two of those five cases, *HA (Nigeria)*[57] and *D*[58] concerned detention at Brook House IRC. The latter occurred when he was in post. He says at §223 of his first witness statement that "*there was no communication whatsoever from senior Managers in G4S or the Home Office about what had happened in these two cases and no review or follow up with the IRC staff that he was made aware of*".[59] Both were cases of severe untreated mental disorder, a complete failure to provide medical treatment, and a misuse of the powers to segregate. In *HA* the use of force was authorised on several occasions. Reverend Ward has also stated that despite the seriousness of these findings "*there was no follow up with Brook House managers or health care staff*" during his time at Gatwick IRCs[60]. They were not informed about the serious failings in the clinical care these two men received at Brook House nor that removal from association and use of force on a person with a mental disorder could contribute to inhuman or degrading treatment in breach of Article 3 ECHR. In a similar vein, it does not appear that any action was taken in respect of anyone responsible for the decisions, acts or omissions that led to such serious mistreatment of these two men at any level. This is despite senior officials such as Mr Schoenenberger and Mr Barrett being aware and involved in decisions concerning *HA*. Certainly, no lesson-learning appears to have taken place despite the obligations under Article 3 ECHR to do so in these or subsequent cases.

77. I note from the evidence provided by INQUEST[61] that even in the context of a death, the findings of an internal investigation (which was itself inadequate) had not been fed back to

[57] *R (HA Nigeria) v SSHD* [2012] EWHC 979.
[58] *R (D) v SSHD* [2012] EWHC 2501.
[59] DL0000141.
[60] Ibid at §225.
[61] INQ000037.

those involved in the death and staff continued to consider the action taken was appropriate. For example, Marcin Gwozdzinski had taken his own life on the 6 September 2017 following inadequate ACDT monitoring and a premature decision to close ACDT monitoring. Significantly, the jury identified "systemic failings" contributed to his death when it gave its verdict on 12 June 2019.

78. That the same or similar systemic problems have been in place for many years is confirmed by the findings in the inquest into the death of Prince Fosu in 2012. That inquest jury found in 2020 that gross neglect had contributed to his death, by the failings and omissions of detention staff and doctors contracted by the Home Office to recognise he was mentally ill, to follow immigration detention policies and properly document and monitor his wellbeing. The scale of the collapse of safeguards was found to have happened at every turn within the IRC and the Home Office and even the Independent Monitoring Board acknowledged that Prince Fosu died "*in plain sight.*"

79. These recurring revelations of serious failings in safeguards to prevent ill-treatment and tragedies have ultimately led me to conclude that whatever steps are taken to draw these serious failings to the attention of the Home Office, through whatever means, they have not taken effective remedial action because they have no will to do so. The safeguards do not work because the Home Office has no real interest in them working. The Home Office has singularly failed to provide any effective oversight and regulation of its contractors at IRC's including most obviously at Brook House. Panorama confirmed our worst fears of just how dangerous this attitude and practice of resistance and indifference to the treatment and welfare of people in detention is. Allowing repeated breaches of the fundamental rights of people in detention to go unaccounted for and largely unpunished in our view is a significant contributor to facilitating the conditions for mistreatment and abuse of vulnerable people in detention for many years and with apparent impunity.

80. Whilst this is our experience across IRCs, Brook House does have a particular role in Home Office enforcement because of its use regarding charter flight removals and in holding a larger proportion of people with criminal convictions where the pressure for enforcing removals is at its most intense and most likely to be at the cost of the rights and welfare of people in detention as the recent IMB Report for 2021 has confirmed.

## (9) Relationship between the Home Office and G4S

81. It is our experience that the very nature of the contracting out arrangements has contributed to the lack of accountability and the culture of impunity that has facilitated conditions for abuse and mistreatment.

82. **First,** there is no transparency and therefore no scrutiny of the tendering process and contractual arrangements and whether they can deliver on the safeguards for the rights and welfare of people in detention. It was only because of legal proceedings in 2020, that it became publicly known that when senior Home Office officials agreed a contract for Brook House with GSL in 2009 (which was taken over by G4S), the Home Office had significant concerns over the GSL bid including the following: *"An ethos of cutting corners and meeting basic standards was evident from much of what we read and we are especially disappointed at the extended lock down hours proposed by these four of bidders. This appears to be a desperate attempt to reduce cost at the expense of welfare."*[62] The staffing levels overnight were deemed to "*border on the unsafe*"[63]. This proved correct with the first HMIP report about Brook House, after this contract in 2010 was agreed, stating it was "*disturbed to find one of the least safe immigration detention facilities we have inspected....At the time of the inspection, Brook House was an unsafe place*"[64]. It is notable that the HMIP identified most of the same factors that the Home Office had predicted would be a problem and indeed have beset Brook House, thereafter.

83. **Second,** the National Audit Office had found the contract "*not fit for purpose*"[65]. It reflected the Home Office's own priorities on security and removal not the safeguards and rights of people detained and was a wholly inadequate means of monitoring and penalising abuse and mistreatment of detained people. It was operated to incentivise removals and cost saving again at the expense of welfare. The introduction of 3-man rooms in 2016 is a good example of this practice.

84. **Third**, and most importantly, the contracting out arrangements have allowed and are exploited by the Home Office to seek to absolve themselves of responsibility for serious failings, in particular in respect of the Rule 34/35 safeguards, deterioration in mental illness, inadequate medical treatment and mistreatment of detained people. A general practice

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[62] First witness statement of Reverend Ward [§87]: DL0000141_0029.
[63] Ibid.
[64] HMIP, *Full announced inspection of Brook House Immigration Removal Centre (15-19 March 2010)* (12 July 2010), Introduction; see also e.g. §2.7, §2.20, §2.27, §2.30, §6.5 and §6.29.
[65] See National Audit Office, *The Home Office's management of its contract with G4S to run Brook House Immigration Removal Centre,* July 2019, at §27.

adopted by the Home Office is to deny knowledge and/or responsibility and to seek to pass the buck to the contractor, even individual doctors or other public authorities. We have seen this position repeatedly taken in respect of cases concerning Article 3 ECHR breaches where the Home Office denies responsibility, for example, for failure to promptly transfer several mentally ill people to psychiatric hospital[66] or for making arrangements for those who lack mental capacity.[67] Whilst this approach has been roundly rejected by the Courts[68], in our experience, it remains the Home Office's approach to utilise the contractual arrangements to resist accountability and action being taken by them to remedy the failings. We have seen little sign of the Home Office recognising and accepting it has primary responsibility for ensuring that the detention system put in place protects the fundamental rights of vulnerable people in detention, and that it has important duties to set high standards for conduct and respect, to robustly oversee, monitor and regulate what happens in IRCs. We have seen little, if any understanding, that claiming lack of knowledge of abuse and mistreatment, even if true, is itself an admission of a gross failure and it is not good enough to try to seek to hide behind delegation of functions to contractors.[69]

85. In light of this experience, I was not surprised to see that Mr Phillip Riley, the current Director of Detention and Escorting Service, has adopted essentially this position in his witness statement to the Inquiry[70]. Whist acknowledging some possible failures in the contractual arrangements and "*shortcomings of oversight and assurance*", his primary focus is upon individual officers and G4S responsibility for its own staff. Mr Riley does not appear to recognise that shortcomings in Home Office oversight and monitoring do make it

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[66] *HA* at [§181]: "*The Defendant submitted that it was not her responsibility but that of other authorities. It was submitted on her behalf that the Claimant was seeking to mount what was in essence a clinical negligence action against those who had responsibility for his care and treatment. In my judgement, that is not the right way to look at it. The Claimant has not sought to mount a negligence action but submits that, in all the circumstances of his case, the combination of acts and omissions of those for whom the Defendant is in law responsible crossed the threshold of ill-treatment required by Article 3. I agree that there was a breach of Article 3 in this case: the Claimant suffered degrading treatment within the meaning of that provision".* See also at [§155].

[67] *VC* at [§144]:"*On behalf of the Secretary of State, Ms Anderson submitted that the court should dismiss the appellant's appeal on the Equality Act ground because this is a "dynamic area in which many public bodies and NGOs are involved so it is inapt to seek to draw the court into an impossible general evaluation of all matters relevant to the equality position in the absence of the principal responsible bodies". I reject this argument. As the body exercising the public function of detention it is for the Secretary of State to ensure compliance with the Equality Act in the exercise of that function. If the Secretary of State has breached that duty she cannot expect the court to decline to declare a breach because the context is complex or dynamic. Such an approach would risk exempting a significant proportion of government activity from the requirements of the Equality Act."* See also at [§137].

[68] *R (Das) v SSHD* [2014] EWCA Civ 45 at [§70]: "*The Secretary of State is not entitled to abdicate her statutory and public law responsibilities to the relevant health authorities or clinicians in the way deprecated by Singh J in R (HA (Nigeria)) v Secretary of State for the Home Department [2012] EWHC 979 (Admin) at [155] and [181]".*

[69] *S* at [§221]: "*Therefore, even had I found that the Defendant had made good her suggestions of failures by contractors, legal responsibility for compliance with Article 3 rests with her as the responsible minister".*

[70] HOM0332005 -see in particular §§4-9, §§15-18, §20, §22, §29, §§32-35.

responsible for the operating at Brook House. He fails to offer any explanation for how and why Home Office staff on-site were or could be "*oblivious*" to the practices and culture operating in Brook House IRC in which such appalling mistreatment could occur.

86. Furthermore, Mr Riley offers no explanation for why the Home Office agreed contractual arrangements that failed to protect the rights and welfare of detained people, and instead exposed them to an unsafe environment and mistreatment. Whilst he is unable to offer explanation for the behaviour of G4S staff "*in Panorama*", he denies that it reflects any broader treatment of people detained under immigration powers at time despite previous abuse scandals in other IRCs. He does not even address the possibility of institutional or cultural issues. There is no mention of racism or the dehumanisation, bullying and the profound disrespect that is recorded on Panorama. Nor that this context may have contributed to the physical mistreatment that occurred.

87. Also, like previous officials with whom we have liaised over the years, Mr Riley seeks to offload the Home Office's oversight and governance responsibility to the monitoring bodies like the HMIP and IMB and without acknowledging the limitations of their roles as exposed by Panorama. He also makes no reference to the Home Office's frequent failure to act on their reports and recommendations for many years at Brook House including in respect of the disproportionate impact of a lock in regime, lack of privacy, poor and dirty conditions of the cells. Even when the IMB reported on a dramatic increase in the use of force in 2017, no action was taken by the Home Office. Mr Riley continues in the same vein as many other Home Office officials over the years, and seeks to dispute and deny the overwhelming evidence of systemic failure in the operation of Rule 34/35 (§§53-54) and the serious inadequacies in the AAR policy at the time and since (§52). Reading this statement further explains the Home Office's ineffectual response to Panorama to date. I address this in more detail below.

**(10) Detention Policy -Adults at Risk**

88. Since the Panorama broadcast in September 2017, we have continued to provide the following further reports focusing on the continued failings of the AAR Policy:

    a. *Putting Adults at Risk* (2018).
    b. *Failure to protect from the harm of immigration detention* (2019).
    c. *Solitary Confinement & Immigration Detention* (2021).

89. As we had anticipated in the consultation on the AAR Policy in 2016, the evidence from practice and our caseload was that the AAR policy was having the opposite effect to its stated aim of increasing protections for the vulnerable and called on the Home Office to review the policy. The first 2018 report, *Putting Adults at Risk,* highlighted problems of identification of vulnerability in screening and in the Rule 35 processes and with the increased evidential burden on individuals to prove their vulnerability, which was resulting in the individual deteriorating during delays and before they had evidence of harm. This was despite the publicly stated intention of the policy change in response to Shaw 1 being to prevent harm. Less people were eligible for release and even in cases assessed at Level 3; in only 2% of those cases were people released and in 14% detention was maintained despite the IRC doctor specifying that the detained person was deteriorating.

90. The follow-up 2019 report, *Failure to protect from the harm of immigration detention,* documented the same issues arising and we were forced to conclude that the AAR policy was not fit for purpose, that the problems were systemic and that it was failing as an effective safeguard to prevent the detention of vulnerable people with their subsequent deterioration causing predictable and long-lasting harm. We again documented the inadequacy of the Rule 35 process which was also beset by continuing delays. The full details of that research are set out in Ms. Schleicher's first witness statement at §§156-158.

91. We have also contributed our findings and evidence to the following post Panorama investigations and reviews:

    a. Joint Committee on Human Rights Inquiry into Mental Health and Deaths in Prison (2017).
    b. HMIP's consultation on new inspection expectations for IRCs (Summer 2017).
    c. HASC Inquiry on Immigration Policy: Principles for Building Consensus (2017).
    d. Independent Chief Inspector of Borders and Immigration's Inspection of the Home Office's approach to the identification and safeguarding of vulnerable adults (2018).
    e. Joint Committee on Human Rights Inquiry into Immigration Detention (2018).
    f. UN Committee against Torture, Five Yearly Review of UK's compliance with the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment (2018).
    g. Tribunal Procedure Committee's consultation on a new fast track process (Oct 2018).
    h. Stephen Shaw's Follow-Up Report: Assessment of Government Progress in Implementing the report on the welfare in detention of vulnerable persons (2019).

i. Independent Chief Inspector of Immigration and Borders annual review of the Adults at Risk policy (2019).

j. Home Affairs Committee's Inquiry into immigration Detention (2019).

k. Evidence to second ICIBI annual review of AAR (2020).

l. New Plan for Immigration consultation (2021).

m. APPG-members only meeting with ICIBI and HMIP (March 2021.)

n. APPG Inquiry into quasi-detention (2021).

o. Secondary Legislation Scrutiny Committee submission regarding SI and revised AAR Guidance (March 2021).

## (11) Home Office Response

92. I am afraid our experience and the evidence documented in the subsequent reports provided to these bodies has confirmed a very similar pattern despite the truly shocking treatment of vulnerable detained persons in Panorama. The ICIBI, which was given the responsibility for carrying out annual reviews of the AAR policies, also found little real or effective change, with respect to the policy and safeguards for vulnerable detained persons, which is indicative of the prevailing culture of indifference and impunity which facilitated the conditions of mistreatment in the first place. Ms. Schleicher discusses this at §§171-176 in TS1. Even in respect of this appalling abuse scandal, we are unaware of what, if any, repercussions there have been for any Home Office official at a senior level responsible for immigration detention and enforcement, nor for the staff overseeing or directly employed at Brook House IRC, even those with responsibility for monitoring the contract facing any kind of accountability or action.

93. The Home Office itself did not undertake an urgent investigation into its role or responsibility for this catastrophic situation. Its denial of any responsibility is totally in keeping with the institutional and individual attitudes and responses we experienced before Panorama was broadcast. It was also of concern to us that no immediate action was taken to make any fundamental change to the arrangements with G4S. Indeed, the contracts were even extended until 2019 and the healthcare contract continued until 2021. The willingness of the Home Office to treat what happened at Brook House as the one-off actions of individual, low level officers ('bad apples') speaks volumes about the institutional culture and practices I have sought to describe.

94. Of most concern is the failure of action in respect of practices that are inherently most likely to result in abuse and ill-treatment, including the circumstances of use of force, segregation and the institutional culture within IRCs. I address these in turn below.

**(i) Use of Force**

As I have explained, concerns about the use of force in immigration detention was one of the factors leading to the establishment of Medical Justice in 2005 and the report, *Outsourcing Abuse*, in 2008 followed by the O'Loan investigation. It has been one of the long-standing concerns ever since. It is one of the most difficult aspects of ill treatment in detention to document without undercover reporting to corroborate the experience. This is closely tied to the challenges arising from the culture of disbelief, the failure within the system to be pro-active in response to assault allegations (e.g recording/photographing injuries) and the inadequacies in the complaints procedures which I also address. It was however, in no way a new issue only exposed by Panorama in 2017. It had already been identified as a fundamental feature of wider practices and culture for well over a decade prior to 2017 as I explain below.

**PPO Report on the treatment of detainees at Yarl's Wood IRC (2004)[71]**

95. The first PPO report by Stephen Shaw on the treatment of detained persons at Yarl's Wood in 2004, following the Daily Mirror undercover reporting, looked at allegations of racism and physical abuse at Yarl's Wood. Shaw made 30 recommendations, mostly involving training and encouraging further investigation, including recommending that the IMB regularly attend training for DCOs (pg.43).

**PPO Report on the treatment of detainees at Oakington IRC (2005)[72]**

96. Despite his above report and recommendations in 2004, further undercover reporting by the BBC in *Detention Undercover: The Real Story* (aired 2 March 2005) revealed what Shaw this time concluded was "*a sub-culture of abusive comment, casual racism, and contempt for decent values*". The programme documented:

    a. Misuse of the 'Detainee Departure Unit' (i.e., segregation) for trivial reasons;
    b. Racist attitudes and language, including racial abuse;
    c. Physical and sexual abuse of detained persons; and

[71] PPO (March 2004) Investigation into Allegations of Racism, Abuse and Violence at Yarl's Wood Removal Centre.
[72] PPO (July 2005) Inquiry into allegations of racism and mistreatment of detainees at Oakington immigration reception centre and while under escort.

d. Open discussion amongst staff at Oakington of abuse and humiliation of detained persons.

97. Shaw found that the BBC's evidence suggested that "*inappropriate behaviour was not confined to a small number of individuals, but that a sub-culture existed*" (pg.18).

98. Shaw also took evidence from a range of external professionals and charities working with detained persons at Oakington. Their evidence is summarised at pp. 37 – 55 of the report, reflecting many of the same concerns and issues now before this Inquiry. A number of contributors stated that these concerns had been previously raised and not acted upon. For example, the Medical Foundation for the Care of the Victims of Torture noted that their report, *Harm on Removal: Excessive force against failed asylum seekers*, was published in 2004, three months before the BBC programme had been aired.[73] That report had noted excessive or gratuitous force being used during attempted removals and made a number of recommendations, including automatic medical examinations following failed removals, healthcare reporting on inappropriate use of force, and a thorough review of use of restraint techniques, but that most of its recommendations had yet to be implemented (pg.50).

99. Shaw found there had been little monitoring at Oakington and no Race Relations management team or Race Relations liaison officer (pp. 56-57). He noted that even the religious affairs team were viewed as "*do-gooders*" and "*perceived to be a thorn in the side*" (pg.60). IRC staff speaking to the inquiry expressed fear of reprisals. There were numerous reports of bullying by managers at all levels (pg.62).

100. Shaw found a sub-culture of contempt for foreigners at Oakington and amongst escort staff. While he did not overstate the scale of the problem, its nature was described as "*appalling*" (pg. 105). In order to address this issue, Shaw found there was a need to (i) strengthen management, (ii) increase monitoring, and (iii) encourage moral integrity and resilience amongst staff (pg. 105). As to the latter need, he observed that detention and escorting work was "*not a job like any other*", yet staff members were not well paid and work long shifts. They required access to whistleblowing and managerial support (pg.106). Shaw accordingly made over 50 recommendations. (pp. 107-111).

101. From the perspective of Medical Justice and the experience of our clients, I can see little

[73] Medical Foundation for the Care of the Victims of Torture (2004) Harm on Removal: Excessive force against failed asylum seekers.

discernible change in practice following this PPO report by Shaw in 2005 and his attendant recommendations. We continued to receive accounts from our clients of what appeared to be excessive use of force and racist attitudes and abuse from staff. Whilst the use of force by escorts on removal was more readily identified, an overriding concern was that the increasing use of force in the immigration detention and removal context had led to a situation where force was becoming routinely used, including against highly vulnerable people with histories of torture and trauma and/or serious mental health issues. We observed the recurrent use of force in cases where, for example, a detained person refuses to move from one wing of a detention centre to another, from one detention centre to another, from the wing into segregation or for simply disobeying an order given by a detention custody officer even where not actively resisting. Our concern was that force was being used as a routine mechanism to manage detained persons, including as a means to address and contain the distressed and often at-risk behaviours of highly vulnerable people in detention.[74] This was further compounded by the fact that the 'control and restraint' techniques, applied in this context, were originally developed for use against refractory and violent offenders within the entirely different prison estate setting, and even then were only intended to be used as a measure of last resort. What seemed clear was that, in practice, the 'control and restraint' model was being used as the default response to incidents, and was being applied inappropriately to highly vulnerable people in detention. The suitability of the application of the current HMPPS model for restraint, within the IRC estate, is considered in detail by Dr Brodie Paterson in his witness statement, in particular at §§44-70.

***A Secret Punishment: Misuse of Segregation in Immigration Detention* (2015)**

102. In a report Medical Justice undertook on the use of powers of segregation in 2015, *A Secret Punishment: Misuse of Segregation in Immigration Detention*, we documented evidence of the inappropriate use of force often being applied to transfer people in or out of the segregation unit, even in cases where detained persons were compliant. Other examples of the inappropriate use of force in a segregation context included its use against people in detention with mental illness and those at risk of self-harm, which risked causing further traumatisation and destabilisation of people in crisis. This is to be considered together with the detailed findings of Dr Brodie Paterson in his statement concerning the use of force incidental to removal to segregation, as well as the use and impact of segregation on mentally vulnerable detained persons, in his witness statement at §§71-88.

[74] *Outsourcing Abuse*: pp.7 and 8.

103. Medical Justice also found evidence suggesting that the excessive restrictions and oppressive environment of segregation units in themselves lead to escalations of violence. The HMIP found in its 2006 report of Harmondsworth that 36% of all use of force had involved detained persons under Rule 40 or 42[75], whilst in Brook House in 2011 the Inspectorate found that almost half the incidents of use of force had been in the segregation unit[76]. The IMB at Harmondsworth IRC reported that instances of segregation and use of force tended to have arisen in the parts of the facility with the most prison-like and restricted environment. This led to the conclusion that the segregation setting was poorly equipped to defuse situations of perceived conflict, and that it may in fact contribute to escalating levels of violence in IRCs. There was also evidence that proper de-escalation procedures had not been followed in order to avoid either having to place individuals in segregation in the first place, or to avoid the use of force to move the person to segregation.

104. The research also gave examples cited by the IMB and HMIP of staff using unprofessional language, the inappropriate use of control and restraint gear, excessive force and unauthorised techniques in the context of use of segregation powers. The research also quoted two other examples of the use of excessive force to effect removal to segregation at Brook House, referenced by HMIP in their 2010 report[77]. In the first example, an officer used a full-length Perspex riot shield to hit and then pin a detained person to a bed. The second incident concerned the use of a riot shield to again pin a detained person to a bed to enable other officers to apply physical restraint locks to move him to segregation.

**Report by the assistant deputy coroner relating to the inquest into the death of Jimmy Mubenga (2013)[78]**

105. Following the death of Jimmy Mubenga during a forced removal in 2010, there were a number of investigations into the use of force in the context of immigration removals. The Home Affairs Committee held two evidence sessions and concluded that it was not convinced that the Home Office was ensuring that its contractors provided adequate training and supervision on the use of force.[79] The Parliamentary Joint Committee on Human Rights' Inquiry into

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[75] HMIP, *Report on an announced inspection of Harmondsworth Immigration Removal Centre (17-21 July 2006),* (28 November 2006) §8.21.
[76] HMIP, *Report on an unannounced full follow-up inspection of Brook House Immigration Removal Centre (12-23 September 2011),* (31 January 2012), §7.24.
[77] HMIP, *Report on a full announced inspection of Brook House Immigration Removal Centre (15-19 March 2010),* (12 July 2010), §§7.22-7.23.
[78] Report by Assistant Deputy Coroner Karon Monaghan QC under the Coroner's Rules 1984, Rule 43: Inquest into the Death of Jimmy Mubenga, 23 July 2013.
[79] House of Commons Home Affairs Committee, The Work of the UK Border Agency. 4th Report of Session 2010-11, 21 December 2010.

deaths in custody also highlighted the failure to learn lessons from previous restraint-related deaths in a number of contexts. It emphasised that Coroners had repeatedly called for restraint training in the past, but there was still no monitoring or communication of this.[80]

106. In the 2013 Inquest into Mr Mubenga's death, the jury found that the cause of his death was cardio-respiratory collapse due to restraint during the flight. They found that his death was caused by unreasonable force, by way of being pushed or held down by one or more of the DCOs, which impeded his breathing. The jury returned a majority verdict that Mr Mubenga had been unlawfully killed (§18).

107. The Assistant Deputy Coroner presiding over the inquest subsequently issued a report pursuant to Rule 43 of the Coroner's Rules 1984 which issued various recommendations to the Home Office. Key findings of relevance to the Inquiry include the following:

    a. *Contractual arrangements*: which were found to incentivise pressing on with removal (§35) and giving rise to real concerns that inappropriate and dangerous methods might be used (§38).

    b. *Racism*: racist material was found on the private mobile phones of two of the DCOs (§39) and evidence of "*a more pervasive racism within G4S*" (§43-44).

    c. *Use of force*: which was not uncommon in escorted removals (§53). The restraint of Mr Mubenga was not authorised by the *Use of Force* manual or Control and Restraint techniques (§56). Concerns were identified about (i) training (ii) C&R on aircraft (iii) practice (iv) handcuffing to the rear, which was known to pose significant risks, and (v) restraint / positional asphyxia (§57).

**Report of the independent advisory panel on non-compliance management (2014)[81]**

108. The follow up report by the Independent Advisory Panel on Non-Compliance Management, headed by Stephen Shaw, also identified serious failings in respect of the use of force in escorted removals. The key findings of the Panel of some relevance to the Inquiry appear to be:

    a. That "*it is not enough to conclude that certain restraint techniques are, or are not, safe to be employed*" but rather regard should be had to the context in which they are used and how their use is governed and managed and that restraint methods and equipment

[80] Joint Committee on Human Rights: Deaths in Custody, Third Report of Session 2004-2005, Volume 1, 14 December 2004 §237.
[81] Report of the Independent Advisory Panel of Non-Compliance Management, March 2014.

must be considered within the context of individual detained persons' circumstances, vulnerability and presentation (§§2.5-2.7).

b. All use of force necessarily contains some risk and should therefore always be the last resort (§2.10). Simply stating that force must be used as a last resort is not enough, it much be supported by (i) effective training, (ii) a clear focus on the rights of detained people, (iii) explicit expectations about the culture, behaviour and values of DCOs, (iv) effective training in de-escalation, and (v) techniques that are sufficiently effective to ensure DCOs do not feel the need to use unauthorised techniques (§3.10).

c. Reliance upon academic research in the Review of the Medical Theories and Research Relating to Restraint Related Deaths (§2.20),[82] which noted that "*certain groups are more vulnerable to risks when being restrained*", including those with "*serious mental illness, or learning disability and those from black and minority ethnic communities, those with a high BMI, men aged 30-40 years and people under the age of 20*". The review also noted that it should be assumed that everyone is at a potential risk rather than trying to profile individuals only medically at risk (§2.21).

d. The recognition that not only safer restraint techniques are needed but that it is also necessary to ensure that the DCOs act "*ethically and in a way which seeks to preserve the rights and dignities of the detainee*" and that the culture amongst DCOs is one in which "*s are treated as individuals and their rights and dignities are respected and where the use of force is seen absolutely as a last resort*" (§3.4).

e. A values-based practice was required: "*It is necessary for such a culture to exist amongst DCOs as a prerequisite for ensuring that the decisions they take in respect of individual detainees are informed both by the facts of the situation and by the correct values*" (§3.5).

f. It is important to recognise that the process of removing a detained person is not an isolated episode. Nor is that individual's management through the immigration system a series of unconnected episodes. It is, especially for the detained persons themselves, a single process, which may have begun with apprehension by the authorities and which continues through to eventual removal. The experience of the detained person must be understood by staff and others involved at each stage of the process towards removal (§3.6)

[82]Caring Solutions (UK) and University of Central Lancashire (2011) Review of the Medical Theories and Research Relating to Restraint Related Deaths.

g. At every point, the detained person retains the right and expectation to be treated decently, in accordance with the law, and in a way which preserves his or her fundamental rights. For DCOs effecting a removal, and who may be faced with a detained person who is not compliant, or who shows signs of aggression, this means that they (i) must understand this wider context and have an appropriate appreciation of the experience of the detained person; (ii) must be informed of relevant information about the detained person, in order that they may make properly informed decisions concerning his or her management, and that consequently (iii) actions and behaviours, on the part of the detained person, can be put in their proper context (§3.7).

109. From the evidence relating to the incidents of use of force in Brook House in 2017 it is difficult to see how any lessons learnt from the removal context were applied in IRCs after the Panel's Report in 2014. Even if the recommendations were implemented, there was clearly a failure to promote ethical staff practices and a culture of respect for human rights and dignity at Brook House. To the contrary, it appears that the use and misuse of these C&R methods may well have contributed to the mistreatment, abusive practices, and toxic culture that Panorama exposed. I say this having considered the evidence of the former G4S officers, Callum Tulley, Owen Syred and Reverend Nathan Ward, as well as having read the informed opinion of Dr Brodie Paterson. It is the view of Medical Justice that the evidence about the practice and culture at Brook House confirms the overall inadequacy of the framework for use of force within the IRC estate. Baroness O'Loan recognised the need for a review in light of the particular complex mental health issues in IRCs and to consider the method used in mental health establishments.

110. The parallels between the themes and evidence drawn from these reports, dating back to 2005, with those exposed by Panorama at Brook House is clear. This reflects the experience of Medical Justice that, without fundamental change, abuse and mistreatment is entirely predictable and perpetuated. The tenor of these earlier reports also starkly illustrates the failure by the Home Office and their contactors, in the period leading up to the events at Brook House in 2017, to engage with the lessons learned process and to implement, either effectively or at all, the myriad recommendations made by these various bodies to review the appropriate use of force model, to closely monitor and maintain robust systems of accountability and high standards of professional practice.

**(ii) <u>Complaints Mechanisms</u>**

111. Medical Justice also published research on the inefficacy of the IRC complaints system in its 2014 report, '*Biased and Unjust – The Immigration Detention Complaints Process*'. The overriding concern for Medical Justice was and is that the lack of a robust complaints system allows certain abuses to continue unchallenged and contributes to the overall failure of the Home Office and its contractors to learn from mistakes or improve practice.

112. This report documented Medical Justice's project to provide support and assistance to people in detention making complaints against the Home Office and its contractors, which ran from 2011 - 2013. This comprised 31 complaints made by 28 detained persons from various different IRCs. The complaints ranged from serious misconduct, particularly injuries sustained during attempts to transfer the detained person or remove them from the UK, as well as inadequate healthcare, frequent cancellation of hospital appointments, use of handcuffs and the presence of guards in medical consultations. Other complaints included verbal abuse, including racial and sexual language.

113. The findings identified significant practical failings within the complaints framework: complaints forms were difficult to access, detention staff lacked training about complaints procedures and there was a lack of information about the complaints process provided to detained persons. The conduct of investigations was also found to be inadequate: timescales for replies to complainants were not met, and investigations were frequently inadequate, partial and biased towards the Home Office's contractor, even when there was evidence to the contrary. Almost half the complaints required escalation to the Ombudsmen. The report identified further difficulties caused by the use of subcontracting and the complexity of identifying the correct avenue for a complaint, as well as the lack of oversight and co-ordination by the Home Office.

114. The report also drew attention to the fact that, again, these were not new issues. Similar findings about the inadequacy of the complaints system had been made by the Complaints Audit Committee, which had oversight and auditing responsibilities for complaints in both the prison and detention estates until it was disbanded in 2008. The Committee's last report in 2008 had assessed 83% of complaints investigations as inadequate. Moreover, some of the systemic problems identified in our research on the complaints system had been previously raised by the IMB and the HMIP[83]. Both organisations had raised concerns about the lack of

[83] HMIP, *Report on an unaccounted inspection of Harmondsworth Immigration Removal Centre (5-16 August 2013);* IMB annual report on Morton Hall, 2011-2012.

impartiality of investigations, with the HMIP also noting examples where complaints were not upheld "*which should have been*."

115. The HMIP and IMB had previously recommended that the complaints response should be provided in the same language as the original complaint, and that there should be speedier responses to complaints, with overall timescales for investigations shortened. Neither suggestion has been accepted by the Home Office to date, as evidenced by the current pro forma complaints form issued to detained persons wishing to make a complaint. Both the Inspectorate and the Monitoring Board also agreed on the need for a systematic overview of complaints in order to identify trends and ensure that lessons were learned. However, there is still no such single independent entity with this overarching responsibility.

116. Medical Justice also documented evidence of detained persons' reluctance to make complaints and the fear that complaining would adversely affect their treatment in detention or their immigration case. Practical difficulties with the system also included the use of information provided in a complaint to undermine an immigration case, difficulties with accessing evidence to support the complaint and inadequate CCTV recording of use of force.

117. The following case example aptly illustrates the sense of fear and hopelessness felt by many detained persons in respect of the complaints process:

> "*I was made to believe that the guards were within their realm of their duty and it was my fault that they had to beat me up. This made me fear for the worst, as I had been made to believe that I had proven to be the trouble maker, and that they were going to treat me likewise.*
>
> *I feared making any complaints, or voicing anything against the guards and other detention staff because it was for my benefit to lie low and not be seen as a trouble maker, this was for my own good, (or so we/I was made to believe). The detention guards' treatment towards me and other detainees made it clear that we had no say. You are shown that you are worthless, you are not a human being anymore. I was made to feel like they can stamp on me or spit at me, and I had no option than to submit to anything they subjected me to.*"[84]

118. Even in cases where the detained person has not themselves been subject to specific

[84] *Biased and Unjust: The Immigration Detention Complaints Process* (2014) pg.5.

mistreatment, the report found that they would often describe witnessing the physical or verbal abuse of other people in the IRC, when no one intervenes to challenge it, as frightening and demoralising. The picture painted by the collective experiences of these detained persons was that the IRCs operated as an entirely closed environment, within which officers can act with impunity. My experience is that, whilst this is a long-standing feature of IRCs, it has been intensified by the hostile political rhetoric surrounding asylum seekers and more recently migrants generally.

119. At the time of the report Medical Justice identified the need for various changes to made to the complaints process and oversight structure, which remain outstanding and which we would ask the Inquiry to consider. These are detailed at Annex 2 to this witness statement.

### (iii) Institutional Racism, Racist and Other Abuse

120. Similarly, racist and other dehumanising verbal and psychological abuse was not a new phenomenon in 2017. Medical Justice documented in its 2008 report, *Outsourcing Abuse*, stark accounts of racist abuse, such as detained persons being called a *"black bitch", "black monkey",* and a *"fucking black slave"*. The report also included an account of a detained person being called a *"fucking piece of shit, go back to your own country"* and threatened with having *"his arms and legs broken to make him go"*.[85] Evidence of similar racist attitudes and language amongst DCOs is a significant feature in both the *Oakington* and *Mubenga* Investigations as already identified above.

**Undercover in the secretive immigration detention centre[86]**

121. Only a year later in 2015, Channel 4 broadcast two undercover documentaries. One of those programmes, "*Yarl's Wood: Undercover in the secretive immigration centre*", again exposed the existence of racist and other dehumanising and derogatory abuse at Yarl's Wood IRC. The footage showed detained women being referred to as "*animals*", "*beasties*" and "*bitches*" by officers, and suggestions of detained persons being headbutted and beaten.

122. Despite these repeated patterns of abusive mistreatment, and the focus and cogency of the recommendations made by Stephen Shaw, it is plain from the material we have seen in Panorama and which this Inquiry has already uncovered in Phase 1, that racist, derogatory and abusive attitudes continued to operate at Brook House at the material time. This appears to

[85] *Outsourcing Abuse*: pg.47.
[86] Channel 4 (2015) *'Yarls Wood: Undercover in the secretive immigration detention centre'*.

have taken the form of both overt racist abuse and broader institutional racism, embedded within a culture of othering, dehumanisation and an attitude of "*us and them*". I note that Dr Paterson examines this in his witness statement at §§89-117, in particular the development and impact of a corrupted staff culture in which such racist and derogatory language and behaviours exacerbate the risk and of and contribute to mistreatment.

123. Medical Justice has also routinely supported clients who have reported being treated with disrespect and feeling depersonalised and disempowered whilst in detention. A frequently used description is feeling like the person is being treated as less than human and like an animal. Typical responses from former detained persons about the experiences of detention include as follows:

(i) "*I was just another asylum seeker in their eyes, they don't care where you are from, what you have been through, they treat you like a prisoner...'*

(ii) *"The officers had no respect, they would enter our rooms without knocking, when you were naked or on the toilet, embarrassing you."*

(iii) "I *wish no-one to be in that place, the staff are racist*"[87]

**(iv) Healthcare**

124. This pattern of abusive and indifferent treatment is not limited to custodial staff alone. Medical Justice clients regularly describe their interaction with healthcare staff as particularly crushing, because they expected medical professionals, of all staff members, to be sympathetic and concerned about their welfare. When clinical staff show a similar disinterest to officers, and disregard or are even hostile to individuals presenting with medical problems and expressly seeking their help, detained persons are left confounded and despairing. It is not uncommon for clients to say that they thought medical staff simply did not care.

125. Dr Paterson has addressed in detail the links between dehumanisation and the risk of mistreatment in his statement (at §§105-121), including with respect to the failures of healthcare staff to fulfil their safeguarding roles in respect of mentally vulnerable detained persons. Professor Katona also explores the connection in his statement. I would add only that such an institutional culture of indifference can contribute to deaths in detention, as the death

[87] *The Second Torture*, pg.46 (box 3).

of Prince Fosu graphically illustrates. There, the PPO identified how a range of staff from across the Home Office, IRC, Healthcare and even IMB had apparently become "*de-sensitised to behaviour that at the very least suggested significant mental distress*".[88]

**(v) Misuse of Segregation**

126. The use of segregation, and in particular its misuse for vulnerable people in detention, including those with pre-existing mental illnesses and at risk of self-harm, had been identified as an issue by the HMIP and in the annual reports of the IMB for some time. Despite criticism, the concerning practices associated with the use of segregation continued to occur. In 2015 Medical Justice issued the detailed report, *Misuse of Segregation in Immigration Detention - a Secret Punishment.* The primary concerns we identified relevant to the Inquiry were: i) the use of segregation power as a way to manage detained persons who self-harm and to exert control over detained persons subject to removal; ii) the misuse of segregation powers as contributing to deaths in detention; and iii) systemic deficits in the safeguards for detained persons with mental health issues and those who lack mental capacity.

127. In summary, our findings were that segregation was being misused in the following ways:

(i) As a form of punishment. This was of particular concern given the use of segregation for people in detention with a mental illness in the context of poor screening, assessment and treatment of people with such conditions.

(ii) To manage people in detention with mental health disorders. This includes persons whose behaviour is rooted in on-going and untreated mental health issues and is often mistaken as confrontational behaviour and managed through the use of segregation.

(iii) To manage people in detention at risk of self-harm, despite segregation being an entirely unsuitable environment for those in crisis.

(iv) As a means of aiding immigration processes, particularly removal, in the absence of individual risk assessments.

122. Furthermore, the report found evidence of:

[88] PPO (2019) Independent investigation into the death of Mr Prince Fosu, a detainee at Heathrow Immigration Removal Centre on 30 October 2012.

a. The profound impact on the health and wellbeing of people in detention who are segregated, particularly for those with pre-existing mental health disorders, and the risk that it may also actively cause mental illness.

b. People in detention with mental health problems, including symptoms of psychosis and at risk of self-harm, were being managed in segregation, with the isolation causing an exacerbation of their condition and being a feature of the underlying treatment found to breach Article 3 ECHR in certain cases.

c. People in detention with mental illness being subject to repeated periods of segregation and records showing no meaningful engagement by staff responsible for monitoring the detained person's welfare during their separation.

d. "Cursory" medical visits with a lack of medical screening for the use of segregation beforehand and lack of multi-disciplinary reviews of the use of the power once this was utilised.

e. The use of *de facto* segregation in so called Care and Separation Units without the safeguards of formal segregation decisions under R40/42 DCR.

f. The failure of the Home Office to provide oversight and monitoring of the use of segregation, which was left to the HMIP and IMB.

128. Medical Justice made various detailed proposals for change to the Home Office, which are still highly relevant and many of which remain outstanding. These are outlined at Annex 2 to this statement.

129. We provided a detailed written response to the Home Office's consultation on a draft 'Detention Service Order: Removal from Association (R40) and Temporary Confinement (R42)' the year following the publication of our report on segregation, in July 2016, in which we provided very similar information and recommendations to the above. We did the same for a further revised draft Detention Service Order in April 2017, issued in July 2017. The changes introduced by this DSO however were too little and too late. They were limited to Rule 40 and Rule 42, did not address *de facto* segregation in E wing, nor many of the main issues we had raised. The lack of urgency and inadequacy of the Home Office response to the long-standing and pressing concerns about the misuse of segregation, and its role in deaths of

people in detention, is confirmed and indeed underscored by the evidence before the Inquiry.

130. A detailed analysis of the material relating to the use of force and segregation during the relevant period at Brook House in 2017 has been undertaken by Medical Justice for the purposes of this Inquiry. A thematic overview of this material is provided in a schedule appended to the witness statement of Dr Rachel Bingham at Annex 3. The issues identified therein are developed by Dr Bingham, from a clinical perspective, in her witness statement at [§§128-166] and in greater detail by Dr Brodie Paterson at [§§44-70] and [§§81-88], who applies his combined expertise on clinical and use of force issues. Both are experts within their respective fields, and I defer to them on these matters. However, even from a general review of this material, it appears evident that the repeated failure of the Home Office and its contractors to squarely address these issues has had a direct bearing on what happened at Brook House. It is no coincidence that CSU and E wing appear, in the material before this Inquiry, as the recurrent context for the abuse and ill-treatment of detained people. The evidence and concerns Medical Justice raised in 2015 about the link between the use and misuse of the segregation power, the use of force and harmful effects on mentally ill people is starkly confirmed by the experiences at Brook House.

131. Moreover, the evidence before this Inquiry concerning the misuse of segregation illustrates the inadequate policy reforms implemented by the Home Office. The mere introduction of very general DSOs is wholly inadequate to address the underlying systemic problems and to correct ingrained practice and attitudes. It is another example of a recurrent failure to recognise that the primary underlying reason as to why segregation powers are so widely used is precisely because of the systemic failings of detention policy and safeguards. In particular, it is the high numbers of vulnerable people with mental illness held in detention, and for prolonged periods, whilst their mental health was deteriorating, which results in the high rates of self-harm, open ACDTs and use of segregation which are before this Inquiry.

132. The fundamental failure of the detention safeguards is, on the evidence Medial Justice has reviewed, therefore, closely linked to the misuse of segregation and restraint practices. This extends to the incidental and escalating use of force to manage the adverse effects of segregation itself which risks worsening the underlying illness. Detention is unsuitable for those with serious mental illness precisely because it is likely to be exacerbated by detention, including the nature of the regime and security measures imposed. In our representations in response to the 2017 consultation, we made reference to the fact that segregation was a feature in several of the cases of mentally ill people in detention where breaches of Article 3 ECHR

were found:

> *"However, we continue to have serious concerns about this draft. In January 2017 the High Court found that aspects of ARF's detention, including the use of segregation, amounted to 'cruel and inhuman' treatment, a breach of her rights under Article 3... (ARF v SSHD [2017] EWHC 10 (QB)). We are concerned that the current policy would not avoid such unacceptable breaches of detained persons' human rights. Stephen Shaw was "particularly concerned that segregation may on occasions become the default location for those with serious mental health problems" and referred to the case of MD (MD v SSHD [2014] EWHC 2249 (Admin), in which a breach of Article 3 was found MD suffered from major depression with psychotic features and generalised anxiety disorder. In response to her distress, self-harm and aggressive outbursts she was removed from association and isolated, measures that an independent doctor identified as liable to make her condition worse. Segregation was also an issue in HA (Nigeria) and R (D) v SSHD, two other 2 cases where courts have found that detention breached article 3, referred to in Stephen Shaw's review."*

133. Despite this known context and the Panorama scandal, no urgent steps were taken to address these issues. A new DSO on segregation was not even issued until September 2020, this time with no general consultation at all. Whilst it provides stronger guidance on the relationship between segregation and mental illness, many of our concerns even from 2015 remain unaddressed. There is still no connection within the segregation policy to the AAR safeguards, such as the need to issue a Rule 35 report and/or to conduct an urgent review of continued detention in respect of mentally unwell detained persons. Once again, the issue of a DSO does not indicate any substantial operational change in the culture, conditions and practices which give rise to the risk of harm.

## (12) Ongoing Casework

134. Despite the impact of the pandemic on numbers in detention, Medical Justice continues to see these same fundamental systemic failings and practices at play in its casework and wider evidence. Current casework experience is addressed in detail by Ms. Schleicher in her second witness statement, where she analyses five separate case examples in detail concerning clients' recent experiences at Brook House, since 2017. The full case studies, and a summary of the key thematic problems illustrated by the cases, are annexed to her statement at Annex 2. These

can however be drawn out as follows:

(i) All 5 of these cases concerned the misapplication of the AAR policy.

(ii) In 3 out of 5 cases no Rule 34-compliant examination was conducted.

(iii) In 4 out of 5 cases there was a failure to initiate a Rule 35(3) further to reception screening.

(iv) All 5 cases concerned the failure to produce a R35(3) report at all or promptly or properly.

(v) In all 5 cases no Rule 35(1) report was produced, despite evidence of harm.

(vi) In all 5 cases no Rule 35(2) report was produced even though the detainees were on an ACDT, 4/5 actually self -harmed and 3 expressed suicide intent or attempted suicide.

(vii) All 5 cases concerned the failure in mental health provision, including the ongoing failure to recognise and assess serious mental health issues and refer for psychiatric assessment.

(viii) All 5 cases concerned the use of ACDT monitoring, including constant supervision, as an isolated containment strategy with no therapeutic purpose.

(ix) In 2 of the 5 cases Rule 40 was used as a containment strategy to manage mental illness.

(x) In 3 of 5 of the cases, there was a failure to treat prolonged period of Food and Fluid period as an issue of self-harm and/or manifestation of mental distress.

(xi) In 2 of 5 of the cases, there were instances of use of force to prevent self-harm and/or to remove from association to CSU/E Wing.

## (13) Most Recent Developments in the IRC Estate

### Charter Flight Removals 2020

135. The ongoing and high incidence of vulnerable detained people suffering from serious mental illness who are subject to the use of force and segregation, and the heightened risk of mistreatment, is evidenced by the experiences documented during the Home Office's Charter flight removal programme run between August and December 2020.

136. The most comprehensive overview of the evidence from this period is from the Brook House IMB and IMB Charter Flight Monitoring Team, ("CFMT"). It confirms the experience at Medical Justice that, to date, little has been done or achieved by the Home Office by way of

reflective learning and effective reforms. This underscores the Home Office's wholly inadequate understanding of why the mistreatment occurred in the first place, and as I have sought to explain above, is tied to its continuing refusal to accept responsibility or accountability for what went wrong.

**IMB Notice under Detention Centre Rules 61 (3) and (5)**

137. On 2 October 2020 the Brook House IMB and IMB CFMT issued a notice under the Detention Centre Rules 61 (3) and (5), to then Minister Chris Philp in respect of practices at Brook House IRC that it had concluded could amount to inhuman or degrading treatment within Article 3 ECHR. It refers to evidence that the concerted use of charter flights to effect enforced removals:

> "*indicates a series of issues ... collectively and cumulatively having an unnecessary, severe and continuing impact on detained persons, particularly those facing removal on charter flights, as well as across the detained person population as a whole.* ***We believe that the cumulative effect of these concerns amounts to inhumane treatment***". (emphasis added)

**The IMB Report for Brook House 2021**

138. The IMB's concerns were set out in greater detail in its annual report for 1st January -31 December 2020 (published in May 2021). They are addressed in greater detail in Theresa Schleicher's second witness statement at [§§110-113; §137; §§143-144]. I emphasise that the IMB report confirmed its findings that:

> "*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, detained persons 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 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 detained persons who had crossed the Channel in small***

***boats.*** *This was evidenced by the high levels of self-harm and suicidal ideation in that time."* (emphasis added)

139. Furthermore, the IMB considered that the use of Brook House for Charter Flight removals during that period amounted to *"inhumane treatment of the whole detained person population by the Home Office in the latter months of 2020*". It went on to find that:

> *"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. The Board expressed the view that circumstances in the centre* ***amounted to inhumane treatment of the whole detained person population.*** *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.* ***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 detained persons, but rather of the circumstances in the centre.***" (emphasis added)

**Liberty Investigates /Observer Report**

140. It appears from an article in the Observer newspaper dated 26 December 2021 that there are additional allegations of excessive use of force being used during this period in 2020 at Brook House[89]. I understand that documents obtained through freedom of information requests of written accounts, minutes of oversight meetings, and complaints filed by people in detention and staff, which record concerning information about what happened in 2020 at Brook House, have now been disclosed to the Inquiry. I understand from the Observer report that officers were given a dispensation from the minimum requirement for eight hours of training per year in the safe use of control and restraint. A use of force expert was quoted as described this as normally representing a "*significant institutional failure*".

141. The Observer report states that, on at least six occasions, force was used when the officer was "*out of ticket*" and on three occasions when officers were on ACDT duty. It also states that:

[89] '*Suicidal asylum seekers subjected to 'dangerous' use of force by guards at detention centre',* 26 December 2021, The Observer.

*"Officers used force, including techniques that deliberately cause suffering to gain compliance – called 'pain-inducing restraint' – to prevent self-harm on 62 occasions from July to December. The population of Brook House was about 100 people at any one time".*

142. An example given was a technique known as a "back hammer" to intervene when a suicidal detainee was attempting to wrap a power cable from the kettle around his neck. Another recorded incident was pain inducing restraint to force a detained person to accept an ad hoc medical assessment which was said to be in his best interest. Use of a shield on a prone detainee was also noted.

143. The Observer quotes graphic details of self-harm from officers' accounts including:

> *"Between August and December, there were 14 attempts by detainees to end their lives using improvised ligatures. Two tried to suffocate themselves using plastic bags. On 21 September, the day before a flight, a man jumped from an upper floor but was caught in safety netting before trying to push himself through the edge of the netting so he could fall headfirst to the ground".*

144. It also records that SERCO warned the Home Office in monthly updates that incidents of self-harm linked to the Charter flight programmes "*were driving up rates[of] use of force.*"

145. The further documents now provided by Liberty state that there were 98 use of force reports completed by custody staff between 1 August and 31 November 2020, at a time when the population at Brook House was about 100 people. It also states that 17 staff behaviour complaints were submitted by Brook House staff and people in detention about staff behaviour between 20 May 2020 and 31 December 2020 and 14 complaint responses from SERCO. This information would appear to correlate with our own recent case studies, and the 2020 IMB report, and confirms the same recurring themes in play in 2017, namely:

(i) High levels of vulnerable people in detention.
(ii) High Levels of self-harm.
(iii) The frequent use of ACDT to manage self-harm rather than effecting release under the AAR policy.
(iv) Systemic dysfunctions in the Rule 35 safeguards; no R35(2) reports were issued.
(v) The continued use of force to prevent self harm with 62 instances from July to December 2020, at a time when the population at Brook House was very small

(100). This correlates with force being used against a large proportion of the detained population

(vi) A cavalier approach to safe use of force training, with the Home office prioritising its removal imperatives over the safety and welfare of detained people.

(vii) Complaints of excessive force, including the use of a pain-inducing restraint to force a detained person to accept a medical assessment after a planned use of force.

146. Whilst the allegations were refuted by SERCO, the information reported and recorded by the IMB and Liberty/Observer reporting does strongly suggest that some of the contributory factors to the context of excessive and unlawful force and wider mistreatment of mentally ill people in 2017 were evident in 2020. The continued practice of use of force and pain-inducing techniques on vulnerable, suicidal asylum seekers is extremely disturbing and is only likely to increase stress and fear, heightening the risk of self-harm and suicide and acting as a further trigger for escalation in the use of force to transfer to segregation or to remove.

147. We are not aware of any Home Office response to the IMB notice or to the Liberty investigation. The finding of the IMB that the conditions at Brook House IRC were "not safe" and were "inhumane" are conclusions with which Medical Justice would agree. We also believe this applies with equal force to the situation in 2017. Many of the same factors were in play in 2017 when the IRC was at capacity given the high rates of severe mental illness[90] self-harm, use of ACDT, segregation and force to manage these issues as well as removals. The general conditions could also have been exacerbated by additional distressing factors such as higher levels of violence, bullying, drug abuse and substandard living conditions.

## (14) Examples of Effective Reform

148. A review of the evidence relating to policy and safeguards for vulnerable people in detention, the use of force, control and restraint, segregation and racism supports the long-standing conclusion of Medical Justice that only radical change can hope to address these ingrained institutional practices and culture. Medical Justice is able to identify two examples where, in similar contexts, significant and sustained change has been made to substantially reduce systemic failures and recurring harmful practices of serious concern in respect of the detention and treatment of two other vulnerable groups, namely children and of pregnant women.

[90] Owen Syred, first witness statement, §171; INN000007_0042: he assesses 20 % of the population at Brook House were suffering from severe mental health issues at any given time– that would normally account for about 80 people.

(i) Children

149. The detention and treatment of children with their families was a matter of significant concern for Medical Justice over a number of years. It was the subject of repeated stakeholder concerns, multiple reports[91] and individual legal cases of unlawful detention. In 2010 Medical Justice published a detailed report entitled *'State sponsored cruelty': Children in Immigration Detention.* It documented what was already well known by those in the field, namely that physical and psychological harm was caused and aggravated by the detention of children under immigration powers. At that time families were regularly detained as part of enforced removals, with very serious consequences for the children and young people involved. 141 cases are featured in this report, involving children who were detained between 2004 and April 2010. The report found that there had been a significant increase in the use of detention of children in 2008/9 often in breach of the policy only to detain children in exceptional circumstances and only then for the shortest possible time immediately before removal. The key finding was based on evidence which included that significant numbers of children had witnessed racist abuse on arrest and violence in detention, the vast majority of cases involving detention staff, as well as receiving inadequate food and medical care.

150. In 2010 the Family Returns Process[92] was implemented which, although not ending detention of children very severely curtailed the powers to detain them. Under this policy, children with families may be detained up to 72 hours but only in exceptional circumstances and only with ministerial approval can this be extended to seven days. The Family Returns Panel was established, which is involved in every case where detention is planned to ensure that this only takes place after extensive prior steps have been taken to address all relevant matters relating to the welfare of the child and that arrangements are in place for removal shortly after detention, normally within 72 hours. This change in policy and practice, although not ending every issue and still permitting detention of children, has improved the position. The policy and safeguards work better in practice, it has reduced the numbers of children being detained and for prolonged periods and has ended the most harmful practices damaging to the health and welfare of children and their parents.

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[91] Children's Society and Bail for Immigration Detainees, Op. Cit; and Crawley, H. and Lester, T. (2005) *No Place for a Child*, London Save the Children; Lorek, A. Ehntholt, K. Nesbitt, A. Wey, E. Githinji, C. Rossor, E. and Wickramasinghe, R. (2009) '*The mental and physical health difficulties of children held within a British immigration detention center: A pilot study'*, Child Abuse & Neglect, 33, pp. 577-585 and *Outcry! Party conference briefing on children and immigration detention* – September 2009, London: The Children's Society and Bail for Immigration Detainees. Royal College of Paediatrics and Child Health. Royal College of General Practitioners. Royal College of Psychiatrists and the Faculty of Public Health (2009) Intercollegiate Briefing Paper: *Significant Harm – the effects of administrative detention on the health of children, young people and their families.*

[92] Home Office (2020) Guidance on Family returns process.

(ii) Pregnant Women

151. In 2013 Medical Justice published its report *Expecting Change: the case for ending the detention of pregnant women*. This report drew on the expertise of a large number of charities, NGOs, law centres and other organisations working with pregnant women experiencing immigration detention at Yarl's Wood IRC who had been raising concerns over a number of years. During that time, SERCO was contracted to run Yarl's Wood. Our report was supported by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. The conclusion was that the Home Office's policy of detaining pregnant women was "*ineffective, unworkable and damaging*". The report documented evidence that pregnant women had suffered harm and serious shortcomings in antenatal care and healthcare for detained pregnant women, which contributed to these outcomes. They were detained even where there was evidence of torture, trafficking or other trauma, and mental illness. There was also evidence of force being used to effect the removal of pregnant women. The concerns in the report reflected those of HMIP going back to 2006. Legal challenges were also brought in 2013 against the unlawful use of force on pregnant women[93] and the systemic failure in policy on detaining pregnant women[94]. Both cases were conceded by the Home Office after permission was granted. Despite this body of evidence and legal cases, the Home Office was belligerent in maintaining this policy. No remedial action was taken to address the systemic failures in policy and safeguards and to prevent recurring harm to pregnant women which continued for the subsequent 2 years. This was confirmed by the reports from the All-Party Parliamentary Group on Migrants and Refugees (2015)[95] and Stephen Shaw's Review into the Welfare of Vulnerable Persons (2016). The only change made by the Home Office was yet again to issue a new Detention Service Order (DSO) on the Care and Management of Pregnant Women in Detention introduced in 2016, which remained a wholly inadequate response.

152. In 2016 Medical Justice and other organisations briefed Baroness Lister who introduced an amendment to the 2016 Immigration Bill to end the detention of pregnant women which was passed in the House of Lords. The government only then made concessions, and Section 60 of the Immigration Act 2016 was introduced which, although not ending detention of pregnant women, limited the detention of this vulnerable cohort under immigration powers for no more

[93] R (Yiyu Chen) v Secretary of State for the Home Department [CO/1119/2013].
[94] R(PA) v Secretary of State for the Home Department [CO/1978/2014].
[95] APPG on Migration and APPG on Refugees (2015) Report of the Joint Inquiry into the Use of Immigration Detention in the United Kingdom.

than 72 hours, unless extended up to a maximum of seven days with ministerial approval. This amendment also expressly provides that women may only be detained if the Secretary of State is satisfied that (i) the woman will shortly be removed from the UK or (ii) there are exceptional circumstances which justify the detention.

Again, it was only a change, this time in statute law, severely limiting the circumstances in which pregnant women can be detained that has, in most cases, largely brought an end to the systemic failures, and some of the most harmful effects to this highly vulnerable group who were previously frequently detained in breach of policy and for prolonged periods without access to appropriate medical care.

## (15) Proposals for change, suggestions and lessons learned

153. From the experiences that Medical Justice has described in my statement, and those of Dr. Bingham and Ms. Schleicher, Medical Justice is of the strong view that immigration detention should end. It is the most draconian power available to a government department, and closed environments are inherently difficult to monitor. The Home Office has proved incapable of diligent and robust oversight and has failed to instil a strong institutional human rights-compliant culture of prevention, protection, and accountability. When this is absent and executive powers are used in a hostile political climate, abuse is predictable, even inevitable. That is why it is a recurrent problem in the immigration detention context, confirmed by court cases finding Article 3 ill-treatment, jury findings in inquests and repeated exposés of abuse, racism and ill-treatment by undercover reporting and subsequent investigations.

154. The presence of multiple systemic problems is another a key factor in understanding why abuse occurs in immigration detention. This dysfunction in the safeguards to prevent unlawful detention and harm to vulnerable people in detention, the deficiencies of healthcare to identify and report urgent concerns about vulnerabilities, the institutional culture of dehumanisation and racism reflect recurring collective and individual failures on the part of the he Home Office, its contractors and the healthcare providers.

155. It is simply not possible – and would be a travesty – to seek to relegate the abuse and ill-treatment at Brook House captured by the BBC to 'a few rotten apples' and to the particular practices of some individual officers in one IRC for a narrowly defined period of time. A toxic institutional culture, attitudes of racism and dehumanisation along with a *laissez-faire* approach toward the provision of healthcare, the use of force and segregation does not develop

overnight and cannot be attributed just to the actions of a few individuals; it requires acquiescence of the state. The responsibility for ensuring a lawful, humane, and safe detention environment, compatible with the fundamental rights of detained people, rests with the Home Office as the detaining authority and the department responsible for designing, arranging and operating the regime on behalf of the state. The abdication of overall responsibility is what allows abuse to recur. It should not be allowed to continue.

156. Change can only begin with the introduction of strict measures to circumscribe the exercise of the power to detain. Nothing less will begin to address the deficits in the system, in the institutional culture and practices of both the Home Office and its contactors, which have proved impervious to any significant or durable change to date, identified in the many reports, reviews and recommendations made over the past decade. The Inquiry should take into account that even before, but certainly since, the Brook House scandal there is widespread recognition that the only realistic solution capable of achieving any real change is, to curtail this power and to end its indefinite nature. The list of these reports and their recommendations for a limit to the detention power and length of detention is set out at Annex 1

**Phase out the use of immigration detention**

157. Medical Justice agrees with the position taken by the British Medical Association ("BMA") that ultimately immigration detention should be phased out and replaced with a humane and indeed more effective means of monitoring and managing people facing removal from the UK. Detention under current policy is meant to be the last resort; if that is to mean anything, all reasonable alternatives have to be tried or properly considered before the power is exercised.

158. The Home Office should undertake a proper evidence-based investigation into the need for immigration detention, and such an investigation must not lose sight of the fact that reporting to immigration officers is 95% effective[96] and compliance could be further improved by implementing the recommendations of the ICIBI , so it is plainly a viable alternative to detention. A report was recently published on a pilot scheme overseen by UNHCR, which showed no increase in absconding when alternatives to detention are used for women.[97]

[96]James Brokenshire MP letter with enclosed evidence to the APPG on Refugees/Migration joint inquiry into immigration detention (13 October 2014).
[97] Taylor. D (January 2022) '*Scheme not to detain women seeking asylum leads to only one staying in UK.*' Guardian.

159. For a period of time during the Covid-19 Pandemic, the detained population significantly reduced. That presented a unique opportunity for the Home Office to consider whether the significantly reduced numbers of people being detained actually had a detrimental effect on immigration control. Instead, the Home Office embarked on a politically driven project to detain and remove large numbers of asylum seekers with reckless indifference to the consequences for both the staff and people detained at Brook House IRC creating an inhumane environment in breach of Article 3 ECHR. The Home Office has also inexplicably opened a new IRC for women, IRC Derwentside in county Durham, despite the very low number in detention and before evaluation of the UNHCR polite scheme. At the same time, the Home Office is seeking a statutory power to reintroduce the discredited, unfair and unjust detained fast track system for asylum seekers without addressing and remedying the ongoing defects in screening and Rule 34/35 before seeking to implementing in IRCs.

**Limit on the power to detain**

160. If immigration detention lasts for any longer than an escort to an airport, then its indeterminate and indefinite length should end and be restricted in line with the time limits operated for pre-departure accommodation for family returns and the detention of pregnant women, that is up to 72 hours, extendable to up to 7 days in total but only with ministerial approval and only where there is clear evidence of its necessity. Even then:

    a. Detention should only be used in circumstances where all necessary processes and procedures for removal have already been carried out and there are no barriers to removal, notice of removal has already been issued, and all medical issues considered. In this way, detention is used as stated as a last resort, in its truest sense, to facilitate actual removal.

    b. Automatic judicial oversight within 24 hours should be introduced, where a case must be presented to satisfy a judge as to removability and the necessity of detention for carrying this out.

161. This system should reflect the current Family Returns process, and Section 60 of the Immigration Act 2016, which has, in Medical Justice's experience been a more effective and more humane way of managing removals for vulnerable groups.

162. This approach should be no different for foreign national offenders facing deportation. This group is likely to face prolonged detention and the witness statement of Professor Katona

explains at §§115-118 how this group may include some of the most vulnerable and with the most complex needs.

**Strong Presumption against detention**

163. The presumption against detention must mean that detention is the last resort in any case with all reasonable alternatives exhausted and considered in the individual case before the power to detain is exercised.

164. The failures of the AAR policy to safeguard against vulnerable people being detained and suffering harm are clear from our casework experience, as well from by statutory, Parliamentary, and other reviews.

165. There is an urgent need to return to a category-based approach to the identification of vulnerabilities as recommended by Mr. Shaw in his first report, where vulnerable people are treated as unsuitable save in *"very exceptional circumstances"*.

166. The categories of vulnerabilities need to encompass all of those groups now identified in the AAR Statutory Guidance. There should be no requirement for additional or specific evidence of risk of harm. It must be operated on preventive principles in recognition of the clinical evidence that detention is harmful for those with existing vulnerability.

**Effective Screening of Vulnerabilities, Disabilities, Trauma and Mental Health Problems**

167. There must be effective screening before a person is detained. The Detention Gatekeeper is an internal process and is not adequate. A system for independent and robust oversight must be introduced, such as Detention Review Panel with a procedure for proactive inquiry so that the Panel is satisfied that there are no legal or practical barriers to removal and all relevant up to date evidence has been obtained and considered by the Home Office about the person's health and any other vulnerability.

**Effective safeguards for identify vulnerable people**

168. Pre-detention screening must be coupled with an effective clinical screening process upon a person's detention. This must be more than a mere tick-box exercise. It must include a targeted mental and physical health assessment by properly trained medical staff aimed at identifying any vulnerability indicators which contraindicate detention.

169. The continued serious and intractable failings in the current Rules 34 / 35 DCR safeguards cannot continue.

170. As Mr. Shaw identified in his report in 2016,[98] further and better monitoring and training are not going to get at the root problems. Allowing other healthcare professionals to also complete Rule 35 report will not address the problem; it will compound it. It will not result in improvement in the quality of responses to Rule 35 reports. The simple answer is for the Home Office to end the fundamental "*disconnect*" and accept the advice of the IRC doctor identifying the detained person as vulnerable. In the absence of very exceptional circumstances, the Home Office should release them.

171. There is also an urgent need to address the "*disconnect*" between the Rule 35 safeguard and the AAR policy. Under the category-based system, any Rule 35 report should be treated as triggering the requirement for detention only to be maintained in very exceptional circumstance. The requirement for levels of evidence of harm should be removed. Rule 35(1) should apply the criteria of particular risk of harm in detention and include the wider categories of vulnerability set out in the AAR policy. A Rule 35(2) should be triggered whenever a person is placed on ACDT procedures.

**Healthcare**

172. There are recurrent failures by IRC mental health staff to diagnose and treat mental health problems, and by the primary healthcare staff to identify obvious clinical concerns, despite being within a setting in which it is or ought to be known that there is a high incidence of mental illness, trauma, and overall vulnerability. As Dr Bingham notes at §62 of her statement, there may be a number of contributing factors, including the level of training, support and supervision, alongside inadequate reflective practice and ongoing professional development activities, as well as the impact of staff working in an environment in which there is a high risk of becoming "*desensitised*" to the needs and suffering of detained people.

173. Medical Justice is of the view that there must be robust training delivered by independent trainers, for all healthcare staff, in the delivery of trauma-informed clinical care. IRC healthcare staff should fulfil a primary protective role in identifying and escalating indicators of mental or physical vulnerability. Particular attention must be given to the identification of individuals suffering from PTSD, the symptoms of which are often missed or mis-identified in

[98] Shaw 1, §4.118.

an environment which remains wilfully resistant to the recognition of the psychological consequences of trauma.

174. There is also an allied need for improved and more regular training by independent experts for all healthcare staff in the AAR policy and safeguards, with particular emphasis on the ongoing suitability for detention, so that assessments for this purpose are not done on a one-off basis usually only at the request of the Home Office.

175. The use of the criteria of "fit for detention" should be ended and should be consistent with the AAR policy of particular risk of harm. This reflects the need for IRC healthcare staff to adopt a precautionary model of care, rather than a reactive response to evidence of harm already caused by detention. It would also better safeguard their independence both functionally and in the eyes of the detained person.

176. The appraisal and revalidation process for GPs to ensure they are competent in their full scope of practice should be reviewed. The GMC Responsible Officer is accountable for clinical governance processes, and should have an important role in ensuring doctors' performance and patients' safety. Understanding the range of areas in which IRC doctors are required to be competent requires some understanding of the unique environment in which they work. This includes, but is not limited to: understanding the crucial role of IRC healthcare in the safeguards designed to identify and protect vulnerable people from continued detention; the potential harm caused by inadequate 35 reports; appreciating the need for clinicians to maintain personal fitness to practice through activities which reduce the risk of desensitisation; appreciating the need for doctors to maintain and develop knowledge of health and mental health issues more common in refugee and asylum seeker populations; understanding the need for clinicians to be aware of the evidence base about the impact of immigration detention on mental health, given the uniquely high relevance of this to their role. We propose that Responsible Officers ensure that these issues are addressed in adequate and specific clinical policies and are evidenced in reflective practice in doctors' appraisals.

177. Medical Justice agrees with the Royal College of Psychiatrists' position on the limitations of being able to provide effective mental health treatment within the context of immigration detention. Treatment of mental illness requires a holistic approach and continuity of care. Psychotropic medication is very unlikely to achieve good outcomes unless given as part of a broader multi-model therapeutic approach. The recovery model cannot be implemented effectively in a detention centre setting, and in these circumstances, healthcare has a

responsibility to raise concerns about the suitability of the person for continued detention as soon as mental illness is identified.

**Mental Capacity**

178. Healthcare professionals working in IRCs must be aware of, and alert to, indicators that a person may lack capacity in their behaviours, in concerns reported by other staff, and in their presentation. GPs must be properly trained in how to carry out a capacity assessment if such concerns arise, and must be able to recognise when further specialist input is needed. Mental capacity assessment is covered in routine safeguarding training for GPs. However, the unique environment of IRCs means that additional, specifically tailored training, would be required to enable healthcare staff to recognise the range of areas in which lack of mental capacity may impact on a person in detention and to ensure that concerns about lack of mental capacity in relation to the person's legal situation is addressed. Further, or alternatively, healthcare staff should have speedy access to an external medical professional suitably qualified to conduct capacity assessments on their behalf.

179. It is also crucial to establish a role for *independent* advocacy services being promptly made available for detained people with serious mental illness where it *appears necessary,* the person has *substantial difficulties* and there is an absence of an appropriate individual to support them.[99]

**Management of self-harm and suicide risks**

180. The current use of the prison-based ACDT mechanism for managing self-harm risk is inadequate and effective in the immigration detention context. If a person is self-harming, it necessitates an urgent review of their mental state and suitability for detention. It is disconnected from the AAR policy, this situation should be amended so that if a person self-harms this triggers an urgent assessment under Rule 35(2) or an alternative mechanism, leading to a review of detention.

181. As a suicide prevention tool, ACDT is inadequate; is not clinically led and does not trigger clinically informed risk assessments of immediate physical harm or underlying mental deterioration. It is a containment tool and not a therapeutic one. It requires the person to have expressed explicit suicidal intent and due to lack of clinical input risks failing to identify the

[99] Care Act 2014 s. 9.

range of other risk factors for suicide and specifically the risk of impulsive self-harming and suicidal acts.

**Use of Force / Segregation of vulnerable people**

182. The current use of the prison-based Control and Restraint (C&R) model for use of force within the IRC context is inappropriate, in view of the nature of administrative detention and the high proportion and nature of clinically vulnerable people in detention. The C&R model fails to adequately address the position of vulnerable detainees, such as alternative de-escalation strategies, attempting to identify underlying vulnerabilities potentially associated with a person's distressed behaviour, and the distinct psychological damage that may be caused by restraint for those who are particularly clinically vulnerable due to a history of torture or other experiences of trauma.

183. Medical Justice endorses the opinion of Dr Paterson as to the need for a therapeutic and preventative model of intervention, aligned to what is adopted in clinical contexts, as a safer and more suitable means of managing challenging situations involving mentally ill people .

184. Segregation should not be used to manage and contain people who are suffering from serious mental illness or at risk of self-harming/suicide other than in the most exceptional circumstances where there is an immediate threat to the person's safety. Those that are so unwell that they require segregation for clinical reasons require urgent review of their mental state and suitability for detention by a medical practitioner. Any transfer to segregation for clinical reasons should trigger a Rule 35 report and release from detention unless the person is transferred into a secure mental health setting.

185. There must be robust scrutiny over the use of segregation, with healthcare playing a lead role providing clinical input on both on the use of segregation powers and review. Healthcare staff should not approve or authorise the use of segregation. Their remit is to identify, assess and raise concerns about contraindications to its use and in triggering review of continued detention.

186. The Home Office and SERCO must urgently review the use of E wing in Brook House, and end de facto segregation, to manage and treat seriously unwell people in detention. The Home Office should ensure that the same practice is not applied to other IRCs. Any segregation must be within and subject to the safeguards in Rules 40 and 42 DCR.

**Monitoring and oversight**

187. There are serious gaps in oversight and monitoring by the Home Office. The ICIBI made a recommendation for improvements on this in the Annual Inspection of Adults at Risk in Immigration Detention (November 2018 – May 2019), describing consistent and comprehensive data collection as essential to a thorough understanding and assurance of the effectiveness of the AAR policy. The absence of data has been a long-standing concern of Medical Justice and it has impaired the ICIBI inspections from properly testing the efficiency and effectiveness of a particular Home Office function. Specifically:

a. **Decision-making**: the data concerning gatekeeper decision-making on vulnerability remains unclear and difficult to monitor. The Home Office must strengthen its data monitoring and assurance processes concerning the detention decision-making.

b. **Rules 34 / 35**: The long-standing failure to audit and monitor the Rules 34 / 35 process must end. Whilst statistics are now kept about Rule 35 reports under each limb and the number of reports leading to release, there remains no audit of the quality of the reports or the responses by the Home Office, particularly in the light of low release rates. This is essential for assessing the efficacy of any detention policy as it is dependent on the Rule 35 mechanism operating effectively.

188. **Other audit requirements** that are regularly published by the Home Office needs to also address:

a. Deaths in detention, including publication of all investigations concerning the circumstances of the death;
b. Incidents of self harm leading to medical treatment;
c. People taken to hospital for treatment of mental illness: both under the MHA and as informal patients;
d. Numbers of detainees with a history of mental illness prior to detention, broken down by reference to ICD-11 diagnosis and people diagnosed with a mental illness in detention, again referencing ICD-11;
e. Numbers of people subject to ACDT procedures, and the length of time held in detention whilst on such a process, with information about the proportion with a diagnosed mental illness broken down by reference to ICD-11 diagnosis and supported by local ACDT policies being publicly available;

f. Review of the audit requirements and consultation with stakeholders on an annual basis.

189. Whilst the HMIP, ICIBI, IMB and CQC play a relevant and important role in oversight and monitoring, they cannot be the only mechanisms:

a. HMIP reports take a snapshot of a particular detention centre at a given time and are unable to systematically monitor how the detention centre and the safeguards within generally operate (or not) and over time. Recommendations can be made with no enforcement mechanism for serious and persistent failures.

c. The ICIBI's Adults at Risk annual reviews are important thematic assessments of the policy. But as the outgoing ICIBI David Bolt highlighted in his Valedictory report in March 2021, since the Home Secretary assumed control of the publication of inspection reports, there had been significant delays in reports being published, of between 11 to 53 weeks from the date they are sent to the Home Secretary. Over a period of five years, the ICIBI made 62 recommendations, and although 67.2% were accepted, the ICIBI noted that narrative responses were too often caveated or non-specific in terms of what the Home Office would do to implement recommendations and by when, and many are still outstanding several years on.

d. Concerns were raised in the Verita report about the sense of collegiality between the IMB and G4S and a tendency on the part of the IMB members to over-empathise with the G4S management team and the Home Office, rather than to hold them to account and press them on their plans for action to address concerns and make improvements at Brook House. The Rule 6 Notice and evidence in the IMB's annual 2020 report on Brook House appears to be an important improvement further to these criticisms, but the impact of its reports still depend on the Home Office not only accepting the findings and recommendations but also taking concrete action to respond where there is no requirement that it do so. We are not aware of any response to the Rule 6 Notice nor the 2020 Report.

e. To our knowledge, the CQC has not yet inspected Brook House. Medical Justice has made recommendations to the CQC regarding the Inspection Criteria for IRCs in 2015. Appropriate expertise is required and should include experts in the clinical care of asylum seekers, and those with a lived experience of immigration detention, in addition

to secure environments expertise. It is essential that people who are detained are spoken to confidentially in the course of the inspection. It is essential that as part of assessing the safety of the service, the ability of healthcare staff to function as safeguards in the Adults at Risk Policy is considered and the treatment of the vulnerable is prioritised

**Accountability**

190. The fact that no one has been prosecuted following the Panorama documentary is a major failure of the system of accountability. It reflects other failures to secure prosecution and punishment of serious wrongdoing. It underscores the culture of impunity which marks the use of immigration detention powers.

191. The recurrence of abuse, ill-treatment, a culture of dehumanisation and racism at IRCs across the country is perpetuated by an absence of proper vetting and scrutiny of commercial contracts entered into by the Home Office with private companies to run immigration detention centres. Contractual arrangements are opaque and not published. There needs to be transparency.

192. The monitoring of the contract from both the perspective of compliance by the Home Office and the Contractor is inadequate and should be done by an independent professional inspectorate.

193. Those responsible for unlawful decision making, and breaches of safeguards should face consequences including disciplinary action and systems should be in place for reporting and lesson learning.

194. Mangers and senior managers with responsibility for oversight of Brook House (and other such IRCs) should be held responsible for such actions, face disciplinary action and systems should be in place for reporting and lesson learning.

195. Directors responsible for oversight of Brook House should face disciplinary action and systems should be in place for reporting and lesson learning.

196. Any such staff and officials responsible for misconduct should not be permitted to be employed under any other government contracts or subcontracting.

197. Senior Officials in the Home Office responsible for systemic or institutional failure of policy or its implementation should be held to account and face disciplinary action and systems should be in place for reporting to Ministers and lesson learning.

198. Ministers should be held responsible and to account for any findings of systemic or institutional failure contributing to breaches of fundamental rights under Articles 2 and 3 ECHR.

**Institutional culture, openness and restoration of confidence**

199. The Verita report identified a series of push and pull factors that contributed to the desensitisation and dehumanisation of detained people, such as low staffing levels, staff turnover and challenges of caring for a significant population of detained people who suffer from mental ill-health and other vulnerabilities for a prolonged period of time. Training on racial and cultural awareness, and more robust tendering, vetting and recruitment, as highlighted by Reverend Ward are also important suggestions. The Verita report also sets out a list of specific recommendations on centre management, training, staffing, regime and detainee welfare, physical environment and arrangement at the IRC, learning from incidents, and safety and security in the centre.

200. But more fundamental change is required to root out the institutional culture that has allowed for and contributed to ill-treatment and abuse to re-occur time and again. The *culture of disbelief* must be addressed.

201. The Home Office must take primary responsibility for ensuring that the detention system is arranged and operated by its contractors in a manner that is safe, humane and protects the fundamental rights of people in detention. A "humane" and "safe" approach will not be realised if the agenda of the Home Office is to continue to promote a hostile environment policy and rhetoric. Its role in fostering division, an "*us and them*" mentality and prejudice institutionalising racism, and dehumanisation must also be acknowledged and addressed.

202. The Home Office must commit to the elimination of racist prejudice and discrimination in the implementing immigration enforcement and detention and must comply with the duty :

a. to regularly examine its policies and publish its evaluation the outcomes of its policies and practices to guard against discriminatory attitudes and treatment;

b. to implement, monitor and assess:

i. the sufficiency and efficacy of strategies for the prevention, recording, investigation and prosecution of racist and other discriminatory incidents directed at people in detention;

ii. measures to encourage reporting of racist and other discriminatory incidents;

iii. the nature, extent and achievement of racism and anti-discrimination awareness training for its staff and contractors;

iv. the efficacy of direct and indirect performance indicators in contractual arrangements to ensure staffing levels, working practices, hours and demands do not breed discontent, frustrations and desensitisation, all of which have been identified to be factors triggering and perpetuating discriminatory "us and them" attitudes and actions;

c. to ensure robust vetting of tendering and vetting of contractual arrangements, which must include scrutiny of policies, practices and outcomes for preventing racial discrimination and that appropriate sanctions are in place treating racism as gross misconduct for which dismissal is the appropriate sanction.

d. to ensure that the staff employed at IRCs are from as racially and culturally diverse backgrounds as possible;

e. to ensure that the HMIP and IMB's conduct race audits of staff attitudes and behaviour as a specific part of their inspection or monitoring duties;

f. to undertake an immediate review and revision of training in racism awareness, and respecting cultural diversity;

g. to ensure independent and regular monitoring of training within all IRCs to test both implementation and practice of such racism awareness training.

**Statement of Truth**

203. 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.

Name: **Signature**

Emma Ginn

Date: 08/02/2022

**ANNEX 1**
**Recommendations on Time limits**

| Name | Recommendation |
|---|---|
| **HMIP (2015)** | **Report on an unannounced inspection of Yarl's Wood Immigration Removal Centre (13 April – 1 May 2015)**[1]<br><br>**Recommendation**:<br><br>1) Rigorously evidenced concerns we have identified in this inspection provide strong support for.a strict time limit. It must now be introduced on the length of time that anyone can be administratively detained.<br>2) Caseworkers should act with diligence and expedition in any event. |
| **APPG Refugees and APPG Migration's Joint Inquiry on detention (2015)** | **Report of the Inquiry into the Use of Immigration Detention in the United Kingdom**[2]<br><br>**Recommendation: (p9)**<br><br>1) A maximum of 28 days should be introduced and this should be set in statute. Decisions to detain should be taken much more sparingly and only as a genuinely last resort and to effect removal.<br>2) To prevent the 28 day time limit from becoming the default period individuals are detained for, the Government should introduce a robust system for reviewing decisions to detain in the form of automatic bail hearings, statutory presumption that detention is to be used exceptionally and for the shortest period of time or with judicial oversight, either in person or on papers. |
| **Shaw 1 (2016)** | **Review into the Welfare in Detention of Vulnerable Persons**<br><br>**Recommendation 62:** I recommend that the Home Office give further consideration to ways of strengthening the legal safeguards against excessive length of detention.<br><br>§10.26 – there are many ways (with or without a formal time limit) that the current system of detention reviews could be strengthened. For example, bail hearings could be automatic at the 28-day stage, or after three or four months. |

[1] https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/08/Yarls-Wood-web-20151.pdf
[2] https://detentioninquiry.files.wordpress.com/2015/03/immigration-detention-inquiry-report.pdf

Annex 1

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| **Home Affairs Select Committee (2017)** | **The work of the Immigration Directorates (Q4 2015): Second Report of Session 2016-2017**[3]<br><br>**Recommendation (p40):** Further legal interventions, such as a statutory time limit on detention will need to be considered if there has not been a significant impact on the length of detention.<br><br>§80: Immigration detention is costly, as is the compensation which has to be paid when detention is found to be unlawful. The adverse effects of detention on an individual's mental health are also well-established. We support the recommendations of the independent reviewer, Stephen Shaw, that the Home Office should both do more to reduce the length of time that detainees are held and investigate alternatives to detention. Particular attention should be paid to those who are held in detention for the longest periods. We welcome the Government's commitment to an independent case review after three months' detention, and the new statutory automatic presumption of bail after four months' detention. |
| **HMIP (2017)** | **HM Chief Inspector of Prisons for England and Wales: Annual Report 2016-17. HMIP**[4]<br><br>**Recommendation:** There remains a pressing need for a maximum time limit on immigration detention, especially in light of shortcomings in legal assistance. |
| **British Medical Association (2017)** | **Locked Up, Locked Out: Health and Human Rights in Immigration Detention**[5]<br><br>**Recommendation: (p73)**<br>1) The use of detention should be phased out and replaced with alternate more humane means of monitoring individuals facing removal from the UK.<br>2) As long as the practice of detention continues, there should be a clear time limit on the length of time that people can be held in detention, with a presumption that they are held for the shortest possible time. |
| **HMIP (2018)** | **Written evidence to the JCHR Detention Inquiry**[6]<br><br>**Recommendation:** A clear time limit on detention is needed**.** Not for HMIP to specify length. |

[3] https://publications.parliament.uk/pa/cm201617/cmselect/cmhaff/22/22.pdf

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/629719/hmip-annual-report-2016-17.pdf

[5] https://www.bma.org.uk/media/1862/bma-locked-up-locked-out-immigration-detention-report-2017.pdf

[6] http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/immigration-detention/written/88814.html

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| | §11 – HMIP regularly finds individuals held in detention for extended periods of time, citing more than 1 year, 4 ½ years, 3 years, all as unacceptably long times to hold people in administrative detention.<br><br>§12 – Home Office inconsistently manage and progress cases where people have been detained for extended periods. Home Office regularly ignores advice of its own case progression panel.<br><br>§13 – HMIP regularly encounters individuals whose mental well-being is affected by prolonged and open-ended detention. |
| **JCHR (2019)** | **Immigration Detention: Sixteenth Report of Session 2017-19 (30 January 2019)**<br><br>**Recommendation: 28 day time limit.**<br><br>P3: *"Without such a time limit, there is a reduced incentive for officials to progress cases as quickly as possible, so that individuals can have their status resolved swiftly, for example by being removed or having their status regularised."*<br><br>*"this will end the trauma of indefinite detention. In exceptional circumstances, for example when the detainee seeks unreasonably to frustrate the removal process and has caused the delay, the Home Office would be able to apply to a judge would could decide whether to extend the detention for up to a further 28 days."*<br><br>See also Chapter 4 (p23 onward) |
| **HASC (2019)** | **Immigration Detention: Fourteenth Report of Session 2017-2019 (12 March 2019)**[7]<br><br>**Recommendation**: It is time to implement radical change. In line with the JCHR, HASC urges the Government to bring an end indefinite detention and to implement a maximum 28-day time limit with immediate effect.<br><br>§222: a maximum immigration detention time limit is long overdue. It is clear that lengthy immigration detention is unnecessary, inhumane and causes harm.<br><br>§223: Home Office policies which should prevent unlawful detention and harm of vulnerable people are regularly flouted or interpreted and applied in such a way that the most vulnerable detainees, including victims of torture are not being afforded the necessary protection. Detainees can be held despite serious risk to their life. … |

[7] https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/913/913.pdf

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| | §224: 28 days would be a reasonable statutory immigration detention time limit to enforce, given that the Home Office's own Enforcement Instructions and Guidance stipulate that detention should only be maintained when removal is imminent (i.e. within 28 days (four weeks)). |
| **Professor Mary Bosworth** | **Report of 17 November 2021 to the Inquiry**<br><br>Recommendation<br>1) Follow international human rights standards and bring in a time limit to immigration detention. (§2.28). A time limit would significantly reduce the kinds of distress shown in the video footage (Panorama) and would make the purpose of these institutions clearer.<br>2) When a time limit has been introduced, numbers in detention have declined. Were this to happen, the UK could revisit the reliance on custody for enforcing border control and to consider alternatives to detention. |
| **Nathan Ward** | **DL0000141 – Witness Statement of Nathan Ward**<br><br>**Recommendation §353 (p125):**<br><br>1) A 28 day time limit should be imposed on all detentions.<br>2) The equivalent of the family returns policy should be implemented for all removals and an independent returns panel should be established similar to the "Family Returns Panel" for all detainees<br>3) Detention for those with vulnerabilities should be limited to 72 hours and only extended for a further 72 hours by a Judge.<br>4) This scheme should be scoped for all those detained. |
| **GDWG (Anna Pincus)** | **DPG000002 – First Witness Statement to the Inquiry**<br><br>**Recommendation**: Need for a time limit on immigration detention. The indefinite nature has a terrible impact on detained people and makes people feel more vulnerable and appears to exacerbate pre-existing vulnerabilities and mental health problems. (§228) |
| **Dr. Oozeerally** | **DR0000001 – Witness Statement to the Inquiry**<br><br>**Recommendation (§115)**: There needs to be a reduction in the stay within IRCS (1 week maximum). |

# ANNEX 2

## Summary of Key Recommendations from Medical Justice Reports

1. *"Biased and Unjust: The Immigration Detention Complaints Process"* (2014).

   (i) An independent body should be established to have oversight of the complaints process in the same way that the Complaints Audit Committee had done before it was disbanded.

   (ii) The Home Office should publish quality reviews of the standard of complaint responses provided to detained persons and should consider an appeal stage before invoking an appeal to the Ombudsmen.

   (iii) The Home Office should publish the reports about all complaints in IRCs and their outcomes and the identified learning from these complaints.

   (iv) The obligations on staff to report incidents and ensure that healthcare staff are called to record and photograph injuries should be strengthened in all incidents, whether or not a complaint is made.

   (v) If staff do not comply with existing Detention Service Orders this should be regarded as misconduct.

   (vi) An independent panel of investigators should replace the PSU and should investigate all cases of serious misconduct, as previously recommended by the Complaints Audit Committee.

   (vii) While an allegation of assault is being investigated, the detained person should not be removed.

   (viii) Any allegation of a criminal offence requires an independent police investigation.

   (ix) An allegation of assault, including sexual assault, should be conducted with the same standards as any allegation in the community.

   (x) The time limits for investigations of serious misconduct should be reduced from 12 weeks to 8 weeks.

2. '*Misuse of Segregation in Immigration Detention - a Secret Punishment'* (2015).

(i) End the use of segregation. It is a disproportionately retributory measure for a low-risk and vulnerable population, contrary to the notion of a 'relaxed regime' as set out in DCR 2001 and altogether unnecessary considering some prisons operate without the use of this power.

(ii) If the use of segregation is not ended, it should be limited and governed by strict policy guidelines that prohibit prolonged or de facto segregation, the use of segregation as punishment, segregation of the mentally ill or those at risk of self-harm.

(iii) Centralised data on the use of segregation and the attributes of those segregated must be published or made publicly available to ensure proper monitoring, oversight and comparability. This data must be regularly reviewed by an independent auditor.

(iv) An initial health screening must be carried out before segregation and at regular review intervals during segregation. This is in addition to daily visits. All medical interactions must be thoroughly recorded and added to medical notes of the detained person.

(v) Multi-disciplinary reviews of segregation similar to arrangements in the prison context should be introduced. People in detention should have access to the reasons for their segregation in a language they understand as well as access to a neutral and independent adjudication process and financially aided legal counsel to challenge their segregation in a timely manner.

(vi) All staff need to be trained in identifying signs of trauma and torture as well as receiving mental health awareness training, in order to ensure that indicators of trauma and mental illness are not inappropriately treated as behavioural issues. Specialist training must also be provided to IRC staff working in segregation unit.

(vii) Segregation should only be used in exceptional circumstances, as a last resort when all other options have been exhausted and for the shortest time possible. The exceptional circumstances, as well as all efforts to find alternatives, must be thoroughly recorded in each case

(viii) All IRCs should follow the same guidelines on regime whilst under Rule 40 and 42. The regime should be the least restrictive and provide as much stimulation as possible. Social interaction should be maximised, be this through education opportunities or meaningful social contact with other detained persons either in the unit or in other settings. Visits must be allowed and unrestricted.

Annex 3

**Bibliography**


1. APPG on Migration and APPG on Refugees (2015) Report of the Joint Inquiry into the Use of Immigration Detention in the United Kingdom

2. APPG (March 2021) members only meeting with ICIBI and HMIP

3. APPG on Immigration Detention (December 2021) Report of the Inquiry into Quasi-Detention

4. BBC (2005) Detention Undercover: The Real Story

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