BROOK HOUSE INQUIRY

First Witness Statement of Deborah Coles

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

I, Deborah Coles, will say as follows:

Introduction

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

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

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

3. I have given evidence to numerous parliamentary committees and inquiries, most recently oral evidence to the Home Affairs Select Committee Inquiry into Police Complaints (January 2021) and the Justice Committee Inquiry on the Coronial System (May 2021).

Role of INQUEST

4. INQUEST is a charity and non-governmental organisation ("NGO") founded in 1981 to provide expertise on contentious deaths. We are the only charitable organisation in England and Wales that provides an independent, specialist, comprehensive advice service to bereaved people, lawyers, other advice and support agencies, the media, parliamentarians and the wider public on contentious deaths, their investigations and the inquest process, with a particular focus on deaths in custody and detention, including immigration detention. We work with bereaved families from the outset, supporting them through the investigation by the Prisons and Probation Ombudsman ("PPO") and then the inquest. We co-ordinate a national network of over 250 lawyers, the Inquest Lawyers Group, ("ILG") who provide specialist legal representation for bereaved families. We hold regular roundtable meetings between ILG members and investigative bodies to inform discussions around best practice and raise issues of concern. This includes regular meetings with the PPO and a range of PPO staff members and investigators, and other relevant stakeholders including the HM Inspectorate of Prisons ("HMIP"), the Chief Coroner and the Crown Prosecution Service.

5. Our specialist casework service gives INQUEST a unique perspective on how the whole investigative system operates through monitoring of the investigative and inquest processes. This overview enables us to identify systemic and policy issues arising from deaths and the way they are investigated; how the PPO and coronial investigation systems are operating in practice; and how recommendations arising from individual deaths are followed up and changes made, both at a local and national level.

6. Our focus on deaths in custody and detention mean that we have particular knowledge and experience around detention systems and arrangements. We have seen how and where those go wrong over many years. Our knowledge and experience is extensive,

detailed, and based on deaths in immigration detention centres as well as in prisons and elsewhere.

7. NGOs serve a vital function in monitoring deaths of detained people, particularly where there are no family members present to demand openness and accountability. Under Article 2 of the European Convention on Human Rights ("ECHR"), there is an obligation on the state to conduct full, open and transparent investigations into deaths, particularly where the person was detained. This should be public, independent and should involve members of the family of the victims. This is particularly challenging for people with unsettled immigration status, where it is more likely that their family do not live in the UK and may be frightened of the authorities or lack the resources to make sure that the interests of the deceased are represented in what is often a protracted and confusing process. In contrast, the Home Office and private companies routinely have multiparty legal representation at all inquests. It is not uncommon to see as many as seven Interested Persons representing immigration detention staff and service providers, paid for out of the public or company purse, but no representation for the family of the deceased. In practice this can lead to limited inquests with reduced scope, less likely to find systemic failings or consider the wider issues.

8. In investigations and inquests following deaths of people detained under immigration powers where the family of the deceased have been able to properly participate through legal representation, fundamental failings in treatment and care have been exposed, as well as unsafe systems and practices, thereby shining a spotlight on this closed world. Deaths are at the sharp end of the harm caused by indefinite immigration detention and illustrate the human cost of UK immigration policies.

Background information on deaths in IRCs

9. During the relevant period there were no deaths at Brook House Immigration Removal Centre ("Brook House") and of the deaths that occurred after the relevant period none of the deceased had been housed at Brook House during the relevant period. However, it is important to note that whilst there were no deaths at Brook House, identification of failings in systems, policies and practices at other Immigration Removal Centres ("IRCs") during the relevant period and the years before and after, will have direct

relevance to all IRCs, the safeguarding of detained people and learning that should be taking place nationally.

10. The collection of data and statistics that are publicly available in relation to deaths in IRCs, including in the community soon after release, is generally fragmented and lacking in transparency. The Home Office only publish data annually, only confirm that deaths have occurred if asked, and generally avoid or delay confirmation. INQUEST has therefore been reliant on information shared between NGOs. This is in contrast to the more open practices of the Ministry of Justice and prison service following deaths in prisons, including deaths of people who have foreign national status and/or who die while detained under immigration powers in prison.

11. INQUEST contributed to an analysis of deaths presented by Medical Justice in their report published in 2016, "*Death in Immigration Detention: 2000 – 2015*".[2] That report identified that between 2000 and 2015 there were 35 deaths of people detained under immigration powers.[3] That number is alarmingly high, not least in view of the average age of those who died during the period that Medical Justice reported on, which was 38 years old. When responding to the Joint Committee on Human Rights ("JCHR") inquiry into Immigration Detention in 2018, INQUEST reviewed deaths between 1 January 2016 and 30 August 2018.[4] We identified seventeen deaths in IRCs, in prisons (while subject to immigration detention powers) or within five days of release from immigration detention over that period. In 2017, there were a total of eleven deaths, which marked an unprecedented and dramatic rise.

12. Following a recent Freedom of Information ("FOI") request to the Home Office submitted by INQUEST for data on deaths that occurred in IRCs and other relevant places of detention and asylum or pre-departure accommodation, the Home Office provided a table showing the number of people who died in IRCs from 2016 to 2019. Taking deaths in IRCs only, the Home Office recorded seven deaths of detained people between 2016 and 2019. Not all of the information that we requested in our FOI request

[2] http://www.medicaljustice.org.uk/wp-content/uploads/2016/09/MJ_death_in_immigration_detention__FINAL_WEB-1.pdf
[3] See Tables contained at Annex 1 and 2 of the Medical Justice Report for the deceased people's names, date and location of death, sex, age, nationality and cause of death, pp. 46-47, Ibid.
[4] https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=26167b21-82e2-44f9-91fb-0744f3b055ef

was provided, including data from 2020, which was declined on the basis that that data will be published shortly (we are not aware that such data has been published to date).

13. Since 2018, some information on deaths of detained people has been included in Home Office immigration statistics on an annual basis.[5] Those tables show that in addition to the seven deaths cited above between 2016 and 2018, there were at least three deaths in the community that are acknowledged by the Home Office to have resulted from an incident occurring while detained or where the Home Office has been informed of some credible information that the death might have resulted from their period of detention.

14. We made the above FOI request with a view to seeking information that would complement our own monitoring of the deaths of detained people. In contrast to the data that we regularly obtain from the prison service, the Home Office refused to provide us with the names, dates of birth and religions of the deceased.[6] The Home Office also did not provide us with requested data regarding ethnicity on the basis that "nationality" rather than "ethnicity" is what the Home Office use on a person's record. It is important to be aware that statistics in relation to "cause of death" in regard to deaths in detention at any given time will be limited by the fact that an inquest often will not be concluded until many years after the death. We are very concerned by the lack of transparency and oversight in terms of recording information in relation to deaths in IRCs and detention related deaths. The limited response from the Home Office to our FOI request is just one example of how difficult it is to confirm our own monitoring of deaths in detention, including at Brook House.

15. The scrutiny afforded to deaths of detained people by investigations, particularly inquests, can elicit important insights about policies and procedures across IRCs, patterns of mistreatment and failures to provide adequate care, and identify learning that is relevant at the national, as well as the local level. It is on that basis that INQUEST is well placed to provide this statement due to our unique overview of deaths in IRCs and the way that they are investigated and responded to.

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[5] https://www.gov.uk/government/statistics/immigration-statistics-year-ending-september-2020/list-of-tables#detention-and-returns, see tables 5a and 5b, which contain some data on deaths in the community following detention.

[6] Relying on Section 38 of the Freedom of Information Act 2000.

16. Below are summaries of five inquests that have investigated the circumstances in which people have died in immigration detention, and that illustrate powerfully some of the issues that I refer to in the remainder of this statement. In providing these examples, I have drawn upon information that has been provided for INQUEST by our caseworkers and also from information shared and/or published by ILG members. These are of course only five of the very many cases where there have been serious failings identified and which I believe point to systemic issues. There are other cases that I could have written about.

Brian Dalrymple

17. Brian Dalrymple was an American national who died on 31 July 2011 at Colnbrook IRC (having recently been transferred from Harmondsworth IRC). The inquest took place in 2014 and the Coroner's Preventing Future Deaths ("PFD") report was issued on 18 September 2014.

18. Mr Dalrymple suffered from schizophrenia and severe hypertension (very high blood pressure). He arrived in the UK as a tourist but was refused entry because his behaviour was "odd", and he was later detained at Harmondsworth IRC. A Home Office Chief Immigration Officer thought Mr Dalrymple needed a psychiatric assessment but his repeated requests for an assessment to be arranged went unanswered. Negative assumptions made by detention staff about Mr Dalrymple's behaviour contributed to a failure to identify problems. A locum IRC GP failed to obtain a record of his hospital medical treatment. Wing staff recorded increasingly bizarre behaviour but did not refer Mr Dalrymple for a mental health assessment and clinical staff never read the wing staff entries. When his behaviour deteriorated Mr Dalrymple was placed in segregation. He was later transferred to Colnbrook IRC where a mental health nurse immediately recognised that he was very mentally unwell but did not know about the hypertension because there was a failure to transfer his medical notes. As a result, a psychiatric assessment which should have been undertaken as a priority was arranged for a week's time. Mr Dalrymple then died of an aortic rupture four days after arrival at Colnbrook IRC, having been held in segregation until his death.

19. The Inquest heard evidence from IRC staff, one of whom described Mr Dalrymple's "muttering" to himself and urinating on the wall of his cell as "not unusual" as this is how "so many behaved" and a number of witnesses said they assumed the behaviour was explained by cultural differences rather than mental illness or distress. The 77-year-old locum GP employed by the IRC healthcare provider admitted in evidence that he had not heard of the Mental Capacity Act 2005, had received no induction training, did not know he could access wing records and had never heard of Rule 35 of the Detention Centre Rules 2001. As would be seen again in the case of Prince Fosu, the training and competence of locum GPs to treat people detained under immigration powers, and to know and understand the systems they are tasked with operating, appears to be a very real concern.

20. The Jury at the inquest into Mr Dalyrmple's death concluded that neglect was a factor. "Neglect" in the inquest context means a "gross" failure of basic medical attention.[7] The Coroner's PFD report[8] noted various matters of concern about which action needed to be taken to avert a risk that future deaths would occur: lack of awareness amongst detention staff of behaviours which may indicate mental illness and the need to ensure that potential indicators are brought to the attention of healthcare staff, particularly as significant reliance is placed on detention officers to raise concerns; detention staff had not received sufficient training and relevant and significant observations by detention staff and others were not actively brought to the attention of healthcare; deficiencies in the training and knowledge of the locum GP; medical visits to segregated detained people were inadequate to properly assess needs; and the absence of a computerised and accessible clinical record relating to each detained person.

Prince Fosu

21. Prince Fosu was a Ghanaian national who died in Harmondsworth IRC in October 2012. The inquest took place many years later in 2020 as the case had been subject to a

[7] For Guidance on the concept of neglect in Coroner's law, see the Chief Coroner's Guidance No.17, Conclusions: Short-form and Narrative, https://www.judiciary.uk/wp-content/uploads/2020/08/guidance-no-17-conclusions.pdf, paras 74-85.

[8] Regulation 28: Report to Prevent Future Deaths, 18/09/2014, Jeremy Chipperfield, Assistant Coroner, West London Coroner's court: https://www.judiciary.uk/wp-content/uploads/2014/11/Dalrymple-2014-0410.pdf

lengthy police investigation and consideration by the CPS. The subsequent PFD report was issued on 6 July 2020.

22. Prior to his transfer to the IRC Mr Fosu had been arrested while running naked in the street. In police custody he spent time naked and urinated on the floor of his cell. Home Office staff sent his police medical records to Harmondsworth IRC in advance and highlighted that a mental health assessment had taken place. Mr Fosu continued to exhibit peculiar behaviour on arrival, to the extent that the searching officer picked it up. Despite that, and the history from the police records, no one referred Mr Fosu to Harmondsworth IRC's mental health team from the IRC Reception or at any other time.

23. A few hours after he arrived at Harmondsworth IRC, Mr Fosu assaulted a member of staff and was placed under restraint and segregated under Rule 42 of the Detention Centre Rules 2001 on the IRC's separation unit. Staff treated him as a "dirty protester" and removed his bedding and mattress which were not returned for the remainder of his life. That was pursuant to a policy or practice at the time which was said to have been authorised by management. Once in the separation unit Mr Fosu was observed by staff over the next six days to be naked in his room and to have dirtied the cell with faeces and urine. He was usually recorded as lying on the floor or under his bed, rarely engaging with staff and most of his meals went uneaten. He remained living in these conditions until his death at the end of the six days.

24. Mr Fosu's death came to be recognised, by all who looked in detail at it, as having been profoundly shocking. The report in June 2019 into Mr Fosu's death of Sue McAllister of the PPO found that "No one [detention staff, Home Office managers, IRC doctors, the Independent Monitoring Board ("IMB")] referred him for a mental health assessment or even seemed to consider whether there might be any underlying physical or mental ill health conditions affecting his behaviour." [9] Although his segregation should have been independently reviewed every 24 hours by a Home Office manager, the manager who conducted these reviews did so without seeing or speaking to Mr Fosu herself. Apart from one very brief interaction, the doctors who were supposed to

[9] PPO Report (June 2019): Independent investigation into the death of Mr Prince Fosu, a detainee at Heathrow Immigration Removal Centre, on 30 October 2012, Introduction: https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2020/02/F1786-12-Death-of-Mr-Prince-Fosu-Harmondsworth-30-10-2012-NC-31-40-31.pdf

assess those on segregation each day also failed to see or speak to Mr Fosu. Staff on the segregation unit "appeared to assume that Mr Fosu understood what he was doing and was being purposefully disruptive." They "had apparently become de-sensitised to behaviour that appeared at the very least to suggest significant mental distress, and we consider that managers were responsible for a culture in which this could occur."[10] The PPO also commented, "There were several omissions from what I consider to be the basic requirements of caring for a detainee who has been segregated. No one considered whether there were any health reasons to prevent Mr Fosu being segregated, and the reviews of his segregation and reintegration planning were poor. I am particularly troubled that Mr Fosu lived in an unfurnished room without proper justification or review, which I consider to be inhuman and degrading. I consider that IRC managers were responsible for a culture which I can only describe as uncaring."[11]

25. At the inquest into his death in 2020, the jury's conclusions included: "The control points put in place to protect vulnerable detainees at Harmondsworth IRC were grossly ineffective. There was a gross failure across all agencies to recognise the need for and provide appropriate care in a person who was unable to look after himself or change his circumstances… [Mr Fosu's death] was in part due to the failure to assess, recognise, monitor and respond to Mr Fosu's deteriorating condition. Neglect contributed to the cause of death."[12]

26. The Coroner's PFD report noted two matters of continuing concern which required action: "all staff who would be expected to refer cases to healthcare need as much assistance as possible in order to discharge that responsibility effectively" with improved training needed on when to make a referral, and the IMB should report concerns to healthcare managers at the same time as reporting to the Home Office.

Tarek Chowdhury

[10] PPO Report (June 2019), Ibid, para 167.
[11] PPO Report (June 2019), Ibid, Introduction.
[12] Regulation 28: Report to Prevent Future Deaths, 06/07/2020, Chinyere Inyama, Senior Coroner, West London Coroner's Court: https://www.judiciary.uk/wp-content/uploads/2020/10/Prince-Fosu-2020-0148.pdf

27. Tarek Chowdhury was killed in Colnbrook IRC on 1 December 2016. The inquest took place in 2019 and a PFD report was issued on 2 April 2019.[13] The man who killed him was a Zana Ahmed, someone who was suffering from serious mental ill health with a history of violence, who had been transferred into the IRC shortly before. It was accepted by the Home Office at the inquest that Mr Ahmed should never have been transferred into an immigration detention centre in view of his violent behaviour in prison. There were failures to properly assess Mr Ahmed's mental health and his risk of violence and no one took responsibility for ensuring that it was safe for him to be there. At breakfast time, with no staff on the wing due to shortages, Mr Ahmed wandered around naked from the waist down before entering the room of 64-year-old Mr Chowdhury and beating him to death.

28. There were very particular failures in this case, including the Home Office having run out of prison beds and so deciding to transfer into the immigration detention estate more high risk men, without informing the IRCs of this policy.

29. This case also, however, shone a light on the failure of medical assessment. Mr Ahmed had been flagged for a mental health assessment, but the Home Office kept moving him and so one had not taken place. Information sharing failed. The SystmOne medical records system was not working, at least not on reception (the key moment for catching risky presentations) because staff said they could not search properly without a detainee number which they did not always have until one had been allocated or records had been reconciled. A detention custody officer from The Verne, who had also been a prison officer when The Verne was a prison, and where Mr Ahmed had been before Colnbrook IRC, explained how immigration detainees were different to prisoners. The transient nature of the population – with people being repeatedly moved for removal attempts – meant that relationships did not develop, and so staff never got to know them. This meant they were less likely to pick up problems.

[13] Regulation 28: Report to Prevent Future Deaths, 02/04/2019, Richard Furniss, Assistant Coroner, West London Coroner's Court: https://www.judiciary.uk/wp-content/uploads/2019/06/Tarek-Chowdhury-2019-0131_Redacted.pdf

30. The jury heard evidence that Mr Chowdhury was suitable for an interview for administrative removal without being detained but that he was held in an IRC due to an error by the Home Office.

Marcin Gwozdzinski

31. Marcin Gwozdzinski was a 28-year-old Polish national who died on 6 September 2017 at Heathrow IRC, three days after he was found hanging in his room.[14] The inquest into Mr Gwozdzinski concluded on 6 September 2017. The jury concluded that the main contributory factor was premature closure of suicide and self-harm prevention procedures ("ACDT") in the days leading up to his death.

32. Mr Gwozdzinski had told officers at the IRC that he could not take detention anymore and wanted to die. Just five days before he died, the ACDT to support Mr Gwozdzinski was closed with staff concluding that his only problem was toothache. No input was sought by detention officers from healthcare staff, contrary to national guidance. On 2 September 2017, Mr Gwozdzinski telephoned the Ambulance Service numerous times asking for assistance. In one of the calls that was played to the jury, Mr Gwozdzinski was heard asking the operator to come to the centre to save his life. The Ambulance Service operator was later heard calling the IRC to be informed that Mr Gwozdzinski was making hoax calls.

33. Concerns were raised by fellow detained people, including one detained person who took an officer to one side and showed the officer Mr Gwozdzinski's room, where he had been smashing things up. Very soon afterwards, Mr Gwozdzinski was found by other detained people hanging in his room.

34. The jury returned a lengthy list of failings which they found probably contributed to his death. These included the failure of several detention staff to take due care in following their own ACDT procedures "with more than just the minimum administrative effort"; failure of detention staff to consult with healthcare staff when Mr Gwozdzinski was on an ACDT; failure to assess Mr Gwozdzinski's mental health; and failure to train

[14] https://dpglaw.co.uk/jury-finds-systemic-failures-contributed-to-death-of-marcin-gwozdzinski/

healthcare agency staff in ACDT processes. Unusually, the jury found that there were "systemic failings" that had contributed to Mr Gwozdzinski death, specifically failure of administrative systems to work together and share information between healthcare and detention staff.

35. The inquest heard evidence that an internal investigation following Mr Gwozdzinski's death, conducted by Mitie (the private security company running Heathrow IRC), concluded that the notes of the assessment and case review were "poor" and "limited"; and that a quality case review could not be completed in such a short time. They recommended that those involved should not be allowed to have any further involvement in ACDTs until managers were satisfied with the quality of their work. They further recommended the previous Head of Safer Communities who took part in the three minute case review be removed from his role.

36. Extraordinarily, during the course of the inquest it became apparent that the results of the review had not been fed back to those involved, and whilst the previous Head of Safer Communities had been removed from his role another Residential Manager had continued to take part in ACDT case reviews. Staff involved in the ACDT continued to consider the actions they had taken were appropriate.

Carlington Spencer

37. Also very close to the relevant period was the death of Carlington Spencer who died in hospital after he suffered a stroke in November 2017 at Morton Hall IRC. The inquest into his death concluded in August 2020. Possible contributing factors identified by the jury at his inquest included inadequate management of his Type 1 Diabetes and numerous missed opportunities by "discipline" staff to sufficiently monitor him. A complacent attitude of the healthcare staff was also commented upon.

38. The Coroner's PFD report[15] said that the case demonstrated the failures of existing systems, management and working practices within discipline and healthcare staff. The

[15] Regulation 28: Report to Prevent Future Deaths, 28/08/2020, Timothy Brennand, Senior Coroner, Lincolnshire Coroner's Court: https://www.judiciary.uk/wp-content/uploads/2020/10/Carlington-Spencer-2020-0167_Redacted.pdf

long lists of failings included: the existence of "confirmation bias" or "confirmatory bias" when dealing with detainees with a known history of recreational use of drugs: when a detained person presented in a manner that was interpreted as being a consequence of being under the influence of drugs, this presumption and/or assumption is not challenged or tested or verified (as an example, by meaningful searches of the detainee or his room; review of CCTV evidence or escalation for advice from healthcare personnel); concerns of other detained people were not appreciated or noted or actively sought by the healthcare or discipline staff; poor record keeping and observation of those assumed to be self-intoxicated – record keeping was "partial, incomplete and undertaken in circumstances where the provenance of such records is unverifiable"; lack of meaningful training of self-induced intoxication, particularly in relation to "Spice" and poor systems of communication between discipline and healthcare when dealing with a presumed drug related incident. The Coroner recommended training to enable staff to appreciate the potential for their decision making to be affected by "confirmation bias" in addition to the need for diversity awareness training.

Mistreatment by failure of care and neglect by staff of detained people and healthcare

39. Whilst we do not have any first-hand knowledge of physical mistreatment or verbal abuse of detained people by staff at Brook House, or of violence or verbal abuse between detained people, in the relevant period, INQUEST does have wider experience of the mistreatment of persons by IRC staff in failing to care for vulnerable detained persons who have died. We have been involved in several inquests which have concluded that lack of care and neglect by detention, healthcare and Home Office staff contributed to the deaths in IRCs and those conclusions and the basis for them may well be relevant to this Inquiry. Issues often include failures to properly assess and care for the person who has died. Many deaths have exposed failures of safeguarding practices, such as Rule 35, which could have operated to prevent the unnecessary detention of vulnerable people suffering from mental or physical ill health. When detained people become ill, there are frequently inadequate healthcare facilities, failures in risk assessment, treatment and care and inadequacy in emergency response. There have also been occasions, however, that concern failures to assess and care for someone who goes on to kill another detained person.

40. These deaths also show that the very practice of indefinite detention creates vulnerability, on already vulnerable people, often with histories of trauma, exacerbated by the conditions and regimes operating. They reveal the reality of detention and its impact on the physical and psychological health of detained people as well as the often cruel and degrading treatment that they are subject to and the cultures of racism, indifference, and dehumanisation. Inquests have also exposed the impact of privatisation and the lack of accountability and additional secrecy this results in with the sub-contracting of various services and distancing of government from these.

41. All the cases that I have written about by way of example reveal systemic issues of a kind which may be relevant to the present Inquiry. Had changes been put in place following Mr Dalrymple's death, the death of Mr Fosu over a year later may have been prevented.

42. The investigations into the deaths of Mr Dalrymple and Mr Fosu heard evidence which suggested a lack of empathy on the part of detention staff, a tendency on the part of some to see a detained person as "other" and/or not worthy of care or attention in the same way (including a tendency to see behaviour as deliberate or malingering or somehow protesting) and a loss of a sense of individual responsibility for the welfare of detained people. Whilst the investigations did not directly examine the effect that racism and prejudice may have played in the failures of care, there were overtones of it in some of the evidence. I have in mind, in particular, staff referring to "cultural" reasons for detainee behaviour that should have been seen as clearly symptomatic of mental health ill health. This raises questions about racist and discriminatory treatment towards people held in immigration detention and how that bias is embedded in culture and practices and I suggest that the present Inquiry might want to be alert to this important area of investigation.

43. I would like here to refer to the Coroner's Report under Rule 43 of the Coroner's Rules 1984[16] arising from the death of Jimmy Mubenga, who died whilst in the custody of three Detention and Custody Officers employed by G4S ("**Exhibit DC1"**). I have

[16] The relevant provision at the time for raising matters of concern for preventing future deaths.

chosen to exhibit that report to this statement and I particularly want to draw the Inquiry's attention to the section of that report that addresses "Racism: Culture and Personnel", starting from paragraph 39 onwards.

44. Many of the issues uncovered by these inquests persist today: the detention of very seriously unwell people in IRCs; the failure to identify indicators of mental illness; the mis-characterisation of behaviour related to mental ill health as non-compliant behaviour; the inappropriate use of segregation to manage those who are mentally ill; the use of locum GPs who are unfamiliar with the detention environment and the Detention Rules they are supposed to operate under; and the training issues that lie behind these other issues. All of these matters remain a concern and I understand these are issues linked to those the Inquiry is considering.

45. There is also, however, one further issue. This concerns the professional culture, ethics, and personal responsibility of those who work in immigration detention. The striking thing in the Prince Fosu case, for example, was the number of professionals who walked away, who simply lost sight of the human being before them, the shocking dehumanisation of a vulnerable man. That was not just detention custody officers, but also senior Home Office staff, two nurses, four GPs, and three members of the IMB. It is notable that the IMB in particular recognised this problem and recognised that they needed to train their volunteers more, not just about matters such as mental health awareness, but in order to ensure that members had the confidence to challenge other staff, and not take things at face value (indeed, the IMB expressly aligned themselves with a submission from the family that there should be a PFD report aimed at improving professional responsibility).

46. I hope the Inquiry will keep all these things in mind and try to draw together the various strands to build on what has been seen before. This is a unique opportunity to do so. All these cases shockingly illustrate how failings by detention, healthcare and Home Office staff can contribute to the death of a detained person. Whilst there were no deaths at Brook House in the relevant period, and the Inquiry is therefore concerned with mistreatment that contravenes Article 3 ECHR rather than Article 2, unless there are real and long-lasting changes to remedy these matters there is a significant risk that future failings of this nature could result in deaths or serious harms at Brook House.

Healthcare

47. Our casework evidence at INQUEST continues to point towards severe levels of neglect in the delivery of healthcare services to detained people at IRCs. In addition to the observations above, many of which are relevant to the provision of healthcare, I will make some points specifically about healthcare and also refer briefly to further inquests that have identified serious deficits in the area of healthcare.

48. Muhammad Shukat died on 2 July 2011 following a cardiac arrest at Colnbrook IRC. It was found by the jury hearing the inquest in May 2012 that neglect contributed to the death of Mr Shukat. As referred to in the case examples that I have provided, "neglect" in the inquest context means a "gross" failure of basic medical attention. It is a relatively rare finding for an inquest to reach. Amongst the jury's comments, it was stated that "there was a total and complete failure of care in the management of his health at Colnbrook". The particular failings included in relation to the use of diagnostic tools; to call an ambulance in a timely fashion; to apply CPR immediately; and a systems failure in the provision of defibrillators. Mr Shukat's room-mate, a 19 year old man, had been for almost two hours calling for help and asking for a doctor before assistance eventually arrived.[17] The jury also commented on the fact that the preliminary investigation report into the death of Mr Shukat by Colnbrook Healthcare had failed to identify any of the above matters.

49. Another death which occurred in close proximity to the relevant period was that of Bai Bai Ahmed Kabia who died in December 2016 at Morton Hall IRC of a brain haemorrhage arising from an undiagnosed malformation of blood vessels in his brain. The jury at his inquest found that there was a missed opportunity for his ill health to be diagnosed and treated and that his death at Morton Hall IRC could have been prevented. Other detained people raised concerns that he may have suffered a seizure, yet he was not referred to a doctor and instead the staff thought that he might have taken illicit substances.

[17] https://detentionaction.org.uk/2011/10/02/man-pleaded-for-help-for-dying-room-mate/

50. Some of the issues emerging from these investigations are insufficient training for GPs and other healthcare professionals; the employment of unskilled staff; a culture amongst healthcare staff that is uncaring and disbelieving of detained people and lack of accountability, which we see repeated death after death, year after year, with no real change. This raises concerns about the role and effectiveness of monitoring by oversight bodies and in relation to health, the Care Quality Commission ("CQC").

51. The death of Carlington Spencer, about which I have included a summary, was also close to the relevant period and the recommendations of the Coroner in regard to confirmation bias and diversity awareness training would appear to be important areas for the Inquiry to explore.

Drugs/alcohol

52. Whilst at INQUEST we do not have direct knowledge of the availability of drugs/alcohol at Brook House during the relevant period we know from the case of Mr Spencer above, and other deaths, that detention and healthcare staff often make assumptions that a person has taken an illicit substance and in doing so fail to investigate other potential reasons for behaviour. I understand there is evidence that New Psychoactive Substances ("NPS"/Spice) were readily available and prevalent at Brook House in the relevant period and that detained people were frequently falling ill from the use of Spice. That is unsurprising to me; precisely the same was and is true of the prison estate. NPS presents a very real problem and is a feature in a large number of prison deaths. The points that were identified by the inquest into Mr Spencer's death are therefore likely to be relevant.

Suicide/self-harm

53. I also want to touch on the issue of suicide and self-harm in immigration detention. I understand that the treatment of those who exhibit these ideations are within the purview of the Inquiry.

54. I know a lot about suicide, other self-inflicted deaths and self-harm arrangements in prison, because around 80 prisoners a year die in this way and INQUEST is involved in a lot of those inquests. I also know that the arrangements for dealing with suicide and self-harm in immigration detention are based on those used in prisons, i.e. PSI 64/2011[18], although procedures in IRCs are organised via local systems.

55. Amir Siman-Tov died at Colnbrook IRC on 17 February 2016 following an overdose of painkiller medication. The Coroner's PFD report[19] identified a catalogue of failings in regard to the operation of systems for the management of self-harm and suicide, including ACDT.[20] Mr Siman-Tov had pronounced mental health vulnerabilities and there were a number of documented suicide attempts. The Coroner's PFD report details the fact that he remained formally on constant watch from his arrival at Colnbrook IRC until his death, repeatedly expressed suicidal thoughts and articulated that he would save his medication and take an overdose. Amongst the failings identified in the Coroner's PFD report, a GP who had seen Mr Siman-Tov during his detention, "told the jury that he [had] never seen and was not aware of the content of ACDT documents". The nurses were "similarly uncertain of their role with respect to the ACDT process". On the night of Mr Siman-Tov's death, no explicit handover or instruction was given to the staff on duty in regard to observations. Again, as with other cases I have mentioned, we see clinical staff unaware of detention systems.

56. The following calendar year, Marcin Gwozdzinski died at Heathrow IRC, on 6 September 2017. The jury at the inquest concluded that the main contributory factor was the premature closure of an ACDT days before his death.

57. These cases illustrate with tragic consequences the problems in the handling of self-harm and detained people at risk of self-inflicted death in the immigration detention context.

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[18] https://www.gov.uk/government/publications/managing-prisoner-safety-in-custody-psi-642011

[19] Regulation 28: Report to Prevent Future Deaths, 28/08/2019, Dr Séan Cummings, Assistant Coroner, West London Coroner's Court: https://www.judiciary.uk/wp-content/uploads/2019/11/Amir-SIMAN-TOV-2019-0302_Redacted.pdf

[20] "Assessment Care in Detention and Teamwork" is the care planning system used for monitoring detained people who are identified as at risk of self-harm.

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

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

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

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

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

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

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

Oversight – IMB, PPO and HMIP

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

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

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

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

breach of the ECHR. At INQUEST, we routinely see cases where contemporary Inspectorate reports make broad findings that the standards are "good", for example mental health care or ACDT management, and then inquests investigating deaths in the same period, heard often many years later, find serious failings in relation to the same processes. We regularly see discrepancies between the findings of the relevant HMIP reports and IMB reports and issues raised by juries in their inquest conclusions or by Coroners in PFD reports. This all follows because inquests allow for oral evidence and questioning matters, and the intensity of examination and scrutiny means a clearer picture is obtained.

64. If any of the oversight bodies were to hear a credible allegation or indeed encounter evidence of an immediate or recent breach of Article 3 ECHR, there is nothing that I am aware of in their methodology that would ensure that this was reported to an independent body, in line with international standards. It is not clear what inspectors or monitors would do in such an instance but it could include reporting back to the prison or triggering safeguarding protocols. The PPO, as an independent body, may be best placed to investigate such allegations but I am not aware of an active mechanism by which incidents would be referred or escalated.

65. I would also add that a feature of deaths in immigration detention is the family is often abroad, which can often mean that the family is not informed by the Home Office or Coroners of their rights to representation, and how to access specialist support and advice. This means that the inquest may go ahead without anyone representing their interests. This can result in the inquest not being as effective. INQUEST tries to act, identifying families and referring them to specialist lawyers, but it is not always possible. Coroners do not always adjourn to allow time for this to happen.

66. INQUEST made written submissions in September 2020 to Ministry of Justice's consultation on "*Strengthening the Independent Scrutiny Bodies through Legislation*".[21] At paragraphs 6-15 we set out our broad questions and proposals for strengthening the roles and independence of the IMBs, HMIP and the PPO to improve the scrutiny these bodies apply. As we explained in those submissions, there is a need to consider

[21] https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=dccc37dd-5130-46b4-8125-b36b2a954491

the extent to which the scrutiny bodies individually and collectively safeguard the rights of people in detention, prevent abuse and mistreatment, learn from systemic failures (whether in individual cases or relating to wider policy) and hold government and detention authorities to account. We have long campaigned for a more rigorous approach to learning from individual cases, and better systems for accountability.

67. On the PPO specifically, we support the Ministry of Justice's proposal to put the body on a statutory footing.

68. In addition to the above oversight bodies, it will be relevant for the Inquiry to consider the role of the CQC as the body that monitors and inspects healthcare provision in immigration detention.

69. Racism and discrimination against immigration detained people is an issue that must not be overlooked. It is prevalent but not always found in direct language. One needs to look harder, and more intelligently. Yet I have never seen racism form part of the terms of reference for a PPO investigation. The inquest into the death of Jimmy Mubenga, mentioned above, revealed a culture of racism within private contractors and complacency and inaction by management. It is eleven years since Mr Mubenga died but at INQUEST we have seen no evidence of cultural change. HMIP and IMB reports also rarely, if at all, specifically deal with racism and discrimination.

70. In terms of criminal justice system involvement in post incident investigations, cases of mistreatment, restraint or death that result in a criminal prosecution, let alone conviction, are vanishingly rare. The fact that the eventual criminal prosecution into the death of Mr Mubenga did not result in convictions is a case in point. Prior to the inquest, the Director of Public Prosecutions ("DPP") had decided that there was insufficient evidence to justify criminal charges. It was only after the inquest returned a finding of unlawful killing that the case was reviewed by the CPS and the officers prosecuted for manslaughter (none were found guilty by the criminal court).

71. In the case of Mr Fosu, there was a decision to prosecute, but five years later, following a change in advising counsel, the DPP reversed that decision. I understand that decision

is again being revisited, in the wake of the evidence uncovered by the inquest. However this looks like too little, far too late.

Oversight – the National Preventative Mechanism

72. As the Inquiry will know, the UK National Preventive Mechanism ("NPM")[22] was established in 2009 after the UK ratified the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment[23] ("OPCAT") in December 2003. The role of the NPM is to strengthen the protection of people in detention through independent monitoring. It is made up of 21 statutory bodies that independently monitor places of detention, including the IMBs, HMIP and the CQC. The NPM focuses attention on practices in detention that could amount to ill-treatment, and works to ensure its own approaches are consistent with international standards for independent detention monitoring.

73. The UN Subcommittee on Prevention of Torture ("UN SPT") made its first visit to the UK in September 2019 and reported on 26 February 2020[24], with observations and recommendations addressed to the NPM, which are relevant to this Inquiry.

74. The UN SPT report addressed to the NPM emphasises (at paragraph 39) the need to put the NPM on a statutory footing, including the need to put OPCAT responsibilities of individual NPM members (including IMBs and HMIP) on a statutory basis. INQUEST supports this recommendation.

75. Importantly, the UN SPT concluded (at paragraphs 80-82) that the NPM and individual NPM bodies should have a more "preventive" and human rights-based focus. At paragraph 80 the UN SPT stated:

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22 https://www.nationalpreventivemechanism.org.uk/

23 https://www.ohchr.org/en/professionalinterest/pages/opcat.aspx

24 Report of the UN Subcommittee on Prevention of Torture: Visit to United Kingdom of Great Britain and Northern Ireland undertaken from 9 to 18 September 2019: recommendations and observations addressed to the national preventive mechanism: https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2020/12/SPT-Report-to-UK-NPM-CAT.OP_.GBP_.RONPM_.R1.pdf

"The SPT considers that monitoring visits carried out by NPM bodies are being largely geared towards needs' assessments of persons deprived of liberty, and aimed at ensuring that places of deprivation of liberty, including psychiatric facilities, comply with the existing national standards. In this connection, the Subcommittee believes that the preventive focus of visits conducted by NPM to places of deprivation of liberty must be strengthened"

76. As regards the IMBs, the UN SPT commented that they are "*often regarded as a body inspecting material conditions of the day-to-day life in the removal center, rather than an interlocutor working for human rights of persons deprived of their liberty. During the visit to the IRC, the SPT noted that some persons deprived of liberty perceived IMB members as insensitive to their concrete allegations (a person alleging recent beatings and presenting injuries in his head, a man reporting risk of refoulement, etc.) and some went as far as alleging that IMB is part of IRC administration."*[25]

77. The UN SPT recommended that the IMB have a system to refer complaints capable of amounting to human rights abuses:

"*91. While acknowledging that the IMB members are not in the position to deal with individual complaints, and while noting the levels of anxiety and frustration of persons awaiting a removal, the SPT suggests that a referral system be envisaged, so that to preserve the reputation of the IMB of an impartial advocate for human rights of persons deprived of their liberty.*"

78. The UN SPT recommendations (at paragraph 105) of relevance include that NPM bodies (which includes the IMBs and HMIP) should:

"ensure that their working practices are consistent with standards for preventive monitoring;"

"establish and use the referral system for individual complaints, which should not be handled by the NPM;"

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[25] Report of the UN Subcommittee on Prevention of Torture: Ibid, Paragraph 90.

79. The UN SPT reported to the UK government on 25 May 2021.[26] The report includes a recommendation (summarised at paragraph 52 of the report) that the mandate and responsibilities of a NPM be incorporated into the statutes of individual members (which includes HMIP and IMBs).

Current position

80. I do not have any direct knowledge or experience of the current position at Brook House and whether treatment (physical and health) of detained persons has improved.

81. However, it is a concern that the most recent full HMIP Inspection Report of July 2019[27] found that "Self-harm had increased significantly and ACDT procedures were not consistently applied." (Paragraph S4). The report commented that "40% of detainees said they had felt suicidal while in the centre, reflecting a high level of distress among the population. The number of self-harm incidents had risen substantially since the previous inspection. The quality of ACDT documentation was not good enough. Assessments and reviews were timely but care maps frequently lacked detail, case reviews were not *sufficiently* multidisciplinary and some post-closure reviews were not completed. ACDT observations were regular but did not always demonstrate enough meaningful engagement. Not all key departments attended the safer community meetings and there was little evidence of actions being taken in response to the very useful data that were gathered and presented." (Paragraph S10).

82. GPs were still not complying with Rule 35 requirements in that: "Despite a higher level of self-harm than at the last inspection, and nearly a hundred constant watches in the previous six months, no Rule 35 reports had been completed on suicidal ideation." (Paragraph S9).

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[26] Report of the UN Subcommittee on Prevention of Torture: Visit to the United Kingdom of Great Britain and Northern Ireland undertaken from 9 to 18 September 2019: recommendations and observations addressed to the State party - Report of the Subcommittee: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CAT%2fOP%2fGBR%2fROSP%2fR.1&Lang=en

[27] https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/09/Brook-House-web-2019.pdf

83. This all speaks to the observation I have made that, whilst we have not been involved directly with incidents at Brook House, it is deeply concerning that HMIP has identified shortcomings in processes and procedures at Brook House that are similar and echo the type of systemic failings that have been identified by inquests concerning deaths at other IRCs. The Home Office should be acting across the piece to enact learning from inquests across IRCs.

84. It is also a concern that there has been limited HMIP scrutiny of Brook House since Panorama, and during the COVID-19 pandemic. It is approaching four years since the programme was aired, which did of course have the unique benefit and insight of undercover reporting and camera footage – a truthful account of the institution, something not available to inspection and oversight bodies. In addition though, I would have expected that, following Panorama, the Home Office itself would have recognised that ongoing matters at Brook House are worthy of more scrutiny, and for that matter, systemic issues across the detention estate.

85. Since 2017, there has been only one full inspection. There is a question mark over whether HMIP have been sufficiently focused on the issues of interest to the Inquiry during the pandemic – their approach to scrutiny of the IRCs during the pandemic has been limited.[28]

86. The most recent report of the IMB for Brook House (published May 2021) suggests very significant concerns: "…centre's systems, detainees and staff under great stress and raised some serious concerns for the Board. Most notably, there was a dramatic increase in levels of self-harm and suicidal ideation, deficiencies in the induction process and increased needs for legal support and Detention Centre Rule 35 assessments."[29]

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[28] HMIP, Alternative approach to scrutiny of immigration removal centres during the COVID-19 pandemic, 20 April 2020: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/03/Short-scrutiny-visit-briefing-document-for-IRCs-for-website.pdf

[29] Executive Summary 3.1: https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2021/05/Brook-House-AR-2020-for-circulation.pdf

87. The recent UN SPT report to the government referred to above also set out the fundamental concern about immigration detention: "that the absence of a time limit may lead to de facto indefinite detention, affecting the mental health of migrants deprived of their liberty and increasing the risk of torture and ill-treatment" (Paragraph 55); the failure (in all UK places of deprivation of liberty) to implement the Istanbul Protocol, (Paragraphs 67-71) and criticisms of healthcare in IRCs and concern "about reports of a significant increase in deaths, especially self-inflicted deaths, in immigration detention over recent years." (Paragraph 100).

Recommendations

88. I have been asked to set out any suggested recommendations which INQUEST think might help to prevent a recurrence of the mistreatment identified on Panorama.

89. There have been repeated, myriad recommendations over many years made by INQUEST and other NGOs campaigning to end the dehumanising experience that we believe is inherent in immigration detention, that by its nature makes all detained people very vulnerable.[30] However, drawing on my own experience – and I have included many examples of the mistreatment and harm that have resulted in the deaths that have remained a tragic constant in the immigration detention estate – what really seems to be necessary is a shift in culture. The type of mistreatment and unhealthy culture that was exposed by the Panorama documentary is not an isolated or accidental event. It was a snapshot of a failing system. The chance of such events occurring increases exponentially where there are multiple private and contracted providers and fragmentation of responsibility for detained people's welfare, safety, physical and mental integrity across multiple organisations. That creates information sharing problems – a common feature in deaths in custody – but often overlooked is the effect it has on professional responsibility. Too often, we see professionals assuming that someone else will do it, or that someone has already done it. This is not just about

[30] Please refer to recommendations made jointly with Medical Justice in the 2016 report, *Death in Immigration Detention: 2000 – 2015*:
http://www.medicaljustice.org.uk/wp-content/uploads/2016/09/MJ_death_in_immigration_detention__FINAL_WEB-1.pdf

whistleblowing the worst abuses; it concerns officers taking day to day professional responsibility.

90. A profound shift in culture is required, which foregrounds people who are detained as human beings worthy of proper care and treatment and worthy of being treated with dignity and respect. Much clearer structures and lines of responsibility are necessary. It is not only important that junior level staff are held responsible and accountable; but that there is a system for corporate level responsibility and accountability for the continuation of unsafe practice and systems. I think that significant time should be devoted, by specific, experienced individuals to understanding these matters and what might be done to strengthen protections, in order to root out the causes of the mistreatment and the failure of the safeguards that seems to have been endemic at Brook House in 2017.

91. There needs to be far greater action taken in response to the failings identified at inquests across the IRC estate so that it is recognised that operational and systemic failings contributing to the deaths of detained people are relevant across the IRC estate, at national as well as local level. There needs to be a much more proactive role on the part of the oversight, inspection and monitoring bodies to ensure that changes are enacted.

Statement of Truth	
I believe that the facts stated in this witness 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	Deborah Coles
Signature	**Signature**
Date	22 September 2021
