Tuesday, 5 April 2022
(10.00 am)
THE CHAIR: Good morning, thank you. Mr Altman, good morning.
MR ALTMAN: Thank you, chair.
Closing statement by MR ALTMAN
MR ALTMAN: Chair, the purpose of my remarks this morning is to outline counsel to the inquiry's suggested approach to the making of findings of fact by you under the inquiry's terms of reference. Can I say immediately that a note containing these submissions has already been circulated to all core participants.
So that those listening can follow the remarks I am about to make, can I set out my headings. First, I am going to deal with what we submit to be the correct approach to the standard of proof; second, the type and quality of evidence required to meet the standard of proof; and, third, its application to the evidence the inquiry has received during the course of these hearings. Finally, I am going to deal with the kind of questions which ought to be considered by you before you arrive at individual conclusions on article 3.
So let me start by setting out how the terms of reference relate to the findings that you, chair, will be considering under article 3.

The terms of reference invite you to reach conclusions about the treatment of detainees held at Brook House during the relevant period. Where there is credible evidence of mistreatment contrary to article 3 -- that is to say, torture, inhuman or degrading treatment or punishment -- and then make any such recommendations as may seem appropriate.
Point 1 of the terms of reference states the inquiry will investigate "the treatment of complainants, including identifying whether there has been mistreatment and identifying responsibility for any mistreatment."
Points 2 to 6 of the terms of reference require investigation of methods, policies, practices, et cetera, that caused or contributed to identifiable instances of mistreatment. These issues are only relevant to the article 3 assessment if the failure of those policies, practices, et cetera, or cumulatively if the policies or the implementation of those policies were, by their very nature, of such a poor standard that they would reach the high article 3 threshold, rendered the detained persons vulnerable, or more vulnerable, to the identified abuse.
It is our view that you should not identify failures in policies and practices alone as amounting to

article 3 violations but only when they are accompanied by identified mistreatment or abuse that is linked to those failures.
We suggest it is open to you to make findings of investigative failures under article 3 where such failures created the environment in which individual cases of abuse could occur. We submit that there are two essential questions to be answered before any finding regarding the credibility of a claim can be made.
First, do the facts give rise to an identifiable incident of physical or verbal abuse capable of amounting to article 3 mistreatment; and second, if so, does it amount to article 3 mistreatment?
So with that in mind, what are the principles which may be applied when considering the correct standard of proof to be applied when assessing the credibility of a claim of article 3 mistreatment? The Inquiries Act of 2005 and the Inquiry Rules of 2006 do not assist, as they don't provide for any burden or standard of proof to be applied when an inquiry finds facts. Inquiries have, therefore, adopted different approaches to the standard of proof as required by the particular factual circumstances.
In his ruling on the standard of proof in the

Undercover Policing Inquiry, the late Sir Christopher Pitchford concluded:
"1) The panel of a statutory public inquiry is not required to adopt any specific standard of proof so long as it acts fairly;
"2) Uniform application of the criminal standard of proof is most unlikely to be appropriate, even in inquiries involving grave conduct. However, this does not mean that the chair cannot express him/herself as being 'sure' that something occurred if it chooses to adopt a flexible and variable approach to the standard of proof.
"3) When deciding upon its approach to the standard of proof, an inquiry should have regard to the task which has been set for its terms of reference. As long as he/she acts fairly, the chair is free to decide upon an approach to findings of fact which best suits discharging the inquiry's terms of reference.
"4) The majority of recent public inquiries have found it appropriate to adopt a flexible and variable approach to the standard of proof so as to enable a full and nuanced approach to the determination of facts.
"5) Expressions of suspicion are permissible. They are properly analysed not as findings of fact, but as comment permitted under section 24(1) of the Inquiries

Act 2005."

Sir Christopher Pitchford acknowledged that recent public inquiries have adopted a flexible and variable approach to the standard of proof so as to enable a full and nuanced approach to the determination of facts, as I say. He said that most inquiries, including those concerned with homicide, have taken the civil standard of proof as their starting point. He relied in part on the approach in the Baha Mousa Inquiry.

In that inquiry, Sir William Gage, who was the chair, adopted "the flexible and variable standard of proof as applied in the Shipman Inquiry". He explained his approach at paragraph 1.114 of the inquiry's report, saying:

"... where in this report I use such expressions as 'I am sure' or 'I have no doubt', I will have found a fact to the criminal standard. When I state simply 'I find', the standard of proof will have been the ordinary civil standard of proof, namely, the balance of probabilities. Where it is obvious that I have found a fact, but have not used the words 'I am sure' or 'I find', the standard will have been the civil standard. All other expressions, such as an expression of 'suspicion', will not be a finding of fact, but will indicate my state of mind in respect of the issue being

considered."

Chair, we invite you to take a similar approach.

The starting point in relation to the appropriate standard of proof, as stated in European Court jurisprudence is that in cases of ill-treatment in detention under article 3, the court should adopt the standard of proof "beyond reasonable doubt", or being sure. However, in the case of Ananyev v Russia, the European Court found that it has never been the court's purpose to borrow the approach of the national legal systems that use that standard. Its role is not to rule on criminal guilt or civil liability, but on contracting states' responsibility under the Convention. It adopts conclusions that are supported by the free evaluation of all evidence, including inferences that may flow from the facts and the parties' submissions. The European Court said that, according to its established case law, proof may follow from the coexistence of sufficiently strong, clear and concordant inferences or of similar unrebutted presumptions of fact, adding that the level of persuasion necessary for reaching a particular conclusion and, in this connection, the distribution of the burden of proof, are intrinsically linked to the specificity of the facts, the nature of the allegations made and the Convention right at stake.

In terms of the quality of the evidence required to prove such an allegation, European Court in Ananyev took into account the "objective difficulties" experienced by prisoners in collecting evidence to substantiate their claims about conditions in detention. It added that an applicant must, nevertheless, provide "an elaborate and consistent account of the conditions of his or her detention, mentioning the specific elements ... Only a credible and reasonably detailed description of the allegedly degrading conditions of detention constitutes a prima facie case of ill-treatment ..."

So, chair, in light of those principles, we consider that the following approach to the standard of proof and to the quality of the evidence should be followed by you.

First, a variable and flexible approach to the standard of proof should be adopted, as was favoured in the Baha Mousa and Undercover Policing Inquiries.

Second, as in the Baha Mousa Inquiry, the starting point should be to apply the civil standard of proof -- in other words, "on the balance of probabilities" -- when determining whether the alleged incidents of mistreatment did occur. This recognises the inquisitorial nature of inquiry proceedings as compared with legal proceedings that affect a person's rights,

liabilities and obligations, and the fact that no participant in the proceedings has a "case" to prove.

Third, where, however, you are "sure" -- which is the criminal standard -- that an alleged incident of mistreatment did occur, it may be appropriate to say so.

Fourth, at the other end of the spectrum, where you are unable to reach a conclusion "on the balance of probabilities", it may, nevertheless, be appropriate to record a "possibility" or a "suspicion".

Fifth, to find a violation of article 3, there must be "sufficiently strong, clear and concordant inferences or similar unrebutted presumptions of fact". The supporting evidence must be "elaborate and consistent ... mentioning the specific elements ... credible and reasonably detailed".

Finally, sixth, consideration must be given to the difficulties of detained persons in providing corroborating or supporting evidence.

Chair, in order to find an allegation credible, you might also wish to consider the following questions: first of all, how clear and detailed is the evidence of mistreatment?

Second, are there other similar unrebutted facts that have been established?

Third, is a complainant's account of mistreatment

consistent with any other account the complainant has given, or with other evidence independent of his account?

Fourth, what other evidence is there to support a complaint of mistreatment? In this regard, the absence of evidence in support is not determinative.

Fifth, what is the quality of that evidence?

Sixth, is there any evidence that contradicts or rebuts the account? If so, what is the quality of that evidence?

Seventh, if rebuttal evidence ought to have existed and doesn't -- for example, because there are missing records -- what, if any, inferences can be drawn from their absence?

Let me now move on, please, to what type of treatment can be considered as article 3 mistreatment. Article 3 speaks of "inhuman or degrading treatment or punishment". The word "punishment" may be given its ordinary meaning. European Court case law tends to focus more on the words "inhuman or degrading" while the words "treatment or punishment" have attracted little attention, but, by way of example, the European Court has found that the imposition of a disciplinary punishment by the segregation of prisoners who suffer from serious mental disturbance runs counter to the

requirements of article 3. It would therefore be open to you, chair, to find that it was "punishment", for instance, if a detained person was moved to the CSU, the Care and Separation Unit, in Brook House, by the improper or deliberate misapplication of rules 40 or 42.

What about "torture"? Before treatment or punishment can be characterised as "torture", it must be deliberate, inhuman treatment, causing very serious and cruel suffering. It has to "attain a minimum level of severity", considering all the circumstances of the case, such as the duration, the physical or mental effects of that treatment or punishment, and the age and state of health of the victim.

The important point to note is that a very high degree of physical suffering, and often humiliation intentionally inflicted by someone acting officially, is needed to reach the minimum level of suffering in order to qualify as torture. An episode of relatively short duration wouldn't likely reach the necessary level of suffering and humiliation to qualify as torture. If the treatment or punishment did not amount to torture, the question then is whether the treatment was "inhuman or degrading".

It is "inhuman" if it causes intense physical or mental suffering. It is "degrading" if the treatment

arouses in the victim feelings of fear, anguish and inferiority, capable of humiliating and debasing. As was said in the case of Rooman v Belgium in the European Court, although the question whether the purpose of the treatment is to humiliate or debase a victim is a factor to take into account, the absence of such a purpose cannot conclusively rule out a finding of a violation of article 3.

In terms of vulnerability and mental illness, the case of Rooman sets out the principles to be followed, and they are these:

First, detainees are in a vulnerable position and the authorities are under a duty to correct them.

Second, detainees with mental disorders are more vulnerable than ordinary detainees.

Third, certain requirements of detained life pose a greater risk that their health will suffer, exacerbating the risk that they suffer from a feeling of inferiority and are necessarily a source of stress and anxiety. In such circumstances, there must be increased vigilance in reviewing whether article 3 has been complied with.

Fourth, and finally, the assessment must also take into consideration the possibility that a detainee may be unable to complain coherently, or at all, about how

they are being affected by any particular treatment.

So, chair, with all of that in mind, the following non-exhaustive list of questions may assist you when making a determination about whether and what treatment constitutes an article 3 breach.

First of all, was the treatment or punishment physical or verbal?

Second, what was the severity of the treatment or punishment?

Third, what was its duration?

Fourth, was there any racist, religious or homophobic element to it?

Fifth, was there an intention to humiliate and degrade?

Sixth, what was the physical or mental effect of the treatment or punishment?

Seventh, if it was physical, did the detained person suffer injuries?

Eighth, if it was mental, was there mental suffering as a result?

Ninth, was the detained person's state of physical or mental health such as to make him more vulnerable to the treatment or punishment?

Tenth, did the detained person's age make him particularly vulnerable to the treatment or punishment?

And eleventh, bearing in mind all the circumstances of the case, three further sub-questions, as it were:

First of all, was it torture? Did it amount to deliberate, inhuman treatment causing very serious and cruel suffering, such that it obtained a minimum level of severity considering all of the circumstances.

Second, further or alternatively, was it inhuman treatment or punishment? Did it cause intense physical or mental suffering?

And finally, third, further or alternatively, was it degrading treatment or punishment? Did it arouse in the victim feelings of fear, anguish and inferiority, capable of humiliating and debasing?

So, chair, that is all I propose saying by way of closing remarks on behalf of counsel to this inquiry.

You may now wish to invite the core participants to address you, beginning with counsel on behalf of D1527, D523, D2077, D1538, D313, D1914 and Reverend Nathan Ward.

THE CHAIR: Thank you very much, Mr Altman, I am grateful. Ms Harrison, I am grateful.

Closing statement by MS HARRISON

MS HARRISON: Chair, if I could clarify, as I did in opening, it is my intention to make submissions on the systems and institutional failures, the generic issues

that arise in the context of this inquiry. I do so on behalf of all of the core participants represented by Duncan Lewis Solicitors and Bhatt Murphy Solicitors, but my submissions will be followed by Ms Morris on behalf of Reverend Nathan Ward. In terms of addressing the criminal question for the individuals, whether there is credible evidence in the case of mistreatment, and their links to the systemic and institutional issues that I will outline, that will be addressed first by Mr Goodman, on behalf of the Duncan Lewis core participants, along with Mr Lee, and, finally, on behalf of the individual core participants, represented by Bhatt Murphy Solicitors, that will be by Ms Shu Shin Luh.

THE CHAIR: Thank you, Ms Harrison.

MS HARRISON: I hope that we can conclude that within the two hours we have been allocated.

THE CHAIR: Am I right in understanding we will hear from you for the first hour, and then, I assume, at that point, we will maybe take our morning break and then we will pass to others who are going to represent individual clients?

MS HARRISON: I think it is intended I will conclude my submissions, then we will have the break, and then go on to -- I get the indication of the hour, and I am going

to try my absolute best.

THE CHAIR: Thank you.

MS HARRISON: Can I say then in -- as we did in opening, we highlighted the two main tasks for the inquiry in its evidential phases. The first was to bring to light the full facts of what happened at Brook House; identify the dangerous policies, practices, management and arrangements that caused or contributed to mistreatment; identify responsibility for any mistreatment to inform what remedial course of action is necessary and prevent its recurrence. That is of particular importance in this inquiry because, as we now know, there have been numerous past investigations, reviews and test cases, all of which have failed to achieve that critical goal.

The second important task for the inquiry in its evidential phases was to give the former detained persons an important opportunity to confront those responsible for their mistreatment and abuse and on an equal footing. It is an important part of restorative justice to be able to question and hold to account not just the frontline staff who perpetrated acts of violence, physical and mental abuse, humiliation, medical neglect and disregard of their suffering and denial of their human dignity, but also the absent, complicit and complacent senior managers

running the centres and sitting in corporate offices of G4S and the Home Office.

The latter has always been a priority for the individual core participants, who want to ensure that the mistreatment and abuse that they experienced is not repeated. This has been at some personal cost for many of them, but they have been willing to relive these traumatic and life-changing experiences to achieve that purpose. Putting their experience and their wishes at the heart of this inquiry in these hearings as you, chair, promised, has been achieved, but it now must be your task to deliver that in respect of your findings and recommendations, to ensure, as they wish, that no one else suffers what they did whilst detained at Brook House.

Medical Justice and Nathan Ward want the impunity that has marked the system for so long to end. They know all too well, from direct knowledge of the institutions, and bitter experience, that the sacking of a handful of custody officers, albeit guilty of grave misconduct, did not beginning to identify or address the root causes or contributory factors in the mistreatment that occurred and was allowed to go unchecked for so long.

Previous abuse scandals at Oakington in 2005,

Yarl's Wood in 2004, 2014 and 2015 at Medway, and of course Mr Shaw's review in 2016 that identified practices that were an affront to civilised society, none of this resulted in the change needed to prevent the abuse scandal at Brook House in 2017.

Those measures were still not in place to prevent inhumane conditions in Brook House in 2020, as the IMB report so graphically exposed, and they are certainly not present in 2022 and at the time when intense enforcement practices of the past will shortly resume to pre-pandemic levels and incidence.

We commend the inquiry for the rigour with which it has sought to fulfil its functions commensurate with the importance of the rights at stake in article 3. Once the inquiry went beyond the Panorama programme itself, it has uncovered through unbroadcast BBC footage, CCTV, body-worn and handheld camera footage, pages of transcripts and reams of documents and, of course, the written and oral testimony of individuals and the extensive case summaries that Medical Justice was able to provide to the inquiry, that the Panorama programme was not the end and limits of the abuse.

This inquiry has uncovered shocking patterns of inhumane and degrading treatment of detained persons, central to which is the overuse and misuse of force and

segregation, often without lawful authority or justification, and segregation used as punishment. The normalisation of the infliction of pain, suffering and humiliation, even whilst detained when naked, as we saw in the case of D1234, or even when so emaciated the person could barely hold his own body weight; D2159 is an example of that.

In addition we have seen extensive evidence of the pervasive, violent, derogatory and debasing verbal abuse, and in addition, racism, vitriolic, casual and institutional, underscored by an underlying lack of empathy, even when individuals are at their most distressed and vulnerable, even in life- or potentially life-threatening situations.

Mr Collier has told us that even this material relating to use of force is not complete. He identified in, of the 93 cases of use of force during the period, that there may well be other incidents of misuse of force, but the paucity of documentary material, the failure of oversight and investigation, the limits of the PSU complaints procedure, means that that full picture is still not, and will now never be, properly made available to this inquiry.

We can say then, without any doubt, this is not a case of isolated incidents by isolated individuals out

of sight. This is how the regime operated on a day-to-day basis and what was the day-to-day experience of those incarcerated within it. It has, of course, been profoundly disturbing to witness repeated physical abuse, the severe mental anguish and the denial of human dignity. Both Owen Syred and Callum Tulley described alarming incidents of abuse well before April 2017. It has been harrowing to hear the direct evidence of detainees who were brutalised by what Dr Paterson has described as the "corrupted" and "toxic" environment marked by violence, chaos, disrespect, disregard and callous indifference to fundamental rights and human suffering. It has been equally disconcerting to listen to custody officers, who, even in oral evidence, maintained patently untrue accounts or claimed no memory in the face of incontrovertible evidence of misconduct and cover-up and who have sought to deflect responsibility, even to Callum Tulley, accusing him of misrepresenting them, inciting them or failing, himself, to report the misconduct.

Several of these officers still work at Brook House and whose misconduct was not caught on camera and has only been fully exposed by the inquiry but they remain in post. Some, like Mr Loughton and Mr Dix, have even been promoted.

Ben Saunders, the director, adopted a not dissimilar approach to his responsibility for a fundamental failure of management and oversight. He, too, blamed Callum Tulley for not reporting abuse to him. Despite his own obvious culpability, he was allowed to resign and work elsewhere for another private contractor, Mitie, involved in immigration enforcement.

In our system of justice, lessons are not learned unless you are willing to confront and accept misconduct, wrongdoing and failings that harm others.

Peter Neden and Jerry Petherick, both G4S senior corporate managers did not accept their own culpability or responsibility for the dysfunctional senior management team at Brook House of which they were aware from at least 2014, but at least they recognised that there must have been serious failure on the part of G4S because this abuse and mistreatment occurred.

Not so its managing director, Gordon Brockington, with his prepared script, his dissembling, evasion and denials, his evidence alone exposes why G4S was not a fit and proper company to have carried on with the contract after 2017 and should not now be entrusted with public functions in the containment and care of prisoners or detainees.

The evidence of senior Home Office officials --

Mr Cheeseman, Mr Schoenenberger and Mr Riley -- confirm a state body that is driven by political imperatives to sacrifice welfare on the altar of enforcement and administrative convenience. It relegates safeguarding of detainees to a virtual footnote in a contract that puts cost-cutting over safety and care. It also confirmed the utter disinterest in criticisms of its actions, failures of its policies and practices, whether by oversight bodies, judges, coroners, or its own appointed reviewer, Stephen Shaw.

It is clearly cavalier about its legal duties and the adverse impacts on those it detains, and is apparently indifferent to ensuring the necessary changes to prevent the repeat of abuse and mistreatment occurring.

Phil Riley did not look much beyond limited contractual tweaking and increase in staff numbers. He was unable to accept that the original corner-cutting contract that baked in dangerously low staffing levels, a harsh regime and impoverished conditions would have an impact on welfare. "Maybe other operations", he speculated, "but not welfare".

Phil Riley, without irony, said that the Home Office had "taken every step we could take proportionately to deliver a safe environment" and claimed that the rule 35

system had now been improved and even that there was no systemic failure in 2017.

This is of real concern, the same pattern of wilful denial of Home Office responsibility. It simply cannot be reconciled with the evidence that the inquiry has heard over many weeks and to which Mr Riley, even now, is apparently oblivious.

This is important because it is the mindset and attitudes of men like these who will be responsible for considering and implementing any recommendations that the inquiry makes and it must inform your recommendations.

Their attitude and analysis of the events at Brook House provides key evidence for the inquiry's remaining crucial function, to identify why mistreatment and abuse was allowed to reoccur in 2017, again only exposed by undercover reporting. Where and how the detention system, regime and policy and practices sanctioned or allowed it to occur, why lessons have not been learned from past abuse scandals and even from this one, five years on, and what effective remedial action can now be taken, particularly in the wake of another abuse scandal in Brook House in 2020 where the IMB found a cumulative effect of their concerns amounted to inhumane treatment of the entire population.

Fundamental remedial action needs to be taken and urgently. It is already far too late. The evidence obtained by the inquiry post Panorama has in no way diminished this imperative. If anything, it has only grown more pressing.

Dr Hard described a deprivation of safeguards to protect detainees from harm was a significant factor in 2017 and it is still continuing. The institutional culture of bullying and intimidation, according to Ms Michelle Brown, one of the longest-serving G4S managers is also continuing. She says at paragraph 12 of her witness statement:

"I left in November 2020, as I still observed bullying and abusive behaviour towards myself, staff and detainees."

The IMB's 2021 report found high incidence of vulnerability, mental illness, self-harm and there is a clear correlation between increased use of force and segregation as the first resort to managing vulnerable detainees as well as a complete collapse of the rule 35 process.

There is evidence of increased complaints over the use and misuse of force. This is critical to the inquiry's considerations because it shows without any doubt that the key themes that have led to a cycle of

abuse over many years, including in 2017, still remain very much in play.

It also shows that contractual numbers and increased better-trained staff, even with a low population, did not prevent inhumane conditions occurring and which are the breeding ground for excessive and unlawful use of force.

It is stark and important to recall the evidence of Mary Molyneux of the IMB on the Home Office's response to their notice of the inhumane conditions operating at Brook House in 2020. She identified a wholly inadequate response. She said there was nothing, not even an acknowledgment:

"I mean I knew they had it, because we copied in our people, and then, I think, nearly six weeks later, this response comes in. I don't think it was coincidental it was received on the day we were giving evidence before the Home Affairs Select Committee. You know, it was a concern about safety, that there is going to be more of this, if you persist."

The Home Office's response was:

"It is all about process. We have the right, we have the process, so there is just a total disconnect and not, in my view, acknowledgment of the problem and the issues we have raised."

That evidence is critical for this inquiry and for what it decides to do when identifying recommendations that can address this kind of recalcitrant resistance to recognising the damage and harm that immigration enforcement policies pursued have on vulnerable individuals.

We also know from the current healthcare contractor, PPG, that they cannot make remedial action on the system's failure in respect of safeguards without direction and resources from the Home Office. Serco's Steve Hewer could give no assurance that another situation like that identified by the IMB in 2020 could not reoccur. That, he says, is only within the control of the Home Office.

Given this, the inquiry needs to identify a fundamentally different approach to previous failed investigations and reviews. Not because it is bold or political, but because it is the only rational and logical consequence of where the evidence has taken this inquiry. Alternatives to detention are available and must be found. Current policy fails, but must, in any event, constrain the use of the power to detain within clearly defined and strict limits. It must prevent its exercise where the person is vulnerable -- in particular by reason of a history of torture, trauma and mental

illness -- once and for all. This is not a radical conclusion, it was the finding and recommendations of Stephen Shaw in his 2016 review. It has been the recommendation of the HMIP since 2015 as well as that of numerous parliamentary committees and many witnesses to this inquiry. No civilised society should tolerate anything else.

The inquiry should also conclude that Brook House must not be used as an IRC. It should follow the conclusion of the HMIP that it is simply an inappropriate environment for administrative detainees and the expert evidence of Professor Bosworth which is, in fact, backed up by all medical evidence, the accounts of some G4S custody officers and senior staff and, of course, the experience of those detained there.

Looking, then, at the legal framework and the system's duty that we are here concerned with under article 3, article 3 requires states not only to prohibit and punish ill-treatment, but also to forestall its occurrence. It is insufficient merely to intervene after its infliction when the physical or moral integrity of human beings has already been irredeemably harmed. Whether the state does so through its policies, practices and arrangements at Brook House reflects

paragraph 2 and 4 of the inquiry's terms of reference. In accordance with those terms, the inquiry is tasked not only with making findings of operational failures in individual cases, but also failures at a systems level and to ascertain whether those arrangements either caused or contributed to the operational breaches and can be changed to prevent recurrence.

The forms of harm under article 3.

Although counsel to the inquiry's article 3 note focuses on physical and verbal mistreatment, the inquiry is also, of course, concerned with mental mistreatment and suffering, including that which flows from naturally occurring physical or mental illness, where it is exacerbated by treatment in detention for which the authorities can be held responsible. This reflects the Grand Chamber's judgment referred to by Mr Altman in Rooman v Belgium. Thus the conditions of detention which subject a person to distress or hardship or compromise and exacerbate mental health, engage the state's responsibility under article 3 just as physical and verbal abuse.

Likewise, a failure to provide appropriate medical care and medical assistance whilst in custody engages the state's obligations under article 3 and the absence of either can subject an individual to inhuman or

degrading treatment.

We understand this to underpin paragraphs 4 and 5 of the terms of reference which must be assessed against the clinical consensus that mental illness cannot be effectively and appropriately treated in immigration detention, nor, as Mr Shaw found in 2016, can it be appropriately managed. That is why it has always been, and continues to be, an imperative for policy and practice to prevent detention of the mentally ill and to secure their prompt release and return. The Strasbourg jurisprudence cited by the counsel to the inquiry's notes concerns prisons, but it applies to this context, subject to one fundamental difference: that is that the question of the legality of the underlying detention and the option for release are not normally an issue in a prison case. The starting point for evaluating the minimum threshold of severity under article 3 is different whether detention arose from a discretionary power and where its exercise is unlawful because it is in breach of policy and safeguards to protect vulnerable people in detention.

If detention is unlawful, this is highly material to the assessment of whether there was a violation of article 3 for the period of the detention because the person is not suffering harm incidental to a legitimate

measure and which is inherent in lawful detention.

Institutional racism has a special place in article 3. Counsel to the inquiry's note does not specifically address the case law on institutional racism but it is plain that, where evidenced by explicit, racist language of the most offensive kind used here or the derogatory racial or xenophobic stereotyping, this inherently undermines the dignity of the person on its own and may constitute degrading treatment in breach of article 3. Racism is recognised to be a special form of affront to human dignity; it will certainly be an exacerbating factor if mistreatment of any kind occurs, as it did, we say, here, in the context of institutional racism.

Inhumane treatment at the whole centre in 2017.

Conditions of detention, can cumulatively cause such intensity of physical and mental suffering and anguish that they can constitute inhumane or degrading treatment without deliberate physical mistreatment, not just of individual detainees, but of the whole detained population. This is clear from the IMB's report on the situation in Brook House in 2020.

We invite the inquiry to find that the general conditions in 2017 and 2020 bear stark similarities in respect of key features: high numbers of vulnerable

detainees; high incidents of self-harm; and cases of suicidal risk; the routine use of segregation and force to respond to self-harm; and the complete dysfunction of the rule 34 and 35 safeguards with the same harmful consequences -- resort to force and oppressive measures in the context of intense pressure of charter flights and no-notice removals.

This was a link made by several of the witnesses in their written and oral evidence to the inquiry and we will develop that in our closing submissions.

(Fire alarm)

THE CHAIR: We are not aware of a test, so we will need to leave, I am afraid.

(10.49 am)

(A short break)

(10.57 am)

THE CHAIR: Thank you. A bit of excitement. Thank you, Ms Harrison.

MS HARRISON: I was going to refer to one individual's experience of these inhumane conditions.

D1851, you may recall, gave evidence in the first phase of this inquiry. He gave powerful, compelling evidence about how his experience at Brook House was crushing. He talked in his witness statement of a very stressful and negative environment. He would frequently

hear detainees being taken by and they would be shouting and screaming:

"This created an atmosphere of fear and stress because [they] would be taken at random times, especially if [they] were considered a security risk, and the Home Office would use a policy of giving [them] something called a 'removal window' without notice, which added a lot of stress to us in general. I was given one. I felt under a constant apprehension of being removed at any point. This type of environment is toxic because there is no release from the stress. There was simply no break from the stress and it breaks you inside."

You may recall that D1851 was unlawfully detained in Brook House for three months. He witnessed disturbed people suffering, hearing and seeing incidents of violence, self-harm, drug misuse, distress and chaos. He witnessed the assault, as Mr Collier found, on his roommate, D390, by multiple officers in full PPE and was pinned with a shield to the bed. Even though routine, it was nonetheless terrifying. Despite no pre-existing vulnerability, the cumulative effects caused his mental wellbeing to erode to the point of developing a mental illness diagnosed as PTSD. Brook House broke his moral and physical integrity, it humiliated him and destroyed

his dignity as a human being. He said it made him a different person, and he is not alone.

Turning then to the systems, breaches and institutional factors that we consider are at the heart of the causes or contributory factors leading to the physical and mental mistreatment or abuse which created the inhumane conditions at Brook House in 2017.

First, we do emphasise the policy context and the hostile environment. Stephen Shaw recognised, in 2005, in his investigation into racism and mistreatment at Oakington, that the combination of the coercive powers over foreigners involved in immigration enforcement with the attitude towards asylum seekers and other would-be immigrants of some sections of the media can become a breeding ground for racist and abusive words and deeds. Whatever the position in 2005, that context has only intensified since.

The use of charter flight no-notice removal windows and aggressive policies of immigration enforcement aimed at making the lives of the undeserving unbearable and the demonising political rhetoric, cannot be divorced from the conditions and attitudes of those officers at Brook House Removal Centre.

Reverend Ward gave evidence of a message of hostility as opposed to dignity and humanity already in

play in 2014, and other witnesses have given testimony highlighting it as well, including Lee Hanford, Professor Bosworth and Dr Brodie Paterson.

Second, the safeguards systemically fail. It is plain from the evidence received by the inquiry that the safeguards to protect ordinary and vulnerable people from mistreatment in detention are not fit for purpose and continue to be flagrantly and openly breached. This state of affairs has persisted in spite of repeated recommendations by multiple bodies, reports and reviews. A key task of the inquiry is to make clear findings and recommendations that can finally bring this to an end. The Adults at Risk policy, the centrepiece of the response to Shaw is structurally deficient as an effective safeguard and we now know intentionally so.

It removed the strong presumption against detention, it removed the assumption that those who were vulnerable are at risk of harm and required evidence to be provided leading to actual harm before release is considered. The policy reintroduced by the back door the notion of satisfactory management that Stephen Shaw heavily criticised and found an affront to civilised values. Mr Cheeseman did not dispute this, no Home Office witness could explain how a policy purporting to strengthen protections for vulnerable detainees has, in

fact, achieved the opposite and why no remedial action has since been taken following Mr Shaw's second review in 2018 and the repeated exhortations of the Chief Inspector of Borders on a number of occasions and in recent reports.

There was no independent advocacy provision to facilitate people with serious mental illness, whose capacity is impaired, to participate in decision making, to challenge detention and segregation. That had been found by the High Court in the case of VC -- which has been referred to on a number of occasions in this inquiry and in the evidence of Naomi Blackwell -- who had ruled that this state of affairs was a breach of the Equality Act 2010 for disabled persons and unlawful. That was in 2018, but still no remedy. Mr Cheeseman recognised it was necessary but provided no explanation for why that systemic failure continued.

The actions taken against the Gatwick Detainees Welfare Group and Naomi Blackwell, one of its former caseworkers for facilitating VC's access to legal representation to bring the article 3 breach to an end is a salutary insight in the extent to which G4S and Home Office managers, Mr Dix and Mr Gasson actively deterred oversight and scrutiny, even when key to exposing mistreatment and in respect of the most

vulnerable detainees.

The disconnect between policy and practice.

The inquiry's clinical expert, Dr Hard, concluded there was a complete systems failure of the safeguards. Where they did operate, they were dysfunctional. Sandra Calver, then the current head of healthcare, and Dr Oozeerally, the current lead GP, still at Brook House, gave evidence these were systemic deficiencies across the detention of state and that they are continuing.

Those failures include GP appointments under rule 35 becoming completely disconnected from their statutory and safeguarding purpose. Rule 35 reports not being done at the first opportunity, we know now that only one rule 35 assessment a day is being undertaken at Brook House. That is an effective abandonment of the rule and its statutory purposes. We know, and it has been repeatedly referred to, that the process rarely results in a rule 35(1) report, even though that is the one that is most likely to secure release and, shockingly, there has been no rule 35(2) reports ever done at Brook House.

Dr Hard properly described this as shocking.

The majority of rule 35(3)s do not contain the relevant information on impact and so the Home Office

refuses to release. Even if all these hurdles are overcome, the Home Office released statistics on rule 35(3) remain woeful and inadequate.

None of the officials or even the medical professionals appear to recognise the gravity of their dereliction of duty to those in care or the consequent risk of serious harm through exacerbation of mental illness and trauma, exactly the kind of harm that article 3 is intended to avoid and to protect. The alternatives proposed of part Cs and ACDT have all been roundly rejected as acceptable alternatives by Dr Hard. The fact that they were also rejected by the High Court in 2017, again is another indication of the way in which the Home Office disregards legal judgments and its legal obligations.

Critical, then, is the evidence from Dr Hard and Dr Bingham about the interrelationship between these systems failures and the mistreatment that occurred at Brook House and can reoccur now. They both said -- and this also is the medical evidence of Professor Katona -- that it is impossible to separate the systemic failures of the safeguards from the mistreatment of detainees.

These failures meant that vulnerable people were not released and were kept in an environment known to have a serious negative impact on mental health for

indeterminate periods and suffering a level of harm that engages article 3 of the Convention.

In many individual cases, it is also combined with the treatment of symptoms of deterioration -- such as distress, self-harm and suicidality -- as refractory or manipulative behaviour, leading to segregation imposed as a punishment, and to the use of force as a routine response. Chillingly, because, Dr Hard explained, much of the default use of force and containment in this context is for convenience and because he said there is nothing else that can be done, that is the position that Medical Justice and the Royal College of Psychiatrists have explained for a very long time.

Dr Bingham called this a "perfect storm" for abuse and ill-treatment to occur and reoccur. Dr Hard agreed.

There is a clear correlation between this systems failure and the incidence of ill-treatment.

Fourth, the prisonisation of Brook House is another institutional factor that leads to, and led to, risk and actual mistreatment. We know that Brook House was designed as a category B prison and, for all those who visit it, or are held within it, or work within it, it is a prison in all but name. Little, if anything, can be done to remedy its harsh, brutal features. Mr Bhui reiterated in his evidence the long-standing position

that it is an inappropriate environment for administrative detainees.

The Home Office itself understood the regime to be inconsistent with the ethos and requirements of a relaxed immigration detention under rule 3, but cutting corners and cost saving was prioritised over welfare and dignity. The poor physical state of the cells, the squalid unclean conditions, the lack of natural light and poor ventilation, the recklessly introduced three-man cells with open toilets inadequately screened failed to respect the privacy and dignity of the men held there. The centre was chaotic, noisy and riddled with spice, a situation out of control, and even involving staff bringing drugs into the centre.

In that context, a critical issue for this inquiry is the cross-application of prison policies and methods such as ACDT, segregation and the use of force, through control and restraint methods, that are properly described as "prisonisation" by Professor Bosworth, and are strongly criticised by her as inappropriate and wrong.

These prison policies and measures were, and still are, coercive, custodial, risk management tools aimed at controlling and managing high-risk prisoners. They are

not designed for the specific risks and needs of the IRC demograph, a high proportion of whom suffer from post-traumatic stress disorder, anxieties and other mental illness arising from a history of torture or ill-treatment.

Many custody officers explained how they were completely ill-equipped to cope, both with the harsh environment and, in particular, to respond to the high-levels of vulnerability and mental illness.

That fact led to a process of desensitisation, where the resort was to methods such as use of force and segregation without proper consideration of the individuals' vulnerability.

Evidence of systemic misuse of the power to segregate under rule 40 without lawful authorisation and as a punishment has been identified by the inquiry and, of course, there is the widespread, unlawful, de facto segregation on E wing and the CSU, operated outside of the constraints of rule 40. What was also identified in this context as 100 per cent unacceptable, according to Dr Hard, was the complicity that doctors and nurses at Brook House played in approving, and at times sanctioning, the use of force, restraints and segregation. Dr Oozeerally did not seem to understand his role; Dr Hard and Dr Bingham highlighted the clear

conflict of dual loyalties of the worst kind, allowing Home Office priorities to override the doctor's primary duty of care to his patients and a fundamental safeguarding role of medical practitioners failed in Brook House.

This context leads to key aspects of institutional culture in which use and misuse of force led to mistreatment. Desensitisation and dehumanisation are the hallmarks of the culture that operated at Brook House. Faced with acute levels of vulnerability and distress, in the absence of tools or know-how in how to deal with it, the inevitable response, Professor Bosworth said, was for custody officers to become desensitised.

In that context, the macho-aggressive culture, that we have heard so much of, flourished, normalised and dominated. It was not a subculture among core groups or cliques, it was the dominant culture, because, as Callum Tulley and Owen Syred explained, it was able to inculcate new staff members, was engendered through intimidation, bullying and fear, able to mould others and to normalise complicity and the silence of others. The compelling evidence of Mr Syred on this topic and his experience when challenging racism is well known to the inquiry. It is key evidence, underscoring the

nature of the dominant culture of dehumanisation that was at play.

It was evidenced in a number of different ways: the ubiquitous -- the widespread derogatory and abusive language normalised as everyday banter; and, despite its violence and debasing content, the use of racist language. All illustrated the extent to which dehumanised attitudes and practices were embedded within the service culture, creating a context of impunity and providing the conditions for mistreatment, abuse and racism to thrive.

As Professor Bosworth observed, when staff switched off from the distress of detainees, this inevitably led to dehumanisation. The detainees themselves described how they were treated as less than human, as animals and criminals. Despite its gravity, self-harm was characterised as attention-seeking and manipulative, calculated to avoid removal and requiring a coercive response, not a trigger for review of detention and release.

Healthcare was not immune to desensitisation and dehumanisation. Even their clinical training did not equip them to cope with the environment at Brook House. This was exemplified by the evidence of Jo Buss, who explained her response to the derogatory comments made

by officers in the presence of D1527, in a state of acute vulnerability, that it simply washed over her like banter, "You become immune".

This indicates the extent to which there was a corrupted, institutional culture and one that there is no evidence has been fundamentally identified, addressed and rooted out.

Finally, and in that context, there is the evidence of institutional racism. Professor Bosworth's view on that is clear. She concludes that the seeds are sown in the very nature and function of immigration detention, just as Mr Shaw had warned in 2005, that, unchecked, IRCs are a breeding ground for racist and abusive word and deed.

Evidence of pervasive racism was identified in G4S staff in the Mubenga inquest in 2003, and in Yarl's Wood undercover reporting in 2015. It is not new, and it is ever-present. This means that the inquiry needs to identify what measures were in place to address this critical issue in the institutional culture. It took forms of stereotyping as well as the overt racist language that the inquiry will be familiar with from officers like John Connolly, Graham Purnell and Sam Gurney, and which was said directly to the detainee D643.

We say that when one considers the key factors identified by the Macpherson Inquiry as hallmarks of institutional racism, they are all at play at Brook House. One critical factor that he identified is the failure of the organisation to unequivocally recognise, acknowledge and accept the problem.

No official within the Home Office, no person within G4S, has begun to identify and recognise the significance of the widespread evidence of racism. Anyone who maintains the idea of isolated individuals or the "bad apple" trope is only providing evidence to this inquiry that a key feature of institutional racism is still at play and operating amongst those responsible for this system.

What, then, are the recommendations that the inquiry should make?

The inquiry knows from our opening that the organisation Medical Justice, like the British Medical Association and many others, have called for an end to immigration detention. Professor Bosworth concurs. The evidence uncovered by this inquiry has only confirmed the validity and moral imperative of that view. Indeed, the current Chief Inspector of Borders has himself recently recommended that the Home Office undertake a proper evidence-based investigation into the need for

immigration detention at all. The ICIB pointed to evidence that reporting to immigration officers is 95 per cent effective and made other recommendations for compliance to be further improved. There is a viable policy alternative to detention, and policy questions are firmly within the terms of reference of this inquiry. If, and in any event, policies must operate effectively to constrain the exercise of this power, and to prevent its exercise, where the detained person is vulnerable, in particular by reason of a history of torture and trauma and mental illness.

Policy and statutory time limits already operate for pre-departure accommodation, as explained in the evidence of Ms Ginn at paragraph 150, the Family Returns Policy and the detention of children and pregnant women, other vulnerable groups, already have strict restrictions on the circumstances and the time for which a person can be detained. Those policies have brought to an end the extreme consequences of harm and suffering that are the hallmarks of the policy and context that we are considering.

Again, we say this is not a radical proposition. It is where the evidence takes you. It is the conclusions of Mr Shaw, the ICIB, the HMIP, the Home Affairs Select Committee, the Joint Committee On Human Rights, the

British Medical Association and many others, and it was even the evidence of Dr Oozeerally that detention at Brook House should be no longer than a week.

In the meantime, it is plain that there is a need for urgent measures to correct the complete deprivation of safeguards identified by Dr Hard. Pre-detention screening has been repeatedly urged upon the Home Office by independent oversight bodies and NGOs like Medical Justice, and in this inquiry by Dr Hard and Dr Oozeerally. It has shown to be effective in the context of family removals process, so that all factors such as medical conditions or vulnerability, that point against detention, are identified before detention takes place and avoids the harm occurring.

Decisive urgent steps are required to address the wholesale failure to implement rules 34 and 35 safeguards, as you pointed out, chair, these are currently putting vulnerable individuals at risk of actual harm. Additional resources need to be urgently made available so that GP appointments within the first 24 hours are capable of fulfilling the rule 35 and rule 34 purpose. Rule 35 appointments need to be automatic and the delays must be eliminated.

Opening an ACDT because of risk of harm should result in a rule 35(2) report and consideration of

a rule 35(1) report and, if issued, lead to prompt release. Segregation due to self-harm and suicide risk should, likewise, trigger a rule 35 report and release.

This cannot wait until publication of the inquiry's report. It needs to happen urgently. Chair, you should consider interim findings and recommendations on rule 34 and 35 and the Adults at Risk policy. We have seen a letter sent by the NHS and jointly with the Home Office reminding healthcare professionals of the terms of rule 35 and 34. We say that is woefully inadequate in light of the evidence that this inquiry has heard. We know that those healthcare professionals do not understand rule 34 and 35, and critically, it is a question of resources; nothing has come from the Home Office to indicate that they either understand or know, or are willing to address, the underlying problems that mean that those safeguards will continue to fail and individuals will continue to be at risk of serious harm.

Detailed recommendations have been made on many topics of importance to this inquiry in the Medical Justice Reports and in the position statements of the Royal College of Psychiatrists. We will expand on those in our written submissions but commend them to you.

Detailed submissions have also been made for

suggestions to improve accountability of G4S corporate managers and Home Office officials. The culture of impunity must be addressed.

Challenging institutional culture at all levels is a challenging task. It requires the kind of wide-ranging review and measures recommended by the Macpherson Inquiry and adapted to the present context, again, in the witness statement of Ms Ginn on behalf of Medical Justice.

Finally, this inquiry should conclude that Brook House must not be used as an IRC going forward. It should follow the conclusion of the HMIP that it is simply an inappropriate environment for administrative detainees, and the expert evidence of Professor Bosworth, which reflects the medical -- wider medical evidence, the accounts of G4S custody officers and senior staff, and of course the experience of those detained there.

Last, we request this of the inquiry: this inquiry should have an implementation phase, as others such as the Laming and Soham Inquiries have done. It should reconvene to ascertain what has happened in the interim to implement its recommendations. This was raised in a letter to the inquiry as long ago as 8 November 2019 by my instructing solicitors at Duncan Lewis.

Mr Riley's evidence makes it all the more pressing, because of the deferral of any action pending as a result of the Nationality and Borders Bill currently before parliament. That Bill will have wide-ranging implications for detention, not least the reintroduction of a detained fast track for asylum seekers, previously held to be unlawful and suspended, precisely because of the failure of the safeguards of rule 34 and 35 to identify those who are vulnerable.

Professor Bosworth said, in this context, "We go round and round in circles". She was correct. This inquiry must break the circle. It will be more effective in doing so if Home Office officials and its contractors understand that they will be effectively called to account for their action and, of course, inaction in response to this inquiry's findings and its recommendations.

Those concentric circles should never again be allowed to lead back to the hell that was Brook House in 2017.

THE CHAIR: Thank you very much, Ms Harrison.

This seems a convenient point to take our break and then we will continue with the submissions. So we will return at 11.40. Thank you very much.

(11.26 am)

(a short break)
(11.42 am)
THE CHAIR: Ms Morris, thank you.
MS MORRIS: Chair, I will address you now on behalf of Reverend Nathan Ward.
THE CHAIR: Thank you.

Closing statement by MS MORRIS

MS MORRIS: Reverend Ward had this to say at paragraph 14 of his first witness statement:

"Ultimately, however, after many years of trying to make a change, I felt I just could not cope with continuing to work for G4S. I realised that by remaining in the system, I was perpetuating an unjust, inhumane system which I would now describe as barbaric."

Reverend Ward's perception of the system as unjust, inhumane and barbaric is exactly what the evidence in this inquiry has shown the system to be.

In opening, on behalf of Reverend Ward, I provided a few examples of his experience of working for G4S at Gatwick IRCs. Those include: unlawful uses of force, in other words, assaults; a culture of racism, institutional racism, including the use of cultural stereotypes and generalisations and clear evidence of an "us and them" mentality.

Furthermore, there was evidence of completely

inadequate healthcare provision, unsuited to the needs of the detained population. Reverend Ward described the assaults and abuse as shown on Panorama as a gross manifestation of an institutional and corrupt toxic culture. His views and experience of working for G4S, borne out by the evidence heard in this inquiry, is that the behaviour of staff was perpetuated by the system in which they were working. A system in which abuse could be meted out to detainees with impunity, in the absence of fear of consequences, due to silence and cover-up directly caused by the culture of dehumanisation and "othering".

The toxic, masculine and bullish culture of which Reverend Ward spoke has been further illuminated by the other evidence which this inquiry heard. Such a toxic culture even filtered down through to the training on use of force. Reverend Ward stated in his evidence that he had complained about the training on control and restraint more than anything else, as it was seen as central to the running of Brook House, which he viewed as wrong and which perpetuated a negative, macho-aggressive culture which has been shown, by the evidence this inquiry has heard, to have been pervasive across Brook House.

Reverend Ward's resignation was in 2014, and yet the

inquiry has heard evidence of the exact same, or similar, issues continuing at Brook House during the relevant period. Therefore, the evidence shows no improvement between 2014 and 2017, notwithstanding two things: first, the abuses at Medway STC being exposed in the intervening period, and the Medway Improvement Board highlighting serious issues with leadership, organisational behaviours and culture as causal of the issues at Medway STC in its advice to the Secretary of State for Justice; second, Reverend Ward's own whistleblowing, as set out in his first statement and, just to name a few names of people and organisations he raised concerns with, he raised concerns with Duncan Partridge, Ben Saunders, Deborah Western, Steph Phillips, Jerry Petherick, Kent Police and the Home Affairs Select Committee.

So since 2017 and to the present day, at best, there has been some tweaking around the edges. At worst, the very same fundamental issues as were occurring prior to 2017, in Reverend Ward's experience, are continuing to this day at Brook House, and not just Brook House, in other parts of the immigration detention estate.

There is no sign of any real or substantial change. By way of reminder, it is the lack of accountability and sanctions to date that was Reverend Ward's primary

reason for participating in the inquiry and why he considers it important. I will come back to what he said in his first statement at paragraphs 309 and 310 as quoted in opening. He said:

"I strongly believe that things will not fundamentally change unless people are held to account at all levels of the system and serious consequences occur for the individuals and the corporate bodies. I do not understand how G4S could continue being the contract provider for almost three years after the Panorama broadcast, which included a two-year extension and, equally, why any contract could continue to be run with G4S after the Medway and Brook House reporting. I also do not understand how managers within G4S, with oversight for these centres, or on site, like Ben Saunders, Steve Skitt, Jules Williams or Steve Dix were not dismissed but were able to continue in their roles or take up posts elsewhere. I also do not understand how senior civil servants, responsible for these contracts, such as Paul Gasson or Mr Schoenenberger, and for detention services generally, have not been disciplined but remained in post."

Until concerted action is taken, and is seen to be taken, complaints made will be ignored, or more likely won't be made at all because people will have no

confidence in the system.
Reverend Ward asked this question:
"How, then, could you, chair, be confident that any further tweaks will lead to the real and significant change that is required?"
He says you can have no confidence whatsoever, as history and the evidence has shown that minor tweaks don't stop mistreatment and abuse, and they don't change the toxic culture. Reverend Ward says that the changes that are required involve a dismantling of the whole immigration detention system. His view is that to do anything less than the significant changes that are required will allow the corrupt and toxic institutional culture of abuse, bullying, disrespect and dehumanisation as it was in 2017, and indeed 2014 and prior to that, the system that Reverend Ward had no choice but to leave, to continue.
Such a barbaric system has no place in our society and Reverend Ward hopes that the outcome of this inquiry is swift and systemic change for the sake of humanity.
Thank you for listening.
THE CHAIR: Thank you very much, Ms Morris.
Mr Goodman?

Closing statement by MR GOODMAN
MR GOODMAN: Chair, on behalf of D1527, D1538, D2077 and D1914, may I thank you, chair, and all the inquiry team for the work that has gone into the investigation of mistreatment in Brook House.
I begin with D1527's case.
Before this inquiry started, the Professional Standards Unit had already found, in its report of 22 February 2018, that D1527 was degraded, reflecting the language of degrading treatment in article 3 ECHR and had made a number of findings that amounted to inhuman treatment -- see <CJS001107>.
It is abundantly clear on the evidence that he was subjected to inhuman and degrading treatment, as well as to procedural breaches of article 3. Those breaches are intrinsically connected to the failure of the law, policy and operational safeguards that should have ensured that, as a vulnerable young man, he was not detained at all or that he was released expeditiously, once wrongly detained, or that he was cared for while in detention.
D1527's case has always been that there was both a systemic and operational failure to identify, protect and monitor him as a vulnerable detainee in breach of the positive duties arising from article 3 -- see

HA (Nigeria) v The Secretary of State for the Home Department [2012] EWHC 979 (Admin) at paragraph 70(f) -- and that he was detained without ensuring his mental health, history of torture and suicidality were properly assessed and considered.
Such measures as were in place were not used effectively to diagnose and properly treat and manage his condition -- see MD v Secretary of State for the Home Department [2014] EWHC 2249 (Admin) at 142.
These aspects of his detention will be addressed further in written submissions. In the short time available for this oral submission, I propose only to outline why the ill-treatment he endured amounted to torture.
Paragraph 20 of CTI's note to the inquiry, which we heard orally from Mr Altman earlier says that, in order to make a finding of torture, there must be deliberate and human treatment causing very serious and cruel suffering. That is accepted. However, the gloss at paragraph 21 of the note, that torture involves a very high degree of physical suffering, is too narrow. Acts causing severe mental suffering, that cause no physical injury can amount to torture -- see Ireland v UK (2018) 67 EHRR SE1 and El-Masri v Macedonia (2013) 57 EHRR 25, at paragraph [202].

A fortiori, where the mistreatment involves both physical and mental suffering, it can amount to torture.
Ascertaining whether 1527 has been tortured in line with the definition in the Torture Convention -- as to which see my opening statement -- involves asking the following six questions:
Firstly, should you, chair, consider each individual act of abuse in isolation to determine whether each individual act amounts to torture or should you consider the combination of abuse over the whole ten-week detention? I shall explain why it is the combination.
Was the pain and suffering inflicted intentionally?
Was there infliction of severe pain or suffering, physical and/or mental?
Fourth, was pain or suffering inflicted for the purpose of intimidating or coercing him or was it based on any discrimination of any kind?
Fifth, was pain or suffering inflicted by a public official?
And sixth, was the pain or suffering inherent in, or incidental to, a lawful sanction?
So taking the first question: should the chair treat the acts in isolation or as a whole?
Assessing whether a detainee was subject to torture, or indeed inhuman or degrading treatment, involves

assessing the treatment in detention as a whole over the full ten weeks of D1527's detention. Whether treatment amounted to torture cannot be properly answered on consideration of a series of discrete acts artificially dislocated from one another and likely to omit consideration of the cumulative effects.

This approach, which I commend to the inquiry, is supported by legal authority, in Selmouni v France (2000) 29 EHRR 403, the allegation was of torture in circumstances in which Mr Selmouni was subject to a series of assaults and victimised in a series of bullying acts by police -- see paragraph [103]. At [104], the European Court noted that the events were not confined to any one period of police custody and it held, at 105, that the court was satisfied that the physical and mental violence considered as a whole committed against the applicant's person caused severe pain and suffering and was particularly serious and cruel.

Such conduct must be regarded as acts of torture for the purposes of article 3 of the Convention.

Similarly, in Ireland v UK (2018) 67 EHRR SE1, the European Court considered whether five disorientation techniques used in Northern Ireland in interrogations consisting of wall standing, hooding, exposure to noise,

sleep deprivation and deprivation of food and drink amounted to torture. The Commission's opinion is recorded at paragraph 133 of the court's determination as being that, considered separately, acts such as sleep deprivation or restrictions on diet might not, as such, be regarded as treatment contravening article 3, but that, in combination, the practices amounted to a breach of article 3.

The court conducted its inquiry on the basis of the in-combination effects and the overall impact of being detained. Consideration of in-combination impacts can also be seen in the court's assessment of the three-day extraordinary rendition in Hajrulahu v Macedonia (2018).

That said, chair, turning to 1527's case, 1527 does invite you to determine that the incidents on 25 April 2017 and on 4 May amounted to torture even when taken in isolation.

Professor Katona's evidence in his first statement, which is <BHM000030> at paragraph 50, is that, on viewing the strangulation incident involving D1527, the mistreatment and threat to kill appears to have had a profound emotional reaction and psychological consequences for D1527 that induced an intensive suffering sufficient, from the footage of it, to cross the very high threshold to constitute torture, and he

goes on to explain factors relevant from the Istanbul Protocols to which I refer the inquiry.

These observations can also be read across to the incident on 4 May. However, if, contrary to D1527's primary position, you, chair, consider that, taken alone, those incidents of mistreatment do not amount to torture, it then falls to be considered whether the in-combination effects of the whole detention amount to torture, just as in the case of Ireland, Selmouni and El-Masri I have cited.

D1527's experience of torture involved a combination of both acts of deliberate, violent, physical mistreatment and deliberate, psychological abuse, on the one hand, but also non-intentional factors, including being falsely imprisoned, the conditions of detention, the failure to manage his mental illness and vulnerability, his self-harm, food and fluid refusal, his suicidality, and those factors set the context for, and aggravate the severity of, the individual acts of deliberate violence.

So the second question: was there an act or acts which were intentionally inflicted? The primary act in question is the detention as a whole. The detention as a whole was undoubtedly a deliberate act by the state, and the simple answer to the first question posed by the

definition of torture is, yes, the detention was intentionally inflicted. There were also a series of deliberate acts within that detention. There were at least three deliberate acts of unlawful, physical violence against him, on 24 April, 25 April and 4 May and, as the Professional Standards Unit found, the 24 April incident degraded him. While he was on constant watch his head was banged against a table, by DCO Sanders, who later brags about the incident. The following day, again, as found by the PSU, on 25 April, the use of force filmed by Mr Tulley involving him, Mr Paschali, Clayton Fraser, Charlie Francis and Jo Buss breached article 3. The so-called "choke hold" was evidently intentional, and that has never been denied. Indeed, it was accompanied by threats such as "I am going to put you to sleep, you fucking piece of shit," and other insults by onlookers, such as "Are you a man or a mouse?", mocking him for being a "child" or a "baby" in Nathan Ring's case.

Mr Paschali described his use of the choke hold as a response to being frustrated by D1527's behaviour, even the concocted explanation by Mr Paschali that he was seeking to gain compliance is itself an admission of intentionally using an unauthorised restraint technique. There is no doubt that the acts were intentional.

Mr Collier's view was properly that Mr Paschali's actions were deliberate, the experience was then followed by maintaining him unlawfully and deliberately in isolation.

Then, on 4 May, D1527 endured a psychotic episode on the suicide netting, in which he was mocked and taunted by officers and detainees alike. Half an hour later, he had calmed down and DCM Dix came to the room with several other DCOs. The records show -- that is <CJS001026> -- that the intention was a clearly premeditated one to remove him from association and was clearly unlawful.

"I spoke to D1527 about his behaviour and the consequences of his actions", says Mr Dix at <HOM000251>. In the terms of the UOF report -- use of force report -- <CJS005530>:

"Upon arrival, I saw detainee D1527 on the first-floor netting. I explained, due to his behaviour, he would need to comply and go to the CSU on rule 40. He said no. I explained, if he refused, then, potentially, as a consequence of his actions, force could be used."

And, again, in oral evidence, Mr Dix's evidence was:

"At the time, obviously, when someone is on the netting, then obviously the procedure was to get them to

go to rule 40. I am not sure if it was a policy, it was, you know, due to the fact of the level of disruption caused on the netting and the wing."

The process of physically removing him to E wing involves significant levels of violence and it was obviously deliberate.

On arrival at E wing, D1527 was then subjected to further deliberate mistreatment, a full strip search, which in and of itself breached G4S policy, which reserves it for cases of intelligence a detainee is hiding an elicit item. The body-worn camera footage, UOF 114.17 captures the footage at the point he is being relocated to E Wing, and we hear, again, DCM Dix stating:

"When we leave the room, someone is going to watch you. Okay? If we leave this room and you start self-harming, like you've done before and obviously like you do, the obviously that, your behaviour dictates what happens in your future. Okay? No one wants that. Okay? If you stay calm -- but I told you, the way you have gone about things -- jumping on the netting is not the right way. So you should have spoken to a manager. But your problem is you go from okay to lose the plot in two or three seconds and that's what has landed you in trouble."

He then asks for D1527's trousers and says he will give them back later, and on the footage we see officers guiding him downstairs, cuffed. Again, an officer says, "You will do what I tell you to do, okay, and when we let go of everything, okay, if you start to do what you did last time, self-harming ... constant, then obviously your behaviour will dictate how long you stay there for. It makes sense?"

There is no doubt that this outlawry, on 4 May, under the guise of rule 40, was planned and intentional. Mr Dix admitted as much in his written report and oral evidence. The footage confirms the intention was to punish or impose some perverted sense of discipline on him for his self-harming activities. He was subject to deliberate use of removal from association. It is apparent from the Home Office correspondence of 28 March 2022 -- that is <HOM0332161> -- and G4S correspondence of 22 March -- <CJS0074121> -- that this was also unlawful.

D1527 was the subject of numerous recorded, deliberate insults, mocking and humiliation and names, verbal abuse. They don't need to be explored or further repeated. He was subject to deliberate psychological torment, Mr Dix telling him the extent of time in isolation depending on his behaviour, and

Nurse Karen Churcher tormenting him by saying that he was being detained longer because he was self-harming, racist insults and denial of religious rights, and deliberate acts of concealment of the events in the paperwork.

Looking, then, at the question of whether this caused severe pain or suffering, physical or mental, this question is assessed on a relative basis and it depends on the circumstances, the age of them and the mental health of the victim -- see Ireland v UK, paragraph [162].

The effect here for your consideration, chair, is the accumulation of suffering in making an assessment, whether it meets the severe threshold. That is critical.

For example, D1527 does not suggest that, taken in isolation, the events of 21 April or the events of 24 April amount to torture, albeit they amount to inhuman and degrading treatment.

On 24 April, he attempted suicide using a ligature. He was removed from association without proper legal authority, put on constant watch where his head was banged against a table by the officer responsible for constant watch.

As Dr Hard explained in the evidence:

"Being put in isolation would then have exacerbated and increased any detainee's thoughts of self-harm and suicide, particularly where accompanied by abuse of this kind."

While all of that which happened amounted, taken alone, to inhuman treatment, it is accepted it doesn't amount to torture, but those experiences on 24 April and earlier on the 21st, when he was told his own self-harm is prolonging his detention, an experience which led to him attempting suicide that day, are highly relevant to assessing whether his treatment in combination amounted to torture. The suicide attempts he made on 25 April were not some random, isolated event; they followed at least two preceding suicide attempts and were triggered by, and consequent upon, the E wing isolation which had exacerbated his suicidality. On this day, the same pattern followed: further verbal abuse, extreme physical abuse, further humiliation and isolation in E wing and further exacerbating his suicidality and sense of powerlessness. His only recourse, at this point, was food refusal, which he deployed.

By 4 May, we see the punishment for jumping on the netting, for his behaviour. In this context, he is then violently removed into isolation. 4 May was enacted then as a living flashback, a reiteration and repeat of

the abuse of previous weeks. It could not have been better designed to terrorise him, to exacerbate his suicidality, self-harm and what, by then, had been diagnosed as his PTSD. The repeated nature and duration of the psychological terrorisation cannot be ignored in assessing the severity of the impact on D1527 and whether it amounted to torture.

Indeed, on the late, disclosed footage, Mr Dix is heard to say that D1527 is taken to E wing, "but obviously your behaviour will dictate how long you stay here for. Makes sense?". It is impossible not to hear the echo of the double bind Karen Churcher had imposed on him two weeks earlier, in telling him that his own self-harm would cause him to be detained longer. The cycle of despair where self-harm occasions abuse that occasions more self-harm was both tortuous and torturous.

In assessing the severity of harm and whether it amounts to torture, the inquiry looks to the subjective experience and that involves looking at the totality of the treatment. The inquiry must also have regard to what happened after 4 May in the following five weeks. In Dr Thomas's report on 21 May, she described:

"By that point, he was attempting suicide near daily, with a high likelihood of success."

<HOM002917>.

He continued to refuse food, his sense of powerlessness multiplied and, when confronted with evidence, the Home Office refused to release him.

The fourth question: was the mistreatment inflicted for the purpose of intimidating or coercing him or was it based on any discrimination? The unlawful detention was designed to coerce him to leave the country. The acts of violence, once detained, were inflicted to intimidate or coerce D1527. The use of the threat, "I am going to fucking put you to sleep" was designed to intimidate him. The intimidatory impact, we have seen, induces a panic attack on the footage. Mr Paschali's own defence, that he adopted the choke hold to gain compliance, is, even on his own account, intimidatory and, indeed, coercive.

Similarly, as set out already, the use of removal from association on 4 May can be seen to be riddled with language of officers, particularly DCM Dix, setting up their own ad hoc laws, which he was told he must comply with. All of these threats and exertions of force were evidently being used as forms of coercion and intimidation.

Fifth: was the treatment inflicted by public officials? There is no issue about that. All of the

wrongs were from Home Office, medical and G4S officials.

Sixth: was the pain and suffering inherent or incidental to a lawful sanction? No. The evidence is clear there was no lawful sanction for any of this. D1527 was not lawfully detained, he should not have been there. Once detained, he should have been released, within, at most, 48 hours pursuant to the proper operation of rules 34 and 35. The complete failure of that system meant he was not. The inquiry doesn't have to speculate on that because the High Court came to the view he should be released on 13 June, even on the limited information available to it.

There was no authority for the trespasses to the person while he was detained. The rule 40 removal from associations it is quite clear were all not properly authorised at the right level and not for purposes within the ambit of rules 40 to 42. The correspondence from the Home Office clarifies the only people who could authorise rule 40 were Paul Gasson, as delegate of the Secretary of State, or the manager, Ben Saunders.

Arguably, after 18 July, after D1527 left detention when the DSO came into force, there were other delegates in cases of urgency, but not relevant to his case.

Dr Hard was, in any event, of the view that quite apart from the lack of personal authority, the routine

use of rule 40 for purposes which were not legitimate was evident across the evidence base to the inquiry.

The pain-inducing techniques were clearly not lawful, as Mr Collier said in evidence in relation to 4 May.

So in conclusion, for these reasons, chair, you are invited to find that individual incidents and the treatment as a whole met the severity and the conditions for a finding that D1527 was tortured.

Almost all of what happened to D1527 could, and would, have been avoided if the legal requirements of rules 34 and 35 or the Adults at Risk policy had been observed. There is an urgent need to address the system of failures, as there is on rule 40, where Mr Dix, a chief protagonist in the misuse of that rule, remains in position with greater authority and, as he and Steve Hewer have both confirmed, defiance of the law continues in that regard too.

D1527 therefore emphasises the following requests: firstly, that interim recommendations are made urgently. There are people in detention now subject to the same system failures and neglect to which the core participants in this inquiry were subject.

On this, which is, in fact, the fifth anniversary of D1527's detention in Brook House, there has been no

direct apology, no compensation, no formal recognition of wrongdoing by any wrongdoer to him. You are asked, chair, to recommend the Secretary of State personally apologise to him. That might offer some form of psychological restorative.

And, lastly, you are asked to acknowledge that D1527 is not "a piece of shit", but a human being entitled to dignity as such. That he was subject to torture is a stigma which should lie against the Home Department as a spur for reform.

I turn next to D2077. His submissions will be taken shortly for current purposes. You will recall, chair, he is a recognised refugee from Iran, who fled after multiple incidents of torture related to his Christianity. He suffers from PTSD and has a serious history of self-harm.

The key feature of his case is that he had been detained at Tinsley House in 2016, where a rule 35(3) report confirmed he had mental and physical symptoms consistent with an account of torture, including being whipped in detention in Iran, and it was recorded he was suffering flashbacks in detention and, as a consequence, on 21 June, the Home Office agreed to release him.

In November 2016, he attempted suicide, partly as a result of his fear of being detained. He was marked

as level 3 in the Adults at Risk policy within internal Home Office documentation and, in February 2017, his detention, proposed detention, was, in fact, rejected by the detention gatekeeper on grounds that there was no removal directions he was a safeguarding level 3 case.

However, shortly after this, the Home Office arranged a charter flight and decided to recategorise his status under the Adults at Risk policy as level 2, so as to allow him to be detained prior to the charter flight. He ended up cuffed in a van, transported to Brook House on 6 April. A familiar pattern of the failure of the rule 35 process ensued and D2077 began refusing to eat, in this case, by way of hunger strike, before shortly afterwards sewing his lips together. This then entailed his removal from association for five days, no rule 35 assessment followed. After much work by his lawyers and the intervention of a medical report from a Medical Justice doctor, he was released on 21 April.

His is a case in which, following the first detention, he had been identified as a torture victim and as level 3. There is a glimpse here of how a system of screening vulnerable detainees could operate, so as to prevent the heinous detention of vulnerable people.

However, when the imperative to remove him pressed,

the integrity of the Adults at Risk policy and the system around it was compromised and, in truth, this is another case of how the mere existence of policies and rules is no guarantee the Home Department will comply with the law.

D2077 asks the inquiry find there was a clear breach of the procedural duties to anticipate and safeguard against article 3 mistreatment. This is a case in which the system failures led to an horrendous experience in detention of a vulnerable torture victim who should never have been detained. It was inhuman and degrading treatment and the inquiry is asked to so find.

I turn next to D1538. D1538 was detained at Brook House during the relevant period on two separate occasions: 1 June 2017 to 14 June 2017; and, again, 27 June to 15 July 2017.

No adequate rule 34 process, no rule 35 assessment undertaken at Brook House, despite him asking for one -- see <DL000231>, page 37, and a report was undertaken later at Harmondsworth, which led to an assessment that he was a level 2 Adult at Risk -- <CJS007239>. D1538 found the environment and general conditions at Brook House to be stressful and humiliating. In his evidence to the inquiry, he emphasised the prolonged lock-ins, the lack of adequate medical attention, the

lack of privacy when using the toilet, the cramped, smelly, noisy conditions which he found very scary. He found the inability to communicate with interpreters stressful, and there were delays in accessing legal advice.

The impact of detention on him was to leave him "in a constant state of not knowing and uncertainty", in his words. He said he did not know when he was leaving, or if he was leaving, and where he would be going. He says Brook House is like a "forgotten prison with forgotten prisoners".

Against this background, D1538 experienced, firstly, unlawful use of force, and assault on 3 June, when DCO Instone-Brewer, unreasonably denied 1538 the use of a computer and instigated a verbal altercation with him. DCO Fiddy intervened, dangerously pushing 1538 twice in the area of his neck and head. Not an approved technique.

Second, D1538 was then, as a punishment, transferred to segregation without authorisation from the Home Office and without justification in breach of rule 40.

Third, on 6 June 2017, D1538 was attacked by another detainee, D197. DCO Ryan Bromley and DCO Nick London restrained D1538, and then DCM Steve Farrell grabbed

D1538's head and neck. Footage shows the use of force was unlawful. All three officers provided inaccurate use of force forms and dishonestly claimed the restraint was to prevent 1538 from hitting his head on nearby cabinets. DCO Bromley said to Callum Tulley four days after the incident, that DCM Farrell had taken "[D1538's] head clean off", referring to the grab of his head and neck. D1538 was again taken to E wing to "cool off", which amounted to unlawful de facto segregation, not authorised under rule 40.

On 28 June 2017, Darren Tomsett said to 1538 he "looked gay". D1538 was fearful of the reaction of others and was proven right when other detainees mocked him for days afterwards. On 4 July 2017, he witnessed his cellmate, D865, attempt to kill himself by tying a ligature and hanging it from a TV bracket. He was scared and traumatised by this experience, which has had a lasting impact on him.

The breach of article 3 duty in this case.

Firstly, the systems duty. He was exposed to mistreatment by reason of systemic failures and the corrupt and toxic institutional culture of abuse.

And of the operational duty, D1538 was subject to assaults; homophobic abuse; witnessed a highly distressing and traumatising incident of attempted

suicide; staff were callous and negligent and indifferent to the suffering of his suicidal cellmate or his own trauma.

He was subjected to two episodes of unlawful segregation imposed without authorisation and as punishment.

Individually, and cumulatively, the incidents of physical and verbal abuse, as well as the impact of conditions at Brook House and the lack of adequate care, caused him pain, suffering, anguish, distress and trauma over and above that which is incidental to lawful detention, and breached article 3.

He also relies on a breach of the investigative duty, in the inaccurate and dishonest reporting of these incidents and the failure to investigate.

Then finally, chair, on D1914, you will recall he is a Romanian national who was detained for four months in Brook House Immigration Removal Centre.

You are asked to find that, as a whole, his detention in Brook House constituted inhuman treatment or degrading treatment. Alternatively, that various incidents amounted to such treatment and that in his case, too, procedural duties to anticipate and obviate such treatment were breached, as were investigative duties thereafter.

D1914 should never have been detained. He had won an appeal against extradition on the basis of his article 8 rights. He is an EU national with a wife and child in the UK, and yet, in defiance of that finding, the Home Office detained him on 30 March, 12 days prior to even making a further deportation order served on 11 April. After many horrors, the Home Office appeared before the Immigration Tribunal, unable to offer any explanation as to why, on the appeal against the deportation order to D1914's -- the approach to article 8 family life rights should be any different to that taken by the Divisional Court of the High Court in relation to extradition.

His case is another one where, administratively, the detention was a pointless exercise, serving not to achieve any end related to immigration control, other than to deform a man's life.

Once detained, he should have been released on medical grounds; he was not. The Home Office record of the decision to detain him described the pains in his chest which were, in fact, associated with a serious heart condition as "feigned illness". That he was three times hospitalised whilst in detention and was awaiting a heart operation spoke otherwise, albeit not to the Home Office's ears.

In his case, the Home Office wrote to the detention centre doctor, Dr Chaudhary, shortly after he was detained, asking for that doctor to confirm that he was fit to be detained and fit to fly. In a breach of patient confidentiality, the doctor, without authority from the patient, informed the Home Office he was indeed fit for both. And, on 12 April, Dr Oozeerally also asserted he was fit to fly and be detained. He remained in detention.

On 27 May 2021, Dr Oozeerally again compromised medical ethics and deemed that D1914 was fit to fly and to be detained, adding this time, that he was "happy for control and restraint to be used".

This time, that brief note had a crucial bearing because it has been seen in footage and other evidence that officers regarded this as a medical disclaimer, meaning to one DCO, "If he dies, he dies"; it was a licence to use inappropriate force against a man with a serious heart condition.

On that day, he was subjected to a fully-kitted use of force, orchestrated again by Steve Dix, pursuant to a blatant misuse of rule 40 to secure his translocation to E wing prior to removal the following day. Not only was there no proper authority for this removal from association, in that it was not authorised by the

Secretary of State, it was also not for a purpose legitimised by rule 40 itself. The severity of the psychological impact of the unlawful violence against him is expressed at paragraph 151 of his statement:

"It felt like they were climbing all over me -- on my arms, my back, on my head. I was shouting and howling in pain. I was struggling to breathe. I thought I might be dying. The pain in my chest was very severe. At that moment, I felt I was looking at death."

He was taken in handcuffs to E wing, half-naked and groaning from his medical conditions. There, he was duly humiliated by a strip search, and made to sit in plastic pants. He recalls that he felt like he would rather die than go on like this.

Mr Collier gave evidence as to the dangerous practices deployed in the use of the shields on this occasion, the techniques being deployed including a risk of fatality. Having viewed the CCTV footage, Mr Collier decried the fact that he was undressed in the removal from association and concluded that handcuffs and PPE were unnecessary as there was no physical threat to staff.

The evidence of Dr Hard, as to the impact of isolation being to worsen the feelings of self-harm and

suicidality, is expressed clearly in this unlawful and unnecessary use of isolation by the outlaws that operated as officers in Brook House.

As it transpired, he was not removed from the UK on 28 May, a sensible pilot apparently standing between the Home Office and its attempts to cause further harm to D1914. On his return to detention, his wrists bruised from handcuffs, the DCOs were incensed. Some of the footage we have seen shows officers referring to him by racist epithets such as "traveller", Dan Lake stigmatises him on the basis of a misunderstanding of his criminal record, saying, "He doesn't rape kids, he kills them".

He was hospitalised three times for his heart condition while in detention. On 5 July, he was refused bail and he describes, at paragraph 190 of his witness statement, that, at that point, he no longer wanted to live, and, although never having tried to harm himself before, he attempted to take his own life, taking 57 tablets and cutting himself with a razor. DCO Tulley described the shocking amount of blood in his cell.

Both Dr Chaudhary and Dr Oozeerally sought to defend the medical ethics of disclosing his medical data, but there is no justification for their conduct. It led directly to dangerous and unlawful physical abuse on

27 May. His case also exhibits the dangerous practice, about which both doctors openly boasted, of replacing the rule 35 system mandated by law, and for which official channels are designed, with their own system of sending part C forms to a different branch of the Home Office.

In his case, part Cs were issued on 11 April, 19 April, 27 May, 28 May, 3 June, 5 July, 6 July, 7 July and 13 July. When he belatedly and finally managed to obtain a rule 35 appointment on 17 July, nearly three months after being detained, Dr Oozeerally finally completed a rule 35 report, and, although it still took a fairly long time to process, it was that document which led to his release just in time for his heart operation in August.

In D1914's case, he was subjected to inhuman treatment over the course of detention and to degrading treatment over the course of detention, whose severity is marked by the impact it had in rendering him suicidal. Indeed, he very nearly managed to kill himself as a direct result not of being detained, but of being falsely imprisoned, and then, as a result of the breakdown of systems designed to protect vulnerable detainees from detention, of not being released.

He describes how Brook House has had a lasting

impact on his mental health and that he continues to feel low. Particular factors in his mistreatment were: the unlawful decision making by the Home Office in detaining him; the absence of any screening mechanism to ensure relevant factors were taken into account about his health, and indeed immigration position, before or during detaining him; the medical practices of Dr Chaudhary and Dr Oozeerally in deeming him fit to be detained and fit to fly and fit to be subject to force, failing to comply with their duties under rules 34 and 35; the routine, unlawful use of removal from association by officers, particularly Steve Dix, who neither enjoyed authority for such matters nor used it for lawful purposes; and the absence of any monitoring or checks and balances capable of picking up on the rampant outlawry exhibited in this case.

The inquiry is invited to find that he was subjected to inhuman and degrading treatment both within the individual incidents and in his overall detention. There was a procedural systemic and operational failure to identify and protect and monitor D1914 as a vulnerable detainee in breach of the duties arising under article 3.

Thank you.

THE CHAIR: Thank you very much Mr Goodman.

Mr Lee?

Closing statement by MR LEE

MR LEE: Thank you, chair, I shall be addressing you in closing concerning D643.

Before I begin, just on behalf of D643, I would like to thank you, chair, counsel and solicitors to the inquiry legal team, and all of the support staff, for bringing this inquiry together with such care and such hard work. I will address you slightly later on about what it meant to D643 to be able to come and give live evidence to the inquiry.

D643 spent a total of 558 days in Brook House over the course of four separate occasions. On the fourth occasion, he was detained for 504 consecutive days. He was detained in Brook House for the entire relevant period that the inquiry is concerned of and for substantial periods before and after it.

He was never removed. He remains in the UK and he was paid substantial damages by the Home Office in respect of his unlawful detention in Brook House. No one has ever apologised to him.

503 consecutive days in administrative detention is a scarcely believable amount of time. In and of itself, chair, you may consider that it shows that something very badly went wrong with D643's case.

For context, this is the 45th day that this inquiry has sat. It is 131 days since phase 1 of the inquiry started back in November of last year. That in itself seems a long time ago.

You heard live evidence, chair that, D643 served in the British Army, in Kosovo, Bosnia and Iraq, and first began to experience the symptoms of post-traumatic stress disorder -- PTSD -- in 2007, after returning from service in Iraq where he had seen friends and colleagues die in horrendous circumstances. He made an attempt on his life in 2011, and spent three weeks in hospital before being discharged from the army in 2012. You also heard he was awarded compensation from the Ministry of Defence as a result of the debilitating effects of his PTSD.

D643's case is, in many respects, the embodiment of all of the systemic failings in Brook House that this inquiry has heard about. Just a few examples.

He suffered racist abuse from officers, including when he was so ill from food poisoning that he had passed out in his cell, being woken to hear Graham Purnell, a G4S officer, saying to him, "Why don't you go home, you fucking nigger, why are you pretending that you are sick?". He was mocked by other officers, including DCMs Andrew Lyden and Steve Webb, who told him

he was pretending to be sick to avoid his removal from the country. On other occasions, he heard an officer say, "Why don't these blacks go back to their country?" and "All the blacks are the same".

He describes a culture of disbelief from both guards and healthcare, a description wholly consistent with other evidence that has emerged during this inquiry and that you, chair, have seen and heard. He describes officers mocking and laughing at detainees who were mentally unwell, watching detainees in states of distress and laughing at them. Again, this is wholly consistent with footage that has been examined and other accounts of the toxic culture at Brook House. He described officers stating that detainees were pretending to be ill to avoid deportation, when, in fact, they were in profound mental health distress.

He also describes a culture of complacency and indifference towards bullying and abuse from other detainees, and how he would be subject to homophobic and racist abuse. The guards would do nothing to intervene and sometimes even join in.

He was subject to disproportionate use of force on at least two occasions. He was subjected to a rule 40 removal from association that was clearly illegal, and he describes other more routine, more mundane and petty

cruelties, such as being refused toilet roll and other essential items, having post pushed under the cell door in the dead of night so that men would wake up to see it and fret that it was bad news about a removal flight or a decision on their immigration status. He talked of the frustration of men not being able to contact their lawyers because of poor internet connection and other inadequate communication facilities.

But, chair, it was his treatment by healthcare staff that has had the deepest impact on him and that is, on any analysis, deeply shocking.

In context, in many respects, D643 had huge advantages over many of the other detainees: he is an articulate man; he spent 11 years in the British Army; he speaks fluent English and understands how to operate in a hierarchical, structured and process-driven environment; he had experienced detention in other IRCs, and in prison, and he had even been tasked by the British Army to assist with the detention of people in Iraq.

Despite all of this, he experienced catastrophic failures of care at every turn, beginning with the failures by the doctors to give him a proper physical and mental health examination on entry, failure to take the most basic of steps to check his previous medical

records when he was inducted, and a complete failure to identify, diagnose and to attempt to treat his mental health problems, including his complex combat-related PTSD.

D643 was man who he liked to keep notes, to write things down, to keep a record. He diligently tried to follow the correct procedures, he made complaint after complaint, after complaint, about his treatment and the lack of engagement by healthcare staff. Those complaints either disappeared into the ether or took so long to considered as to be entirely useless.

It must have been like shouting into a void.

You have heard that when D643 entered Brook House on that fourth occasion, despite having had three previous health inductions and having been diagnosed with PTSD while he was in the army, subsequently whilst in prison, and in another IRC, there was simply no mention of PTSD in his health screening records.

Despite having informed Brook House healthcare on previous documented occasions when he was there about this diagnosis, and of the previous treatment he needed and had received, and having, just two weeks previously, prior to his induction, had a rule 35(1) report issued at the Verne on the basis of his PTSD, there was no mention of that diagnosis, the rule 35(1) report or the

medico-legal report that triggered it in his medical record upon entry to Brook House on 21 December 2016.

That careless, indifferent cruelty was to become the theme of his lengthy detention at Brook House. It was a shocking failure from the outset to comply with rule 34 and rule 35 of the Detention Centre Rules. It was a shocking breach of the duty of care to a vulnerable detainee.

Chair, rules 34 and 35 of the Detention Centre Rules have been on the books for over 20 years. It is simply unbelievable that those in charge of healthcare at Brook House did not apply them properly. They are not despite what some corporate witnesses have said, complicated. They amount to a few sentences. They are the rules. To fail to apply one of the few safeguards that vulnerable detainees had to protect them is inexcusable and unforgivable.

Let's not forget that the Home Office watched with folded arms as month after month, year after year passed and no rule 35(2) reports were issued and barely any rule 35(1) reports came through. Did this not pique anyone's curiosity as to what might be happening? Apparently not.

Sandra Calver and Dr Oozeerally gave evidence that the Home Office never once raised any concerns about the

lack of those rule 35 reports. Why? I think we know the answer.

Dr Hard gave evidence that the treatment, or lack of it, of D643 indicated both a systemic failure in the screening process and the application of the rule 34 and 35 processes, and was indicative to be accepted of a lack of a system to identify and cross-refer to previous medical history.

Dr Hard also agreed that if someone like D643, who, as I said, spoke fluent English, he was articulate, he was able to identify precisely what he required to treat his PTSD, having received that treatment before, if he could not obtain the treatment he required, it would be practically impossible for someone, who did not share those advantages, to get adequate treatment.

It is worth pausing to think what that means. It means it is likely that hundreds of detainees, during the relevant period, and before and after, whose names we will never know, and whose stories will never be told, suffered in similar ways.

To suggest that what we have seen in this inquiry amounts to a series of isolated incidents is, with the greatest respect, utter nonsense.

D643 describes being particularly upset at the callous indifference of Drs Chaudhary and Oozeerally,

callous indifference, you may find, chair, which is wholly corroborated by the evidence you have seen in this inquiry. The examples are many, but I shall mention, because of the time restraints, just four.

On 12 June 2017, Dr Chaudhary confirmed to the Home Office in a letter that D643 was fit to be detained and fit to fly, and that was despite not examining D643, not referring to any of his mental health difficulties and not having even seen him for three months. No doubt the good doctor was just giving the customer, the Home Office, what he knew they wanted.

In July 2017, D643 tried to give healthcare three separate medico-legal reports commissioned by his solicitors that confirmed he was not fit for detention. The doctors refused to look at them.

Pausing there, it is, of course, not enough simply to point the finger at the two careless doctors. Those medical reports were provided to the Home Office, yet detention review after detention review kept authorising detention.

In January 2018, D643 tried to tell Dr Chaudhary that he was suicidal and needed help, but was turned away and told he could not help him. Of course, it goes without saying that no rule 35(2) report was even contemplated.

In February 2018, D643 went to Dr Oozeerally again and attempted to get help on the basis that his mental health was deteriorating. Again, no help was proffered and D643 was told that the doctor had no time to waste on him. Again, it goes without saying that no rule 35 report was produced.

Finally, on 12 March 2018, despite all that had gone before, despite the medico-legal reports, the obvious mental health distress and the length of his detention, Dr Oozeerally wrote to the Home Office stating that D643 was fit for detention, fit to fly, and was getting adequate care.

This was despite the fact that he had not examined D643, and D643 was not, in fact, receiving any care at all from healthcare at this time. It was careless cruelty.

Finally, and just ten days later, on 22 March 2018, in a stunning and absurd volte face, Dr Chaudhary wrote to the Home Office and informed them that D643 was indeed in need of specialist PTSD treatment which was not available in detention, and he was, therefore, not fit to be detained. That was 457 days since D643 had entered Brook House with a previous diagnosis of complex combat-related PTSD. It was careless cruelty of the worst kind. It would even be another 47 days before he

was, in fact, released.

D643 informed healthcare on numerous occasions that he was feeling suicidal and he had been identified by members of the healthcare team as having suicidal ideations on four other separate occasions. No rule 35 report was ever produced.

Dr Hard gave evidence that it was inevitable that the detention of a man like D643 for an indefinite period, day after long day, week after long week, asking for help for his mental distress and receiving none in return, would damage him. The damage was long lasting. Indeed, it continues. D643 ended his witness statement by stating:

"When I was released from detention, I was referred by my GP to receive treatment from a psychiatrist at a mental health hospital. My faith in medical professionals had been so shaken by the treatment I had received in the Brook House healthcare that I was extremely anxious. I did not feel able to trust the psychiatrist on meeting her. It was as though I was waiting for her to disbelieve me or to act in a hostile manner that I had been customed to at Brook House. I was unable to move past my fear that she would turn out to be like the healthcare staff and doctors at Brook House and, as a result, I did not feel able to

attend any further sessions with her. Even now, after four years later, I do not feel that I have fully recovered from the treatment I was subjected to at Brook House. I still suffer from flashbacks, in particular in relation to the use of force incidents outlined above and the way I was treated by the healthcare professionals, in particular Dr Chaudhary and Dr Oozeerally."

In hindsight, nobody has, or could, defend the detention of D643 in Brook House. He has received damages for unlawful detention, but he has never received an apology or an indication as to what period the Home Office accept was unlawful.

Karen Churcher gave evidence that it was not an environment where it was possible, or even appropriate, to attempt to give trauma-based therapy, and this must have been known from the outset.

Sandra Calver gave evidence the detainees did not have access to appropriate psychiatric treatment and that detention centres were not the appropriate environment to promote recovery from mental ill-health. Everyone from the Royal College of Psychiatrists to Dr Hard, and to even the former DCOs that you've heard from, agree that it is not a suitable place for a man with PTSD or other mental health difficulties.

The Home Office are the apparently the only people who disagree.

You have heard that it is not just that recovery is impossible for those with PTSD, Dr Hard and others confirmed that detainees are positively harmed by being detained in those circumstances. And so it was with D643.

Finally, chair, what does D643 ask of the inquiry? As I mentioned, he is profoundly grateful to have been given an opportunity to give evidence.

He has emphasised repeatedly to his legal team that the simple act of being listened to, of being taken seriously, of being given an opportunity to put on the record what happened to him, is of immense value to him. He is profoundly grateful to Callum Tulley for shining a light into this dark episode of his life.

As for recommendations, we will go into more detail, chair, in our written submissions, but, briefly, the system of indefinite detention harms people; it is cruel. The system of detaining the mentally ill and the vulnerable harms people; it is cruel.

It does not matter what the corporate logos are on the uniforms or what banal corporate values are displayed on posters on the walls, the system brutalises those that are expected to work in it, it harms those

who are detained within it, and it rewards the careless cruelty of those who displayed indifference to D643's suffering again and again. Tinkering with the machinery of this cruelty will not end it. Nothing short of a radical change will ensure what happened to D643 and the other men you have heard from will not happen again.

As for Brook House itself, Brook House is simply a symptom, a morbid symptom of a sick system, a category B prison that is not a category prison, a 72-hour removal centre that is nothing of the sort. It is a place of harm, it is a place of shame, and it should be shut for good.

Perhaps it should be turned into a museum, chair, and future generations can visit it, read the testimonies of the men who were shut up in it, watch the footage that triggered this inquiry in the first place, and shake their heads in wonder as to how it ever came to this.

Thank you, chair.

THE CHAIR: Thank you very much, Mr Lee.

I wonder whether we actually take our lunch now -- I am so sorry, Ms Luh, do you -- are you able to give me an indication of how long you are likely to need?

MS LUH: I had planned on only being 20 minutes.

THE CHAIR: Let's go ahead and do that then. I'm sorry

about that. Thank you very much.

MS LUH: I will do my best to keep to that.

THE CHAIR: Thank you.

Closing statement by MS LUH

MS LUH: I make these submissions on behalf of D801, D1275, D1713, D2158 and D1473. On behalf of them, I thank the chair, counsel and solicitors to the inquiry for giving them a voice in this inquiry.

If I can just say at the outset, as a shortcut, that each one of them was subjected to a regime which Dr Hard described as "completely deprived of safeguards". It was inevitable that they would experience mental suffering of the kind prohibited by article 3 and in particular, in the circumstances where none of them knew when the situation was going to end, it was, for them -- the detention was, for them, interminable.

If I can take you to D801 first, everything that the Home Office knew about D801 should have, but did not, prevent him from being detained on 1 March. The Home Office knew that he suffers psychotic depression, PTSD, and had attempted to overdose twice in the community. The Home Office had medical evidence that a previous period of detention in 2015 contributed to this and, had they bothered to look at the reports, they patently show that he was an Adult at Risk, level 3, the

highest level, and that he would be harmed if redetained.

There was no fixed date for removal, and he was not a public protection concern case. Therefore, he should not have ever been in Brook House in 2017.

Dr Hard's critique of the treatment of D801 in detention speaks for itself. He said in oral evidence that, although not physically assaulted by staff or verbally abused, leaving D801 in detention for this period of time of a total of 34 days caused him to suffer ill-treatment because none of the safeguards that were meant to function to remove him from detention worked.

D801 was a really good example, Dr Hard said, of a complete inattention of the understanding of the purpose of the rules and the imperative to relay that information to the Home Office at the earliest opportunity with a mechanism that would have meant a review of detention was undertaken at that point in time.

At every opportunity, the safeguards failed. There was no rule 35(1), (2) or (3) raised throughout the entirety of his detention until the very last day, when a rule 35(1) was completed by Dr Chaudhary, only because Dr Belda, the IRC psychiatrist, said unequivocally that

D801 was not suited for detention.

All the signs of this was apparent long before Dr Belda made that statement on 31 March 2017. D801 was someone that the Home Office and healthcare knew required treatment that was unavailable in detention. Dr Belda told them so on day two, but this did not cause the Home Office to recognise that this was a seriously unwell man who, as someone on a proper application of the Adults at Risk policy, should not remain in detention. There was no contemplation of other alternatives to detention, namely, release into the community when a hospital transfer was declined a week later.

Instead, D801 was managed unlawfully, contrary to good psychiatric care, in de facto segregation on E wing, subject to ACDT the whole time, at the beginning, on constant watch. You have heard a lot of evidence of how this is not treatment, and did nothing to prevent deterioration.

In fact, in D801's case he tried to kill himself using a shoelace as a ligature, and razors, whilst on ACDT, but even that didn't trigger any statutory reporting mechanisms under rule 35. There were a total of four part Cs sent to the Home Office, each uploaded onto the system, each ignored.

The only treatment following his suicide attempt was advice to him on how to snap an elastic band around his wrist to help him cope with stress. It is not hard to begin to understand that this cannot be treatment of the kind necessary for him.

You will recall Dr Bingham's evidence that detention has the effect of forcing victims of torture to relive their past torture as if it was happening to them again. There is no doubt, from D801's narrative to an independent expert, Dr Sen, that he suffered article 3 inhumane and degrading treatment at Brook House, and Dr Sen summarises:

"He could not eat and was throwing up all time. He just stayed inside his room and didn't want to socialise with anyone. The food tasted to him as if he was eating a pair of glasses, like it was burning. He didn't wish to explain anything to the authorities, just stayed away from the food, and the whole experience felt to him like walking on fire. Every single day felt as if there was biting on his skin and he physically felt the pain."

D1275. But for this inquiry, the true nature of the ill-treatment suffered by D1275 at Brook House would never have come to light. He was so severely unwell during the time he was there that he couldn't even describe his experiences to anyone in a coherent way and

know how to seek help. His severe mental health issues were unidentified, managed or treated at all at Brook House, and this was despite recurring health logs, citing his bizarre and sometimes aggressive behaviour and incoherent answers to questions. Even the Iranian consulate raised concerns with the Home Office about his strange behaviour. Instead, and frequently, D1275's behaviour was seen as refractory and was managed by segregation for extended periods of time. At Brook House, he was repeatedly referred to the mental health team and repeatedly discharged from that team's case load. No one bothered to do the basic checks to find out why he had missed so many appointments. Karen Churcher and Sandra Calver were both resolved to say that attendance at medical appointments was a matter of patient's choice, irrespective of vulnerabilities. His non-attendance was described in terms of wasted hours and resources of the mental health team, rather than symptomatic of a seriously unwell man. Neither contemplated that he could lack mental capacity to make decisions about accessing medical treatment or speak up for himself about his detention or conditions of detention. There was no practice to do so. They didn't know how to do so. Ms Calver accepted, and rightly so, that this was a serious failure in knowledge and care.

D1275 was just left to languish. But for the tenacity of Naomi Blackwell, a caseworker at GDWG, he could have remained in detention indeterminately in an environment that discriminated against him because the Home Office has refused to make provision for independent advocacy for people who lack mental capacity. By the time GDWG found him, he had been in detention for nearly 400 days, even though the Home Office knew long before that he could not be removed. He would remain in detention for 616 days, 442 at Brook House, before he was able to access lawyers and secure release. Dr Hard said in oral evidence that it was inevitable that a vulnerable detainee, subjected to this kind of length, would suffer harm and, in fact, even someone who didn't have these issues would find it difficult and would deteriorate in an environment like this.

Sandra Calver accepted serious omissions in this case, causing him significant ill-treatment.

His immediate hospitalisation on release under the Mental Health Act for nearly half a year clearly demonstrates the extent of his mental deterioration and how unsuited he was for immigration detention. We all now know too familiarly the footage from 14 June 2017 where he was cruelly and casually mocked by

DCM Nathan Ring and DCO Derek Murphy with derogatory remarks, including "div", "scrotum" and the more chilling and recurring phrase that has been used at Brook House, "If he dies, he dies". All this while he was suffering the acute effects of a spice attack. A nurse present for the mockery didn't challenge it, in fact, joined in with, "Homey is after your coke". The evidence before the inquiry shows that it was widely known that he was vulnerable and being exploited as a guinea pig for spice. No one did anything to stop it. No one reported it. They just watched it happen and some joined in to mock him. It was callous, but allowed to be repeated because of a culture of impunity and dehumanisation that pervaded Brook House, which normalised this kind of behaviour and suppressed dissent.

He still is not able to speak about his experience at Brook House. When his solicitor Hamish Arnott tried, he became distressed. This fragility of his mental state, still, is a product of the intense mental suffering he experienced in prolonged immigration detention and an article 3 breach is inescapable in his case.

D1713 is a victim of torture, sexual and physical abuse with pre-existing PTSD before entering Brook House

in March 2017. He is a classic illustration of the lasting mental harm caused by a complete deprivation of safeguards. No questions were asked at health screening to identify any past history of trauma or torture. Within hours of being at Brook House, he was asking to see a GP because he was experiencing flashbacks from being detained. Although he disclosed self-harm ideation and torture to Dr Chaudhary, no rule 35(3) report was raised and no rule 35(1) was raised. Dr Chaudhary could not give a coherent answer for why this was the case. He said he thought he needed to wait and see if D1713 actually deteriorated, which plainly is not what the rules say.

We now know, of course, that Dr Chaudhary didn't understand what the rule 35 safeguard required of him as a doctor or why, which, as Dr Hard said, put detainees like D1713 directly in harm's way.

The Home Office treated his self-harm, trauma and past torture as self-declared, of no value as far as the Adults at Risk policy was concerned. This reflected, of course, the culture of disbelief built into the evidence levels of the risk, but in circumstances, also, where the Home Office failed to ensure the safeguards linked to it actually functioned.

Again, the only treatment was ACDT, which did

nothing to prevent him from re-experiencing, over and over again, his torture in the form of intrusive flashbacks.

Not one nurse carrying out ACDT reviews thought to refer him for rule 35 assessment, despite repeated disclosure of torture, flashbacks and self-harm. Whilst detained, he was the target for derogatory and demeaning comments. One DCO compared him to locking up a dog. He felt humiliated, scared, "Like I was not being seen or treated as a human being". He was powerless to do anything because, "We were all scared of the consequences of speaking out, we were living in fear. Brook House was like hell". He is now scared to go to sleep at night, scared to close his eyes, fearing that the experiences that he had at Brook House would flash through his mind. Detention at Brook House spawned a severe episode of depression and has had a lasting effect which an independent expert, Dr Galappathie, has said has a poor prognosis for recovery.

D2158's experience is very similar. He was not pre-screened before detention, despite being of a victim of torture or sexual abuse. He was detained unlawfully for the whole time he was at Brook House because there was no power to detain someone like him. Although he was liable to be returned to Germany under the

Dublin Regulations, the tension could only be applied to someone like him if he was at significant risk of absconding, and he was not.

Once detained, again, there were no rule 34 appointments, there were no rule 35 appointments. In the meantime, he suffered worsening heart palpitations and nightmares and often felt like someone was putting their hands around his throat and he struggled to breathe. The sounds of doors opening, banging and the sounds of keys would make his whole body shake and he would feel an electric shock in his body. He couldn't convey the intensity of his mental anguish and physical suffering because, each time he went to healthcare, he was not given an interpreter. So the rule 35 assessment he finally got from Dr Oozeerally was cursory and careless and didn't address the impact of detention on him as a victim of torture, who was suffering recurring trauma symptoms and heart palpitations. His report was one of three quarters of the rule 35 reports at Brook House at the time which failed to address the impact of detention. The Home Office relied on that to keep him in detention, so that he could suffer even more.

When he commenced a period of food refusal because he felt he had no alternative, this was dismissed as

a dietary issue with no investigation into his escalating trauma symptoms and deteriorating mental health. Whilst detained, he was kicked by different custody officers on two occasions and also bullied and demeaned. The violence was unprovoked, doled out casually with the intent of intimidating, demeaning and humiliating.

He couldn't complain, he didn't know how, and he was afraid to because, at night, he often heard other detainees screaming in pain after lock-in. He thought they were being physically assaulted by officers. He didn't want it to happen to him. Such was the culture of fear detainees were subjected to at Brook House.

Finally, D1473, his mistreatment at Brook House is graphically illustrated by the prolonged and excessive restraint he suffered for some five and a half hours during an attempted unlawful removal whilst at Brook House. Whilst the force used -- the waist restraint belt was applied by Tascor officers, it was initiated on Brook House premises with the knowledge and apparent supervision of G4S and Home Office staff.

There was simply no justification for this restraint, it was unplanned, because there was no risk assessment to suggest he should be restrained for removal. He was compliant throughout the removal

process from start to finish and presented no actual risk to anyone. And more importantly, it is another case where it should never have happened, because D1473 was not removable at the time. He had outstanding representations on article 8 grounds and he was recognised as an Adult at Risk, level 3, and manifestly unsuitable for detention and on ACDT.

Mr Shaw, in 2014, in a report prepared by the Advisory Panel on Non-compliance Management, identified the use of a waist restraint belt in these circumstances as inimical to the person's dignity. The duration and effects of this use of force against D1473 actually caused mental and physical suffering. In his own words:

"It was terrifying and humiliating from start to finish. I was treated like an animal you were transporting. The terror was indescribable."

His is but one of many cases concerning routine misuse of a waist restraint belt to facilitate the discharge of vulnerable detainees to Tascor officers. Other examples include the removals of 1234 and D2054, both forcibly restrained whilst naked and subsequently placed in waist restraint belts on handover to Tascor. The routine use of passive restraints in these circumstances, with no prior consideration of the risk of vulnerabilities of the person, reflected the general

normalisation of the use of force in the centre. It was reckless, inhumane and degrading, especially when deployed for prolonged periods of time. The entrenched failure of the Home Office and its contractors to even appreciate and recognise this is illustrated by the PSU's response to the complaint made by D1473 concerning his restraint, categorising it as a "minor misconduct".

On behalf of all of these individuals, I endorse Ms Harrison's submissions on the need for urgent interim recommendations so as to bring to an end, finally, the deprivation of safeguards which continue to this day to currently affect detainees in Brook House. This has to stop and it has to stop now.

Thank you very much.

THE CHAIR: Thank you very much, Ms Luh.

Thank you.

I appreciate you keeping to that time. Much appreciated. We are going to break for lunch now and I am still going to keep us to 2.00 to make sure we don't slip from the timetable. Thank you, see you at 2.00.

(1.05 pm)

(The short adjournment)

(2.00 pm)

THE CHAIR: Thank you. Mr Armstrong, thank you.

MR ARMSTRONG: Now I am going to work out which of these microphones work. It sounds like that one is.

Thank you, chair. I hope -- does that sound like it's working to you?

THE CHAIR: It does to me.

Closing statement by MR ARMSTRONG

MR ARMSTRONG: Chair, my purpose this afternoon is to try to persuade you to be clear and definitive in your findings and to be bold in your recommendations. I do that because this inquiry is unique, it has not been done in this area before, the Home Office didn't want it, and they probably won't do it again.

There have, of course, been investigations, there have been years of them -- Yarl's Wood, Oakington, Shaw -- I know that you know about all of those.

There has also been years of litigation, there have been inquests, we have heard about Jimmy Mubenga and Prince Fosu, but there has been nothing like this. There has certainly not been the volume and range and intensity of the oral evidence you have had. Litigation in this area is almost always judicial review or tribunal and it almost never has much in the way of oral evidence.

Inquests have a bit more, but they are necessarily

limited in their scope and they certainly don't have the assistance that you have had from the solicitor and counsel to the inquiry teams, who have worked as hard as they have worked for as long as they have worked.

So you are in this unique position.

It is also, of course, the fact that none of that previous work prevented what we have seen in 2017 in Brook House. And it also appears that, even when Panorama came out in September 2017, as happened previously with Yarl's Wood and Oakington, the secret recording itself was not enough to stop things. Serious problems continued. And you have heard evidence post the relevant period about what has happened when pressures have been put back on the system, including things like Dublin removals and small boats and you have heard evidence, even from Mr Hewer last week, about constant watches, there were two constant watches in the centre and still it appears in 35(2) reports. So those problems remain. All of that is, of course, with the spotlight of this inquiry on it.

A key question of concern, certainly for those I represent, is what happens when that spotlight is taken away again, and how much and to what extent do things slide because, certainly in this area, things always slide.

Mr Riley gave evidence yesterday, he spoke of change. But he, too, has been forced to speak of change. He was abandoning statements yesterday under questioning from Mr Altman that he made as recently as the beginning of this inquiry in his witness statement when more was being put to him.

So we have, certainly from this side of the room, a degree of skepticism, because we have been here so much more -- so many times before. As that -- when that inertia stays, when that inertia entrenches, what happens is the number of victims mount because they remain in detention and the victims that we already have wait for change or wait for a solution. So I am afraid I am here to say only you can do something about it. Only you can try to achieve sustained and reliable change, so that this does not happen again.

I also say that, related to that, only you have the material, because you have had the breadth and the depth of the evidence and that starts with Callum Tulley's footage and then it moves into the sheer grinding awfulness of the granular detail that you have heard and have sat through, so the inadequate systems, the inadequate management, the inadequate staff, the parade of broken men, remember you -- Mr Lee talked about his client D643, the former army officer struggling with

PTSD, and you may remember how he was on the stand, struggling to give his evidence.

The parade of unreconstructed men, the DCOs, unled and unguided in their attitudes.

One or two people tried to stand up to it, but they got nowhere. So you heard from Owen Syred, you heard of, and we have seen evidence from, David Waldock, and of course there is also, in all of this, the women, the senior women, in fact, Stacie Dean, Michelle Brown, I think, in my submission, broken, too, in their way, not here, including for reasons that -- Michelle Brown, you understand the reasons for that, and we have seen their histories of being stressed, having periods of time off work, and telling you how and when they raised matters and you can see how far those got.

You have seen their emails, you have seen the response or the lack of it, including when raised directly by senior people, directly with Jerry Petherick, in January 2018, in the Stacie Dean example, and one has to remember, if it is like that for them, if those people, at their level, cannot get change or movement, what must it be like being -- or if they are reacting or experiencing that from Brook House, what on earth must it be like for the detained people themselves?

You have heard a lot about their unique and vulnerable characteristics and it is, again, we say, only you who can do something about it. Because, if not you, then who? And if not now, then when?

I do just want to note the chronology because it is not just now nearly 20 years since Yarl's Wood and 17 since Oakington, it is six years since Callum Tulley was concerned about what he was seeing to contact the BBC in the wake of Medway. It is four and a half years since Panorama came out.

It cannot be said that the Home Office has not had the time to do something about this. We have to ask, why haven't they acted? And we'll see some answers to that in a moment.

We say there is just one shot at this, and we certainly have to assume there is only really going to be one shot at this, and I am afraid it is you.

The -- not fiddling with it; we say, fundamentally altering it.

Now, what do we say that you have seen -- and you have sat through all of this, and I am not going to go through all of the evidence, I don't have the time to do the evidence, you have sat through every witness -- I think it may be just you and Zaynab, in fact, and, I think, one other, who has seen every single witness in

the room, so you know what they have said and you have that.

From our point of view, the key point that I would emphasise, and we presage this in our opening, is the toxicity, the unique toxicity, of immigration detention. Now, "toxicity" is a word that has been used a lot, counsel to the inquiry has referred to the contagion of toxicity, and I do want to say something about the language that we have heard.

I am not going to go back through it, I am not going to repeat it, but I am just going to say keep in mind, of course, its extent and its intensity, and it has been shocking even for those who look at these things. Professor Bosworth told you last week, on 29 March, she said it is obviously completely corrosive, and it was, you know, the widespread nature of those sorts of comments that are picked up on the undercover footage that is genuinely shocking, and it clearly was not being addressed by management, it was widespread and, you know, I think played quite a large part in the physical manifestation.

Remember when you are looking at the language, none of that would be acceptable, even in the high-security prison estate where you are dealing with extremely dangerous men, and this is not the high-security prison

estate, this is not even a prison. There are people that we have been looking at in this inquiry who have never been anywhere like this before, gentle men, guileless men, but even those who have been in a prison environment before, a wide variety of people, they, too, often scared, often mentally unwell. They may have committed offences, but those offences may just be documents offences, and they may also well be people who -- and I will come back to this -- will, in fact, end up staying in the UK. All of them are experiencing all of this pretty much all of the time with nothing being done about it, the use of the language not being reported, not being corrected and not being stopped.

That is corrosive, as Professor Bosworth says and it is dehumanising. "Dehumanising" is another word that has been used a lot in this inquiry. It has been the premise for much of the questions from your counsel. No one seriously disagrees about the characterisation of that. But it is worth emphasising the use of the word "dehumanising", because we are fundamentally in an inquiry about article 3 ill-treatment, and article 3 ill-treatment is about treatment that is inhumane and, if you have language that is dehumanising, you will get to a position where it renders something inhumane and we can look at authorities in due course about the

importance of language, but where you have language that robs people of their fundamental humanity, and that that -- and the "dehumanising" is the word that they are all using, then that does take us a long way, we say, to establishing that the treatment was inhumane. And I make another point here, which is a point that Ms Harrison has already made this morning, that both in phase 1, when we heard from detained people directly, but also in phase 2, when we had the read-in evidence from detained people, men spoke of their experience of being -- "I felt like an animal", "I was being treated like I was an animal" and it may very well be that those men spoke in those terms without realising the legal significance of the language that they were using, but it does have a legal significance because it is dehumanising. That is what they are describing, being treated like an animal. So that is also very highly relevant in article 3 terms.

The second point I want to emphasise, moving on from language, is the extent to which we say this obviously goes -- and we just want to knock this on the head -- much wider than that which -- than Panorama showed. There has been this discussion, and it is perhaps not a very helpful discussion, about whether it is bad apples or a bad barrel, and there was that exchange

between Mr Altman and Professor Bosworth last week about it, and we could debate about how many apples it takes to make a barrel. It isn't everyone in Brook House, but it is wider than Panorama, and it is certainly wider than those people who were dismissed as a result of Panorama, and you can see that because we have to add in a number of other groups, and that includes the people that you see on the unbroadcast footage, the people that you see on the body-worn camera footage. All of that is the footage, incidentally, that Mr Brockington didn't bother to watch before he gave his evidence about it being a supposed minority, despite his organisation being responsible for producing much of that footage and producing it late.

You have to add in all of that. You have to add in all of the people who didn't report the ill-treatment and who were complicit, in that sense. And then you have to add in the growing list of others who also seem on the evidence, and we say, to be guilty of very serious behaviour. You have within that list -- and just to name a few of them, Luke Instone-Brewer must be pretty close to the top of that list, in my submission. You have seen an enormous quantity of evidence that he was supplying spice to detained people and that he was making a lot of money supplying spice to detained people

and you have seen that evidence be multi-sourced. You have seen the intelligence that staff had and that Stacie Dean and Michelle Brown were talking about, you have seen all of that material, Mr Livingston took him through it, but you have also seen that chime with a completely different source of evidence, which is my client, D687. He has talked about the detail of that and how he was supplying it and the way that it was done and the mechanics of how it was done and how it was £50.02 in order to identify -- that level of detail. And when that kind of evidence knits together, it shows you, in my submission, that it is true. What that tells you is that Mr Instone-Brewer was doing this or behaving in these ways in 2014/2015 and raising concerns with staff then.

It was raised again specifically with Mr Petherick in January 2017, but he was left in place at Brook House until he left himself in July 2017.

You will -- you may remember, chair, when he was being challenged about this, the slightly cocky way, we say, in which he gave his evidence, laughing as he started his evidence. My submission is we can see very clearly who he was and what he was and draw the conclusions accordingly.

We also have on this list his friend, Mr Fagbo, he

was also friends -- who were also friends. Both he and Mr Fagbo were friends with Jules Williams, and I am emphasising these people because both of those two came into contact -- we see it in his early witness statements. Again, my client, D687, these were the people he was bumping into. Jules Williams was also friends with him and you have these insights as the evidence emerges, you have these insights which come out of the detail, like Jules Williams and the complaint that was made about him, and he was asked about it in his evidence, mucking about with a banana, apparently aimed at a gay female member of staff.

When you look at people who are behaving like that, and he is a member of the SMT and you look at what that is showing the people below him, and then you just imagine for a moment the dexterity which you think he brings, or might bring, to the pain and suffering or concerns of detained persons, you get a real insight into how dehumanising and difficult this environment was. It is awful stuff. And on it goes. We see Gayatri Mehraa, Graham Purnell, Darren Tomsett, all of these names coming up in lots of different aspects of the evidence, all names with extensive poor behaviour and inadequacies recorded against them and, again, multi-sourced. We see Gayatri Mehraa turning up in the

David Waldock complaint at the same time she is turning up in the GDWG materials, where people are talking about how she was trying to stamp on things she thought were second visits. There is no possibility of collusion between GDWG and David Waldock. You see similar things with Mr Purnell -- Mr Lee has talked about that again this morning -- and the extreme racism that he exhibited, and you see that that is being produced by D643 but it was also in Callum Tulley's materials.

Again, multi-source material that all knits together to show -- powerfully, we say -- that the allegations are true. Mr Tomsett, top of the leader board, as the most complained-about officer at Brook House, which is something, given how many others were competing for that and how reluctant people were to complain in the first place. Promoted to DCM by Steve Skitt. All of that material pointing in the same direction, all of them taking part all of the time with this casual language. And I'll just talk about that again. Where do you go when you have used the F word, then they go to the C word, then they go to the N word and you think, where else can they go after this? And then you get Sean Sayers comes out with a new phrase that seems to have taken hold in this inquiry, and you see, again, just how toxic and degrading it has become.

But, now, what you do have, we say, is a significant percentage of the staff list. And you have, a significant percentage of that list, some of the behaviour that is described here, some of them are still working at Brook House. So a number of staff implicated in serious wrongdoing -- it has already been said this morning -- Chris Donnelly, Steve Loughton, Steve Dix, Steve Skitt, all implicated to greater or lesser degrees, still working, and that is a real concern about achieving proper change here.

The point about how wide this is and how culturally broad or otherwise it is, you can also take from Callum himself. He saw all of this in 2015 and 2016, which is why he approached the BBC in January 2016. He then waited for more than a year, he took notes, and they checked whether it was still all happening, they went through the editorial process and realised it was still happening and so started filming.

He told you -- on 30 November, he said:

"Answer: [I know] why the inquiry are interested in the relevant period ... is because of my filming ..."

Then he said this:

"Answer: ... but to me it's -- the years and months before that were just as relevant, if not more relevant, because at least I was able to capture some of the abuse

during -- between March and -- between April and August. You know, to be honest, it's not the things I saw whilst secretly filming undercover which trouble me most, because at least I filmed it so the world can see it. But it's the stuff that I witnessed before I started wearing secret cameras. I know you're going to ask me about one incident in particular. You know, that's the hardest stuff, because those officers have gotten away with it and it seems G4S are only being held accountable for the months of April to August, and I hope that's not going to be the case ..."

The point this comes down to, he didn't just get lucky with what he filmed between April and August. That was representative of the period he had seen for at least the preceding year. I said this in my opening and I will say it again: this is not just a snapshot; it is indeed a panorama.

Mary Bosworth also told you on 29 March -- we can argue about the numbers, but there are clearly systemic issues here. We say they are deep ones and they are long-standing ones.

Now, just while I talk about Callum Tulley's evidence, I want to make one other point. The inquiry has heard a lot from him. He has given evidence over four days, so, in fact, he has been pressed harder and

for longer than any other witness. You have also had the benefit of his notes, his full footage, including during unguarded moments, we all remember the time in the toilet, and my submission is that he has answered the questions that were asked of him clearly, openly and precisely. I imagine that, like the BBC, we will -- and I imagine the BBC will also do the same -- invite you to accept him as being a witness of truth, unlike a number of other people who gave evidence to you.

But, the inquiry has also seen this ongoing number of allegations still mounted, sometimes even here in oral evidence by the DCOs and the DCMs he filmed, who have persisted in this range of allegations that he doctored or dubbed footage. You may remember the exchange between Mr Altman and Mr Connolly about this, where he was asking, whether Mr Connolly was saying:

"Question: Is that a serious proposition, Mr Connolly? When we are all done here and we have all moved on and the chair retires to write her report, is this how you want to be remembered?"

And it was only after that, that Mr Connolly finally abandoned this implausible point and went, "No, actually, no, I don't". That is what it takes, that is the inertia we are seeing, in order to get them to move off these attempts to minimise and say, "It wasn't me",

and not to acknowledge and not to reflect.

But we have still had people -- we still had the senior people, we still had people like Mr Neden persisting in claiming that Callum should have reported, that he could have relied on the systems, and then saying that people were harmed because Mr Tulley did not do that.

Chair, I just want to note that. Others represent Callum, but I do want to note that on behalf of those I represent. All of that is obvious nonsense. Those kinds of statements are entirely reprehensible, and we say two things should flow from it.

First, we say you should reject it expressly. We say Mr Tulley's actions in bringing all of this to light have been entirely exemplary and we should all be grateful for them. It cannot sensibly be suggested that he did anything other than the right thing. 20 years old, 20 years old, and he managed to stand up in the face of all of this when other people, who were much7 older, much more experienced and whose job it was to do this stuff, stayed silent. We say the inquiry should record that and record its gratitude. He stood up when the system which he had happened to join crushed so many others.

But secondly, we should just reflect for a moment in

relation to those who persist in these baseless allegations and nonsensical allegations against him, record that, too, and bear in mind what that means for the chances of sustained or reliable change. And this is just propping up the submission I make to you about being bold, because that is what we are facing down, this persistence of holding the line, because that doesn't look like people who are seriously interested in changing, people who are seriously interested in examining their own actions or inactions or taking responsibility for them. Instead, they are determined to minimise, and we say the people who maintain those fictions as an attempt to cover their own responsibility should be called out on it.

Also, chair, the longer that goes on, the longer they hold that position, all they are doing is holding up the real change that the system requires and, as they do that, the victims mount and the victims wait.

But returning to what we saw with the DCOs, can I also just make this point very clear. It is entirely hopeless to suggest that it stops with them, or even with G4S more generally. That is, of course, who Verita were looking at; they were looking at G4S primarily. But it obviously goes up to the Home Office, too, because they are ultimately the detainer, they are the

contracting department with the enforcement powers and we have to look at where all of this comes from. If we are looking at leadership and void of leadership and so on, what leadership or tone are they showing and setting? We say that is very obvious. You see it everywhere you look. Start at the bottom end and look at the likes of Vanessa Smith in that February 2018 Hibiscus training session, laughing along, using some of the same language, certainly not reporting the language as Hibiscus did, and you will remember, chair, that was 13 separate upheld allegations of misbehaviour in relation to that incident and the language was serious.

Hibiscus report it. Nobody else does. That was five months after Panorama where they were supposedly looking at this stuff seriously because Panorama had just come out and it was two years after Medway when they were supposed to be looking at these things very seriously.

When she gave evidence to you, Vanessa Smith couldn't say why she didn't report it, but that, as I think he accepted yesterday, did undermine what Mr Riley told us in his witness statement about having the confidence that, had they seen it, officers would have reported it. And they didn't. Because they did see it, five months after Panorama, and still didn't

report it. And that was put to him. Mr Riley got -- told you that he got a daily update from the inquiry, but didn't appear to get an update on that issue, about one of his own officers. He hadn't read the material, he hadn't read the investigation report, and he said this -- Mr Altman put to him:

"Question: Presumably, Mr Riley, none of that is anything you would expect of a Home Office officer?

"Answer: No, it isn't.

"Question: Do you think that undermines your confidence in Home Office attitudes or a willingness to report things or do you think this is just a one-off?

"Answer: I would hope that that is a one-off."

Then, "Well, on what basis do you think it is a one-off?", is what follows from that, because -- and it means this: when Mr Riley thought about what needed to be done, and what needed to change, he did it not knowing that Vanessa Smith or immigration officers were behaving in this way, and that can't be a promising basis for sustained or meaningful change or reform.

Moving on from her, you can also look at Mr Gasson. We start moving up the scale and look at Mr Gasson. Mr Gasson, it is said -- we are told, doesn't often come out of his room, doesn't like to mix with detained people, but when he does turn up in the evidence, we can

see a number of things. Nathan Ward talked of his cold functionality and you may think -- a matter for you, of course, but you may think that you saw some of that in the way he gave evidence.

You have more direct evidence of that in the evidence of James Wilson and GDWG. You remember the meeting in August 2017. Now, I want to just touch on that briefly. What on earth was the problem with GDWG, you may think? Gentle people trying, politely and appropriately, to help people who we can see obviously needed that help. They were filling in the gaps in a system that obviously had many, many gaps. Yes, they are a campaigning organisation, for many years, for the end of immigration detention, but they do have force in that point. There are absolutely grounds for that campaign.

What was the response -- what was the response of the Home Office to them? And you have Mr Wilson's oral evidence where he said this:

"That was a dynamic that I felt was increasingly there. I was particularly -- I was vividly aware of that in that meeting, the dynamic. I remember the meeting very vividly. I remember it was Steve Skitt and Paul Gasson who were in the meeting. They were nearest the door. I was on my own. They were very, very

agitated. Very. As I put it, I felt that they were toying with me, they were threatening me with something, with something a very immediate threat to our access. I remember it being -- in my recollection, it was a dark and rainy day. I remember walking out of the centre feeling shaken by the meeting, and I had had meetings before when they had been difficult, but I was really shaken by that meeting."

That evidence is supported by the contemporaneous email that he wrote, and that you have seen, where he talks about, "I've just had a gruelling meeting, drop-ins are on a knife edge, it sounds draconian, but this is serious", and you may have picked up that he didn't give as much detail the first time he gave evidence on this, which was in his witness statement for the judicial review which produced this inquiry, but the reason why he was saying less at that stage is also something that he explained in that witness statement, which he was scared of losing drop-ins at that stage, back in 2018, when those proceedings began. He was still very worried about what might happen if he challenged G4S or the Home Office.

Both Mr Gasson and Mr Skitt were challenged about this and were asked about what they did, and both of them simply gave the manifestation of bullies who had

just slightly been caught out and were now sullenly staring at their feet in the head's office, giving grudging apologies, saying, "Well, if we were hostile, we didn't mean to be".

By way of, also, further emphasis on this, remember it has been referred to a couple of times already but that Naomi Blackwell statement. She gave evidence and you have got the witness statement in the materials, about, in a very sober, very restricted way, talking about an incapacitated detained person who was obviously very vulnerable and who, it turned out, was not only unlawfully detained, but was being detained in breach of article 3.

Now, the knowledge of that witness statement, the way G4S and others came to know of that witness statement, must have come from the Home Office because it was the Home Office that was the party to the litigation.

When that comes to light, what do they do? They don't respond saying "Oh, this is very serious, we have a vulnerable individual in detention who maybe shouldn't be in detention. How have we missed this?", they attack GDWG, was their response. "How dare they write the statement". Remember, then, how GDWG come to be examined and described in all of those meetings, and you

will remember the phrase "The problem is one of trust". The problem is one of trust. Immediately characterising this as an "us and them" situation, GDWG are a "them" not an "us", they are on the wrong side of that line, and all of that is, of course, stifling the production of evidence that, in seeking to stifle the production of evidence that was very desperately needed, but in an article 3 context, because if you are stifling the production of an evidence in an article 3 context, you are breaching article 3.

Now, as well as, it may be noted, in August 2017, driving or helping drive the IMB to a degree of hostility and distrust towards GDWG. That is pretty serious and pretty telling stuff. And it was the Home Office at least as much as it was G4S. And you will remember the evidence of Mr Haughton who thought the steer -- he even told you that the steer he had had with regard to GDWG was unfortunate and was a shame, but it came from the Home Office and from Ben Saunders.

All of that material, chair, points in the same direction. It certainly doesn't point to a compassionate approach. In fact, I don't think we can see, in the relevant period, any evidence of any Home Office official behaving in a compassionate way towards a detained person.

It also chimes with other material, it chimes with Lee Hanford in his Verita interviews, and in his oral evidence, talking about G4S having been criticised for being too empathetic. Ben Saunders was asked about that evidence and he agreed that he also had that take. Ben Saunders was, of course, trying to please the Home Office and he was said to be good at it, but he did that by showing little or no empathy.

He told us -- we heard that he stayed in his room as well as Mr Gasson staying in his room, not being visible, and that is important because it is, of course, much easier to mistrust and it is much easier to mistreat and much easier to dehumanise if you do it from a distance. If you separate yourself out, you will find it much easier to mistreat.

So that is where we saw -- when you look at all of that evidence, that is what you see about the approach of the Home Office. But is that really very surprising, that you are finding those sorts of uncompassionate attitudes from the Home Office? When you look at things like the overall political rhetoric in this area, the overall agenda of the Home Office and you see that in all sorts of places too. So you look at the contract, and you see the absence of relevant provisions, so there is nothing in there on welfare, nothing specific on

welfare, there is nothing on checking use of force in schedule G, you look at the way schedule G works or doesn't work, you look at the focus that everybody describes on immigration throughput. We have looked a lot at things like the KPIs and the complete absence of any KPI, and suicide and self-harm, despite 60 incidents in the relevant period.

We cannot see how that system could sensibly have work because, in order to have a KPI, it requires all these steps in the chain for Barry Timms to find out, in order to report it, and then to get sufficient information to characterise it as a procedural breach, and then somebody to check whether that judgment is correct. Mr Gasson is asked about that. He cannot remember doing it, doesn't know how it worked. Mr Castle didn't know how it worked and couldn't remember the system either. And the reason they can't is because there wasn't one because it wasn't happening.

The only inference you can draw from that is because nobody really cared about whether G4S was failing in its monitoring of suicide and self-harm arrangements.

I would just ask briefly about that. How is that happening now? Because the KPIs and the contract now, how does that now work? How have they improved those or filled in those gaps in the system?

Again, we have had two people on constant obs. Have they self-harmed? Has that become a KPI? Has it become a rule 35(2) report? Dr Oozeerally tells us he has never done one, et cetera.

You have also got, in all of this, the use of force. Obviously a critical issue for this inquiry. You know that the use of force reports were done much later, sometimes by the same person who was involved in the use of force. Steve Webb did that.

Just dealing with D687 himself, the use of force on him, or the key one, is 13 May. The use of force review form is done on 31 July, two and a half months later. Tick box, not even picking up the fact that BWC -- body-worn camera -- footage wasn't used, even though the box was ticked for it. You will remember how important that is because Mr Collier told you how important it was. If you don't review it, if you don't pull people up on it, then they won't write their reports correctly, they won't write their reports accurately, they won't learn, and nothing will change.

Chair, in my submission, the use of force in this case was a car crash. So much of it was badly done, but, again, nobody seemed to pick it up. No Scrutiny Committee meetings, nobody is picking up the fact that Steve Webb is both being involved and doing

the review, and doing them two months later.

Then tie in, all of that shows no real interest in welfare, but of course you see it in all of these other places, like no 35(2) reports, for years. That is astonishing and nobody picks up it. Article 3 findings in respect of this detention centre, article 3 findings more generally not being handed back, nobody can tell the system for feeding that back to the people involved.

What on earth is going on? But, moreover, what kind of message is that sending? What is that saying to the DCO on the wing who has never done anything like this before, who is paid £25,000 flat rate a year with no chance of an increase, understaffed, in the noise, firefighting, and is unguided and unled? Is that saying to that DCO, spend more time, engage more, try to understand what is happening with this vulnerable individual? Of course it is not. And where will he look, then, for help and support? He will look at people above him and look at how they are behaving or expressing themselves.

Chair, the Home Office -- I have talked about political rhetoric. The Home Office wanted a hostile environment. They got one. This is what it looks like. They need to own this.

The consequence of that is it is degrading and it is

inhumane and that is what it flows from.

It is also, of course, the Home Office that built a category B prison on the fiction of a 72-hour detention period, and so they didn't bother building much in the way of outside space, very little in the way of outside activities. Everything in that, too, says "We don't care". Mr Riley yesterday was asked about the culture of the Home Office and he told you:

"Answer: ... We live in a society where the debate on migration and enforcement is polarised and entrenched and that doesn't help either. And it is a difficult operating environment."

Who do we think drove that, Mr Riley? Where do we think that came from? Who do we think is polarising the debate on migration and enforcement?

So that is what I say about the Home Office.

On the other side of this, of course, we have the detained people themselves and I gave you in our opening a list of characteristics and vulnerabilities, mental ill-health, English not as first language -- I know you have all of those points. Much harder to build relationships -- which is the normal way in which you run establishments of this kind, is by building relationships. It is much harder to build relationships when you have those characteristics.

I do want to just briefly summarise some of the characteristics for D687 himself. You have seen a bit of him around, he was at the early stages of the inquiry, a cheeky, likeable man -- I hope he will forgive me for saying so. He finds it quite hard to watch. Turns up in court and finds himself on the video, which is part of the reason why he has not been here as much, because -- and he had recurrent depressive disorder, PTSD, he is suspected of undiagnosed learning difficulties and bipolar disorder. Been in the UK nearly all of his life. He might well have had British citizenship, but for the fact that he was in care and social services didn't apply for him -- so the rest of his family got citizenship and he didn't -- and he was in care because he had suffered childhood abuse. It is not -- he's not had an easy time, hasn't D687. Schooled here, family here, being told regularly, "Fuck off home", but feels that he is home. His suicide and self-harm, clearly there for years, clearly serious, well recorded. Remember the scarring, which only came out in this inquiry, because, when his solicitors saw the unreleased footage that nobody had seen before, they saw him doing something and said, "What are you showing the officer, there?" And then he showed them and that is how the scarring came out for the first time.

So he has always found it difficult to express himself about those things and, by May 2017, two years and three months in immigration detention, in that patch, and a year and a half of which had been at Brook House, and that is, of course, very significant because he has had all of the stuff we are looking at for that period of time.

He was significantly suffering as a result of that, which is not very surprising, because all of the medical evidence you have had, all of the independent doctors in particular, have told you how detention impacts.

They have told you about the indeterminate nature of detention in particular and how that impacts, and D687 had done a lot of that and, throughout that time, he has been bumping into the likes of Luke Instone-Brewer, who he has described in his early witness statements, and we can imagine how that was and we can imagine how those interactions were, and Vanessa Smith, who he tells he is writing a suicide note, but doesn't open an ACDT, or Dr Oozeerally, who doesn't open an ACDT either and doesn't do a 35(2) report. And he had just, at that point, told this individual -- for the first time, he had opened up about his childhood abuse and the story of his life there. Where does it get him? What does that tell him? He opens up and nothing happens, so it tells

him the system really doesn't care. And remember Dr Hard here, because these interactions -- he told you, these actions being regularly dismissed has a negative impact on mental health, and D687, we say, is the paradigm of that. You may not need Dr Hard's evidence to understand that.

Just put it all together and imagine what two years and three months of that must be like. Being denied the identity that you feel and believe to be yours, not being taken to the funeral of his brother and his grandmother. Remember here the contemporaneous notes, Callum's video diary, and he's deteriorating, and where does it end up? In a disabled toilet with a ligature around his neck. He goes into the disabled toilet, too broken even to lock the door properly, "I have had enough, bruv, I want to go, bruv", that is what he tells you. That is what we hear on the video. And Brook House has reduced him to that. That has degraded him, that has dehumanised him, that has broken him. And where does it end up? It ends up with a use of force which, in domestic legal terms, Mr Collier cannot justify, and -- because it is not planned. There is no healthcare present, despite the ACDT, despite the ligature. There is no BWC footage, despite it being a duty director who is in charge that day, and there are

two DCMs who are wearing BWC but don't turn it on. They are both individuals who abuse D687 in the course of the use of force. One of them is responsible for the "We'll just wait for it. If you do put it on, we will wait for a minute until you pass out and then we will cut you down", said by a DCM. Humanity, chair, at that point, has left the building.

Then it -- Mr Collier says they should have engaged more. Force may not have been required if they had. Then they used the trick with the cigarette lighter, they take him to the ground, he's got four or five men on top of him whilst he's still got a ligature around his neck. They cuff him. He's subdued and in cuffs, so he doesn't appear to be a threat to anybody, but at that point he has a pain-inducing inverted wrist hold applied, and he cries out in pain. We also know that he turns up -- when he gets to hospital later in Dorset that night, when he has got to the Verne, he has got bruising to his ribs which has not been explained.

So, chair, in relation to him, we say in relation to D687, he was degraded in breach of article 3 before he entered that toilet, but when you -- that is -- he's a very good example of what Brook House can do to you, particularly over a sustained period of time, but if you add in a domestically unlawful use of force,

an unjustifiable use of force into that mix on top of that, then that is the breach and that is where it all absolutely goes over threshold with that final, slightly chaotic, thoughtless act, unplanned, as it were, by Duty Director Haughton.

Can I also just bear in mind what D687 has said about all of that, and the number of times he has told the story about what happened then before the footage came out? And when the footage does come out and we have been able to examine it with the detail that you have been able to examine it with, it does show that he was right, in terms of what he was describing, and it shows also that the PSU was wrong about that. We haven't got time to go through the difficulties of what the PSU does and the way that it does it, not checking things unless -- "No, we don't check things. Unless you can tell us what date it was, and which individual it was, we won't do it". We will not weigh in -- I will dismiss the allegations of racial abuse, because I will not weigh, because it is not in front of me, what Panorama is showing about racist abuse, but he is clearly right -- D687 is clearly right about that and we say the PSU was wrong because of the narrowness of the approach that they took, but that PSU dismissal degraded D687 yet further.

So those are the findings that we invite you to reach, chair. There is some law to deal with here about the correct approach. I am not going to go through that in any detail, we have CTI's note on it. We may have some points of difference, but I think they will be minor difference. What I say about that is essentially this.

You will need to reach findings about what happened, you will need to reach findings that inform an article 3 assessment. That will mean looking at what happened, but also why it happened, and when you come to look at why it happened, you will need to look at things like the motivation of the abuser, any justification for it, the language which surrounds it, whether that is intended to degrade, whether it is racist because that sounds particularly heavily in an article 3 assessment, and D687 had all of that, but then you will need to look at things like, even from an individual breach point of view, even the individual treatment point of view, things like official indifference or the failure to operate safeguards is also relevant to whether or not you get to an article 3 threshold, so that will require you to examine the systems, the training and the resources. Even on that individual assessment, one will have look at both what happened and why it happened and

that will take you into systems issues.

When you then come to look at whether there are systems breaches. Again, I am going to leave this to written submissions, but you are concerned here with whether there were inadequacies in the system which materially increased the risk of an article 3 breach or, to put it another way, would a system without these inadequacies have had a real prospect of producing a different outcome? Now, I am slightly borrowing that phrase from the operational side of article 3, but it must be the same.

Now, what counsel to the inquiry is saying, that there will need to be something that ties a system breach to an individual breach, so there will need to be a system that produces a consequence, there will need to be an impact. We say you won't need that because you can be future looking and say, "Is there an inadequate system that might produce an outcome of that kind?", and that would be an article 3 breach and, therefore, you should look at it, but it is very difficult. I am not sure I need to get that far, because it is very difficult to look at all of the systems that you have been examining through the course of this inquiry, without finding somebody who that will have had an impact on it -- that will have had an impact on.

So whether it is five-minute rule 34 assessments or whether it is rule 35(1) and 35(2) reports or the reliance on part Cs or the absence of use of force scrutiny or the absence of staff or staff culture making systems ineffective because they don't believe what is being said about suicide and self-harm ideation, all of those are capable of being article 3 systems breaches and all of those are impacting, we say, on the people you are hearing from, including, to a large extent, D687. So we say there will need to be findings and we invite you to do that in relation to all of those matters.

Now, where, then, does that take you? I started this by saying I was going to invite you to be bold in your recommendations. What does that entail? Now, back to this point: we say that the problems here are too legion and they are too manifest and they are too long-standing and too entrenched to call for anything short of fundamental change. Otherwise, you are facing too much inertia. Look at how long these go back, 20 years to Yarl's Wood, look at how the Home Office had to be dragged kicking and screaming to do it; it required an order. They said in the judicial review, "There is nothing here to be found, we don't need to do this". We don't, in particular, need to have witness

compellability in order to get Yan Paschali -- we don't need the powers to hear from Yan Paschali, or to hear from the others, or from Connolly, or from Nathan Ring, or any of those individuals. You did need to hear from all of those individuals to understand how bad it was, you did need to hear from all of those individuals, and the -- and you needed to have that enforcement power available to you. So the Home Office was wrong about that. And, as it has continued to be wrong about many things -- and I have already said Phil Riley was still revising his remarks yesterday on rules 35(1) and (2) and on part C. He was also, yesterday, when he sought to reassure you that it was now a changed Home Office under him, he told you that "We have done "-- he said:

"Answer: ... [chair], we have done an awful lot of work over the last four years -- three years, four years -- in learning from the Wendy Williams report ..."

Which was a slightly astonishing piece of timing, given that Wendy Williams had issued her Windrush progress report five days earlier, when she said that -- which contains 13 expressions of disappointment in the progress that has been made in relation to Windrush. Only eight of her 30 recommendations have been acted on. Much more progress was required and there was limited evidence that a compassionate approach had been embedded

consistently.

So none of that is giving a great deal of reassurance, you may feel.

Mr Brockington also sought to reassure you change is being made, "It is only a minority", et cetera, et cetera. It's not immediately clear to me how he was seeking to persuade you or be persuasive in circumstances where he had not read the Mary Bosworth report, he had not read the transcripts, he hadn't listened to the key bits of evidence and he sought to come along and tell you what he knew when you have heard all of that material at great length. Again, not a terribly promising start, but what those attitudes tell you is that these are not organisations that welcome change. These are organisations that tell you what they think you want to hear in order to make the issue go away. And they will need again -- I have said this already -- to be dragged, kicking and screaming, into any serious alteration.

They have also told you, a number of them have told you, Mr Riley in particular has told you, and told you in some detail, that further change is waiting for the Nationality and Borders Bill, and you can be reassured that because -- big changes coming in relation to that and they will do something after that, but you don't

have to look at that very closely to be pretty concerned too. Do we think that a Home Office that is currently proposing offshore processing of asylum seekers is seriously committed to migrant welfare? Do we think an Ascension Island Brook House is going to be better than this one? What do we think the scrutiny is likely to be there -- like there? What do we think an Ascension Island IMB is likely to be like? What do we think that that degree of removal from the world will do for the situational psychology of that potential environment?

So we say one has to be -- one has to be fundamental in what one does.

We can work down the list of the other things. And I will just do mine, briefly. One can adjust the contract, as it is said it has been done, but, as I have already said, things like KPI problems appear to remain. We can increase the staffing. I remember your question, chair, about moving the ratios around because, in the same way as you move the ratios around in open prison and closed prison, think about the fact that immigration detention has a different purpose and has different needs and has a different cohort. We can do that. And we can introduce better work or better activities, we can train staff in mental health and capacity, we can

put prompts on ACDT forms that then link it into the 35(2) report, we can do all of those things, energise the IMB or the other monitors, but we submit that none of that is likely to be enough. All of those things have been done or said before and all of them are capable of sliding when the spotlight moves away, and they will fade as the energy fades, or when you get the pressure -- small boats, Dublin -- remember the 2020 IMB report and the Observer and Liberty materials telling you what it is like yet -- what it is like certainly in 2020, and what Mary Molyneux told you. They were clearly not coping in 2020 with suicide and self-harm, is what she told you.

Ian Castle was asked about that IMB report. We said that -- treating the whole of the detention estate inhumanely and he said he couldn't disagree.

The numbers are down at the moment, but Mr Hewer told us, unsurprisingly, in his oral evidence, that he expected an increase. What will happen when that increase comes? Mary Molyneux, again, she told you that, "The Home Office kept" -- this is at the time of the Dublin Convention situation:

"The Home Office kept bringing these men in. The Home Office were aware of the problem. The Home Office knew this was happening -- the numbers, and the numbers

of self-harm."

And then she said the reply that she got was all about process. "We have the right, we have the process", and then she said, "There was just a total disconnect and not, in my view, acknowledgement of the problem". That is what they do, that is what the Home Office seems to do, on that evidence, they plough on.

Now, the other thing I just mention, that I would single out for special mention, is that, yes, you could look at what you can do to change the culture. But in order to change the culture of the number of witnesses told you, you would need clarity of purpose and a recalibration of the purpose in favour of detained person welfare.

Professor Bosworth talked about that, she talked about how hard it was for DCOs in circumstances when the purpose of the detention was not clear to them. The Jill Dando Institute said the same thing. You have more clarity of purpose in a prison because it is about punishment and rehabilitation and release, so you know what that is for, but immigration detention is much more difficult, and it is difficult for this reason, because it does need openness and honesty about what it is really about. The problem with immigration detention is

there is just no point in pretending it is about a short period of detention just in order to affect removal because we know that is not, in fact, what is happening, as soon as you look at the release statistics you see the numbers are very low. The only reason the release numbers are anywhere is because, essentially, when you look at the numbers, you have places like Poland and Romania, where there is a probability of removal, but in relation to all the tricky countries, if I can put it informally, when you look at places like Sudan, Syria, Afghanistan, Iraq, Iran -- also, coincidentally, the countries where the people coming from there are most likely to be most damaged -- the removals in relation to those countries are very low. The latest statistic, below 5 per cent for all of those. So this isn't really about removal, and all that is happening is the Home Office is pretending it is and, once it does that, as it ploughs on, believing, or wanting to believe, that it is, in fact, about removal and that all of these people are off and all these people are charlatans and they are maintaining claims to remain that are not real, then that fosters the abuse, because as long as you maintain that, that you are on the way out, it informs the language of, "Why don't you fuck off home?".

The -- so, yes, look at that. Yes, see if we can do

that. Yes, see if we can bring some honesty and transparency to bear about what the real purpose of the function of immigration detention actually is, but are we going to achieve that, are we going to get there with that, is that a realistic thing that we can alter, given the political rhetoric and everything else that we have around this area? And the problem that we have and the people I represent have, is that, absent something really hard and robust and fundamental, we can do all of the work around those softer issues, but it won't actually produce the outcome that we need.

What you need to do is just get much shorter periods of immigration detention or no immigration detention at all. Professor Bosworth has told you, and it is very interesting the timing of all this, that the pandemic has shown that much larger numbers can be managed in the community. We have not -- there is no evidence that we have seen that suggests that the pandemic and large numbers of people being managed in the community has produced an escalation in absconding or offending. There is no evidence of that and, if there was, we would expect the Home Office to produce it because the burden of proof in detention is on them.

Absent that, we are entitled to infer that very large -- much larger numbers of people can be managed in

the community.

But what you are also being told is, "Why not do time limits?". Now, I understand that it would be said this is outside of the terms of reference, but is it? Because the terms of reference say, "examine the reasons for the mistreatment and the experience", and the reasons for the experience, at least in part, is a lot of people are telling you, the detained people are telling you, that indeterminate detention is making the experience worse for them, at the same time as Mary Bosworth tells you it is making it harder to respond to them because it is undermining the clarity and the purpose of immigration detention. So one does have to reflect what the evidence is telling us, and that is what it is telling us.

Even Jerry Petherick said in his oral evidence:

"I think the real issue -- and you are right, I am not a clinician at all, but my experience would say that the real issue that impacted on detainees' wellbeing and mental health was their sense of not knowing -- the uncertainty of the situation."

When you have that consistency of evidence all saying the same thing across these different kinds of witnesses, then we need to do something about that, we need to take it seriously and we certainly need to

record it.

Equally, why isn't indeterminate detention a method policy practice or management arrangement, that causes or contributes to any identified mistreatment? That is something that you are tasked with looking at within your terms of reference. It seems to us that it is amply wide enough for indeterminate detention to be a contributing practice and, therefore, within the terms of reference.

Equally, your scope determination, 6 January, confirms you can make any recommendation you like, and you were clear in the scope determination that you would be flexible and go where the evidence takes you. That is where we say the evidence has taken you. Too many people from too many different stripes are saying the same thing. You are unconstrained, we say. Again, we say look at the scale of what we've seen. You should respectfully do all you can about it. If not you, then who, and if not now, then when? And don't succumb to the siren song of Mr Blake, who told you -- who's not now in the room to hear me say this, but Mr Blake said in opening, "Don't go into the politics. The things that Brook House require is mundane. Don't do that". It is impossible to avoid politics. We are talking about immigration here. Certainly stay off the mundane,

certainly let's go beyond mundane.
So a couple of other things very briefly. If Brook Houses are to continue, the mentally ill need to be out. They just need to not be in Brook House, they need to be not in detention. Not just those who can produce a certain calibre of medical report that just results in the Home Office then complaining about there being too many medical reports, "We don't like the medical reports because they all say these people are ill". Well, there may be a reason why they say that.
We know that you can't do therapeutic work in the centre. All of the doctors say that. And not just the mentally ill, all of the vulnerable need to come out -- the trafficking victims, torture victims, all of them.
Bring into the systems those who understand the experience of detention, and that may be GDWG, but it also means the former detained people themselves because that will bring them closer, that will foster understanding, it will foster empathy and care, and it will do more to understand the detained person experience that has not, so far, been well understood. And stop, absolutely stop, using this building to detain people for any length of time beyond the 72 hours for which it has been designed.
Chair, there are other longer lists of

recommendations and they are contained in the fourth witness statement of Anna Pincus, who I represent in the GDWG, but there is also more from BID, from Detention Action, from Medical Justice. You have long lists of recommendations, and I can't improve on all of those. You have all of those and I will put them in our written submissions, but there is a reason why all of those people agree. They all know their own bits of a system and they all agree, and there is a reason why they agree. And I conclude simply by saying, again, go where the evidence takes you. Now is the time. Be bold.
Thank you very much.
THE CHAIR: Thank you, Mr Armstrong. Thank you.
Mr Stanton, do you require a lectern or anything?
MR STANTON: No, I'm fine, thank you.
THE CHAIR: Okay, thank you.
Closing statement by MR STANTON
MR STANTON: Chair, I will be giving the closing statement on behalf of Owen Syred, who is in attendance today and is sat beside me.
At the outset, Mr Syred would like to say that he has followed the evidence of the inquiry closely, and has been disgusted at the actions and attitudes of some staff which demonstrated a lack of humanity towards

people in their care. He regrets not having done more to counteract these behaviours at the time. He would like to commend the bravery and resilience of those formerly detained persons who have provided evidence to the inquiry.
As Mr Syred said in his opening statement to the inquiry, he welcomes the inquiry's scrutiny, and continues to be hopeful that the inquiry's findings and recommendations will lead to significant improvement for those who are detained within immigration detention centres like Brook House, but also for the people who work in these centres. This closing statement is focused on issues that concern staff and management at the centre, which is where Mr Syred feels that he can add the most value.
It will address six areas as follows: first, dysfunctional leadership; second, recruitment; third, training; fourth, career progression and professional standards; fifth, the impact of staff -- sorry, the impact on staff of working at Brook House; and sixth, balance.
First, dysfunctional leadership. Part of the reason for addressing this area first is because the leadership is responsible and accountable for the behaviours within the centre. But also to highlight at the outset

an issue that Mr Syred believes runs throughout the whole of Brook House, including the senior leadership, namely, the lack of clarity and awareness about the fact that immigration detention is not a punitive measure but a means of facilitating immigration controls.
There are some features of immigration detention at Brook House which are clearly punitive without any obvious justification, such as being locked in a room with strangers for 11 hours a day.
There is also a very obvious tension between the caring element of ensuring the welfare of detained persons and the reality of immigration detention, including the need, on occasion, to use force. It was striking the number of occasions that staff spoke when giving oral evidence about their empathy with detained persons, which Mr Syred believes is, on the whole, genuine, only to be confronted with recordings of their actions and statements which evidenced authoritarian, aggressive, abusive or uncaring behaviour.
Some staff appeared visibly shocked while giving evidence and being confronted by their own behaviour.
Mr Syred believes the lack of clear direction from senior leaders as to the purpose of an immigration detention centre, most particularly, that it is not to operate as a punitive measure, is at the heart of the

problem, coupled with the fact that the majority of staff were inexperienced and without adequate training.

Mr Syred has always been aware that there were two camps within the DCO and DCM staff, those like Mr Syred, who believed that their role and priority was to ensure the welfare of detained persons, and those who believed that Brook House should be run more like a prison. However, having engaged with the inquiry proceedings, Mr Syred now realises that this fault line also ran through the senior leadership team.

The inquiry has heard how there was a lack of cohesion among the senior leadership team. Lee Hanford referred to the "toxic" relationship between senior management, to an element of chaoticness, to the fact that the relationship between the centre director, Ben Saunders, and his deputy, up to 2015, Duncan Partridge, had broken down and that other staff knew there were two camps on site.

The statement of Michelle Brown refers to a clear lack of trust within the senior management team.

Mr Syred believes that Ben Saunders was out of his depth and did not command the respect of his senior leadership team, which was in part due to his social care background. There were many within the senior leadership team who saw Mr Saunders as too soft and

wanted to see the centre run more like a prison, such as Duncan Partridge, Steve Skitt, Jules Williams and Ian Danskin(?). The prison approach was too ingrained within many of the senior leadership team and this filleted down through the whole organisation and resulted in the promotion of individuals who shared these values and contributed to the "us and them" culture. Attempts to lighten the prison-style environment were opposed and the less austere atmosphere at Tinsley House was referred to by some senior managers, DCMs and DCOs as "Disney House".

Mr Syred believes that Brook House suffers from an identity crisis for which the senior leadership team bear a significant responsibility. In addition to this specific and profoundly damaging failure, the staff at Brook House were generally not well led. Brook House is not a particularly large work force, and almost all staff are required to be physically present to carry out their work. It should not have been difficult to instill a positive supportive team ethos and to communicate important messages such as the importance of freedom to speak out and to create and reinforce positive shared values.

An example of the ineffectiveness of the senior leadership team is the failure to support Mr Syred when he reported the fact that he was being bullied, following his report of a racist incident. You will recall, chair, that a poster which contained photographs of staff so that they could be identified within the centre had been defaced next to Mr Syred's image with the words "Grass" and Post-It notes were also placed over his locker stating "[N-word] lover" and "Grass".

Such an appalling example of bullying in support of a member of staff who had engaged in racist behaviour ought to have resulted in an immediate, visible and unequivocal response from senior leadership, including clear communication to the workforce that this type of behaviour is unacceptable, an investigation to identify those responsible and a review of processes, procedures and training so that the staff were in no doubt of their responsibility to call out inappropriate behaviour, and that the more senior the member of staff, the greater their responsibility to call it out.

Instead, nothing was done, other than the provision of hollow expressions of support. The fact that inappropriate behaviour was not routinely challenged by the senior leadership team and managers led to staff feeling empowered to behaviour inappropriately because

they knew there would be no consequences.

The lack of proper recruitment, training and induction processes, which will be mentioned in more detail later in this statement, was also a significant failure of the senior leadership team, as was the lack of presence and visibility and any real insight and awareness of what was happening on the shop floor. There were no proper mechanisms for feeding the views and experiences of DCOs and DCMs into the senior leadership team and, worse, suggestions for improvement and expressions of concern were actively suppressed.

An example of this within Mr Syred's first statement that ironically occurred at a staff forum concerns Mr Syred's attempt to discuss what he considered had been an unnecessary use of force to facilitate a transfer which had caused injury to a detained person and to suggest that, in future, officers who may have a positive relationship with a detained person be afforded an opportunity to explain and persuade the detained person to transfer without the need for use of force. This is the same type of engagement that the inquiry's expert witness Jon Collier indicated when giving evidence was not happening enough at Brook House. However, Mr Syred was told by Ian Danskin, who was chairing the staff forum, that it wasn't for discussion.

The inquiry has heard a lot from staff witnesses about the fact that bad language was rife within the centre. Some staff continued to seek to justify its use, whereas others had come to realise that, whatever poor language and abuse they faced while working at Brook House, it was not acceptable to respond in kind. Given the relative inexperience and lack of training of many of the staff, it is understandable that they responded in this way. However, it was the job of the senior leadership team to ensure that staff behaved professionally through training, messaging, monitoring and role modelling and, again, in this regard they failed.

Second, recruitment. If staff are not interested and concerned at the conditions and circumstances in which people are detained, and do not have an interest and concern for the individuals that they are caring for, then they will not be motived to do a good job. Motivational fit needs to become a central plank of the recruitment process and more emphasis should be placed on identifying people who will take pride in their roles.

Mr Syred experienced verbal abuse and was sworn at and assaulted on a number of occasions for relatively modest pay but he stayed because he enjoyed the work,

particularly the interaction with detained persons, and he felt that he was making a difference. He is not alone in this view and, with more effort, a higher number of candidates with these values could be identified.

Assessment days for recruitment were often staffed by people such as Graham Purnell and Derek Murphy, both of whom face allegations of violent behaviour against detained persons. This is yet another example of the inappropriate emphasis and value placed on control and restraint and the macho culture at Brook House.

Mr Syred applied to run an assessment day and was turned down, which illustrates that the values he promoted and his caring approach to detained persons were not regarded by the senior leadership team as attributes to look for in new recruits.

There is a need to identify and attract staff who will treat the role as a career and not as a stopgap for something else, as was too often the case and which resulted in staff who were content to do the bare minimum. Some suggestions of how this can be achieved are made in a later section in this statement.

The inquiry has heard from a number of staff witnesses that the reality of the role was nothing like advertised and that many staff left soon after they

started, once reality had dawned. This is a huge waste of recruitment and training resource and another aspect of a flawed recruitment strategy.

Mr Syred believes that there is a need for a much more robust assessment process to identify and attract people with the right skills who are interested in undertaking the role for the right reasons. The assessment process should continue both through the initial training course and a properly assessed, not just time-served, probationary period.

Third, training. The inquiry has been repeatedly told that the initial training course did not prepare staff for the realities of the job, which, similar to the failure to accurately advertise the role to identify the right candidates, makes no sense because time and money is wasted on training staff, who often leave shortly after starting once they become aware of the reality of Brook House. On any level the role of a wing DCO as someone who is required to safeguard the welfare of approximately 100 detained persons, together with only one or two colleagues, taking account of physical and mental health issues, the ACDT process, drugs issues and incidents of violence and bullying, as well as contending with verbal abuse and threats of violence, is an extremely challenging position and to perform the

role properly there needs to be significantly more and better training.

Given the high levels of incidents of self-harm and mental illness, it is a particularly shocking failure that more training and insight into mental health was not provided to the staff. Some staff have told the inquiry that they received no mental health training. Mr Syred believes that they are mistaken in this regard; however, the fact that many staff do not recognise that they received mental training at all speaks volumes.

Mr Syred has been a little puzzled at some criticisms of staff during inquiry proceedings for comments made while engaging in role play scenarios, because the whole point of role play training is for it to be as realistic as possible. The language used by detained persons could sometimes be threatening and abusive and there is a need for this to be reflected in the training.

Mr Syred suggests that there should be more scenario based training and that staff should be confronted in group learning sessions with how and how not to behave in the difficult and challenging circumstances that they will inevitably encounter.

Mr Syred will also recommend there should be an opportunity during the initial training course for

engagement between trainees and detained persons, perhaps former detained persons if they would be willing to take part in such a programme, to better help trainees to see detained persons as individuals, to gain a better insight into the impact of detention and to establish and build empathy.

Staff must be better equipped to meet the complex needs of detained persons. The range of needs is huge, from short term stays by people who have overstayed their visa and wish or do not object to a return, to people who suffer from serious mental health issues and may have suffered torture and persecution. There are also significant numbers of detained persons who are liable to behave aggressively or violently or to self-harm.

Mr Syred felt it necessary to undertake additional training at a two-day course on immigration law delivered by Amnesty International to gain a better understanding of the legal issues involved in immigration and so that, as a DCO, he was better able to engage with detainees who were subject to the legal process of removal or deportation. As a result of this interest and commitment, Mr Syred was able to assist a detained person who had been described by officials from his home country as an a abomination because of his

sexuality; and Mr Syred spoke about this in his evidence before the inquiry.

It is accepted that it is not the role of staff at immigration detention centres to advise detained persons about their claims. However, given the context of immigration detention, and the length of time that some detained persons spent at Brook House, there is a need for better training on the basic principles of immigration law in order to effectively carry out the role of DCO and DCM.

Training is also largely based on the National Offender Management Service training, which is designed for prisons and not immigration detention centres. The rules governing the running of a prison and an immigration detention centre are different and there are a number of other factors that make the role of a prison officer and that of a DCO and DCM very different, including the uncertainty around the length of detention, the mixed population of detained persons who have been convicted of serious criminal offences with overstayers with no previous experience of detention, and freedom of association and movements, at least during the day, which requires a different set of skills to manage.

An example of the inadequacy of the training

provided is the fact that Mr Syred was never trained in the operation of rule 35, which represents a significant failure given the importance of this provision, as has been emphasised in the inquiry proceedings. It was only when he started working in welfare several years after he had started at Brook House that he learned about the requirements and the significance of the rule.

Fourth, career progression and professional standards. There needs to be an opportunity to progress within the DCO grade, so that the centre can build a reservoir of experienced and committed practitioners as well as managers. Mr Syred had no ambition to become a DCM; however, it was the only way to achieve career progression. He wanted to carry on and develop his role as a welfare officer, which allowed him to assist people on a daily basis. Mr Syred believes that the introduction of a senior DCO role to allow for career progression, development and job satisfaction would improve standards within immigration detention centres and also greatly improve staff retention.

The lack of financial remuneration for experience and commitment to the role also needs to be addressed. As a 10-year served DCO, Mr Syred was earning the same salary as a new recruit with no experience, which was a source of frustration and needs to be addressed in

order to retain people with the right skills and experience.

As an example of the benefits of experience, Mr Syred's reaction when he first started working at Brook House was to become offended by abusive comments or aggressive behaviour by detained persons. However, he came to recognise that it was the detained persons who were locked up while he was not, and to see past such behaviours as isolated incidents, realising that the detained person was in a stressful situation or perhaps having a bad day. The inquiry's counsel team have highlighted this imbalance of power and the duty on staff to behaviour professionally at all times, even in the face of abusive or aggressive behaviour. However, it can be particularly difficult for inexperienced or immature staff to do so, particularly without effective and reinforced training and the availability of experienced role models, such as Mr Syred.

DCOs and DCMs should be recognised as a specialist profession, not the cheap cousin of prison officers. A recognised qualification tailored to immigration detention centres should be developed and become mandatory for those seeking to work in the centres. This would provide staff with a sense of pride and professional duty.

Fifth, the impact of working at Brook House on staff. Professor Bosworth spoke about the secondary trauma experienced by DCOs and DCMs when confronted by the trauma suffered by detained persons, and many officers and managers have been adversely affected by their experiences at Brook House. The evidence of Professor Katona has prompted Mr Syred to reflect about the challenges of seeking to support people in dire need without the appropriate knowledge, training and support, and the detrimental impact on how staff cope and work with people with mental illness.

Working at Brook House, you are exposed to high-levels of aggression, abuse and violence, and Mr Syred has been assaulted on a number of occasions. There is a need to be hyper vigilant to respond to drug misuse, violence and threatening behaviour, and this can cause mental health problems for staff, particularly when the training and support is inadequate. Mr Syred has been diagnosed with post-traumatic stress disorder and when he tried to raise his own mental health issues, the management of Brook House wouldn't listen.

The strain of working at Brook House led some officers to hide their lack of confidence with bravado or to act out of character in order to fit in. The inquiry heard a particularly distressing example of this

when Mr Sanders gave his evidence. Staff were also frustrated by staff shortages, the lack of support from senior management and by colleagues who were not pulling their weight, leaving staff who took the role seriously to become overwhelmed and dispirited by not having sufficient time to do their jobs properly.

Sixth, balance. Mr Syred's main aim as a core participant is to tell the inquiry what it was really like at Brook House. The inquiry has seen and heard about the worst of Brook House but there is also another side which was not shown in Panorama or drawn out in the inquiry hearings. It was a small minority of staff who conducted themselves as Yan Paschali and Derek Murphy did. By and large, staff at Brook House behaved well and treated residents with care, dignity and compassion. There are no recordings of officers and detainees chatting, having a coffee, sharing a joke or playing pool. However, these were everyday occurrences at Brook House.

In his evidence in December of last year, Mr Syred told the inquiry:

"When you worked on a wing with guys, you got to know them, they got to know you. It felt like you were almost a community. Believe it or not, I had some very funny times joking and laughing together."

Lee Hanford told the inquiry that the behaviours you see from the majority of staff, their relationships with detainees were excellent. A number of officers and managers have told the inquiry about the efforts they made to build relationships with detained persons and to look after their needs. The inquiry has already heard evidence of officers seeking to support detained persons by helping them with forms and documents needed for immigration cases and assisting with access to legal representatives and charities.

Mr Syred can recall numerous examples of caring and supportive behaviour by staff, such as a welfare officer colleague, Nikki Madgwick, who arranged for a detained person's dog to be cared for by a canine charity; James Begg, safer custody manager, who provided detained persons with his contact number so that they could contact him 24/7 if they had thoughts of self-harm; Ramon Giraldo, a highly respected and well liked colleague who worked tirelessly to provide activities for detained persons with the limited resources available to him; Michelle Brown, who attended Surrey Accident and Emergency with an Egyptian national who required specialist treatment for mental health issues and stayed at hospital all night to support him; and Mr Syred's colleagues in welfare, who all went the extra

mile on a daily basis.

There are also many officers who Mr Syred believes were caring individuals who were shown in the BBC recordings behaving inappropriately, for example Charlie Francis, Steve Webb, Kalvin Sanders and Clayton Fraser. Mr Syred has known some of them for years and witnessed them trying to do their best. In his evidence to the inquiry, Mr Syred described Clayton Fraser as someone who he had "always witnessed being quite caring, considerate; to me that was quite really out of character but I do believe that was probably more just to fit in, just to be accepted and it's a very common thing".

The inquiry has understandably focused on a small selection of the recordings made by Callum Tulley. However, they do not present a balanced picture of life within Brook House, which is a point recognised by Professor Bosworth in her expert evidence to the inquiry. It is important to Mr Syred that the inquiry has a balanced view of what Brook House was like and that it should find some way of recognising the many positive interactions that took place between staff and detained persons. Mr Syred is conscious of the distressing experiences that many detained persons experienced. However, not all allegations made by

detained persons are accurate; for example, the witness statement of D390 submitted to the High Court that referred to the use of batons by staff in circumstances where video evidence demonstrated that this was not the case. There were other examples, and a careful examination of the availability facts is needed when assessing the merits.

Mr Syred would also ask the inquiry to take account of the fact that there have been significant improvements in the conditions at Brook House between 2009, when Mr Syred first joined, and the relevant period in 2017, so that recommendations can be made for the future, having regard to relevant past developments.

In his first witness statement, Mr Syred states:

"When Brook House first opened in 2009, it was a dreadful place. 90 per cent of the detainees were foreign national criminals and it was infested with drugs. There were also problems with prostitution, bullying and gambling. It was a very menacing atmosphere which you could cut with a knife."

Some of the factors that Mr Syred believes contributed to the problems in the first few years were the fact that the overwhelming majority of residents were time-served prisoners; the failure to allow the centre time to bed in -- almost immediately it was

opened, it was filled with residents -- and an even less experienced workforce than in 2017; less recreational activities were available and the fact that all wings were open to each other, which caused considerable disruption and violence.

The atmosphere changed completely from 2009 to 2017, and you could not compare the two periods. The main reason that conditions and behaviour improved was because staff were able to build positive relationships with detained persons, and Mr Syred suggests a continued focus in this area will lead to further improvements.

Finally, Mr Syred would like to suggest two other broad areas for improvement. First, an independent state-run service to better ensure the welfare of people in immigration detention. In Mr Syred's view, the role of a DCO and DCM is far too important for it to be left to a private company whose priorities are to profit and shareholders. Mr Syred also has concerns about the need of any private company to protect their corporate image and the disincentive this brings, conscious or not, to seek to identify poor practices and areas of concern by thorough investigation and external reporting, so that issues can be addressed and improved. In Mr Syred's experience, staff rarely have loyalty to profit companies. However, they will take pride in what they

do if they feel they are able to have a positive impact on the circumstances of detained persons and their families, and they are able to positively influence management of the centre.

Second, the act of locking someone up for 11 hours each day, either alone or with one or more other detained persons, is stressful and damaging to mental health and wellbeing. It is also punitive nature and cannot be said to be in any way necessary to ensure lawful immigration controls. There is no reason that detained persons could not be provided with their own key, with wing officers being able to access rooms which are locked from within where necessary. This is a practice adopted in other countries, notably Norway, and the current low numbers of people in immigration detention would be an ideal time to trial it in the UK.

One has only to imagine how it would feel to be locked in a room for such a long period of time each day to begin to appreciate the levels of anxiety the practice causes. The fears of detained persons about being locked up at night were very obvious to Mr Syred. Staff would spend considerable time persuading people to be locked up together with a stranger and when detained persons refused they would be taken to the Care and Separation Unit.

For people who have difficulty sleeping, which is very common in those who are experiencing stress or anxiety, it would be far better for them to have access to communal areas and to be able to undertake an activity, rather than lying in bed with negative thought patterns. Staffing levels would need to increase, but not significantly, and the additional cost would be a small price to pay for the potentially significant improvements to the wellbeing of those in immigration detention.

A final final point, picking up on what Mr Armstrong said about a hostile environment. Mr Syred can confirm that he was encouraged to make known the hostile environment to detained persons.

Thank you, chair.

THE CHAIR: Thank you very much, Mr Stanton.

Mr Kelly, we are going to be hearing from you next but I am going to suggest that we take our 15-minute break and we will hear from you when we return at 3.45.

MR KELLY: That is fine.

THE CHAIR: Thank you very much. 3.45.

(3.30 pm)

(A short break)

(3.46 pm)

THE CHAIR: Mr Kelly, thank you.

Closing statement by MR KELLY

MR KELLY: Thank you very much, chair.

I propose to just deal effectively in a thumbnail sketch with the submissions that we are making, because we will be making full written submissions later dealing with all of the points.

The very first point I would like to make is that, in section 2 of the Inquiries Act 2005, it provides at subsection (1) that an inquiry must not "rule on, and has no power to determine, any person's civil or criminal liability". It is an inquiry, not a court of law. No one is on trial.

Subsection (2) provides that an inquiry is "not to be inhibited in the discharge of its functions by any likelihood of liability being inferred from facts that it determines or recommendations that it makes". The use of the word "inferred" clearly refers to subsequent litigation, thereby reinforcing the point.

In respect of article 3, it of course prohibits torture, inhumane treatment and punishment. We say, in short, that there is no credible evidence that either Nathan Ring nor Stephen Webb, as individuals, engaged in such conduct. The thrust of the allegations against them is the use of foul language on limited occasions.

Brook House, it has to be said, was an exceptionally

difficult environment for everyone involved -- detainees, employed custody officers and other employees alike. It was on virtually all accounts a building with physical inadequacies, with poor facilities, a building which suffered from overcrowding, and a place which was under-resourced and understaffed.

Looking at just some of those things, briefly, it could be said to be a poor environment and there was certainly uncertainty as to how long the detainees would be kept prisoner in Brook House and that contributed, we say, to its problems. The cells were not kept clean, there was poor ventilation, some exercise areas were closed, the exercise space was far too limited, and that is just according to Jeremy Petherick of G4S.

Mr Singh from Her Majesty's Inspectorate of Prisons had this to say:

"But I think one of the major ones is the fact that, you know, this is in relation to Brook House in particular, it is a centre which looks and feels like a prison and is designed like a prison."

As we have said many times, that is inappropriate for a detainee population.

The length of detention was uncertain or, put another way, detainees were subject to indefinite detention. That had a serious impact on the detainees

and indeed created an atmosphere leading to frustration and aggression, all of which contributed to the problems this inquiry is examining.

Professor Mary Bosworth also identified the length of time detainees were held in centres such as this as a problem, which, among other things, contributed to the detainees' poor mental health. If people are subject to a regime where they don't know how long they will be detained, it is hardly surprising that there will be anger and frustration.

Brook House was overcrowded. There is a significant amount of evidence that Brook House was overcrowded and that was certainly not helped by putting in a third bed in many cells in early 2017 -- the so-called 60 extra beds. The independent investigation into concerns about Brook House by Kate Lampard and Ed Marsden used three words about it.

THE CHAIR: Sorry, Mr Kelly, I think we have lost your microphone. Could you just give us a moment and we will get that fixed. (Pause)

MR KELLY: Is that working?

THE CHAIR: That is better, thank you.

MR KELLY: Thanks.

Do you want me to repeat the last bit or have you got that?

THE CHAIR: If you could start again -- you were going to start talking about the independent investigation by Kate Lampard, if you want to start there. I think we lost you then. Thank you.

MR KELLY: The independent investigation into concerns about Brook House by Kate Lampard, and Ed Marsden in 2018 described it as "overcrowded and unsettled".

Brook House was under-resourced. Footage of Callum Tulley looking for a evacuation chair but there were not any to be had, nor were there any where they were supposed to be. In any event, Brook House didn't have enough evacuation chairs.

There was a group complaint submitted by detainees regarding the lack of internet access. There was a lack of translators, long queues to use IT equipment or access to the welfare office. There was no clean bedding often, no cleaning equipment provided, officers unable to provide basics such as toilet roll, not enough showers for the number of detainees, poor internet, poor phone signal, malfunctioning phones and poor quality food.

Brook House was also understaffed. As Nathan Ring put it:

"The Home Office contract was, I believe, very prescriptive, particularly in terms of how many hours

G4S were prepared for. Staff on the ground, however, generally felt that Brook House was understaffed. On a good day, we were lucky to have 50 officers in the whole centre. On evenings, you might be lucky to have six DCOs and two DCMs. It left staff on the ground of the centre often feeling vulnerable, overworked and uneasy."

However, there was a high turnover of staff and, because a lot of the candidates were inexperienced, some candidates never came back following the training course or decided that, after a month of working in the role, it was not what they expected. It was the residential side which suffered the most with retaining staff.

The counsel to the inquiry, Mr Altman, on the first day seemed to recognise this when, in opening, he said:

"You may want to consider whether the range of staffing problems described contributed to dissatisfaction amongst detained persons and a growing feeling of hopelessness and frustration among them, which, in turn, had an impact on the levels of self-harm, substance misuse and violence at Brook House."

The more challenging or non-compliant detained persons became in consequence of their environment, the more some staff resented them for the additional work

and stress this added to their lives. Understaff and overwork were also reported to affect staff morale in a direct sense.

Much has been said about the use of foul language. However, we cannot treat Brook House as a normal workplace like an office. Swearing was, on the evidence, a common method of communication and was not intended to be offensive. In many cases it appears that such swearing was speaking to detainees in the common language in use by staff, including in fact Callum Tulley and detainees on occasions. As Mr Ring in his evidence said, such language often was a coping mechanism for many in Brook House.

Now, when it comes to the inquiry considering the role of Callum Tulley, you should bear in mind the evidence of officers such as Yan Paschali, who described Callum Tulley as always fishing for stories. He told you how he, Mr Paschali, responded by making up stories and how he embellished the stories. You should also bear in mind Callum Tulley's own evidence that he only turned his camera on when he thought he would capture interesting material. That footage should not be treated as intrinsically representative of everyone at Brook House.

The true ill-treatment and cruelty at Brook House

lay in the indefinite nature of the detention. That was the root of all the problems -- the fact that it was designed and supposedly intended to house people for short term, pending their removal from the United Kingdom -- and I personally, and I think many others in this room are still in the same position, whether it was 28 days, 72 days or 72 hours and, if so, when that changed, are none the wiser after the evidence heard but, whatever it was, through Home Office failings and inefficiency the detention of its residents stretched to many months in some cases.

The Home Office in the form of Mr Phil Riley characterised the notion of detention for no more than 72 hours in Brook House as an "urban myth". That uncertainty as to how long an individual might be deprived of his liberty led inevitably to frustration on the part of those detained. This was recognised by Jeremy Petherick on Day 34, when he said:

"The real issue that impacted on detainees' wellbeing and mental health was their sense of not knowing what was happening with them and the frustrations of their progress towards their release either into the United Kingdom or their repatriation, and so the major impact on their wellbeing was the uncertainty of the situation they found themselves in."

The problem, in our submission, is the system. It would be an error to scapegoat the former employees and put events down to a few bad apples. Such an approach would do nothing to address the issues which have given rise to the need for this inquiry, and would not address what has been dealt with by a variety of different witnesses. In short, such an approach would be no more than a cop out with little credibility.

The two men we represent, Nathan Ring and Stephen Webb, if guilty of anything, are guilty of little more than a few facetious comments, silly comments, which were made in what they thought were private conversations. In short, the staff must not be portrayed trade as the scapegoats; nor are they self-evidently responsible for immigration or deportation policy. They merely worked in a dysfunctional system.

It is, we submit, on the evidence clear that many of the problems with Brook House were and are due to indefinite detention as a policy, combined with housing detainees in what in effect was a prison, with extremely limited facilities, understaffed, under-resourced, badly managed, and the responsibility for that should be laid where it belongs: at the door of the Home Office and its contractors, here G4S.

Thank you, chair. I am glad to say that I have finished well within time.

THE CHAIR: Thank you very much, Mr Kelly.

Mr Jacobs.

Closing statement by MR JACOBS

MR JACOBS: Chair, I represent Charlie Francis and I am instructed by Howe & Co. Charlie Francis was a DCO at Brook House from 2012 and during the relevant period, and he appears in the Panorama programme. I don't propose to deal with the evidence at length today, and will do that in more detail in the written submissions.

Mr Francis gave evidence on Day 23, 3 March 2022. He became a core participant on the previous day, so you don't have opening submissions in respect of him. Mr Francis would like the inquiry to know that he is watching today on the live link -- he cannot be here this afternoon.

It is important that I say from the outset that Mr Francis does not seek to excuse his behaviour towards D1527 and D728, as shown on the Panorama programme. He accepted in his evidence that he was shocked when he saw that programme and couldn't believe, he said, that he was seeing himself.

Generally speaking, my client was a capable and competent DCO. He had no antipathy towards those

detained at Brook House and told the inquiry that he treated detainees as human beings. He also told the inquiry in his evidence that he intervened on two occasions to save detainees who had tried to kill themselves, and the detail of that is detailed in his witness statement.

DCM Webb referred to Mr Francis when he gave evidence on Day 26, and he said:

"Charlie was a good officer, he was a very good officer who I relied on a lot and I am sorry that he got tied up in what I said."

The core participant Syred, who is to my right, Owen Syred said, when asked about the officers on E wing who were macho and cliquey, he said:

"Yes, most of the guys apart from one, Charlie, I knew very well. He was always very good with detainees."

Mr Francis is shown on the Panorama programme making inappropriate remarks towards D1527 on 25 April 2017 and using inappropriate language towards that detainee in the aftermath of the Paschali choking incident, an incident which my client has described in his evidence as "horrific". My client accepts that he used the words, "Are you going to continue being a tool? Are you a man or a mouse? Are we getting bored with this

now?" He said that, at the time, he used those words believing he was bringing D1527 out of a state of anxiety, "to bring him back to reality", in his words.

He confirmed in his evidence, when asked by Mr Altman, that he now understands that he was unable then to distinguish between a detainee who was capable of rational actions and a suicidal man who was suffering from mental illness. Mr Francis received no training in mental health or PTSD awareness. In the absence of such training, he believed at the time that he was able to distinguish between those who he believed were genuine people who wished to harm themselves and those who he thought at the time were attention seeking. Mr Francis' position, looking back and reflecting, is that, had he been appropriately trained by G4S, he would have acted entirely differently towards D1527.

The same lack of awareness in relation to mental health issues apply to my clients exchanges with D728 on 6 July 2017. The video footage shows my client arguing with this detainee who had been trying to frustrate officers by covering the observation hatch with tissue paper and had been complaining about lack of access to medication. Mr Francis was heard to say to the detainee, "If I have to come back again, you won't be going anywhere today. You will be staying down here

permanently, do you understand?" And after they were out of the detainee's earshot, Mr Webb used derogatory language saying he would like to punch the detainee. He made it clear in his evidence that the detainee couldn't have heard that, and Mr Francis replied "If you don't, I will".

Mr Francis accepts there is no excuse for his behaviour but, again, he was not able to understand that D728 was a man who had significant mental health problems. Mr Francis' primary problem here is that he was not properly trained to deal with detainees with mental health and PTSD issues and that is a systemic failing at Brook House.

Neither was my client trained or equipped to deal with the negative macho-aggressive culture that had been allowed to develop and fester at Brook House. Sarah Newland in her Verita interview referred to a large cadre of DCMs who are testosterone-filled and Mr Francis stated in his evidence that there were two categories of staff members at Brook House, some in his words were "very hard-nosed uncaring types without compassion or softness", and he confirmed that that certainly included Yan Paschali, who in his view shouldn't have been working on E wing. The second category were officers who, like my client and Mr Syred,

were more human, more sympathetic and more placid men.

In Mr Francis' case, the former group prevailed over the latter. Mr Francis agreed in his evidence that he was one of those who was easily led by more dominant staff members. He was led into behaviour by other officers but did not instigate that behaviour. The Reverend Ward has made the same point in his evidence to the inquiry. He described my client as someone who did not have bad intent but an example of someone who was caught up in the culture of Brook House. He goes on to say that, in both incidents in which Mr Francis is featured in the Panorama programme, he took inappropriate action and used inappropriate and offensive language when in the company of more dominant staff members.

But, chair, this is as far as it goes. It is important to note that Mr Francis, when giving evidence, clearly and categorically rejected any suggestion that he tried to cover up Paschali's conduct or that his reluctance to give a police statement over and beyond the information that he had given in detail to G4S represented any attempt to protect Paschali from prosecution.

We respectfully say there is no proper basis for the inquiry to make any finding along the lines that my

client was involved in any cover up, aside to what is said about the inquiry not being able to make findings in relation to liability, but that is an important point for my client.

We agree, and we say that there is broad agreement amongst the core participants' representatives, that the evidence has shown that the problem at Brook House was not one of bad apples or, as Mr Brockington for G4S suggested, "isolated incidents". The problems at Brook House in the relevant period arose from systemic failings, as Dr Patterson has said "a corrupted culture", and ultimately it was the responsibility of G4S and the Home Office to secure the welfare of detainees at the facility and the systems in place at Brook House failed to do this.

Chair, like Mr Stanton before me, I will address you on six issues, six areas. The first area, which I have already touched on, is lack of mental health training. Mr Francis stated in his witness statement that, when he attended DCO refresher courses, he would say that officers needed to receive psychological training to understand and respond to what detainees were experiencing. He states that he was not alone in thinking this and he recalls others on his shift saying the same thing but, despite having raised this issue

with G4S, my client received no mental health training. Indeed my client may have believed he was actually doing some good by speaking harshly to detainees. He talks in his statement about trying to snap someone out of an emotional or vulnerable state.

Dr Hard told the inquiry on Day 39 that staff didn't understand D1275's mental health problems and he confirmed they were not concerned about his welfare as such, rather they were frustrated by the presentation of symptoms. The nurse in the room behaved no differently.

The inquiry witness Bosworth, Professor Bosworth, dealt with this issue on Day 40. She said that the training given to DCOs was pretty minimal and focused on security. It did not enable staff to see the residents as highly vulnerable, but rather dangerous and difficult. She recommended that mental health training have a focus on secondary trauma training for DCOs, as that would enable them to conduct their duties with empathy and recognise that the dehumanisation, aggression and losing control of emotions that we have seen in the evidence can be symptoms of secondary trauma in the detention centre staff themselves.

There appears to have been no mental health element in C&R training. Jon Collier told the inquiry that the test criteria used to medically evaluate the

appropriateness and safety of C&R techniques employed in an IRC does not include consideration of mental illness or vulnerabilities such as history of torture and trauma.

Chair, this is a matter of some concern. Mentally ill detainees subjected to these procedures in the relevant period are likely to have found the experience terrifying and to have been retraumatised by it, but none of this was in the thinking of G4S or the Home Office. So we say that the inquiry should recommend that all IRC staff receive mandatory mental health awareness training, including PTSD training from a recognised and independent source, such as HMIP.

Chair, the second issue is that Brook House involved a unique situation for which the training given to DCOs was inadequate and Mr Francis' evidence highlighted the fact that it was no ordinary detention facility. He stated in his evidence that there were DCOs who left Brook House shortly after completing their training because they realised they had not been properly trained to deal with the condition there and a particular problem, as Mr Kelly touched on before I spoke, and as Mr Lee submitted in his submissions in relation to D643, who was at Brook House for 558 days, is that some individuals believed they would be staying at

Brook House for two weeks or two months but ended up staying there for two years. In reality, Brook House must have seemed like a place of internment for many who were there. Unsurprisingly, this created levels of exasperation and desperation and many detainees would eventually lash out and resort to self-harm.

Professor Bosworth said in her evidence on Day 40 that this issue affects staff because it makes their role unclear. She said:

"If you don't know how long someone is there for, it is hard to motivate yourself to invest in them as a person."

She said this factor affected staff culture and led to desensitisation as a mechanism for dealing with people who staff members were unable to help.

Another problem which Mr Francis highlighted in his evidence was the mixing of often dangerous and violent criminal deportees in cells with vulnerable asylum seekers or overstayers, and we saw this on the Panorama programme. My client said this led to intimidation and bullying of the non-criminal detainees. There were also high-levels of the drug spice that came through the doors largely unchecked, and my client confirmed in his evidence that he received no training on substance abuse and would dread the prospect of violence, which was

potentially likely when the effects of the drug wore off.

It is quite clear, chair, that Mr Francis' evidence is that Brook House was dysfunctional with unique systemic problems for which no proper training of staff was given to Mr Francis and other DCOs.

The third issue is that detainees, many of those at Brook House, were simply not suitable to be deputy in detention in the first place. That affected my client's working conditions and that is an issue that has been exposed by the Panorama programme. No amount of training could have equipped my client to deal with those detainees whose experiences of past torture or whose mental health conditions were such that they were incapable of being managed in detention.

Dr Hard said on Day 39 that rules 34 and 35 were not properly operated in the relevant period. We have heard that, in early operating and nursing screening on arrival, healthcare failed to take account of the specific needs of the detainees. So DCOs like my client were charged with looking after individuals who had already been failed by healthcare. Dr Hard agreed with the view taken by Medical Justice that the arrangements at Brook House made it impossible to comply with rules 34 and rule 35.

My client stated in his evidence that the E wing segregation -- that is the wing on which he worked -- was used to manage distressed behaviour, including self-harm and suicidal ideation, certainly not for the purpose of providing treatment. Dr Hard stated that E wing detainees were primarily being managed by detention staff with very little clinical input. Sandra Calver gave evidence that some people did indeed deteriorate as a result of being on that wing.

So much of the detention in the relevant period in 2017 was unlawful detention. People were being kept in conditions where they hadn't been properly assessed when, if they had been assessed, they would have been released under the DCO and under the Adults at Risk policy.

I should say a little something about that policy. There is a problematic element to it because it involves as balancing exercise between risk factors and so-called immigration factors which has been criticised, but there is an underlying presumption that detention will not be appropriate if a person is considered to be at risk through having experienced traumatic events, or where there is a medical or professional or observational core of evidence that an individual is suffering in the way that they have a condition such as a mental health

condition that would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention. Yet that system didn't work because it was let down by a culture of disbelief by healthcare at Brook House.

So Mr Francis' position is not only was he inadequately trained to deal with detainees who were lawfully present at Brook House, but he was required through systemic failures to deal, whilst untrained, with numerous detainees who suffered from mental health conditions which, under the Secretary of State's own policies, rendered them unsuitable for administrative detention.

Chair, the fourth issue is that Brook House was understaffed at the time and run for profit by G4S. This was a contributing factor to the situation in Brook House which affected my client and which is shown in the Panorama documentary -- the financial motivation of the institution that which was charged with running the facility. We saw evidence yesterday that the tender delivered 35 cost savings compared to the original budget.

In my submission, my client was required to work in an inhuman environment where removal and security were prioritised over health and safety, and nothing

underscores this is point better, the perversity of the situation at Brook House, than the penalty points in schedule G of the G4S-Home Office contract, which fixes a fine of £35,000 if a detainee escapes but only £10,000 if a detainee dies. That is the underlying perversity of the system as it operated at Brook House.

Sarah Newland of G4S gave evidence on Day 34 and said that G4S ran Brook House as understaffed during the relevant period in order to attain profit and that this was evidence of G4S prioritising profit over detainee welfare. It is inescapable that my client was required to work in difficult conditions due to understaffing. He says in his evidence:

"Most of the time there were not enough officers. Usually there would be two officers in the place of my work and one officer would have to go down to conduct searches or monitor or appear at a case review. Very often I was the only officer and that would increase the pressure that I was under."

Mr Francis has also stated in his statement that the work was constantly juggling plates, with detained people having problems and officers having to respond to a crisis with each detained person:

"I would go home after a 12-hour shift and we would come back later, six hours after that, and do the same

thing again, which really took it out of all of us. I remember a new staff coming on to where I was working and saying how many can you possibly do this day in, and day out."

Mr Francis described his work as mentally draining and he referred to 12-hour shifts with a one-hour break. Officers on the wing where he worked would have to be there from 7.45 until after 5.00 in the afternoon, occasionally, without staff cover to enable them to take a break.

Chair, in answer to questions from yourself, my client when he gave evidence said it would have been helpful for him to have had other staff present to have taken him away from a situation where he was feeling frustrated or tired. However, G4S didn't provide that staff support to assist when officers were struggling to cope. That is because, chair, they had no motivation to do so.

The fifth issue is whistleblowing. My client told the inquiry that he was horrified, shocked and mortified at Yan Paschali's actions on 25 April 2017. However, he told Mr Altman that his life would not have been easy had he tried to speak of his concerns. Callum Tulley told the inquiry that there was a Speak Out poster on the wall outside some lavatories; however, it had been

defaced with words such as "Snitch" and "Grass".

Effectively my client was powerless to report the abuses that he had seen and experienced and I would draw your attention to what Mr Stanton has said about his client and the issue in relation to the racist comments that Mr Syred attempted to report and how he was treated in the aftermath of that. Callum Tulley told the inquiry that he had no option other than to go to the BBC because officers would have closed ranks and it would have been their word against his.

There was also a further systemic problem in relation to reporting conduct and you have heard the evidence of Stacie Dean, who made a complaint in 2015. She says that the senior management team at Brook House was consistently uninterested and some SMT members found the situation amusing. So Mr Francis was dragged into a culture which had an absence of effective complaint procedures and DCOs were in effect powerless to change the system.

Chair, the sixth point is that the Home Office created a hostile environment. The ethos of the Home Office is a significant issue in this inquiry. Ben Saunders gave evidence on Day 35 and confirmed that the Home Office created a hostile environment and that was linked to discouraging people from coming to the UK

in the first place. He said in his Verita interview that the Home Office line was that detainees at Brook House had had opportunities to leave the UK and, if they found themselves in an IRC, well they had brought this upon themselves. He went on to confirm that, although some individuals in the Home Office may have cared, as a corporate entity the Home Office was more interested in getting people out of the country. It is this approach which has ultimately led to the dehumanisation of the detainees that we have seen on the Panorama programme.

Dr Patterson has stated that there is a higher risk of dehumanisation when the victim is a member of a marginal group, which would be foreign nationals facing removal. Dr Patterson referred to the narrative which has gained prominence since 2012 as a result of UK government policy, which has sought to create a hostile environment, the aim being to create a life so unpleasant for an undocumented migrant that they would voluntarily choose to leave as their access to public services becomes increasingly restricted.

On Day 40, the professor agreed that this dehumanisation contributes to the risk of abuse. She said:

"The only moral narrative about IRCs from the

Home Office's point of view is either one in relation to security, dangerous criminals or a moral narrative; they don't deserve to be here (interference)."

This narrative, the Home Office's narrative, led to desensitisation or dehumanisation of staff members. Karen Churcher said it was the Home Office's view that detainees with mental health difficulties were better off in detention, rather than being released from detention. Lee Hanford says that the Home Office criticised G4S staff for showing too much empathy.

On Day 40, what Professor Bosworth said is that the Home Office must have known what was going on but her understanding is that they did not concern themselves with detention. Dr Hard has agreed that people suffering from PTSD may go on to suffer from secondary psychosis in detention, owing to the stresses of being there and traumatisation.

Chair, Mr Francis was required to work within a toxic culture at Brook House, but the entire system was dysfunctional. The Home Office were aware of and caused this disfunctionality. Essentially, the Home Office's view was that they found Brook House too cumbersome to bring about any meaningful change and, as Mr Altman put to the witness, the corporate witness yesterday, they simply sat on the problem; and I endorse

what Ms Morris said this morning, that at best all the Home Office are doing is tweaking around the edges.

So in relation to the findings that we ask you to make, I endorse what Mr Armstrong has said, that you must make bold and robust findings, because we don't want another inquiry to sit here in five years' time dealing with the same points.

Ultimately, while my client behaved unacceptably towards detainees, he was at the centre of a perfect storm where DCOs were not trained to deal with mentally ill detainees at a facility in which men were often detained for apparently indefinite periods, in which detention of those with mental health problems was very often unlawful, in which vulnerable asylum seekers and visa overstayers were required to share rooms with dangerous criminals, in which there was a drugs and violence problem, and in which segregation was used as a means of managing vulnerable detainees. Furthermore, the facility was run by an organisation that prioritised profit over safe staffing and the welfare of detainees. On top of all of this, Brook House was overseen by a government department that had sought to stigmatise and marginalise immigration overstayers, failed asylum seekers and criminal deportees.

So we ask on Mr Francis' behalf that following

recommendations are made: one, that the Home Office exercises a greater degree of oversight of IRCs to ensure that contractors operate in a transparent fashion so that we don't see a repeat of those incidents on the Panorama programme; that contracts with IRC operators are varied or drafted to contain provisions requiring prioritisation of the welfare of detainees; that those contracts are varied or drafted to contain provisions requiring mandatory staffing levels; that all IRC staff receive mandatory mental health awareness and PTSD training from a recognised and independent source, such as HMIP; that all IRC staff are provided with counselling and other facilities to manage secondary trauma and stress levels; that those who are unsuitable for detention, as Dr Hard recommends, are screened out at an early stage in which the Home Office engages with independent medical advisers to assess individuals prior to admission to an IRC; that segregation is no longer used as a means of managing those with mental health problems; that effective complaints whistleblowing procedures are implemented in all IRCs with a specific focus on dealing with the abuse of detainees; that policies are brought into effect to bring about the change to the culture within the Home Office in relation to immigration detainees; and, finally, that the

practice of apparently indeterminate detention is brought to an end, with detainees being informed of a fixed date when their detention will end, in the event that they cannot be returned to their countries of origin.

I agree with Mr Armstrong that this does fall within the terms of reference of this inquiry.

Chair, I am aware of the time. I think I have ended at the right time. Unless I can assist further, those are my submissions.

THE CHAIR: Thank you very much, Mr Jacobs.

I am grateful for all of the submissions I have heard today and we will be returning tomorrow at 10.00 am for the remaining submissions.

Thank you very much.

(4.33 pm)

(The inquiry adjourned until 10.00 am the following day)

I N D E X

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