

<p>1 Tuesday, 5 April 2022</p> <p>2 (10.00 am)</p> <p>3 THE CHAIR: Good morning, thank you. Mr Altman, good</p> <p>4 morning.</p> <p>5 MR ALTMAN: Thank you, chair.</p> <p>6 Closing statement by MR ALTMAN</p> <p>7 MR ALTMAN: Chair, the purpose of my remarks this morning is</p> <p>8 to outline counsel to the inquiry's suggested approach</p> <p>9 to the making of findings of fact by you under the</p> <p>10 inquiry's terms of reference. Can I say immediately</p> <p>11 that a note containing these submissions has already</p> <p>12 been circulated to all core participants.</p> <p>13 So that those listening can follow the remarks I am</p> <p>14 about to make, can I set out my headings. First, I am</p> <p>15 going to deal with what we submit to be the correct</p> <p>16 approach to the standard of proof; second, the type and</p> <p>17 quality of evidence required to meet the standard of</p> <p>18 proof; and, third, its application to the evidence the</p> <p>19 inquiry has received during the course of these</p> <p>20 hearings. Finally, I am going to deal with the kind of</p> <p>21 questions which ought to be considered by you before you</p> <p>22 arrive at individual conclusions on article 3.</p> <p>23 So let me start by setting out how the terms of</p> <p>24 reference relate to the findings that you, chair, will</p> <p>25 be considering under article 3.</p> <p>Page 1</p>	<p>1 article 3 violations but only when they are accompanied</p> <p>2 by identified mistreatment or abuse that is linked to</p> <p>3 those failures.</p> <p>4 We suggest it is open to you to make findings of</p> <p>5 investigative failures under article 3 where such</p> <p>6 failures created the environment in which individual</p> <p>7 cases of abuse could occur. We submit that there are</p> <p>8 two essential questions to be answered before any</p> <p>9 finding regarding the credibility of a claim can be</p> <p>10 made.</p> <p>11 First, do the facts give rise to an identifiable</p> <p>12 incident of physical or verbal abuse capable of</p> <p>13 amounting to article 3 mistreatment; and second, if so,</p> <p>14 does it amount to article 3 mistreatment?</p> <p>15 So with that in mind, what are the principles which</p> <p>16 may be applied when considering the correct standard of</p> <p>17 proof to be applied when assessing the credibility of</p> <p>18 a claim of article 3 mistreatment? The Inquiries Act of</p> <p>19 2005 and the Inquiry Rules of 2006 do not assist, as</p> <p>20 they don't provide for any burden or standard of proof</p> <p>21 to be applied when an inquiry finds facts. Inquiries</p> <p>22 have, therefore, adopted different approaches to the</p> <p>23 standard of proof as required by the particular factual</p> <p>24 circumstances.</p> <p>25 In his ruling on the standard of proof in the</p> <p>Page 3</p>
<p>1 The terms of reference invite you to reach</p> <p>2 conclusions about the treatment of detainees held at</p> <p>3 Brook House during the relevant period. Where there is</p> <p>4 credible evidence of mistreatment contrary to</p> <p>5 article 3 -- that is to say, torture, inhuman or</p> <p>6 degrading treatment or punishment -- and then make any</p> <p>7 such recommendations as may seem appropriate.</p> <p>8 Point 1 of the terms of reference states the inquiry</p> <p>9 will investigate "the treatment of complainants,</p> <p>10 including identifying whether there has been</p> <p>11 mistreatment and identifying responsibility for any</p> <p>12 mistreatment."</p> <p>13 Points 2 to 6 of the terms of reference require</p> <p>14 investigation of methods, policies, practices,</p> <p>15 et cetera, that caused or contributed to identifiable</p> <p>16 instances of mistreatment. These issues are only</p> <p>17 relevant to the article 3 assessment if the failure of</p> <p>18 those policies, practices, et cetera, or cumulatively if</p> <p>19 the policies or the implementation of those policies</p> <p>20 were, by their very nature, of such a poor standard that</p> <p>21 they would reach the high article 3 threshold, rendered</p> <p>22 the detained persons vulnerable, or more vulnerable, to</p> <p>23 the identified abuse.</p> <p>24 It is our view that you should not identify failures</p> <p>25 in policies and practices alone as amounting to</p> <p>Page 2</p>	<p>1 Undercover Policing Inquiry, the late Sir Christopher</p> <p>2 Pitchford concluded:</p> <p>3 "1) The panel of a statutory public inquiry is not</p> <p>4 required to adopt any specific standard of proof so long</p> <p>5 as it acts fairly;</p> <p>6 "2) Uniform application of the criminal standard of</p> <p>7 proof is most unlikely to be appropriate, even in</p> <p>8 inquiries involving grave conduct. However, this does</p> <p>9 not mean that the chair cannot express him/herself as</p> <p>10 being 'sure' that something occurred if it chooses to</p> <p>11 adopt a flexible and variable approach to the standard</p> <p>12 of proof.</p> <p>13 "3) When deciding upon its approach to the standard</p> <p>14 of proof, an inquiry should have regard to the task</p> <p>15 which has been set for its terms of reference. As long</p> <p>16 as he/she acts fairly, the chair is free to decide upon</p> <p>17 an approach to findings of fact which best suits</p> <p>18 discharging the inquiry's terms of reference.</p> <p>19 "4) The majority of recent public inquiries have</p> <p>20 found it appropriate to adopt a flexible and variable</p> <p>21 approach to the standard of proof so as to enable a full</p> <p>22 and nuanced approach to the determination of facts.</p> <p>23 "5) Expressions of suspicion are permissible. They</p> <p>24 are properly analysed not as findings of fact, but as</p> <p>25 comment permitted under section 24(1) of the Inquiries</p> <p>Page 4</p>

<p>1 Act 2005."</p> <p>2 Sir Christopher Pitchford acknowledged that recent</p> <p>3 public inquiries have adopted a flexible and variable</p> <p>4 approach to the standard of proof so as to enable a full</p> <p>5 and nuanced approach to the determination of facts, as</p> <p>6 I say. He said that most inquiries, including those</p> <p>7 concerned with homicide, have taken the civil standard</p> <p>8 of proof as their starting point. He relied in part on</p> <p>9 the approach in the Baha Mousa Inquiry.</p> <p>10 In that inquiry, Sir William Gage, who was the</p> <p>11 chair, adopted "the flexible and variable standard of</p> <p>12 proof as applied in the Shipman Inquiry". He explained</p> <p>13 his approach at paragraph 1.114 of the inquiry's report,</p> <p>14 saying:</p> <p>15 "... where in this report I use such expressions as</p> <p>16 'I am sure' or 'I have no doubt', I will have found</p> <p>17 a fact to the criminal standard. When I state simply</p> <p>18 'I find', the standard of proof will have been the</p> <p>19 ordinary civil standard of proof, namely, the balance of</p> <p>20 probabilities. Where it is obvious that I have found</p> <p>21 a fact, but have not used the words 'I am sure' or</p> <p>22 'I find', the standard will have been the civil</p> <p>23 standard. All other expressions, such as an expression</p> <p>24 of 'suspicion', will not be a finding of fact, but will</p> <p>25 indicate my state of mind in respect of the issue being</p> <p style="text-align: center;">Page 5</p>	<p>1 In terms of the quality of the evidence required to</p> <p>2 prove such an allegation, European Court in Ananyev took</p> <p>3 into account the "objective difficulties" experienced by</p> <p>4 prisoners in collecting evidence to substantiate their</p> <p>5 claims about conditions in detention. It added that</p> <p>6 an applicant must, nevertheless, provide "an elaborate</p> <p>7 and consistent account of the conditions of his or her</p> <p>8 detention, mentioning the specific elements ... Only</p> <p>9 a credible and reasonably detailed description of the</p> <p>10 allegedly degrading conditions of detention constitutes</p> <p>11 a prima facie case of ill-treatment ..."</p> <p>12 So, chair, in light of those principles, we consider</p> <p>13 that the following approach to the standard of proof and</p> <p>14 to the quality of the evidence should be followed by</p> <p>15 you.</p> <p>16 First, a variable and flexible approach to the</p> <p>17 standard of proof should be adopted, as was favoured in</p> <p>18 the Baha Mousa and Undercover Policing Inquiries.</p> <p>19 Second, as in the Baha Mousa Inquiry, the starting</p> <p>20 point should be to apply the civil standard of proof --</p> <p>21 in other words, "on the balance of probabilities" --</p> <p>22 when determining whether the alleged incidents of</p> <p>23 mistreatment did occur. This recognises the</p> <p>24 inquisitorial nature of inquiry proceedings as compared</p> <p>25 with legal proceedings that affect a person's rights,</p> <p style="text-align: center;">Page 7</p>
<p>1 considered."</p> <p>2 Chair, we invite you to take a similar approach.</p> <p>3 The starting point in relation to the appropriate</p> <p>4 standard of proof, as stated in European Court</p> <p>5 jurisprudence is that in cases of ill-treatment in</p> <p>6 detention under article 3, the court should adopt the</p> <p>7 standard of proof "beyond reasonable doubt", or being</p> <p>8 sure. However, in the case of Ananyev v Russia, the</p> <p>9 European Court found that it has never been the court's</p> <p>10 purpose to borrow the approach of the national legal</p> <p>11 systems that use that standard. Its role is not to rule</p> <p>12 on criminal guilt or civil liability, but on contracting</p> <p>13 states' responsibility under the Convention. It adopts</p> <p>14 conclusions that are supported by the free evaluation of</p> <p>15 all evidence, including inferences that may flow from</p> <p>16 the facts and the parties' submissions. The European</p> <p>17 Court said that, according to its established case law,</p> <p>18 proof may follow from the coexistence of sufficiently</p> <p>19 strong, clear and concordant inferences or of similar</p> <p>20 un rebutted presumptions of fact, adding that the level</p> <p>21 of persuasion necessary for reaching a particular</p> <p>22 conclusion and, in this connection, the distribution of</p> <p>23 the burden of proof, are intrinsically linked to the</p> <p>24 specificity of the facts, the nature of the allegations</p> <p>25 made and the Convention right at stake.</p> <p style="text-align: center;">Page 6</p>	<p>1 liabilities and obligations, and the fact that no</p> <p>2 participant in the proceedings has a "case" to prove.</p> <p>3 Third, where, however, you are "sure" -- which is</p> <p>4 the criminal standard -- that an alleged incident of</p> <p>5 mistreatment did occur, it may be appropriate to say so.</p> <p>6 Fourth, at the other end of the spectrum, where you</p> <p>7 are unable to reach a conclusion "on the balance of</p> <p>8 probabilities", it may, nevertheless, be appropriate to</p> <p>9 record a "possibility" or a "suspicion".</p> <p>10 Fifth, to find a violation of article 3, there must</p> <p>11 be "sufficiently strong, clear and concordant inferences</p> <p>12 or similar un rebutted presumptions of fact". The</p> <p>13 supporting evidence must be "elaborate and consistent</p> <p>14 ... mentioning the specific elements ... credible and</p> <p>15 reasonably detailed".</p> <p>16 Finally, sixth, consideration must be given to the</p> <p>17 difficulties of detained persons in providing</p> <p>18 corroborating or supporting evidence.</p> <p>19 Chair, in order to find an allegation credible, you</p> <p>20 might also wish to consider the following questions:</p> <p>21 first of all, how clear and detailed is the evidence of</p> <p>22 mistreatment?</p> <p>23 Second, are there other similar un rebutted facts</p> <p>24 that have been established?</p> <p>25 Third, is a complainant's account of mistreatment</p> <p style="text-align: center;">Page 8</p>

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<p>1 consistent with any other account the complainant has</p> <p>2 given, or with other evidence independent of his</p> <p>3 account?</p> <p>4 Fourth, what other evidence is there to support</p> <p>5 a complaint of mistreatment? In this regard, the</p> <p>6 absence of evidence in support is not determinative.</p> <p>7 Fifth, what is the quality of that evidence?</p> <p>8 Sixth, is there any evidence that contradicts or</p> <p>9 rebuts the account? If so, what is the quality of that</p> <p>10 evidence?</p> <p>11 Seventh, if rebuttal evidence ought to have existed</p> <p>12 and doesn't -- for example, because there are missing</p> <p>13 records -- what, if any, inferences can be drawn from</p> <p>14 their absence?</p> <p>15 Let me now move on, please, to what type of</p> <p>16 treatment can be considered as article 3 mistreatment.</p> <p>17 Article 3 speaks of "inhuman or degrading treatment or</p> <p>18 punishment". The word "punishment" may be given its</p> <p>19 ordinary meaning. European Court case law tends to</p> <p>20 focus more on the words "inhuman or degrading" while the</p> <p>21 words "treatment or punishment" have attracted little</p> <p>22 attention, but, by way of example, the European Court</p> <p>23 has found that the imposition of a disciplinary</p> <p>24 punishment by the segregation of prisoners who suffer</p> <p>25 from serious mental disturbance runs counter to the</p> <p style="text-align: center;">Page 9</p>	<p>1 arouses in the victim feelings of fear, anguish and</p> <p>2 inferiority, capable of humiliating and debasing. As</p> <p>3 was said in the case of <i>Rooman v Belgium</i> in the European</p> <p>4 Court, although the question whether the purpose of the</p> <p>5 treatment is to humiliate or debase a victim is a factor</p> <p>6 to take into account, the absence of such a purpose</p> <p>7 cannot conclusively rule out a finding of a violation of</p> <p>8 article 3.</p> <p>9 In terms of vulnerability and mental illness, the</p> <p>10 case of <i>Rooman</i> sets out the principles to be followed,</p> <p>11 and they are these:</p> <p>12 First, detainees are in a vulnerable position and</p> <p>13 the authorities are under a duty to correct them.</p> <p>14 Second, detainees with mental disorders are more</p> <p>15 vulnerable than ordinary detainees.</p> <p>16 Third, certain requirements of detained life pose</p> <p>17 a greater risk that their health will suffer,</p> <p>18 exacerbating the risk that they suffer from a feeling of</p> <p>19 inferiority and are necessarily a source of stress and</p> <p>20 anxiety. In such circumstances, there must be increased</p> <p>21 vigilance in reviewing whether article 3 has been</p> <p>22 complied with.</p> <p>23 Fourth, and finally, the assessment must also take</p> <p>24 into consideration the possibility that a detainee may</p> <p>25 be unable to complain coherently, or at all, about how</p> <p style="text-align: center;">Page 11</p>
<p>1 requirements of article 3. It would therefore be open</p> <p>2 to you, chair, to find that it was "punishment", for</p> <p>3 instance, if a detained person was moved to the CSU, the</p> <p>4 Care and Separation Unit, in Brook House, by the</p> <p>5 improper or deliberate misapplication of rules 40 or 42.</p> <p>6 What about "torture"? Before treatment or</p> <p>7 punishment can be characterised as "torture", it must be</p> <p>8 deliberate, inhuman treatment, causing very serious and</p> <p>9 cruel suffering. It has to "attain a minimum level of</p> <p>10 severity", considering all the circumstances of the</p> <p>11 case, such as the duration, the physical or mental</p> <p>12 effects of that treatment or punishment, and the age and</p> <p>13 state of health of the victim.</p> <p>14 The important point to note is that a very high</p> <p>15 degree of physical suffering, and often humiliation</p> <p>16 intentionally inflicted by someone acting officially, is</p> <p>17 needed to reach the minimum level of suffering in order</p> <p>18 to qualify as torture. An episode of relatively short</p> <p>19 duration wouldn't likely reach the necessary level of</p> <p>20 suffering and humiliation to qualify as torture. If the</p> <p>21 treatment or punishment did not amount to torture, the</p> <p>22 question then is whether the treatment was "inhuman or</p> <p>23 degrading".</p> <p>24 It is "inhuman" if it causes intense physical or</p> <p>25 mental suffering. It is "degrading" if the treatment</p> <p style="text-align: center;">Page 10</p>	<p>1 they are being affected by any particular treatment.</p> <p>2 So, chair, with all of that in mind, the following</p> <p>3 non-exhaustive list of questions may assist you when</p> <p>4 making a determination about whether and what treatment</p> <p>5 constitutes an article 3 breach.</p> <p>6 First of all, was the treatment or punishment</p> <p>7 physical or verbal?</p> <p>8 Second, what was the severity of the treatment or</p> <p>9 punishment?</p> <p>10 Third, what was its duration?</p> <p>11 Fourth, was there any racist, religious or</p> <p>12 homophobic element to it?</p> <p>13 Fifth, was there an intention to humiliate and</p> <p>14 degrade?</p> <p>15 Sixth, what was the physical or mental effect of the</p> <p>16 treatment or punishment?</p> <p>17 Seventh, if it was physical, did the detained person</p> <p>18 suffer injuries?</p> <p>19 Eighth, if it was mental, was there mental suffering</p> <p>20 as a result?</p> <p>21 Ninth, was the detained person's state of physical</p> <p>22 or mental health such as to make him more vulnerable to</p> <p>23 the treatment or punishment?</p> <p>24 Tenth, did the detained person's age make him</p> <p>25 particularly vulnerable to the treatment or punishment?</p> <p style="text-align: center;">Page 12</p>

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<p>1 And eleventh, bearing in mind all the circumstances</p> <p>2 of the case, three further sub-questions, as it were:</p> <p>3 First of all, was it torture? Did it amount to</p> <p>4 deliberate, inhuman treatment causing very serious and</p> <p>5 cruel suffering, such that it obtained a minimum level</p> <p>6 of severity considering all of the circumstances.</p> <p>7 Second, further or alternatively, was it inhuman</p> <p>8 treatment or punishment? Did it cause intense physical</p> <p>9 or mental suffering?</p> <p>10 And finally, third, further or alternatively, was it</p> <p>11 degrading treatment or punishment? Did it arouse in the</p> <p>12 victim feelings of fear, anguish and inferiority,</p> <p>13 capable of humiliating and debasing?</p> <p>14 So, chair, that is all I propose saying by way of</p> <p>15 closing remarks on behalf of counsel to this inquiry.</p> <p>16 You may now wish to invite the core participants to</p> <p>17 address you, beginning with counsel on behalf of D1527,</p> <p>18 D523, D2077, D1538, D313, D1914 and Reverend</p> <p>19 Nathan Ward.</p> <p>20 THE CHAIR: Thank you very much, Mr Altman, I am grateful.</p> <p>21 Ms Harrison, I am grateful.</p> <p>22 Closing statement by MS HARRISON</p> <p>23 MS HARRISON: Chair, if I could clarify, as I did in</p> <p>24 opening, it is my intention to make submissions on the</p> <p>25 systems and institutional failures, the generic issues</p> <p style="text-align: center;">Page 13</p>	<p>1 to try my absolute best.</p> <p>2 THE CHAIR: Thank you.</p> <p>3 MS HARRISON: Can I say then in -- as we did in opening, we</p> <p>4 highlighted the two main tasks for the inquiry in its</p> <p>5 evidential phases. The first was to bring to light the</p> <p>6 full facts of what happened at Brook House; identify the</p> <p>7 dangerous policies, practices, management and</p> <p>8 arrangements that caused or contributed to mistreatment;</p> <p>9 identify responsibility for any mistreatment to inform</p> <p>10 what remedial course of action is necessary and prevent</p> <p>11 its recurrence. That is of particular importance in</p> <p>12 this inquiry because, as we now know, there have been</p> <p>13 numerous past investigations, reviews and test cases,</p> <p>14 all of which have failed to achieve that critical goal.</p> <p>15 The second important task for the inquiry in its</p> <p>16 evidential phases was to give the former detained</p> <p>17 persons an important opportunity to confront those</p> <p>18 responsible for their mistreatment and abuse and on</p> <p>19 an equal footing. It is an important part of</p> <p>20 restorative justice to be able to question and hold to</p> <p>21 account not just the frontline staff who perpetrated</p> <p>22 acts of violence, physical and mental abuse,</p> <p>23 humiliation, medical neglect and disregard of their</p> <p>24 suffering and denial of their human dignity, but also</p> <p>25 the absent, complicit and complacent senior managers</p> <p style="text-align: center;">Page 15</p>
<p>1 that arise in the context of this inquiry. I do so on</p> <p>2 behalf of all of the core participants represented by</p> <p>3 Duncan Lewis Solicitors and Bhatt Murphy Solicitors, but</p> <p>4 my submissions will be followed by Ms Morris on behalf</p> <p>5 of Reverend Nathan Ward. In terms of addressing the</p> <p>6 criminal question for the individuals, whether there is</p> <p>7 credible evidence in the case of mistreatment, and their</p> <p>8 links to the systemic and institutional issues that</p> <p>9 I will outline, that will be addressed first by</p> <p>10 Mr Goodman, on behalf of the Duncan Lewis core</p> <p>11 participants, along with Mr Lee, and, finally, on behalf</p> <p>12 of the individual core participants, represented by</p> <p>13 Bhatt Murphy Solicitors, that will be by</p> <p>14 Ms Shu Shin Luh.</p> <p>15 THE CHAIR: Thank you, Ms Harrison.</p> <p>16 MS HARRISON: I hope that we can conclude that within the</p> <p>17 two hours we have been allocated.</p> <p>18 THE CHAIR: Am I right in understanding we will hear from</p> <p>19 you for the first hour, and then, I assume, at that</p> <p>20 point, we will maybe take our morning break and then we</p> <p>21 will pass to others who are going to represent</p> <p>22 individual clients?</p> <p>23 MS HARRISON: I think it is intended I will conclude my</p> <p>24 submissions, then we will have the break, and then go on</p> <p>25 to -- I get the indication of the hour, and I am going</p> <p style="text-align: center;">Page 14</p>	<p>1 running the centres and sitting in corporate offices of</p> <p>2 G4S and the Home Office.</p> <p>3 The latter has always been a priority for the</p> <p>4 individual core participants, who want to ensure that</p> <p>5 the mistreatment and abuse that they experienced is not</p> <p>6 repeated. This has been at some personal cost for many</p> <p>7 of them, but they have been willing to relive these</p> <p>8 traumatic and life-changing experiences to achieve that</p> <p>9 purpose. Putting their experience and their wishes at</p> <p>10 the heart of this inquiry in these hearings as you,</p> <p>11 chair, promised, has been achieved, but it now must be</p> <p>12 your task to deliver that in respect of your findings</p> <p>13 and recommendations, to ensure, as they wish, that</p> <p>14 no one else suffers what they did whilst detained at</p> <p>15 Brook House.</p> <p>16 Medical Justice and Nathan Ward want the impunity</p> <p>17 that has marked the system for so long to end. They</p> <p>18 know all too well, from direct knowledge of the</p> <p>19 institutions, and bitter experience, that the sacking of</p> <p>20 a handful of custody officers, albeit guilty of grave</p> <p>21 misconduct, did not beginning to identify or address the</p> <p>22 root causes or contributory factors in the mistreatment</p> <p>23 that occurred and was allowed to go unchecked for so</p> <p>24 long.</p> <p>25 Previous abuse scandals at Oakington in 2005,</p> <p style="text-align: center;">Page 16</p>

<p>1 Yarl's Wood in 2004, 2014 and 2015 at Medway, and of</p> <p>2 course Mr Shaw's review in 2016 that identified</p> <p>3 practices that were an affront to civilised society,</p> <p>4 none of this resulted in the change needed to prevent</p> <p>5 the abuse scandal at Brook House in 2017.</p> <p>6 Those measures were still not in place to prevent</p> <p>7 inhumane conditions in Brook House in 2020, as the IMB</p> <p>8 report so graphically exposed, and they are certainly</p> <p>9 not present in 2022 and at the time when intense</p> <p>10 enforcement practices of the past will shortly resume to</p> <p>11 pre-pandemic levels and incidence.</p> <p>12 We commend the inquiry for the rigour with which it</p> <p>13 has sought to fulfil its functions commensurate with the</p> <p>14 importance of the rights at stake in article 3. Once</p> <p>15 the inquiry went beyond the Panorama programme itself,</p> <p>16 it has uncovered through unbroadcast BBC footage, CCTV,</p> <p>17 body-worn and handheld camera footage, pages of</p> <p>18 transcripts and reams of documents and, of course, the</p> <p>19 written and oral testimony of individuals and the</p> <p>20 extensive case summaries that Medical Justice was able</p> <p>21 to provide to the inquiry, that the Panorama programme</p> <p>22 was not the end and limits of the abuse.</p> <p>23 This inquiry has uncovered shocking patterns of</p> <p>24 inhumane and degrading treatment of detained persons,</p> <p>25 central to which is the overuse and misuse of force and</p> <p style="text-align: center;">Page 17</p>	<p>1 of sight. This is how the regime operated on</p> <p>2 a day-to-day basis and what was the day-to-day</p> <p>3 experience of those incarcerated within it. It has, of</p> <p>4 course, been profoundly disturbing to witness repeated</p> <p>5 physical abuse, the severe mental anguish and the denial</p> <p>6 of human dignity. Both Owen Syred and Callum Tulley</p> <p>7 described alarming incidents of abuse well</p> <p>8 before April 2017. It has been harrowing to hear the</p> <p>9 direct evidence of detainees who were brutalised by what</p> <p>10 Dr Paterson has described as the "corrupted" and "toxic"</p> <p>11 environment marked by violence, chaos, disrespect,</p> <p>12 disregard and callous indifference to fundamental rights</p> <p>13 and human suffering. It has been equally disconcerting</p> <p>14 to listen to custody officers, who, even in oral</p> <p>15 evidence, maintained patently untrue accounts or claimed</p> <p>16 no memory in the face of incontrovertible evidence of</p> <p>17 misconduct and cover-up and who have sought to deflect</p> <p>18 responsibility, even to Callum Tulley, accusing him of</p> <p>19 misrepresenting them, inciting them or failing, himself,</p> <p>20 to report the misconduct.</p> <p>21 Several of these officers still work at Brook House</p> <p>22 and whose misconduct was not caught on camera and has</p> <p>23 only been fully exposed by the inquiry but they remain</p> <p>24 in post. Some, like Mr Loughton and Mr Dix, have even</p> <p>25 been promoted.</p> <p style="text-align: center;">Page 19</p>
<p>1 segregation, often without lawful authority or</p> <p>2 justification, and segregation used as punishment. The</p> <p>3 normalisation of the infliction of pain, suffering and</p> <p>4 humiliation, even whilst detained when naked, as we saw</p> <p>5 in the case of D1234, or even when so emaciated the</p> <p>6 person could barely hold his own body weight; D2159 is</p> <p>7 an example of that.</p> <p>8 In addition we have seen extensive evidence of the</p> <p>9 pervasive, violent, derogatory and debasing verbal</p> <p>10 abuse, and in addition, racism, vitriolic, casual and</p> <p>11 institutional, underscored by an underlying lack of</p> <p>12 empathy, even when individuals are at their most</p> <p>13 distressed and vulnerable, even in life- or potentially</p> <p>14 life-threatening situations.</p> <p>15 Mr Collier has told us that even this material</p> <p>16 relating to use of force is not complete. He identified</p> <p>17 in, of the 93 cases of use of force during the period,</p> <p>18 that there may well be other incidents of misuse of</p> <p>19 force, but the paucity of documentary material, the</p> <p>20 failure of oversight and investigation, the limits of</p> <p>21 the PSU complaints procedure, means that that full</p> <p>22 picture is still not, and will now never be, properly</p> <p>23 made available to this inquiry.</p> <p>24 We can say then, without any doubt, this is not</p> <p>25 a case of isolated incidents by isolated individuals out</p> <p style="text-align: center;">Page 18</p>	<p>1 Ben Saunders, the director, adopted a not dissimilar</p> <p>2 approach to his responsibility for a fundamental failure</p> <p>3 of management and oversight. He, too, blamed</p> <p>4 Callum Tulley for not reporting abuse to him. Despite</p> <p>5 his own obvious culpability, he was allowed to resign</p> <p>6 and work elsewhere for another private contractor,</p> <p>7 Mitie, involved in immigration enforcement.</p> <p>8 In our system of justice, lessons are not learned</p> <p>9 unless you are willing to confront and accept</p> <p>10 misconduct, wrongdoing and failings that harm others.</p> <p>11 Peter Neden and Jerry Petherick, both G4S senior</p> <p>12 corporate managers did not accept their own culpability</p> <p>13 or responsibility for the dysfunctional senior</p> <p>14 management team at Brook House of which they were aware</p> <p>15 from at least 2014, but at least they recognised that</p> <p>16 there must have been serious failure on the part of G4S</p> <p>17 because this abuse and mistreatment occurred.</p> <p>18 Not so its managing director, Gordon Brockington,</p> <p>19 with his prepared script, his dissembling, evasion and</p> <p>20 denials, his evidence alone exposes why G4S was not</p> <p>21 a fit and proper company to have carried on with the</p> <p>22 contract after 2017 and should not now be entrusted with</p> <p>23 public functions in the containment and care of</p> <p>24 prisoners or detainees.</p> <p>25 The evidence of senior Home Office officials --</p> <p style="text-align: center;">Page 20</p>

<p>1 Mr Cheeseman, Mr Schoenenberger and Mr Riley -- confirm</p> <p>2 a state body that is driven by political imperatives to</p> <p>3 sacrifice welfare on the altar of enforcement and</p> <p>4 administrative convenience. It relegates safeguarding</p> <p>5 of detainees to a virtual footnote in a contract that</p> <p>6 puts cost-cutting over safety and care. It also</p> <p>7 confirmed the utter disinterest in criticisms of its</p> <p>8 actions, failures of its policies and practices, whether</p> <p>9 by oversight bodies, judges, coroners, or its own</p> <p>10 appointed reviewer, Stephen Shaw.</p> <p>11 It is clearly cavalier about its legal duties and</p> <p>12 the adverse impacts on those it detains, and is</p> <p>13 apparently indifferent to ensuring the necessary changes</p> <p>14 to prevent the repeat of abuse and mistreatment</p> <p>15 occurring.</p> <p>16 Phil Riley did not look much beyond limited</p> <p>17 contractual tweaking and increase in staff numbers. He</p> <p>18 was unable to accept that the original corner-cutting</p> <p>19 contract that baked in dangerously low staffing levels,</p> <p>20 a harsh regime and impoverished conditions would have</p> <p>21 an impact on welfare. "Maybe other operations", he</p> <p>22 speculated, "but not welfare".</p> <p>23 Phil Riley, without irony, said that the Home Office</p> <p>24 had "taken every step we could take proportionately to</p> <p>25 deliver a safe environment" and claimed that the rule 35</p> <p style="text-align: center;">Page 21</p>	<p>1 Fundamental remedial action needs to be taken and</p> <p>2 urgently. It is already far too late. The evidence</p> <p>3 obtained by the inquiry post Panorama has in no way</p> <p>4 diminished this imperative. If anything, it has only</p> <p>5 grown more pressing.</p> <p>6 Dr Hard described a deprivation of safeguards to</p> <p>7 protect detainees from harm was a significant factor in</p> <p>8 2017 and it is still continuing. The institutional</p> <p>9 culture of bullying and intimidation, according to</p> <p>10 Ms Michelle Brown, one of the longest-serving G4S</p> <p>11 managers is also continuing. She says at paragraph 12</p> <p>12 of her witness statement:</p> <p>13 "I left in November 2020, as I still observed</p> <p>14 bullying and abusive behaviour towards myself, staff and</p> <p>15 detainees."</p> <p>16 The IMB's 2021 report found high incidence of</p> <p>17 vulnerability, mental illness, self-harm and there is</p> <p>18 a clear correlation between increased use of force and</p> <p>19 segregation as the first resort to managing vulnerable</p> <p>20 detainees as well as a complete collapse of the rule 35</p> <p>21 process.</p> <p>22 There is evidence of increased complaints over the</p> <p>23 use and misuse of force. This is critical to the</p> <p>24 inquiry's considerations because it shows without any</p> <p>25 doubt that the key themes that have led to a cycle of</p> <p style="text-align: center;">Page 23</p>
<p>1 system had now been improved and even that there was no</p> <p>2 systemic failure in 2017.</p> <p>3 This is of real concern, the same pattern of wilful</p> <p>4 denial of Home Office responsibility. It simply cannot</p> <p>5 be reconciled with the evidence that the inquiry has</p> <p>6 heard over many weeks and to which Mr Riley, even now,</p> <p>7 is apparently oblivious.</p> <p>8 This is important because it is the mindset and</p> <p>9 attitudes of men like these who will be responsible for</p> <p>10 considering and implementing any recommendations that</p> <p>11 the inquiry makes and it must inform your</p> <p>12 recommendations.</p> <p>13 Their attitude and analysis of the events at</p> <p>14 Brook House provides key evidence for the inquiry's</p> <p>15 remaining crucial function, to identify why mistreatment</p> <p>16 and abuse was allowed to reoccur in 2017, again only</p> <p>17 exposed by undercover reporting. Where and how the</p> <p>18 detention system, regime and policy and practices</p> <p>19 sanctioned or allowed it to occur, why lessons have not</p> <p>20 been learned from past abuse scandals and even from this</p> <p>21 one, five years on, and what effective remedial action</p> <p>22 can now be taken, particularly in the wake of another</p> <p>23 abuse scandal in Brook House in 2020 where the IMB found</p> <p>24 a cumulative effect of their concerns amounted to</p> <p>25 inhumane treatment of the entire population.</p> <p style="text-align: center;">Page 22</p>	<p>1 abuse over many years, including in 2017, still remain</p> <p>2 very much in play.</p> <p>3 It also shows that contractual numbers and increased</p> <p>4 better-trained staff, even with a low population, did</p> <p>5 not prevent inhumane conditions occurring and which are</p> <p>6 the breeding ground for excessive and unlawful use of</p> <p>7 force.</p> <p>8 It is stark and important to recall the evidence of</p> <p>9 Mary Molyneux of the IMB on the Home Office's response</p> <p>10 to their notice of the inhumane conditions operating at</p> <p>11 Brook House in 2020. She identified a wholly inadequate</p> <p>12 response. She said there was nothing, not even</p> <p>13 an acknowledgment:</p> <p>14 "I mean I knew they had it, because we copied in our</p> <p>15 people, and then, I think, nearly six weeks later, this</p> <p>16 response comes in. I don't think it was coincidental it</p> <p>17 was received on the day we were giving evidence before</p> <p>18 the Home Affairs Select Committee. You know, it was</p> <p>19 a concern about safety, that there is going to be more</p> <p>20 of this, if you persist."</p> <p>21 The Home Office's response was:</p> <p>22 "It is all about process. We have the right, we</p> <p>23 have the process, so there is just a total disconnect</p> <p>24 and not, in my view, acknowledgment of the problem and</p> <p>25 the issues we have raised."</p> <p style="text-align: center;">Page 24</p>

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<p>1 That evidence is critical for this inquiry and for</p> <p>2 what it decides to do when identifying recommendations</p> <p>3 that can address this kind of recalcitrant resistance to</p> <p>4 recognising the damage and harm that immigration</p> <p>5 enforcement policies pursued have on vulnerable</p> <p>6 individuals.</p> <p>7 We also know from the current healthcare contractor,</p> <p>8 PPG, that they cannot make remedial action on the</p> <p>9 system's failure in respect of safeguards without</p> <p>10 direction and resources from the Home Office. Serco's</p> <p>11 Steve Hower could give no assurance that another</p> <p>12 situation like that identified by the IMB in 2020 could</p> <p>13 not reoccur. That, he says, is only within the control</p> <p>14 of the Home Office.</p> <p>15 Given this, the inquiry needs to identify</p> <p>16 a fundamentally different approach to previous failed</p> <p>17 investigations and reviews. Not because it is bold or</p> <p>18 political, but because it is the only rational and</p> <p>19 logical consequence of where the evidence has taken this</p> <p>20 inquiry. Alternatives to detention are available and</p> <p>21 must be found. Current policy fails, but must, in any</p> <p>22 event, constrain the use of the power to detain within</p> <p>23 clearly defined and strict limits. It must prevent its</p> <p>24 exercise where the person is vulnerable -- in particular</p> <p>25 by reason of a history of torture, trauma and mental</p> <p style="text-align: center;">Page 25</p>	<p>1 paragraph 2 and 4 of the inquiry's terms of reference.</p> <p>2 In accordance with those terms, the inquiry is tasked</p> <p>3 not only with making findings of operational failures in</p> <p>4 individual cases, but also failures at a systems level</p> <p>5 and to ascertain whether those arrangements either</p> <p>6 caused or contributed to the operational breaches and</p> <p>7 can be changed to prevent recurrence.</p> <p>8 The forms of harm under article 3.</p> <p>9 Although counsel to the inquiry's article 3 note</p> <p>10 focuses on physical and verbal mistreatment, the inquiry</p> <p>11 is also, of course, concerned with mental mistreatment</p> <p>12 and suffering, including that which flows from naturally</p> <p>13 occurring physical or mental illness, where it is</p> <p>14 exacerbated by treatment in detention for which the</p> <p>15 authorities can be held responsible. This reflects the</p> <p>16 Grand Chamber's judgment referred to by Mr Altman in</p> <p>17 <i>Rooman v Belgium</i>. Thus the conditions of detention</p> <p>18 which subject a person to distress or hardship or</p> <p>19 compromise and exacerbate mental health, engage the</p> <p>20 state's responsibility under article 3 just as physical</p> <p>21 and verbal abuse.</p> <p>22 Likewise, a failure to provide appropriate medical</p> <p>23 care and medical assistance whilst in custody engages</p> <p>24 the state's obligations under article 3 and the absence</p> <p>25 of either can subject an individual to inhuman or</p> <p style="text-align: center;">Page 27</p>
<p>1 illness -- once and for all. This is not a radical</p> <p>2 conclusion, it was the finding and recommendations of</p> <p>3 Stephen Shaw in his 2016 review. It has been the</p> <p>4 recommendation of the HMIP since 2015 as well as that of</p> <p>5 numerous parliamentary committees and many witnesses to</p> <p>6 this inquiry. No civilised society should tolerate</p> <p>7 anything else.</p> <p>8 The inquiry should also conclude that Brook House</p> <p>9 must not be used as an IRC. It should follow the</p> <p>10 conclusion of the HMIP that it is simply</p> <p>11 an inappropriate environment for administrative</p> <p>12 detainees and the expert evidence of Professor Bosworth</p> <p>13 which is, in fact, backed up by all medical evidence,</p> <p>14 the accounts of some G4S custody officers and senior</p> <p>15 staff and, of course, the experience of those detained</p> <p>16 there.</p> <p>17 Looking, then, at the legal framework and the</p> <p>18 system's duty that we are here concerned with under</p> <p>19 article 3, article 3 requires states not only to</p> <p>20 prohibit and punish ill-treatment, but also to forestall</p> <p>21 its occurrence. It is insufficient merely to intervene</p> <p>22 after its infliction when the physical or moral</p> <p>23 integrity of human beings has already been irredeemably</p> <p>24 harmed. Whether the state does so through its policies,</p> <p>25 practices and arrangements at Brook House reflects</p> <p style="text-align: center;">Page 26</p>	<p>1 degrading treatment.</p> <p>2 We understand this to underpin paragraphs 4 and 5 of</p> <p>3 the terms of reference which must be assessed against</p> <p>4 the clinical consensus that mental illness cannot be</p> <p>5 effectively and appropriately treated in immigration</p> <p>6 detention, nor, as Mr Shaw found in 2016, can it be</p> <p>7 appropriately managed. That is why it has always been,</p> <p>8 and continues to be, an imperative for policy and</p> <p>9 practice to prevent detention of the mentally ill and to</p> <p>10 secure their prompt release and return. The Strasbourg</p> <p>11 jurisprudence cited by the counsel to the inquiry's</p> <p>12 notes concerns prisons, but it applies to this context,</p> <p>13 subject to one fundamental difference: that is that the</p> <p>14 question of the legality of the underlying detention and</p> <p>15 the option for release are not normally an issue in</p> <p>16 a prison case. The starting point for evaluating the</p> <p>17 minimum threshold of severity under article 3 is</p> <p>18 different whether detention arose from a discretionary</p> <p>19 power and where its exercise is unlawful because it is</p> <p>20 in breach of policy and safeguards to protect vulnerable</p> <p>21 people in detention.</p> <p>22 If detention is unlawful, this is highly material to</p> <p>23 the assessment of whether there was a violation of</p> <p>24 article 3 for the period of the detention because the</p> <p>25 person is not suffering harm incidental to a legitimate</p> <p style="text-align: center;">Page 28</p>

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<p>1 measure and which is inherent in lawful detention.</p> <p>2 Institutional racism has a special place in</p> <p>3 article 3. Counsel to the inquiry's note does not</p> <p>4 specifically address the case law on institutional</p> <p>5 racism but it is plain that, where evidenced by</p> <p>6 explicit, racist language of the most offensive kind</p> <p>7 used here or the derogatory racial or xenophobic</p> <p>8 stereotyping, this inherently undermines the dignity of</p> <p>9 the person on its own and may constitute degrading</p> <p>10 treatment in breach of article 3. Racism is recognised</p> <p>11 to be a special form of affront to human dignity; it</p> <p>12 will certainly be an exacerbating factor if mistreatment</p> <p>13 of any kind occurs, as it did, we say, here, in the</p> <p>14 context of institutional racism.</p> <p>15 Inhumane treatment at the whole centre in 2017.</p> <p>16 Conditions of detention, can cumulatively cause such</p> <p>17 intensity of physical and mental suffering and anguish</p> <p>18 that they can constitute inhumane or degrading treatment</p> <p>19 without deliberate physical mistreatment, not just of</p> <p>20 individual detainees, but of the whole detained</p> <p>21 population. This is clear from the IMB's report on the</p> <p>22 situation in Brook House in 2020.</p> <p>23 We invite the inquiry to find that the general</p> <p>24 conditions in 2017 and 2020 bear stark similarities in</p> <p>25 respect of key features: high numbers of vulnerable</p> <p style="text-align: center;">Page 29</p>	<p>1 hear detainees being taken by and they would be shouting</p> <p>2 and screaming:</p> <p>3 "This created an atmosphere of fear and stress</p> <p>4 because [they] would be taken at random times,</p> <p>5 especially if [they] were considered a security risk,</p> <p>6 and the Home Office would use a policy of giving [them]</p> <p>7 something called a 'removal window' without notice,</p> <p>8 which added a lot of stress to us in general. I was</p> <p>9 given one. I felt under a constant apprehension of</p> <p>10 being removed at any point. This type of environment is</p> <p>11 toxic because there is no release from the stress.</p> <p>12 There was simply no break from the stress and it breaks</p> <p>13 you inside."</p> <p>14 You may recall that D1851 was unlawfully detained in</p> <p>15 Brook House for three months. He witnessed disturbed</p> <p>16 people suffering, hearing and seeing incidents of</p> <p>17 violence, self-harm, drug misuse, distress and chaos.</p> <p>18 He witnessed the assault, as Mr Collier found, on his</p> <p>19 roommate, D390, by multiple officers in full PPE and was</p> <p>20 pinned with a shield to the bed. Even though routine,</p> <p>21 it was nonetheless terrifying. Despite no pre-existing</p> <p>22 vulnerability, the cumulative effects caused his mental</p> <p>23 wellbeing to erode to the point of developing a mental</p> <p>24 illness diagnosed as PTSD. Brook House broke his moral</p> <p>25 and physical integrity, it humiliated him and destroyed</p> <p style="text-align: center;">Page 31</p>
<p>1 detainees; high incidents of self-harm; and cases of</p> <p>2 suicidal risk; the routine use of segregation and force</p> <p>3 to respond to self-harm; and the complete dysfunction of</p> <p>4 the rule 34 and 35 safeguards with the same harmful</p> <p>5 consequences -- resort to force and oppressive measures</p> <p>6 in the context of intense pressure of charter flights</p> <p>7 and no-notice removals.</p> <p>8 This was a link made by several of the witnesses in</p> <p>9 their written and oral evidence to the inquiry and we</p> <p>10 will develop that in our closing submissions.</p> <p>11 (Fire alarm)</p> <p>12 THE CHAIR: We are not aware of a test, so we will need to</p> <p>13 leave, I am afraid.</p> <p>14 (10.49 am)</p> <p>15 (A short break)</p> <p>16 (10.57 am)</p> <p>17 THE CHAIR: Thank you. A bit of excitement. Thank you,</p> <p>18 Ms Harrison.</p> <p>19 MS HARRISON: I was going to refer to one individual's</p> <p>20 experience of these inhumane conditions.</p> <p>21 D1851, you may recall, gave evidence in the first</p> <p>22 phase of this inquiry. He gave powerful, compelling</p> <p>23 evidence about how his experience at Brook House was</p> <p>24 crushing. He talked in his witness statement of a very</p> <p>25 stressful and negative environment. He would frequently</p> <p style="text-align: center;">Page 30</p>	<p>1 his dignity as a human being. He said it made him</p> <p>2 a different person, and he is not alone.</p> <p>3 Turning then to the systems, breaches and</p> <p>4 institutional factors that we consider are at the heart</p> <p>5 of the causes or contributory factors leading to the</p> <p>6 physical and mental mistreatment or abuse which created</p> <p>7 the inhumane conditions at Brook House in 2017.</p> <p>8 First, we do emphasise the policy context and the</p> <p>9 hostile environment. Stephen Shaw recognised, in 2005,</p> <p>10 in his investigation into racism and mistreatment at</p> <p>11 Oakington, that the combination of the coercive powers</p> <p>12 over foreigners involved in immigration enforcement with</p> <p>13 the attitude towards asylum seekers and other would-be</p> <p>14 immigrants of some sections of the media can become</p> <p>15 a breeding ground for racist and abusive words and</p> <p>16 deeds. Whatever the position in 2005, that context has</p> <p>17 only intensified since.</p> <p>18 The use of charter flight no-notice removal windows</p> <p>19 and aggressive policies of immigration enforcement aimed</p> <p>20 at making the lives of the undeserving unbearable and</p> <p>21 the demonising political rhetoric, cannot be divorced</p> <p>22 from the conditions and attitudes of those officers at</p> <p>23 Brook House Removal Centre.</p> <p>24 Reverend Ward gave evidence of a message of</p> <p>25 hostility as opposed to dignity and humanity already in</p> <p style="text-align: center;">Page 32</p>



<p>1 play in 2014, and other witnesses have given testimony</p> <p>2 highlighting it as well, including Lee Hanford,</p> <p>3 Professor Bosworth and Dr Brodie Paterson.</p> <p>4 Second, the safeguards systemically fail. It is</p> <p>5 plain from the evidence received by the inquiry that the</p> <p>6 safeguards to protect ordinary and vulnerable people</p> <p>7 from mistreatment in detention are not fit for purpose</p> <p>8 and continue to be flagrantly and openly breached. This</p> <p>9 state of affairs has persisted in spite of repeated</p> <p>10 recommendations by multiple bodies, reports and reviews.</p> <p>11 A key task of the inquiry is to make clear findings and</p> <p>12 recommendations that can finally bring this to an end.</p> <p>13 The Adults at Risk policy, the centrepiece of the</p> <p>14 response to Shaw is structurally deficient as</p> <p>15 an effective safeguard and we now know intentionally so.</p> <p>16 It removed the strong presumption against detention,</p> <p>17 it removed the assumption that those who were vulnerable</p> <p>18 are at risk of harm and required evidence to be provided</p> <p>19 leading to actual harm before release is considered.</p> <p>20 The policy reintroduced by the back door the notion of</p> <p>21 satisfactory management that Stephen Shaw heavily</p> <p>22 criticised and found an affront to civilised values.</p> <p>23 Mr Cheeseman did not dispute this, no Home Office</p> <p>24 witness could explain how a policy purporting to</p> <p>25 strengthen protections for vulnerable detainees has, in</p> <p style="text-align: center;">Page 33</p>	<p>1 vulnerable detainees.</p> <p>2 The disconnect between policy and practice.</p> <p>3 The inquiry's clinical expert, Dr Hard, concluded</p> <p>4 there was a complete systems failure of the safeguards.</p> <p>5 Where they did operate, they were dysfunctional.</p> <p>6 Sandra Calver, then the current head of healthcare, and</p> <p>7 Dr Oozeerally, the current lead GP, still at</p> <p>8 Brook House, gave evidence these were systemic</p> <p>9 deficiencies across the detention of state and that they</p> <p>10 are continuing.</p> <p>11 Those failures include GP appointments under rule 35</p> <p>12 becoming completely disconnected from their statutory</p> <p>13 and safeguarding purpose. Rule 35 reports not being</p> <p>14 done at the first opportunity, we know now that only one</p> <p>15 rule 35 assessment a day is being undertaken at</p> <p>16 Brook House. That is an effective abandonment of the</p> <p>17 rule and its statutory purposes. We know, and it has</p> <p>18 been repeatedly referred to, that the process rarely</p> <p>19 results in a rule 35(1) report, even though that is the</p> <p>20 one that is most likely to secure release and,</p> <p>21 shockingly, there has been no rule 35(2) reports ever</p> <p>22 done at Brook House.</p> <p>23 Dr Hard properly described this as shocking.</p> <p>24 The majority of rule 35(3)s do not contain the</p> <p>25 relevant information on impact and so the Home Office</p> <p style="text-align: center;">Page 35</p>
<p>1 fact, achieved the opposite and why no remedial action</p> <p>2 has since been taken following Mr Shaw's second review</p> <p>3 in 2018 and the repeated exhortations of the Chief</p> <p>4 Inspector of Borders on a number of occasions and in</p> <p>5 recent reports.</p> <p>6 There was no independent advocacy provision to</p> <p>7 facilitate people with serious mental illness, whose</p> <p>8 capacity is impaired, to participate in decision making,</p> <p>9 to challenge detention and segregation. That had been</p> <p>10 found by the High Court in the case of VC -- which has</p> <p>11 been referred to on a number of occasions in this</p> <p>12 inquiry and in the evidence of Naomi Blackwell -- who</p> <p>13 had ruled that this state of affairs was a breach of the</p> <p>14 Equality Act 2010 for disabled persons and unlawful.</p> <p>15 That was in 2018, but still no remedy. Mr Cheeseman</p> <p>16 recognised it was necessary but provided no explanation</p> <p>17 for why that systemic failure continued.</p> <p>18 The actions taken against the Gatwick Detainees</p> <p>19 Welfare Group and Naomi Blackwell, one of its former</p> <p>20 caseworkers for facilitating VC's access to legal</p> <p>21 representation to bring the article 3 breach to an end</p> <p>22 is a salutary insight in the extent to which G4S and</p> <p>23 Home Office managers, Mr Dix and Mr Gasson actively</p> <p>24 deterred oversight and scrutiny, even when key to</p> <p>25 exposing mistreatment and in respect of the most</p> <p style="text-align: center;">Page 34</p>	<p>1 refuses to release. Even if all these hurdles are</p> <p>2 overcome, the Home Office released statistics on</p> <p>3 rule 35(3) remain woeful and inadequate.</p> <p>4 None of the officials or even the medical</p> <p>5 professionals appear to recognise the gravity of their</p> <p>6 dereliction of duty to those in care or the consequent</p> <p>7 risk of serious harm through exacerbation of mental</p> <p>8 illness and trauma, exactly the kind of harm that</p> <p>9 article 3 is intended to avoid and to protect. The</p> <p>10 alternatives proposed of part Cs and ACDT have all been</p> <p>11 roundly rejected as acceptable alternatives by Dr Hard.</p> <p>12 The fact that they were also rejected by the High Court</p> <p>13 in 2017, again is another indication of the way in which</p> <p>14 the Home Office disregards legal judgments and its legal</p> <p>15 obligations.</p> <p>16 Critical, then, is the evidence from Dr Hard and</p> <p>17 Dr Bingham about the interrelationship between these</p> <p>18 systems failures and the mistreatment that occurred at</p> <p>19 Brook House and can reoccur now. They both said -- and</p> <p>20 this also is the medical evidence of Professor Katona --</p> <p>21 that it is impossible to separate the systemic failures</p> <p>22 of the safeguards from the mistreatment of detainees.</p> <p>23 These failures meant that vulnerable people were not</p> <p>24 released and were kept in an environment known to have</p> <p>25 a serious negative impact on mental health for</p> <p style="text-align: center;">Page 36</p>

<p>1 indeterminate periods and suffering a level of harm that 2 engages article 3 of the Convention.</p> <p>3 In many individual cases, it is also combined with 4 the treatment of symptoms of deterioration -- such as 5 distress, self-harm and suicidality -- as refractory or 6 manipulative behaviour, leading to segregation imposed 7 as a punishment, and to the use of force as a routine 8 response. Chillingly, because, Dr Hard explained, much 9 of the default use of force and containment in this 10 context is for convenience and because he said there is 11 nothing else that can be done, that is the position that 12 Medical Justice and the Royal College of Psychiatrists 13 have explained for a very long time.</p> <p>14 Dr Bingham called this a "perfect storm" for abuse 15 and ill-treatment to occur and reoccur. Dr Hard agreed.</p> <p>16 There is a clear correlation between this systems 17 failure and the incidence of ill-treatment.</p> <p>18 Fourth, the prisonisation of Brook House is another 19 institutional factor that leads to, and led to, risk and 20 actual mistreatment. We know that Brook House was 21 designed as a category B prison and, for all those who 22 visit it, or are held within it, or work within it, it 23 is a prison in all but name. Little, if anything, can 24 be done to remedy its harsh, brutal features. Mr Bhui 25 reiterated in his evidence the long-standing position</p> <p style="text-align: center;">Page 37</p>	<p>1 not designed for the specific risks and needs of the IRC 2 demograph, a high proportion of whom suffer from 3 post-traumatic stress disorder, anxieties and other 4 mental illness arising from a history of torture or 5 ill-treatment.</p> <p>6 Many custody officers explained how they were 7 completely ill-equipped to cope, both with the harsh 8 environment and, in particular, to respond to the 9 high-levels of vulnerability and mental illness.</p> <p>10 That fact led to a process of desensitisation, where 11 the resort was to methods such as use of force and 12 segregation without proper consideration of the 13 individuals' vulnerability.</p> <p>14 Evidence of systemic misuse of the power to 15 segregate under rule 40 without lawful authorisation and 16 as a punishment has been identified by the inquiry and, 17 of course, there is the widespread, unlawful, de facto 18 segregation on E wing and the CSU, operated outside of 19 the constraints of rule 40. What was also identified in 20 this context as 100 per cent unacceptable, according to 21 Dr Hard, was the complicity that doctors and nurses at 22 Brook House played in approving, and at times 23 sanctioning, the use of force, restraints and 24 segregation. Dr Oozeerally did not seem to understand 25 his role; Dr Hard and Dr Bingham highlighted the clear</p> <p style="text-align: center;">Page 39</p>
<p>1 that it is an inappropriate environment for 2 administrative detainees.</p> <p>3 The Home Office itself understood the regime to be 4 inconsistent with the ethos and requirements of 5 a relaxed immigration detention under rule 3, but 6 cutting corners and cost saving was prioritised over 7 welfare and dignity. The poor physical state of the 8 cells, the squalid unclean conditions, the lack of 9 natural light and poor ventilation, the recklessly 10 introduced three-man cells with open toilets 11 inadequately screened failed to respect the privacy and 12 dignity of the men held there. The centre was chaotic, 13 noisy and riddled with spice, a situation out of 14 control, and even involving staff bringing drugs into 15 the centre.</p> <p>16 In that context, a critical issue for this inquiry 17 is the cross-application of prison policies and methods 18 such as ACDT, segregation and the use of force, through 19 control and restraint methods, that are properly 20 described as "prisonisation" by Professor Bosworth, and 21 are strongly criticised by her as inappropriate and 22 wrong.</p> <p>23 These prison policies and measures were, and still 24 are, coercive, custodial, risk management tools aimed at 25 controlling and managing high-risk prisoners. They are</p> <p style="text-align: center;">Page 38</p>	<p>1 conflict of dual loyalties of the worst kind, allowing 2 Home Office priorities to override the doctor's primary 3 duty of care to his patients and a fundamental 4 safeguarding role of medical practitioners failed in 5 Brook House.</p> <p>6 This context leads to key aspects of institutional 7 culture in which use and misuse of force led to 8 mistreatment. Desensitisation and dehumanisation are 9 the hallmarks of the culture that operated at 10 Brook House. Faced with acute levels of vulnerability 11 and distress, in the absence of tools or know-how in how 12 to deal with it, the inevitable response, 13 Professor Bosworth said, was for custody officers to 14 become desensitised.</p> <p>15 In that context, the macho-aggressive culture, that 16 we have heard so much of, flourished, normalised and 17 dominated. It was not a subculture among core groups or 18 cliques, it was the dominant culture, because, as 19 Callum Tulley and Owen Syred explained, it was able to 20 inculcate new staff members, was engendered through 21 intimidation, bullying and fear, able to mould others 22 and to normalise complicity and the silence of others.</p> <p>23 The compelling evidence of Mr Syred on this topic and 24 his experience when challenging racism is well known to 25 the inquiry. It is key evidence, underscoring the</p> <p style="text-align: center;">Page 40</p>

<p>1 nature of the dominant culture of dehumanisation that 2 was at play.</p> <p>3 It was evidenced in a number of different ways: the 4 ubiquitous -- the widespread derogatory and abusive 5 language normalised as everyday banter; and, despite its 6 violence and debasing content, the use of racist 7 language. All illustrated the extent to which 8 dehumanised attitudes and practices were embedded within 9 the service culture, creating a context of impunity and 10 providing the conditions for mistreatment, abuse and 11 racism to thrive.</p> <p>12 As Professor Bosworth observed, when staff switched 13 off from the distress of detainees, this inevitably led 14 to dehumanisation. The detainees themselves described 15 how they were treated as less than human, as animals and 16 criminals. Despite its gravity, self-harm was 17 characterised as attention-seeking and manipulative, 18 calculated to avoid removal and requiring a coercive 19 response, not a trigger for review of detention and 20 release.</p> <p>21 Healthcare was not immune to desensitisation and 22 dehumanisation. Even their clinical training did not 23 equip them to cope with the environment at Brook House. 24 This was exemplified by the evidence of Jo Buss, who 25 explained her response to the derogatory comments made</p> <p style="text-align: right;">Page 41</p>	<p>1 We say that when one considers the key factors 2 identified by the Macpherson Inquiry as hallmarks of 3 institutional racism, they are all at play at 4 Brook House. One critical factor that he identified is 5 the failure of the organisation to unequivocally 6 recognise, acknowledge and accept the problem.</p> <p>7 No official within the Home Office, no person within 8 G4S, has begun to identify and recognise the 9 significance of the widespread evidence of racism. 10 Anyone who maintains the idea of isolated individuals or 11 the "bad apple" trope is only providing evidence to this 12 inquiry that a key feature of institutional racism is 13 still at play and operating amongst those responsible 14 for this system.</p> <p>15 What, then, are the recommendations that the inquiry 16 should make?</p> <p>17 The inquiry knows from our opening that the 18 organisation Medical Justice, like the British Medical 19 Association and many others, have called for an end to 20 immigration detention. Professor Bosworth concurs. The 21 evidence uncovered by this inquiry has only confirmed 22 the validity and moral imperative of that view. Indeed, 23 the current Chief Inspector of Borders has himself 24 recently recommended that the Home Office undertake 25 a proper evidence-based investigation into the need for</p> <p style="text-align: right;">Page 43</p>
<p>1 by officers in the presence of D1527, in a state of 2 acute vulnerability, that it simply washed over her like 3 banter, "You become immune".</p> <p>4 This indicates the extent to which there was 5 a corrupted, institutional culture and one that there is 6 no evidence has been fundamentally identified, addressed 7 and rooted out.</p> <p>8 Finally, and in that context, there is the evidence 9 of institutional racism. Professor Bosworth's view on 10 that is clear. She concludes that the seeds are sown in 11 the very nature and function of immigration detention, 12 just as Mr Shaw had warned in 2005, that, unchecked, 13 IRCs are a breeding ground for racist and abusive word 14 and deed.</p> <p>15 Evidence of pervasive racism was identified in G4S 16 staff in the Mubenga inquest in 2003, and in Yarl's Wood 17 undercover reporting in 2015. It is not new, and it is 18 ever-present. This means that the inquiry needs to 19 identify what measures were in place to address this 20 critical issue in the institutional culture. It took 21 forms of stereotyping as well as the overt racist 22 language that the inquiry will be familiar with from 23 officers like John Connolly, Graham Purnell and 24 Sam Gurney, and which was said directly to the detainee 25 D643.</p> <p style="text-align: right;">Page 42</p>	<p>1 immigration detention at all. The ICIB pointed to 2 evidence that reporting to immigration officers is 3 95 per cent effective and made other recommendations for 4 compliance to be further improved. There is a viable 5 policy alternative to detention, and policy questions 6 are firmly within the terms of reference of this 7 inquiry. If, and in any event, policies must operate 8 effectively to constrain the exercise of this power, and 9 to prevent its exercise, where the detained person is 10 vulnerable, in particular by reason of a history of 11 torture and trauma and mental illness.</p> <p>12 Policy and statutory time limits already operate for 13 pre-departure accommodation, as explained in the 14 evidence of Ms Ginn at paragraph 150, the Family Returns 15 Policy and the detention of children and pregnant women, 16 other vulnerable groups, already have strict 17 restrictions on the circumstances and the time for which 18 a person can be detained. Those policies have brought 19 to an end the extreme consequences of harm and suffering 20 that are the hallmarks of the policy and context that we 21 are considering.</p> <p>22 Again, we say this is not a radical proposition. It 23 is where the evidence takes you. It is the conclusions 24 of Mr Shaw, the ICIB, the HMIP, the Home Affairs Select 25 Committee, the Joint Committee On Human Rights, the</p> <p style="text-align: right;">Page 44</p>

<p>1 British Medical Association and many others, and it was</p> <p>2 even the evidence of Dr Oozeerally that detention at</p> <p>3 Brook House should be no longer than a week.</p> <p>4 In the meantime, it is plain that there is a need</p> <p>5 for urgent measures to correct the complete deprivation</p> <p>6 of safeguards identified by Dr Hard. Pre-detention</p> <p>7 screening has been repeatedly urged upon the Home Office</p> <p>8 by independent oversight bodies and NGOs like</p> <p>9 Medical Justice, and in this inquiry by Dr Hard and</p> <p>10 Dr Oozeerally. It has shown to be effective in the</p> <p>11 context of family removals process, so that all factors</p> <p>12 such as medical conditions or vulnerability, that point</p> <p>13 against detention, are identified before detention takes</p> <p>14 place and avoids the harm occurring.</p> <p>15 Decisive urgent steps are required to address the</p> <p>16 wholesale failure to implement rules 34 and 35</p> <p>17 safeguards, as you pointed out, chair, these are</p> <p>18 currently putting vulnerable individuals at risk of</p> <p>19 actual harm. Additional resources need to be urgently</p> <p>20 made available so that GP appointments within the first</p> <p>21 24 hours are capable of fulfilling the rule 35 and</p> <p>22 rule 34 purpose. Rule 35 appointments need to be</p> <p>23 automatic and the delays must be eliminated.</p> <p>24 Opening an ACDT because of risk of harm should</p> <p>25 result in a rule 35(2) report and consideration of</p> <p style="text-align: center;">Page 45</p>	<p>1 suggestions to improve accountability of G4S corporate</p> <p>2 managers and Home Office officials. The culture of</p> <p>3 impunity must be addressed.</p> <p>4 Challenging institutional culture at all levels is</p> <p>5 a challenging task. It requires the kind of</p> <p>6 wide-ranging review and measures recommended by the</p> <p>7 Macpherson Inquiry and adapted to the present context,</p> <p>8 again, in the witness statement of Ms Ginn on behalf of</p> <p>9 Medical Justice.</p> <p>10 Finally, this inquiry should conclude that</p> <p>11 Brook House must not be used as an IRC going forward.</p> <p>12 It should follow the conclusion of the HMIP that it is</p> <p>13 simply an inappropriate environment for administrative</p> <p>14 detainees, and the expert evidence of</p> <p>15 Professor Bosworth, which reflects the medical -- wider</p> <p>16 medical evidence, the accounts of G4S custody officers</p> <p>17 and senior staff, and of course the experience of those</p> <p>18 detained there.</p> <p>19 Last, we request this of the inquiry: this inquiry</p> <p>20 should have an implementation phase, as others such as</p> <p>21 the Laming and Soham Inquiries have done. It should</p> <p>22 reconvene to ascertain what has happened in the interim</p> <p>23 to implement its recommendations. This was raised in</p> <p>24 a letter to the inquiry as long ago as 8 November 2019</p> <p>25 by my instructing solicitors at Duncan Lewis.</p> <p style="text-align: center;">Page 47</p>
<p>1 a rule 35(1) report and, if issued, lead to prompt</p> <p>2 release. Segregation due to self-harm and suicide risk</p> <p>3 should, likewise, trigger a rule 35 report and release.</p> <p>4 This cannot wait until publication of the inquiry's</p> <p>5 report. It needs to happen urgently. Chair, you should</p> <p>6 consider interim findings and recommendations on rule 34</p> <p>7 and 35 and the Adults at Risk policy. We have seen</p> <p>8 a letter sent by the NHS and jointly with the</p> <p>9 Home Office reminding healthcare professionals of the</p> <p>10 terms of rule 35 and 34. We say that is woefully</p> <p>11 inadequate in light of the evidence that this inquiry</p> <p>12 has heard. We know that those healthcare professionals</p> <p>13 do not understand rule 34 and 35, and critically, it is</p> <p>14 a question of resources; nothing has come from the</p> <p>15 Home Office to indicate that they either understand or</p> <p>16 know, or are willing to address, the underlying problems</p> <p>17 that mean that those safeguards will continue to fail</p> <p>18 and individuals will continue to be at risk of serious</p> <p>19 harm.</p> <p>20 Detailed recommendations have been made on many</p> <p>21 topics of importance to this inquiry in the Medical</p> <p>22 Justice Reports and in the position statements of the</p> <p>23 Royal College of Psychiatrists. We will expand on those</p> <p>24 in our written submissions but commend them to you.</p> <p>25 Detailed submissions have also been made for</p> <p style="text-align: center;">Page 46</p>	<p>1 Mr Riley's evidence makes it all the more pressing,</p> <p>2 because of the deferral of any action pending as</p> <p>3 a result of the Nationality and Borders Bill currently</p> <p>4 before parliament. That Bill will have wide-ranging</p> <p>5 implications for detention, not least the reintroduction</p> <p>6 of a detained fast track for asylum seekers, previously</p> <p>7 held to be unlawful and suspended, precisely because of</p> <p>8 the failure of the safeguards of rule 34 and 35 to</p> <p>9 identify those who are vulnerable.</p> <p>10 Professor Bosworth said, in this context, "We go</p> <p>11 round and round in circles". She was correct. This</p> <p>12 inquiry must break the circle. It will be more</p> <p>13 effective in doing so if Home Office officials and its</p> <p>14 contractors understand that they will be effectively</p> <p>15 called to account for their action and, of course,</p> <p>16 inaction in response to this inquiry's findings and its</p> <p>17 recommendations.</p> <p>18 Those concentric circles should never again be</p> <p>19 allowed to lead back to the hell that was Brook House in</p> <p>20 2017.</p> <p>21 THE CHAIR: Thank you very much, Ms Harrison.</p> <p>22 This seems a convenient point to take our break and</p> <p>23 then we will continue with the submissions. So we will</p> <p>24 return at 11.40. Thank you very much.</p> <p>25 (11.26 am)</p> <p style="text-align: center;">Page 48</p>

<p>1 (a short break)</p> <p>2 (11.42 am)</p> <p>3 THE CHAIR: Ms Morris, thank you.</p> <p>4 MS MORRIS: Chair, I will address you now on behalf of</p> <p>5 Reverend Nathan Ward.</p> <p>6 THE CHAIR: Thank you.</p> <p>7 Closing statement by MS MORRIS</p> <p>8 MS MORRIS: Reverend Ward had this to say at paragraph 14 of</p> <p>9 his first witness statement:</p> <p>10 "Ultimately, however, after many years of trying to</p> <p>11 make a change, I felt I just could not cope with</p> <p>12 continuing to work for G4S. I realised that by</p> <p>13 remaining in the system, I was perpetuating an unjust,</p> <p>14 inhumane system which I would now describe as barbaric."</p> <p>15 Reverend Ward's perception of the system as unjust,</p> <p>16 inhumane and barbaric is exactly what the evidence in</p> <p>17 this inquiry has shown the system to be.</p> <p>18 In opening, on behalf of Reverend Ward, I provided</p> <p>19 a few examples of his experience of working for G4S at</p> <p>20 Gatwick IRCs. Those include: unlawful uses of force, in</p> <p>21 other words, assaults; a culture of racism,</p> <p>22 institutional racism, including the use of cultural</p> <p>23 stereotypes and generalisations and clear evidence of</p> <p>24 an "us and them" mentality.</p> <p>25 Furthermore, there was evidence of completely</p> <p>Page 49</p>	<p>1 inquiry has heard evidence of the exact same, or</p> <p>2 similar, issues continuing at Brook House during the</p> <p>3 relevant period. Therefore, the evidence shows no</p> <p>4 improvement between 2014 and 2017, notwithstanding two</p> <p>5 things: first, the abuses at Medway STC being exposed in</p> <p>6 the intervening period, and the Medway Improvement Board</p> <p>7 highlighting serious issues with leadership,</p> <p>8 organisational behaviours and culture as causal of the</p> <p>9 issues at Medway STC in its advice to the Secretary of</p> <p>10 State for Justice; second, Reverend Ward's own</p> <p>11 whistleblowing, as set out in his first statement and,</p> <p>12 just to name a few names of people and organisations he</p> <p>13 raised concerns with, he raised concerns with</p> <p>14 Duncan Partridge, Ben Saunders, Deborah Western,</p> <p>15 Steph Phillips, Jerry Petherick, Kent Police and the</p> <p>16 Home Affairs Select Committee.</p> <p>17 So since 2017 and to the present day, at best, there</p> <p>18 has been some tweaking around the edges. At worst, the</p> <p>19 very same fundamental issues as were occurring prior to</p> <p>20 2017, in Reverend Ward's experience, are continuing to</p> <p>21 this day at Brook House, and not just Brook House, in</p> <p>22 other parts of the immigration detention estate.</p> <p>23 There is no sign of any real or substantial change.</p> <p>24 By way of reminder, it is the lack of accountability and</p> <p>25 sanctions to date that was Reverend Ward's primary</p> <p>Page 51</p>
<p>1 inadequate healthcare provision, unsuited to the needs</p> <p>2 of the detained population. Reverend Ward described the</p> <p>3 assaults and abuse as shown on Panorama as a gross</p> <p>4 manifestation of an institutional and corrupt toxic</p> <p>5 culture. His views and experience of working for G4S,</p> <p>6 borne out by the evidence heard in this inquiry, is that</p> <p>7 the behaviour of staff was perpetuated by the system in</p> <p>8 which they were working. A system in which abuse could</p> <p>9 be meted out to detainees with impunity, in the absence</p> <p>10 of fear of consequences, due to silence and cover-up</p> <p>11 directly caused by the culture of dehumanisation and</p> <p>12 "othering".</p> <p>13 The toxic, masculine and bullish culture of which</p> <p>14 Reverend Ward spoke has been further illuminated by the</p> <p>15 other evidence which this inquiry heard. Such a toxic</p> <p>16 culture even filtered down through to the training on</p> <p>17 use of force. Reverend Ward stated in his evidence that</p> <p>18 he had complained about the training on control and</p> <p>19 restraint more than anything else, as it was seen as</p> <p>20 central to the running of Brook House, which he viewed</p> <p>21 as wrong and which perpetuated a negative,</p> <p>22 macho-aggressive culture which has been shown, by the</p> <p>23 evidence this inquiry has heard, to have been pervasive</p> <p>24 across Brook House.</p> <p>25 Reverend Ward's resignation was in 2014, and yet the</p> <p>Page 50</p>	<p>1 reason for participating in the inquiry and why he</p> <p>2 considers it important. I will come back to what he</p> <p>3 said in his first statement at paragraphs 309 and 310 as</p> <p>4 quoted in opening. He said:</p> <p>5 "I strongly believe that things will not</p> <p>6 fundamentally change unless people are held to account</p> <p>7 at all levels of the system and serious consequences</p> <p>8 occur for the individuals and the corporate bodies.</p> <p>9 I do not understand how G4S could continue being the</p> <p>10 contract provider for almost three years after the</p> <p>11 Panorama broadcast, which included a two-year extension</p> <p>12 and, equally, why any contract could continue to be run</p> <p>13 with G4S after the Medway and Brook House reporting.</p> <p>14 I also do not understand how managers within G4S, with</p> <p>15 oversight for these centres, or on site, like</p> <p>16 Ben Saunders, Steve Skitt, Jules Williams or Steve Dix</p> <p>17 were not dismissed but were able to continue in their</p> <p>18 roles or take up posts elsewhere. I also do not</p> <p>19 understand how senior civil servants, responsible for</p> <p>20 these contracts, such as Paul Gasson or</p> <p>21 Mr Schoenenberger, and for detention services generally,</p> <p>22 have not been disciplined but remained in post."</p> <p>23 Until concerted action is taken, and is seen to be</p> <p>24 taken, complaints made will be ignored, or more likely</p> <p>25 won't be made at all because people will have no</p> <p>Page 52</p>

<p>1 confidence in the system.</p> <p>2 Reverend Ward asked this question:</p> <p>3 "How, then, could you, chair, be confident that any</p> <p>4 further tweaks will lead to the real and significant</p> <p>5 change that is required?"</p> <p>6 He says you can have no confidence whatsoever, as</p> <p>7 history and the evidence has shown that minor tweaks</p> <p>8 don't stop mistreatment and abuse, and they don't change</p> <p>9 the toxic culture. Reverend Ward says that the changes</p> <p>10 that are required involve a dismantling of the whole</p> <p>11 immigration detention system. His view is that to do</p> <p>12 anything less than the significant changes that are</p> <p>13 required will allow the corrupt and toxic institutional</p> <p>14 culture of abuse, bullying, disrespect and</p> <p>15 dehumanisation as it was in 2017, and indeed 2014 and</p> <p>16 prior to that, the system that Reverend Ward had no</p> <p>17 choice but to leave, to continue.</p> <p>18 Such a barbaric system has no place in our society</p> <p>19 and Reverend Ward hopes that the outcome of this inquiry</p> <p>20 is swift and systemic change for the sake of humanity.</p> <p>21 Thank you for listening.</p> <p>22 THE CHAIR: Thank you very much, Ms Morris.</p> <p>23 Mr Goodman?</p> <p>24</p> <p>25</p> <p style="text-align: center;">Page 53</p>	<p>1 HA (Nigeria) v The Secretary of State for the Home</p> <p>2 Department [2012] EWHC 979 (Admin) at paragraph 70(f) --</p> <p>3 and that he was detained without ensuring his mental</p> <p>4 health, history of torture and suicidality were properly</p> <p>5 assessed and considered.</p> <p>6 Such measures as were in place were not used</p> <p>7 effectively to diagnose and properly treat and manage</p> <p>8 his condition -- see MD v Secretary of State for the</p> <p>9 Home Department [2014] EWHC 2249 (Admin) at 142.</p> <p>10 These aspects of his detention will be addressed</p> <p>11 further in written submissions. In the short time</p> <p>12 available for this oral submission, I propose only to</p> <p>13 outline why the ill-treatment he endured amounted to</p> <p>14 torture.</p> <p>15 Paragraph 20 of CTI's note to the inquiry, which we</p> <p>16 heard orally from Mr Altman earlier says that, in order</p> <p>17 to make a finding of torture, there must be deliberate</p> <p>18 and human treatment causing very serious and cruel</p> <p>19 suffering. That is accepted. However, the gloss at</p> <p>20 paragraph 21 of the note, that torture involves a very</p> <p>21 high degree of physical suffering, is too narrow. Acts</p> <p>22 causing severe mental suffering, that cause no physical</p> <p>23 injury can amount to torture -- see Ireland v UK (2018)</p> <p>24 67 EHRR SE1 and El-Masri v Macedonia (2013) 57 EHRR 25,</p> <p>25 at paragraph [202].</p> <p style="text-align: center;">Page 55</p>
<p>1 Closing statement by MR GOODMAN</p> <p>2 MR GOODMAN: Chair, on behalf of D1527, D1538, D2077 and</p> <p>3 D1914, may I thank you, chair, and all the inquiry team</p> <p>4 for the work that has gone into the investigation of</p> <p>5 mistreatment in Brook House.</p> <p>6 I begin with D1527's case.</p> <p>7 Before this inquiry started, the Professional</p> <p>8 Standards Unit had already found, in its report of</p> <p>9 22 February 2018, that D1527 was degraded, reflecting</p> <p>10 the language of degrading treatment in article 3 ECHR</p> <p>11 and had made a number of findings that amounted to</p> <p>12 inhuman treatment -- see &lt;CJS001107&gt;.</p> <p>13 It is abundantly clear on the evidence that he was</p> <p>14 subjected to inhuman and degrading treatment, as well as</p> <p>15 to procedural breaches of article 3. Those breaches are</p> <p>16 intrinsically connected to the failure of the law,</p> <p>17 policy and operational safeguards that should have</p> <p>18 ensured that, as a vulnerable young man, he was not</p> <p>19 detained at all or that he was released expeditiously,</p> <p>20 once wrongly detained, or that he was cared for while in</p> <p>21 detention.</p> <p>22 D1527's case has always been that there was both</p> <p>23 a systemic and operational failure to identify, protect</p> <p>24 and monitor him as a vulnerable detainee in breach of</p> <p>25 the positive duties arising from article 3 -- see</p> <p style="text-align: center;">Page 54</p>	<p>1 A fortiori, where the mistreatment involves both</p> <p>2 physical and mental suffering, it can amount to torture.</p> <p>3 Ascertaining whether 1527 has been tortured in line</p> <p>4 with the definition in the Torture Convention -- as to</p> <p>5 which see my opening statement -- involves asking the</p> <p>6 following six questions:</p> <p>7 Firstly, should you, chair, consider each individual</p> <p>8 act of abuse in isolation to determine whether each</p> <p>9 individual act amounts to torture or should you consider</p> <p>10 the combination of abuse over the whole ten-week</p> <p>11 detention? I shall explain why it is the combination.</p> <p>12 Was the pain and suffering inflicted intentionally?</p> <p>13 Was there infliction of severe pain or suffering,</p> <p>14 physical and/or mental?</p> <p>15 Fourth, was pain or suffering inflicted for the</p> <p>16 purpose of intimidating or coercing him or was it based</p> <p>17 on any discrimination of any kind?</p> <p>18 Fifth, was pain or suffering inflicted by a public</p> <p>19 official?</p> <p>20 And sixth, was the pain or suffering inherent in, or</p> <p>21 incidental to, a lawful sanction?</p> <p>22 So taking the first question: should the chair treat</p> <p>23 the acts in isolation or as a whole?</p> <p>24 Assessing whether a detainee was subject to torture,</p> <p>25 or indeed inhuman or degrading treatment, involves</p> <p style="text-align: center;">Page 56</p>

<p>1 assessing the treatment in detention as a whole over the</p> <p>2 full ten weeks of D1527's detention. Whether treatment</p> <p>3 amounted to torture cannot be properly answered on</p> <p>4 consideration of a series of discrete acts artificially</p> <p>5 dislocated from one another and likely to omit</p> <p>6 consideration of the cumulative effects.</p> <p>7 This approach, which I commend to the inquiry, is</p> <p>8 supported by legal authority, in <i>Selmouni v France</i></p> <p>9 (2000) 29 EHRR 403, the allegation was of torture in</p> <p>10 circumstances in which Mr Selmouni was subject to</p> <p>11 a series of assaults and victimised in a series of</p> <p>12 bullying acts by police -- see paragraph [103]. At</p> <p>13 [104], the European Court noted that the events were not</p> <p>14 confined to any one period of police custody and it</p> <p>15 held, at 105, that the court was satisfied that the</p> <p>16 physical and mental violence considered as a whole</p> <p>17 committed against the applicant's person caused severe</p> <p>18 pain and suffering and was particularly serious and</p> <p>19 cruel.</p> <p>20 Such conduct must be regarded as acts of torture for</p> <p>21 the purposes of article 3 of the Convention.</p> <p>22 Similarly, in <i>Ireland v UK</i> (2018) 67 EHRR SE1, the</p> <p>23 European Court considered whether five disorientation</p> <p>24 techniques used in Northern Ireland in interrogations</p> <p>25 consisting of wall standing, hooding, exposure to noise,</p> <p style="text-align: center;">Page 57</p>	<p>1 goes on to explain factors relevant from the Istanbul</p> <p>2 Protocols to which I refer the inquiry.</p> <p>3 These observations can also be read across to the</p> <p>4 incident on 4 May. However, if, contrary to D1527's</p> <p>5 primary position, you, chair, consider that, taken</p> <p>6 alone, those incidents of mistreatment do not amount to</p> <p>7 torture, it then falls to be considered whether the</p> <p>8 in-combination effects of the whole detention amount to</p> <p>9 torture, just as in the case of <i>Ireland, Selmouni and</i></p> <p>10 <i>El-Masri</i> I have cited.</p> <p>11 D1527's experience of torture involved a combination</p> <p>12 of both acts of deliberate, violent, physical</p> <p>13 mistreatment and deliberate, psychological abuse, on the</p> <p>14 one hand, but also non-intentional factors, including</p> <p>15 being falsely imprisoned, the conditions of detention,</p> <p>16 the failure to manage his mental illness and</p> <p>17 vulnerability, his self-harm, food and fluid refusal,</p> <p>18 his suicidality, and those factors set the context for,</p> <p>19 and aggravate the severity of, the individual acts of</p> <p>20 deliberate violence.</p> <p>21 So the second question: was there an act or acts</p> <p>22 which were intentionally inflicted? The primary act in</p> <p>23 question is the detention as a whole. The detention as</p> <p>24 a whole was undoubtedly a deliberate act by the state,</p> <p>25 and the simple answer to the first question posed by the</p> <p style="text-align: center;">Page 59</p>
<p>1 sleep deprivation and deprivation of food and drink</p> <p>2 amounted to torture. The Commission's opinion is</p> <p>3 recorded at paragraph 133 of the court's determination</p> <p>4 as being that, considered separately, acts such as sleep</p> <p>5 deprivation or restrictions on diet might not, as such,</p> <p>6 be regarded as treatment contravening article 3, but</p> <p>7 that, in combination, the practices amounted to a breach</p> <p>8 of article 3.</p> <p>9 The court conducted its inquiry on the basis of the</p> <p>10 in-combination effects and the overall impact of being</p> <p>11 detained. Consideration of in-combination impacts can</p> <p>12 also be seen in the court's assessment of the three-day</p> <p>13 extraordinary rendition in <i>Hajrulahu v Macedonia</i> (2018).</p> <p>14 That said, chair, turning to 1527's case, 1527 does</p> <p>15 invite you to determine that the incidents on</p> <p>16 25 April 2017 and on 4 May amounted to torture even when</p> <p>17 taken in isolation.</p> <p>18 Professor Katona's evidence in his first statement,</p> <p>19 which is &lt;BHM000030&gt; at paragraph 50, is that, on</p> <p>20 viewing the strangulation incident involving D1527, the</p> <p>21 mistreatment and threat to kill appears to have had</p> <p>22 a profound emotional reaction and psychological</p> <p>23 consequences for D1527 that induced an intensive</p> <p>24 suffering sufficient, from the footage of it, to cross</p> <p>25 the very high threshold to constitute torture, and he</p> <p style="text-align: center;">Page 58</p>	<p>1 definition of torture is, yes, the detention was</p> <p>2 intentionally inflicted. There were also a series of</p> <p>3 deliberate acts within that detention. There were at</p> <p>4 least three deliberate acts of unlawful, physical</p> <p>5 violence against him, on 24 April, 25 April and 4 May</p> <p>6 and, as the Professional Standards Unit found, the</p> <p>7 24 April incident degraded him. While he was on</p> <p>8 constant watch his head was banged against a table, by</p> <p>9 DCO Sanders, who later brags about the incident. The</p> <p>10 following day, again, as found by the PSU, on 25 April,</p> <p>11 the use of force filmed by Mr Tulley involving him,</p> <p>12 Mr Paschali, Clayton Fraser, Charlie Francis and Jo Buss</p> <p>13 breached article 3. The so-called "choke hold" was</p> <p>14 evidently intentional, and that has never been denied.</p> <p>15 Indeed, it was accompanied by threats such as "I am</p> <p>16 going to put you to sleep, you fucking piece of shit,"</p> <p>17 and other insults by onlookers, such as "Are you a man</p> <p>18 or a mouse?", mocking him for being a "child" or a</p> <p>19 "baby" in Nathan Ring's case.</p> <p>20 Mr Paschali described his use of the choke hold as</p> <p>21 a response to being frustrated by D1527's behaviour,</p> <p>22 even the concocted explanation by Mr Paschali that he</p> <p>23 was seeking to gain compliance is itself an admission of</p> <p>24 intentionally using an unauthorised restraint technique.</p> <p>25 There is no doubt that the acts were intentional.</p> <p style="text-align: center;">Page 60</p>

<p>1 Mr Collier's view was properly that Mr Paschali's</p> <p>2 actions were deliberate, the experience was then</p> <p>3 followed by maintaining him unlawfully and deliberately</p> <p>4 in isolation.</p> <p>5 Then, on 4 May, D1527 endured a psychotic episode on</p> <p>6 the suicide netting, in which he was mocked and taunted</p> <p>7 by officers and detainees alike. Half an hour later, he</p> <p>8 had calmed down and DCM Dix came to the room with</p> <p>9 several other DCOs. The records show -- that is</p> <p>10 &lt;CJS001026&gt; -- that the intention was a clearly</p> <p>11 premeditated one to remove him from association and was</p> <p>12 clearly unlawful.</p> <p>13 "I spoke to D1527 about his behaviour and the</p> <p>14 consequences of his actions", says Mr Dix at</p> <p>15 &lt;HOM000251&gt;. In the terms of the UOF report -- use of</p> <p>16 force report -- &lt;CJS005530&gt;:</p> <p>17 "Upon arrival, I saw detainee D1527 on the</p> <p>18 first-floor netting. I explained, due to his behaviour,</p> <p>19 he would need to comply and go to the CSU on rule 40.</p> <p>20 He said no. I explained, if he refused, then,</p> <p>21 potentially, as a consequence of his actions, force</p> <p>22 could be used."</p> <p>23 And, again, in oral evidence, Mr Dix's evidence was:</p> <p>24 "At the time, obviously, when someone is on the</p> <p>25 netting, then obviously the procedure was to get them to</p> <p style="text-align: center;">Page 61</p>	<p>1 He then asks for D1527's trousers and says he will</p> <p>2 give them back later, and on the footage we see officers</p> <p>3 guiding him downstairs, cuffed. Again, an officer says,</p> <p>4 "You will do what I tell you to do, okay, and when we</p> <p>5 let go of everything, okay, if you start to do what you</p> <p>6 did last time, self-harming ... constant, then obviously</p> <p>7 your behaviour will dictate how long you stay there for.</p> <p>8 It makes sense?"</p> <p>9 There is no doubt that this outlawry, on 4 May,</p> <p>10 under the guise of rule 40, was planned and intentional.</p> <p>11 Mr Dix admitted as much in his written report and oral</p> <p>12 evidence. The footage confirms the intention was to</p> <p>13 punish or impose some perverted sense of discipline on</p> <p>14 him for his self-harming activities. He was subject to</p> <p>15 deliberate use of removal from association. It is</p> <p>16 apparent from the Home Office correspondence of</p> <p>17 28 March 2022 -- that is &lt;HOM0332161&gt; -- and G4S</p> <p>18 correspondence of 22 March -- &lt;CJS0074121&gt; -- that this</p> <p>19 was also unlawful.</p> <p>20 D1527 was the subject of numerous recorded,</p> <p>21 deliberate insults, mocking and humiliation and names,</p> <p>22 verbal abuse. They don't need to be explored or further</p> <p>23 repeated. He was subject to deliberate psychological</p> <p>24 torment, Mr Dix telling him the extent of time in</p> <p>25 isolation depending on his behaviour, and</p> <p style="text-align: center;">Page 63</p>
<p>1 go to rule 40. I am not sure if it was a policy, it</p> <p>2 was, you know, due to the fact of the level of</p> <p>3 disruption caused on the netting and the wing."</p> <p>4 The process of physically removing him to E wing</p> <p>5 involves significant levels of violence and it was</p> <p>6 obviously deliberate.</p> <p>7 On arrival at E wing, D1527 was then subjected to</p> <p>8 further deliberate mistreatment, a full strip search,</p> <p>9 which in and of itself breached G4S policy, which</p> <p>10 reserves it for cases of intelligence a detainee is</p> <p>11 hiding an elicited item. The body-worn camera footage,</p> <p>12 UOF 114.17 captures the footage at the point he is being</p> <p>13 relocated to E Wing, and we hear, again, DCM Dix</p> <p>14 stating:</p> <p>15 "When we leave the room, someone is going to watch</p> <p>16 you. Okay? If we leave this room and you start</p> <p>17 self-harming, like you've done before and obviously like</p> <p>18 you do, the obviously that, your behaviour dictates what</p> <p>19 happens in your future. Okay? No one wants that.</p> <p>20 Okay? If you stay calm -- but I told you, the way you</p> <p>21 have gone about things -- jumping on the netting is not</p> <p>22 the right way. So you should have spoken to a manager.</p> <p>23 But your problem is you go from okay to lose the plot in</p> <p>24 two or three seconds and that's what has landed you in</p> <p>25 trouble."</p> <p style="text-align: center;">Page 62</p>	<p>1 Nurse Karen Churcher tormenting him by saying that he</p> <p>2 was being detained longer because he was self-harming,</p> <p>3 racist insults and denial of religious rights, and</p> <p>4 deliberate acts of concealment of the events in the</p> <p>5 paperwork.</p> <p>6 Looking, then, at the question of whether this</p> <p>7 caused severe pain or suffering, physical or mental,</p> <p>8 this question is assessed on a relative basis and it</p> <p>9 depends on the circumstances, the age of them and the</p> <p>10 mental health of the victim -- see Ireland v UK,</p> <p>11 paragraph [162].</p> <p>12 The effect here for your consideration, chair, is</p> <p>13 the accumulation of suffering in making an assessment,</p> <p>14 whether it meets the severe threshold. That is</p> <p>15 critical.</p> <p>16 For example, D1527 does not suggest that, taken in</p> <p>17 isolation, the events of 21 April or the events of</p> <p>18 24 April amount to torture, albeit they amount to</p> <p>19 inhuman and degrading treatment.</p> <p>20 On 24 April, he attempted suicide using a ligature.</p> <p>21 He was removed from association without proper legal</p> <p>22 authority, put on constant watch where his head was</p> <p>23 banged against a table by the officer responsible for</p> <p>24 constant watch.</p> <p>25 As Dr Hard explained in the evidence:</p> <p style="text-align: center;">Page 64</p>



<p>1 "Being put in isolation would then have exacerbated 2 and increased any detainee's thoughts of self-harm and 3 suicide, particularly where accompanied by abuse of this 4 kind." 5 While all of that which happened amounted, taken 6 alone, to inhuman treatment, it is accepted it doesn't 7 amount to torture, but those experiences on 24 April and 8 earlier on the 21st, when he was told his own self-harm 9 is prolonging his detention, an experience which led to 10 him attempting suicide that day, are highly relevant to 11 assessing whether his treatment in combination amounted 12 to torture. The suicide attempts he made on 25 April 13 were not some random, isolated event; they followed at 14 least two preceding suicide attempts and were triggered 15 by, and consequent upon, the E wing isolation which had 16 exacerbated his suicidality. On this day, the same 17 pattern followed: further verbal abuse, extreme physical 18 abuse, further humiliation and isolation in E wing and 19 further exacerbating his suicidality and sense of 20 powerlessness. His only recourse, at this point, was 21 food refusal, which he deployed. 22 By 4 May, we see the punishment for jumping on the 23 netting, for his behaviour. In this context, he is then 24 violently removed into isolation. 4 May was enacted 25 then as a living flashback, a reiteration and repeat of</p> <p style="text-align: center;">Page 65</p>	<p>1 &lt;HOM002917&gt;. 2 He continued to refuse food, his sense of 3 powerlessness multiplied and, when confronted with 4 evidence, the Home Office refused to release him. 5 The fourth question: was the mistreatment inflicted 6 for the purpose of intimidating or coercing him or was 7 it based on any discrimination? The unlawful detention 8 was designed to coerce him to leave the country. The 9 acts of violence, once detained, were inflicted to 10 intimidate or coerce D1527. The use of the threat, 11 "I am going to fucking put you to sleep" was designed to 12 intimidate him. The intimidatory impact, we have seen, 13 induces a panic attack on the footage. Mr Paschali's 14 own defence, that he adopted the choke hold to gain 15 compliance, is, even on his own account, intimidatory 16 and, indeed, coercive. 17 Similarly, as set out already, the use of removal 18 from association on 4 May can be seen to be riddled with 19 language of officers, particularly DCM Dix, setting up 20 their own ad hoc laws, which he was told he must comply 21 with. All of these threats and exertions of force were 22 evidently being used as forms of coercion and 23 intimidation. 24 Fifth: was the treatment inflicted by public 25 officials? There is no issue about that. All of the</p> <p style="text-align: center;">Page 67</p>
<p>1 the abuse of previous weeks. It could not have been 2 better designed to terrorise him, to exacerbate his 3 suicidality, self-harm and what, by then, had been 4 diagnosed as his PTSD. The repeated nature and duration 5 of the psychological terrorisation cannot be ignored in 6 assessing the severity of the impact on D1527 and 7 whether it amounted to torture. 8 Indeed, on the late, disclosed footage, Mr Dix is 9 heard to say that D1527 is taken to E wing, "but 10 obviously your behaviour will dictate how long you stay 11 here for. Makes sense?". It is impossible not to hear 12 the echo of the double bind Karen Churcher had imposed 13 on him two weeks earlier, in telling him that his own 14 self-harm would cause him to be detained longer. The 15 cycle of despair where self-harm occasions abuse that 16 occasions more self-harm was both tortuous and 17 torturous. 18 In assessing the severity of harm and whether it 19 amounts to torture, the inquiry looks to the subjective 20 experience and that involves looking at the totality of 21 the treatment. The inquiry must also have regard to 22 what happened after 4 May in the following five weeks. 23 In Dr Thomas's report on 21 May, she described: 24 "By that point, he was attempting suicide near 25 daily, with a high likelihood of success."</p> <p style="text-align: center;">Page 66</p>	<p>1 wrongs were from Home Office, medical and G4S officials. 2 Sixth: was the pain and suffering inherent or 3 incidental to a lawful sanction? No. The evidence is 4 clear there was no lawful sanction for any of this. 5 D1527 was not lawfully detained, he should not have been 6 there. Once detained, he should have been released, 7 within, at most, 48 hours pursuant to the proper 8 operation of rules 34 and 35. The complete failure of 9 that system meant he was not. The inquiry doesn't have 10 to speculate on that because the High Court came to the 11 view he should be released on 13 June, even on the 12 limited information available to it. 13 There was no authority for the trespasses to the 14 person while he was detained. The rule 40 removal from 15 associations it is quite clear were all not properly 16 authorised at the right level and not for purposes 17 within the ambit of rules 40 to 42. The correspondence 18 from the Home Office clarifies the only people who could 19 authorise rule 40 were Paul Gasson, as delegate of the 20 Secretary of State, or the manager, Ben Saunders. 21 Arguably, after 18 July, after D1527 left detention 22 when the DSO came into force, there were other delegates 23 in cases of urgency, but not relevant to his case. 24 Dr Hard was, in any event, of the view that quite 25 apart from the lack of personal authority, the routine</p> <p style="text-align: center;">Page 68</p>

<p>1 use of rule 40 for purposes which were not legitimate</p> <p>2 was evident across the evidence base to the inquiry.</p> <p>3 The pain-inducing techniques were clearly not</p> <p>4 lawful, as Mr Collier said in evidence in relation to</p> <p>5 4 May.</p> <p>6 So in conclusion, for these reasons, chair, you are</p> <p>7 invited to find that individual incidents and the</p> <p>8 treatment as a whole met the severity and the conditions</p> <p>9 for a finding that D1527 was tortured.</p> <p>10 Almost all of what happened to D1527 could, and</p> <p>11 would, have been avoided if the legal requirements of</p> <p>12 rules 34 and 35 or the Adults at Risk policy had been</p> <p>13 observed. There is an urgent need to address the system</p> <p>14 of failures, as there is on rule 40, where Mr Dix,</p> <p>15 a chief protagonist in the misuse of that rule, remains</p> <p>16 in position with greater authority and, as he and</p> <p>17 Steve Hower have both confirmed, defiance of the law</p> <p>18 continues in that regard too.</p> <p>19 D1527 therefore emphasises the following requests:</p> <p>20 firstly, that interim recommendations are made urgently.</p> <p>21 There are people in detention now subject to the same</p> <p>22 system failures and neglect to which the core</p> <p>23 participants in this inquiry were subject.</p> <p>24 On this, which is, in fact, the fifth anniversary of</p> <p>25 D1527's detention in Brook House, there has been no</p> <p style="text-align: center;">Page 69</p>	<p>1 as level 3 in the Adults at Risk policy within internal</p> <p>2 Home Office documentation and, in February 2017, his</p> <p>3 detention, proposed detention, was, in fact, rejected by</p> <p>4 the detention gatekeeper on grounds that there was no</p> <p>5 removal directions he was a safeguarding level 3 case.</p> <p>6 However, shortly after this, the Home Office</p> <p>7 arranged a charter flight and decided to recategorise</p> <p>8 his status under the Adults at Risk policy as level 2,</p> <p>9 so as to allow him to be detained prior to the charter</p> <p>10 flight. He ended up cuffed in a van, transported to</p> <p>11 Brook House on 6 April. A familiar pattern of the</p> <p>12 failure of the rule 35 process ensued and D2077 began</p> <p>13 refusing to eat, in this case, by way of hunger strike,</p> <p>14 before shortly afterwards sewing his lips together.</p> <p>15 This then entailed his removal from association for five</p> <p>16 days, no rule 35 assessment followed. After much work</p> <p>17 by his lawyers and the intervention of a medical report</p> <p>18 from a Medical Justice doctor, he was released on</p> <p>19 21 April.</p> <p>20 His is a case in which, following the first</p> <p>21 detention, he had been identified as a torture victim</p> <p>22 and as level 3. There is a glimpse here of how a system</p> <p>23 of screening vulnerable detainees could operate, so as</p> <p>24 to prevent the heinous detention of vulnerable people.</p> <p>25 However, when the imperative to remove him pressed,</p> <p style="text-align: center;">Page 71</p>
<p>1 direct apology, no compensation, no formal recognition</p> <p>2 of wrongdoing by any wrongdoer to him. You are asked,</p> <p>3 chair, to recommend the Secretary of State personally</p> <p>4 apologise to him. That might offer some form of</p> <p>5 psychological restorative.</p> <p>6 And, lastly, you are asked to acknowledge that D1527</p> <p>7 is not "a piece of shit", but a human being entitled to</p> <p>8 dignity as such. That he was subject to torture is</p> <p>9 a stigma which should lie against the Home Department as</p> <p>10 a spur for reform.</p> <p>11 I turn next to D2077. His submissions will be taken</p> <p>12 shortly for current purposes. You will recall, chair,</p> <p>13 he is a recognised refugee from Iran, who fled after</p> <p>14 multiple incidents of torture related to his</p> <p>15 Christianity. He suffers from PTSD and has a serious</p> <p>16 history of self-harm.</p> <p>17 The key feature of his case is that he had been</p> <p>18 detained at Tinsley House in 2016, where a rule 35(3)</p> <p>19 report confirmed he had mental and physical symptoms</p> <p>20 consistent with an account of torture, including being</p> <p>21 whipped in detention in Iran, and it was recorded he was</p> <p>22 suffering flashbacks in detention and, as a consequence,</p> <p>23 on 21 June, the Home Office agreed to release him.</p> <p>24 In November 2016, he attempted suicide, partly as</p> <p>25 a result of his fear of being detained. He was marked</p> <p style="text-align: center;">Page 70</p>	<p>1 the integrity of the Adults at Risk policy and the</p> <p>2 system around it was compromised and, in truth, this is</p> <p>3 another case of how the mere existence of policies and</p> <p>4 rules is no guarantee the Home Department will comply</p> <p>5 with the law.</p> <p>6 D2077 asks the inquiry find there was a clear breach</p> <p>7 of the procedural duties to anticipate and safeguard</p> <p>8 against article 3 mistreatment. This is a case in which</p> <p>9 the system failures led to an horrendous experience in</p> <p>10 detention of a vulnerable torture victim who should</p> <p>11 never have been detained. It was inhuman and degrading</p> <p>12 treatment and the inquiry is asked to so find.</p> <p>13 I turn next to D1538. D1538 was detained at</p> <p>14 Brook House during the relevant period on two separate</p> <p>15 occasions: 1 June 2017 to 14 June 2017; and, again,</p> <p>16 27 June to 15 July 2017.</p> <p>17 No adequate rule 34 process, no rule 35 assessment</p> <p>18 undertaken at Brook House, despite him asking for one --</p> <p>19 see &lt;DL000231&gt;, page 37, and a report was undertaken</p> <p>20 later at Harmondsworth, which led to an assessment that</p> <p>21 he was a level 2 Adult at Risk -- &lt;CJS007239&gt;. D1538</p> <p>22 found the environment and general conditions at</p> <p>23 Brook House to be stressful and humiliating. In his</p> <p>24 evidence to the inquiry, he emphasised the prolonged</p> <p>25 lock-ins, the lack of adequate medical attention, the</p> <p style="text-align: center;">Page 72</p>

<p>1 lack of privacy when using the toilet, the cramped, 2 smelly, noisy conditions which he found very scary. 3 He found the inability to communicate with interpreters 4 stressful, and there were delays in accessing legal 5 advice. 6 The impact of detention on him was to leave him "in 7 a constant state of not knowing and uncertainty", in his 8 words. He said he did not know when he was leaving, or 9 if he was leaving, and where he would be going. He says 10 Brook House is like a "forgotten prison with forgotten 11 prisoners". 12 Against this background, D1538 experienced, firstly, 13 unlawful use of force, and assault on 3 June, when DCO 14 Instone-Brewer, unreasonably denied 1538 the use of 15 a computer and instigated a verbal altercation with him. 16 DCO Fiddy intervened, dangerously pushing 1538 twice in 17 the area of his neck and head. Not an approved 18 technique. 19 Second, D1538 was then, as a punishment, transferred 20 to segregation without authorisation from the 21 Home Office and without justification in breach of 22 rule 40. 23 Third, on 6 June 2017, D1538 was attacked by another 24 detainee, D197. DCO Ryan Bromley and DCO Nick London 25 restrained D1538, and then DCM Steve Farrell grabbed</p> <p style="text-align: center;">Page 73</p>	<p>1 suicide; staff were callous and negligent and 2 indifferent to the suffering of his suicidal cellmate or 3 his own trauma. 4 He was subjected to two episodes of unlawful 5 segregation imposed without authorisation and as 6 punishment. 7 Individually, and cumulatively, the incidents of 8 physical and verbal abuse, as well as the impact of 9 conditions at Brook House and the lack of adequate care, 10 caused him pain, suffering, anguish, distress and trauma 11 over and above that which is incidental to lawful 12 detention, and breached article 3. 13 He also relies on a breach of the investigative 14 duty, in the inaccurate and dishonest reporting of these 15 incidents and the failure to investigate. 16 Then finally, chair, on D1914, you will recall he is 17 a Romanian national who was detained for four months in 18 Brook House Immigration Removal Centre. 19 You are asked to find that, as a whole, his 20 detention in Brook House constituted inhuman treatment 21 or degrading treatment. Alternatively, that various 22 incidents amounted to such treatment and that in his 23 case, too, procedural duties to anticipate and obviate 24 such treatment were breached, as were investigative 25 duties thereafter.</p> <p style="text-align: center;">Page 75</p>
<p>1 D1538's head and neck. Footage shows the use of force 2 was unlawful. All three officers provided inaccurate 3 use of force forms and dishonestly claimed the restraint 4 was to prevent 1538 from hitting his head on nearby 5 cabinets. DCO Bromley said to Callum Tulley four days 6 after the incident, that DCM Farrell had taken 7 "[D1538's] head clean off", referring to the grab of his 8 head and neck. D1538 was again taken to E wing to "cool 9 off", which amounted to unlawful de facto segregation, 10 not authorised under rule 40. 11 On 28 June 2017, Darren Tomsett said to 1538 he 12 "looked gay". D1538 was fearful of the reaction of 13 others and was proven right when other detainees mocked 14 him for days afterwards. On 4 July 2017, he witnessed 15 his cellmate, D865, attempt to kill himself by tying 16 a ligature and hanging it from a TV bracket. He was 17 scared and traumatised by this experience, which has had 18 a lasting impact on him. 19 The breach of article 3 duty in this case. 20 Firstly, the systems duty. He was exposed to 21 mistreatment by reason of systemic failures and the 22 corrupt and toxic institutional culture of abuse. 23 And of the operational duty, D1538 was subject to 24 assaults; homophobic abuse; witnessed a highly 25 distressing and traumatising incident of attempted</p> <p style="text-align: center;">Page 74</p>	<p>1 D1914 should never have been detained. He had won 2 an appeal against extradition on the basis of his 3 article 8 rights. He is an EU national with a wife and 4 child in the UK, and yet, in defiance of that finding, 5 the Home Office detained him on 30 March, 12 days prior 6 to even making a further deportation order served on 7 11 April. After many horrors, the Home Office appeared 8 before the Immigration Tribunal, unable to offer any 9 explanation as to why, on the appeal against the 10 deportation order to D1914's -- the approach to 11 article 8 family life rights should be any different to 12 that taken by the Divisional Court of the High Court in 13 relation to extradition. 14 His case is another one where, administratively, the 15 detention was a pointless exercise, serving not to 16 achieve any end related to immigration control, other 17 than to deform a man's life. 18 Once detained, he should have been released on 19 medical grounds; he was not. The Home Office record of 20 the decision to detain him described the pains in his 21 chest which were, in fact, associated with a serious 22 heart condition as "feigned illness". That he was three 23 times hospitalised whilst in detention and was awaiting 24 a heart operation spoke otherwise, albeit not to the 25 Home Office's ears.</p> <p style="text-align: center;">Page 76</p>

<p>1 In his case, the Home Office wrote to the detention 2 centre doctor, Dr Chaudhary, shortly after he was 3 detained, asking for that doctor to confirm that he was 4 fit to be detained and fit to fly. In a breach of 5 patient confidentiality, the doctor, without authority 6 from the patient, informed the Home Office he was indeed 7 fit for both. And, on 12 April, Dr Oozeerally also 8 asserted he was fit to fly and be detained. He remained 9 in detention.</p> <p>10 On 27 May 2021, Dr Oozeerally again compromised 11 medical ethics and deemed that D1914 was fit to fly and 12 to be detained, adding this time, that he was "happy for 13 control and restraint to be used".</p> <p>14 This time, that brief note had a crucial bearing 15 because it has been seen in footage and other evidence 16 that officers regarded this as a medical disclaimer, 17 meaning to one DCO, "If he dies, he dies"; it was 18 a licence to use inappropriate force against a man with 19 a serious heart condition.</p> <p>20 On that day, he was subjected to a fully-kitted use 21 of force, orchestrated again by Steve Dix, pursuant to 22 a blatant misuse of rule 40 to secure his translocation 23 to E wing prior to removal the following day. Not only 24 was there no proper authority for this removal from 25 association, in that it was not authorised by the</p> <p style="text-align: center;">Page 77</p>	<p>1 suicidality, is expressed clearly in this unlawful and 2 unnecessary use of isolation by the outlaws that 3 operated as officers in Brook House.</p> <p>4 As it transpired, he was not removed from the UK on 5 28 May, a sensible pilot apparently standing between the 6 Home Office and its attempts to cause further harm to 7 D1914. On his return to detention, his wrists bruised 8 from handcuffs, the DCOs were incensed. Some of the 9 footage we have seen shows officers referring to him by 10 racist epithets such as "traveller", Dan Lake 11 stigmatises him on the basis of a misunderstanding of 12 his criminal record, saying, "He doesn't rape kids, he 13 kills them".</p> <p>14 He was hospitalised three times for his heart 15 condition while in detention. On 5 July, he was refused 16 bail and he describes, at paragraph 190 of his witness 17 statement, that, at that point, he no longer wanted to 18 live, and, although never having tried to harm himself 19 before, he attempted to take his own life, taking 20 57 tablets and cutting himself with a razor. DCO Tulley 21 described the shocking amount of blood in his cell.</p> <p>22 Both Dr Chaudhary and Dr Oozeerally sought to defend 23 the medical ethics of disclosing his medical data, but 24 there is no justification for their conduct. It led 25 directly to dangerous and unlawful physical abuse on</p> <p style="text-align: center;">Page 79</p>
<p>1 Secretary of State, it was also not for a purpose 2 legitimised by rule 40 itself. The severity of the 3 psychological impact of the unlawful violence against 4 him is expressed at paragraph 151 of his statement: 5 "It felt like they were climbing all over me -- on 6 my arms, my back, on my head. I was shouting and 7 howling in pain. I was struggling to breathe. 8 I thought I might be dying. The pain in my chest was 9 very severe. At that moment, I felt I was looking at 10 death."</p> <p>11 He was taken in handcuffs to E wing, half-naked and 12 groaning from his medical conditions. There, he was 13 duly humiliated by a strip search, and made to sit in 14 plastic pants. He recalls that he felt like he would 15 rather die than go on like this.</p> <p>16 Mr Collier gave evidence as to the dangerous 17 practices deployed in the use of the shields on this 18 occasion, the techniques being deployed including a risk 19 of fatality. Having viewed the CCTV footage, Mr Collier 20 decried the fact that he was undressed in the removal 21 from association and concluded that handcuffs and PPE 22 were unnecessary as there was no physical threat to 23 staff.</p> <p>24 The evidence of Dr Hard, as to the impact of 25 isolation being to worsen the feelings of self-harm and</p> <p style="text-align: center;">Page 78</p>	<p>1 27 May. His case also exhibits the dangerous practice, 2 about which both doctors openly boasted, of replacing 3 the rule 35 system mandated by law, and for which 4 official channels are designed, with their own system of 5 sending part C forms to a different branch of the 6 Home Office.</p> <p>7 In his case, part Cs were issued on 11 April, 8 19 April, 27 May, 28 May, 3 June, 5 July, 6 July, 7 July 9 and 13 July. When he belatedly and finally managed to 10 obtain a rule 35 appointment on 17 July, nearly 11 three months after being detained, Dr Oozeerally finally 12 completed a rule 35 report, and, although it still took 13 a fairly long time to process, it was that document 14 which led to his release just in time for his heart 15 operation in August.</p> <p>16 In D1914's case, he was subjected to inhuman 17 treatment over the course of detention and to degrading 18 treatment over the course of detention, whose severity 19 is marked by the impact it had in rendering him 20 suicidal. Indeed, he very nearly managed to kill 21 himself as a direct result not of being detained, but of 22 being falsely imprisoned, and then, as a result of the 23 breakdown of systems designed to protect vulnerable 24 detainees from detention, of not being released.</p> <p>25 He describes how Brook House has had a lasting</p> <p style="text-align: center;">Page 80</p>

<p>1 impact on his mental health and that he continues to</p> <p>2 feel low. Particular factors in his mistreatment were:</p> <p>3 the unlawful decision making by the Home Office in</p> <p>4 detaining him; the absence of any screening mechanism to</p> <p>5 ensure relevant factors were taken into account about</p> <p>6 his health, and indeed immigration position, before or</p> <p>7 during detaining him; the medical practices of</p> <p>8 Dr Chaudhary and Dr Oozeerally in deeming him fit to be</p> <p>9 detained and fit to fly and fit to be subject to force,</p> <p>10 failing to comply with their duties under rules 34 and</p> <p>11 35; the routine, unlawful use of removal from</p> <p>12 association by officers, particularly Steve Dix, who</p> <p>13 neither enjoyed authority for such matters nor used it</p> <p>14 for lawful purposes; and the absence of any monitoring</p> <p>15 or checks and balances capable of picking up on the</p> <p>16 rampant outlawry exhibited in this case.</p> <p>17 The inquiry is invited to find that he was subjected</p> <p>18 to inhuman and degrading treatment both within the</p> <p>19 individual incidents and in his overall detention.</p> <p>20 There was a procedural systemic and operational failure</p> <p>21 to identify and protect and monitor D1914 as</p> <p>22 a vulnerable detainee in breach of the duties arising</p> <p>23 under article 3.</p> <p>24 Thank you.</p> <p>25 THE CHAIR: Thank you very much Mr Goodman.</p> <p style="text-align: center;">Page 81</p>	<p>1 For context, this is the 45th day that this inquiry</p> <p>2 has sat. It is 131 days since phase 1 of the inquiry</p> <p>3 started back in November of last year. That in itself</p> <p>4 seems a long time ago.</p> <p>5 You heard live evidence, chair that, D643 served in</p> <p>6 the British Army, in Kosovo, Bosnia and Iraq, and first</p> <p>7 began to experience the symptoms of post-traumatic</p> <p>8 stress disorder -- PTSD -- in 2007, after returning from</p> <p>9 service in Iraq where he had seen friends and colleagues</p> <p>10 die in horrendous circumstances. He made an attempt on</p> <p>11 his life in 2011, and spent three weeks in hospital</p> <p>12 before being discharged from the army in 2012. You also</p> <p>13 heard he was awarded compensation from the Ministry of</p> <p>14 Defence as a result of the debilitating effects of his</p> <p>15 PTSD.</p> <p>16 D643's case is, in many respects, the embodiment of</p> <p>17 all of the systemic failings in Brook House that this</p> <p>18 inquiry has heard about. Just a few examples.</p> <p>19 He suffered racist abuse from officers, including</p> <p>20 when he was so ill from food poisoning that he had</p> <p>21 passed out in his cell, being woken to hear</p> <p>22 Graham Purnell, a G4S officer, saying to him, "Why don't</p> <p>23 you go home, you fucking nigger, why are you pretending</p> <p>24 that you are sick?". He was mocked by other officers,</p> <p>25 including DCMs Andrew Lyden and Steve Webb, who told him</p> <p style="text-align: center;">Page 83</p>
<p>1 Mr Lee?</p> <p>2 Closing statement by MR LEE</p> <p>3 MR LEE: Thank you, chair, I shall be addressing you in</p> <p>4 closing concerning D643.</p> <p>5 Before I begin, just on behalf of D643, I would like</p> <p>6 to thank you, chair, counsel and solicitors to the</p> <p>7 inquiry legal team, and all of the support staff, for</p> <p>8 bringing this inquiry together with such care and such</p> <p>9 hard work. I will address you slightly later on about</p> <p>10 what it meant to D643 to be able to come and give live</p> <p>11 evidence to the inquiry.</p> <p>12 D643 spent a total of 558 days in Brook House over</p> <p>13 the course of four separate occasions. On the fourth</p> <p>14 occasion, he was detained for 504 consecutive days. He</p> <p>15 was detained in Brook House for the entire relevant</p> <p>16 period that the inquiry is concerned of and for</p> <p>17 substantial periods before and after it.</p> <p>18 He was never removed. He remains in the UK and he</p> <p>19 was paid substantial damages by the Home Office in</p> <p>20 respect of his unlawful detention in Brook House.</p> <p>21 No one has ever apologised to him.</p> <p>22 503 consecutive days in administrative detention is</p> <p>23 a scarcely believable amount of time. In and of itself,</p> <p>24 chair, you may consider that it shows that something</p> <p>25 very badly went wrong with D643's case.</p> <p style="text-align: center;">Page 82</p>	<p>1 he was pretending to be sick to avoid his removal from</p> <p>2 the country. On other occasions, he heard an officer</p> <p>3 say, "Why don't these blacks go back to their country?"</p> <p>4 and "All the blacks are the same".</p> <p>5 He describes a culture of disbelief from both guards</p> <p>6 and healthcare, a description wholly consistent with</p> <p>7 other evidence that has emerged during this inquiry and</p> <p>8 that you, chair, have seen and heard. He describes</p> <p>9 officers mocking and laughing at detainees who were</p> <p>10 mentally unwell, watching detainees in states of</p> <p>11 distress and laughing at them. Again, this is wholly</p> <p>12 consistent with footage that has been examined and other</p> <p>13 accounts of the toxic culture at Brook House. He</p> <p>14 described officers stating that detainees were</p> <p>15 pretending to be ill to avoid deportation, when, in</p> <p>16 fact, they were in profound mental health distress.</p> <p>17 He also describes a culture of complacency and</p> <p>18 indifference towards bullying and abuse from other</p> <p>19 detainees, and how he would be subject to homophobic and</p> <p>20 racist abuse. The guards would do nothing to intervene</p> <p>21 and sometimes even join in.</p> <p>22 He was subject to disproportionate use of force on</p> <p>23 at least two occasions. He was subjected to a rule 40</p> <p>24 removal from association that was clearly illegal, and</p> <p>25 he describes other more routine, more mundane and petty</p> <p style="text-align: center;">Page 84</p>

<p>1 cruelties, such as being refused toilet roll and other</p> <p>2 essential items, having post pushed under the cell door</p> <p>3 in the dead of night so that men would wake up to see it</p> <p>4 and fret that it was bad news about a removal flight or</p> <p>5 a decision on their immigration status. He talked of</p> <p>6 the frustration of men not being able to contact their</p> <p>7 lawyers because of poor internet connection and other</p> <p>8 inadequate communication facilities.</p> <p>9 But, chair, it was his treatment by healthcare staff</p> <p>10 that has had the deepest impact on him and that is, on</p> <p>11 any analysis, deeply shocking.</p> <p>12 In context, in many respects, D643 had huge</p> <p>13 advantages over many of the other detainees: he is</p> <p>14 an articulate man; he spent 11 years in the British</p> <p>15 Army; he speaks fluent English and understands how to</p> <p>16 operate in a hierarchical, structured and process-driven</p> <p>17 environment; he had experienced detention in other IRCs,</p> <p>18 and in prison, and he had even been tasked by the</p> <p>19 British Army to assist with the detention of people in</p> <p>20 Iraq.</p> <p>21 Despite all of this, he experienced catastrophic</p> <p>22 failures of care at every turn, beginning with the</p> <p>23 failures by the doctors to give him a proper physical</p> <p>24 and mental health examination on entry, failure to take</p> <p>25 the most basic of steps to check his previous medical</p> <p style="text-align: center;">Page 85</p>	<p>1 medico-legal report that triggered it in his medical</p> <p>2 record upon entry to Brook House on 21 December 2016.</p> <p>3 That careless, indifferent cruelty was to become the</p> <p>4 theme of his lengthy detention at Brook House. It was</p> <p>5 a shocking failure from the outset to comply with</p> <p>6 rule 34 and rule 35 of the Detention Centre Rules. It</p> <p>7 was a shocking breach of the duty of care to</p> <p>8 a vulnerable detainee.</p> <p>9 Chair, rules 34 and 35 of the Detention Centre Rules</p> <p>10 have been on the books for over 20 years. It is simply</p> <p>11 unbelievable that those in charge of healthcare at</p> <p>12 Brook House did not apply them properly. They are not</p> <p>13 despite what some corporate witnesses have said,</p> <p>14 complicated. They amount to a few sentences. They are</p> <p>15 the rules. To fail to apply one of the few safeguards</p> <p>16 that vulnerable detainees had to protect them is</p> <p>17 inexcusable and unforgivable.</p> <p>18 Let's not forget that the Home Office watched with</p> <p>19 folded arms as month after month, year after year passed</p> <p>20 and no rule 35(2) reports were issued and barely any</p> <p>21 rule 35(1) reports came through. Did this not pique</p> <p>22 anyone's curiosity as to what might be happening?</p> <p>23 Apparently not.</p> <p>24 Sandra Calver and Dr Oozeerally gave evidence that</p> <p>25 the Home Office never once raised any concerns about the</p> <p style="text-align: center;">Page 87</p>
<p>1 records when he was inducted, and a complete failure to</p> <p>2 identify, diagnose and to attempt to treat his mental</p> <p>3 health problems, including his complex combat-related</p> <p>4 PTSD.</p> <p>5 D643 was man who he liked to keep notes, to write</p> <p>6 things down, to keep a record. He diligently tried to</p> <p>7 follow the correct procedures, he made complaint after</p> <p>8 complaint, after complaint, about his treatment and the</p> <p>9 lack of engagement by healthcare staff. Those</p> <p>10 complaints either disappeared into the ether or took so</p> <p>11 long to considered as to be entirely useless.</p> <p>12 It must have been like shouting into a void.</p> <p>13 You have heard that when D643 entered Brook House on</p> <p>14 that fourth occasion, despite having had three previous</p> <p>15 health inductions and having been diagnosed with PTSD</p> <p>16 while he was in the army, subsequently whilst in prison,</p> <p>17 and in another IRC, there was simply no mention of PTSD</p> <p>18 in his health screening records.</p> <p>19 Despite having informed Brook House healthcare on</p> <p>20 previous documented occasions when he was there about</p> <p>21 this diagnosis, and of the previous treatment he needed</p> <p>22 and had received, and having, just two weeks previously,</p> <p>23 prior to his induction, had a rule 35(1) report issued</p> <p>24 at the Verne on the basis of his PTSD, there was no</p> <p>25 mention of that diagnosis, the rule 35(1) report or the</p> <p style="text-align: center;">Page 86</p>	<p>1 lack of those rule 35 reports. Why? I think we know</p> <p>2 the answer.</p> <p>3 Dr Hard gave evidence that the treatment, or lack of</p> <p>4 it, of D643 indicated both a systemic failure in the</p> <p>5 screening process and the application of the rule 34 and</p> <p>6 35 processes, and was indicative to be accepted of</p> <p>7 a lack of a system to identify and cross-refer to</p> <p>8 previous medical history.</p> <p>9 Dr Hard also agreed that if someone like D643, who,</p> <p>10 as I said, spoke fluent English, he was articulate, he</p> <p>11 was able to identify precisely what he required to treat</p> <p>12 his PTSD, having received that treatment before, if he</p> <p>13 could not obtain the treatment he required, it would be</p> <p>14 practically impossible for someone, who did not share</p> <p>15 those advantages, to get adequate treatment.</p> <p>16 It is worth pausing to think what that means. It</p> <p>17 means it is likely that hundreds of detainees, during</p> <p>18 the relevant period, and before and after, whose names</p> <p>19 we will never know, and whose stories will never be</p> <p>20 told, suffered in similar ways.</p> <p>21 To suggest that what we have seen in this inquiry</p> <p>22 amounts to a series of isolated incidents is, with the</p> <p>23 greatest respect, utter nonsense.</p> <p>24 D643 describes being particularly upset at the</p> <p>25 callous indifference of Drs Chaudhary and Oozeerally,</p> <p style="text-align: center;">Page 88</p>

<p>1 callous indifference, you may find, chair, which is</p> <p>2 wholly corroborated by the evidence you have seen in</p> <p>3 this inquiry. The examples are many, but I shall</p> <p>4 mention, because of the time restraints, just four.</p> <p>5 On 12 June 2017, Dr Chaudhary confirmed to the</p> <p>6 Home Office in a letter that D643 was fit to be detained</p> <p>7 and fit to fly, and that was despite not examining D643,</p> <p>8 not referring to any of his mental health difficulties</p> <p>9 and not having even seen him for three months. No doubt</p> <p>10 the good doctor was just giving the customer, the</p> <p>11 Home Office, what he knew they wanted.</p> <p>12 In July 2017, D643 tried to give healthcare three</p> <p>13 separate medico-legal reports commissioned by his</p> <p>14 solicitors that confirmed he was not fit for detention.</p> <p>15 The doctors refused to look at them.</p> <p>16 Pausing there, it is, of course, not enough simply</p> <p>17 to point the finger at the two careless doctors. Those</p> <p>18 medical reports were provided to the Home Office, yet</p> <p>19 detention review after detention review kept authorising</p> <p>20 detention.</p> <p>21 In January 2018, D643 tried to tell Dr Chaudhary</p> <p>22 that he was suicidal and needed help, but was turned</p> <p>23 away and told he could not help him. Of course, it goes</p> <p>24 without saying that no rule 35(2) report was even</p> <p>25 contemplated.</p> <p style="text-align: right;">Page 89</p>	<p>1 was, in fact, released.</p> <p>2 D643 informed healthcare on numerous occasions that</p> <p>3 he was feeling suicidal and he had been identified by</p> <p>4 members of the healthcare team as having suicidal</p> <p>5 ideations on four other separate occasions. No rule 35</p> <p>6 report was ever produced.</p> <p>7 Dr Hard gave evidence that it was inevitable that</p> <p>8 the detention of a man like D643 for an indefinite</p> <p>9 period, day after long day, week after long week, asking</p> <p>10 for help for his mental distress and receiving none in</p> <p>11 return, would damage him. The damage was long lasting.</p> <p>12 Indeed, it continues. D643 ended his witness statement</p> <p>13 by stating:</p> <p>14 "When I was released from detention, I was referred</p> <p>15 by my GP to receive treatment from a psychiatrist at</p> <p>16 a mental health hospital. My faith in medical</p> <p>17 professionals had been so shaken by the treatment I had</p> <p>18 received in the Brook House healthcare that I was</p> <p>19 extremely anxious. I did not feel able to trust the</p> <p>20 psychiatrist on meeting her. It was as though I was</p> <p>21 waiting for her to disbelieve me or to act in a hostile</p> <p>22 manner that I had been customised to at Brook House.</p> <p>23 I was unable to move past my fear that she would turn</p> <p>24 out to be like the healthcare staff and doctors at</p> <p>25 Brook House and, as a result, I did not feel able to</p> <p style="text-align: right;">Page 91</p>
<p>1 In February 2018, D643 went to Dr Oozeerally again</p> <p>2 and attempted to get help on the basis that his mental</p> <p>3 health was deteriorating. Again, no help was proffered</p> <p>4 and D643 was told that the doctor had no time to waste</p> <p>5 on him. Again, it goes without saying that no rule 35</p> <p>6 report was produced.</p> <p>7 Finally, on 12 March 2018, despite all that had gone</p> <p>8 before, despite the medico-legal reports, the obvious</p> <p>9 mental health distress and the length of his detention,</p> <p>10 Dr Oozeerally wrote to the Home Office stating that D643</p> <p>11 was fit for detention, fit to fly, and was getting</p> <p>12 adequate care.</p> <p>13 This was despite the fact that he had not examined</p> <p>14 D643, and D643 was not, in fact, receiving any care at</p> <p>15 all from healthcare at this time. It was careless</p> <p>16 cruelty.</p> <p>17 Finally, and just ten days later, on 22 March 2018,</p> <p>18 in a stunning and absurd volte face, Dr Chaudhary wrote</p> <p>19 to the Home Office and informed them that D643 was</p> <p>20 indeed in need of specialist PTSD treatment which was</p> <p>21 not available in detention, and he was, therefore, not</p> <p>22 fit to be detained. That was 457 days since D643 had</p> <p>23 entered Brook House with a previous diagnosis of complex</p> <p>24 combat-related PTSD. It was careless cruelty of the</p> <p>25 worst kind. It would even be another 47 days before he</p> <p style="text-align: right;">Page 90</p>	<p>1 attend any further sessions with her. Even now, after</p> <p>2 four years later, I do not feel that I have fully</p> <p>3 recovered from the treatment I was subjected to at</p> <p>4 Brook House. I still suffer from flashbacks, in</p> <p>5 particular in relation to the use of force incidents</p> <p>6 outlined above and the way I was treated by the</p> <p>7 healthcare professionals, in particular Dr Chaudhary and</p> <p>8 Dr Oozeerally."</p> <p>9 In hindsight, nobody has, or could, defend the</p> <p>10 detention of D643 in Brook House. He has received</p> <p>11 damages for unlawful detention, but he has never</p> <p>12 received an apology or an indication as to what period</p> <p>13 the Home Office accept was unlawful.</p> <p>14 Karen Churcher gave evidence that it was not</p> <p>15 an environment where it was possible, or even</p> <p>16 appropriate, to attempt to give trauma-based therapy,</p> <p>17 and this must have been known from the outset.</p> <p>18 Sandra Calver gave evidence the detainees did not</p> <p>19 have access to appropriate psychiatric treatment and</p> <p>20 that detention centres were not the appropriate</p> <p>21 environment to promote recovery from mental ill-health.</p> <p>22 Everyone from the Royal College of Psychiatrists to</p> <p>23 Dr Hard, and to even the former DCOs that you've heard</p> <p>24 from, agree that it is not a suitable place for a man</p> <p>25 with PTSD or other mental health difficulties.</p> <p style="text-align: right;">Page 92</p>

<p>1 The Home Office are the apparently the only people who 2 disagree. 3 You have heard that it is not just that recovery is 4 impossible for those with PTSD, Dr Hard and others 5 confirmed that detainees are positively harmed by being 6 detained in those circumstances. And so it was with 7 D643. 8 Finally, chair, what does D643 ask of the inquiry? 9 As I mentioned, he is profoundly grateful to have been 10 given an opportunity to give evidence. 11 He has emphasised repeatedly to his legal team that 12 the simple act of being listened to, of being taken 13 seriously, of being given an opportunity to put on the 14 record what happened to him, is of immense value to him. 15 He is profoundly grateful to Callum Tulley for shining 16 a light into this dark episode of his life. 17 As for recommendations, we will go into more detail, 18 chair, in our written submissions, but, briefly, the 19 system of indefinite detention harms people; it is 20 cruel. The system of detaining the mentally ill and the 21 vulnerable harms people; it is cruel. 22 It does not matter what the corporate logos are on 23 the uniforms or what banal corporate values are 24 displayed on posters on the walls, the system brutalises 25 those that are expected to work in it, it harms those</p> <p style="text-align: center;">Page 93</p>	<p>1 about that. Thank you very much. 2 MS LUH: I will do my best to keep to that. 3 THE CHAIR: Thank you. 4 Closing statement by MS LUH 5 MS LUH: I make these submissions on behalf of D801, D1275, 6 D1713, D2158 and D1473. On behalf of them, I thank the 7 chair, counsel and solicitors to the inquiry for giving 8 them a voice in this inquiry. 9 If I can just say at the outset, as a shortcut, that 10 each one of them was subjected to a regime which Dr Hard 11 described as "completely deprived of safeguards". It 12 was inevitable that they would experience mental 13 suffering of the kind prohibited by article 3 and in 14 particular, in the circumstances where none of them knew 15 when the situation was going to end, it was, for them -- 16 the detention was, for them, interminable. 17 If I can take you to D801 first, everything that the 18 Home Office knew about D801 should have, but did not, 19 prevent him from being detained on 1 March. The 20 Home Office knew that he suffers psychotic depression, 21 PTSD, and had attempted to overdose twice in the 22 community. The Home Office had medical evidence that 23 a previous period of detention in 2015 contributed to 24 this and, had they bothered to look at the reports, they 25 patently show that he was an Adult at Risk, level 3, the</p> <p style="text-align: center;">Page 95</p>
<p>1 who are detained within it, and it rewards the careless 2 cruelty of those who displayed indifference to D643's 3 suffering again and again. Tinkering with the machinery 4 of this cruelty will not end it. Nothing short of 5 a radical change will ensure what happened to D643 and 6 the other men you have heard from will not happen again. 7 As for Brook House itself, Brook House is simply 8 a symptom, a morbid symptom of a sick system, 9 a category B prison that is not a category prison, 10 a 72-hour removal centre that is nothing of the sort. 11 It is a place of harm, it is a place of shame, and it 12 should be shut for good. 13 Perhaps it should be turned into a museum, chair, 14 and future generations can visit it, read the 15 testimonies of the men who were shut up in it, watch the 16 footage that triggered this inquiry in the first place, 17 and shake their heads in wonder as to how it ever came 18 to this. 19 Thank you, chair. 20 THE CHAIR: Thank you very much, Mr Lee. 21 I wonder whether we actually take our lunch now -- 22 I am so sorry, Ms Luh, do you -- are you able to give me 23 an indication of how long you are likely to need? 24 MS LUH: I had planned on only being 20 minutes. 25 THE CHAIR: Let's go ahead and do that then. I'm sorry</p> <p style="text-align: center;">Page 94</p>	<p>1 highest level, and that he would be harmed if 2 redetained. 3 There was no fixed date for removal, and he was not 4 a public protection concern case. Therefore, he should 5 not have ever been in Brook House in 2017. 6 Dr Hard's critique of the treatment of D801 in 7 detention speaks for itself. He said in oral evidence 8 that, although not physically assaulted by staff or 9 verbally abused, leaving D801 in detention for this 10 period of time of a total of 34 days caused him to 11 suffer ill-treatment because none of the safeguards that 12 were meant to function to remove him from detention 13 worked. 14 D801 was a really good example, Dr Hard said, of 15 a complete inattention of the understanding of the 16 purpose of the rules and the imperative to relay that 17 information to the Home Office at the earliest 18 opportunity with a mechanism that would have meant 19 a review of detention was undertaken at that point in 20 time. 21 At every opportunity, the safeguards failed. There 22 was no rule 35(1), (2) or (3) raised throughout the 23 entirety of his detention until the very last day, when 24 a rule 35(1) was completed by Dr Chaudhary, only because 25 Dr Belda, the IRC psychiatrist, said unequivocally that</p> <p style="text-align: center;">Page 96</p>

24 (Pages 93 to 96)



<p>1 D801 was not suited for detention.</p> <p>2 All the signs of this was apparent long before</p> <p>3 Dr Belda made that statement on 31 March 2017. D801 was</p> <p>4 someone that the Home Office and healthcare knew</p> <p>5 required treatment that was unavailable in detention.</p> <p>6 Dr Belda told them so on day two, but this did not cause</p> <p>7 the Home Office to recognise that this was a seriously</p> <p>8 unwell man who, as someone on a proper application of</p> <p>9 the Adults at Risk policy, should not remain in</p> <p>10 detention. There was no contemplation of other</p> <p>11 alternatives to detention, namely, release into the</p> <p>12 community when a hospital transfer was declined a week</p> <p>13 later.</p> <p>14 Instead, D801 was managed unlawfully, contrary to</p> <p>15 good psychiatric care, in de facto segregation on</p> <p>16 E wing, subject to ACDT the whole time, at the</p> <p>17 beginning, on constant watch. You have heard a lot of</p> <p>18 evidence of how this is not treatment, and did nothing</p> <p>19 to prevent deterioration.</p> <p>20 In fact, in D801's case he tried to kill himself</p> <p>21 using a shoelace as a ligature, and razors, whilst on</p> <p>22 ACDT, but even that didn't trigger any statutory</p> <p>23 reporting mechanisms under rule 35. There were a total</p> <p>24 of four part Cs sent to the Home Office, each uploaded</p> <p>25 onto the system, each ignored.</p> <p style="text-align: center;">Page 97</p>	<p>1 know how to seek help. His severe mental health issues</p> <p>2 were unidentified, managed or treated at all at</p> <p>3 Brook House, and this was despite recurring health logs,</p> <p>4 citing his bizarre and sometimes aggressive behaviour</p> <p>5 and incoherent answers to questions. Even the Iranian</p> <p>6 consulate raised concerns with the Home Office about his</p> <p>7 strange behaviour. Instead, and frequently, D1275's</p> <p>8 behaviour was seen as refractory and was managed by</p> <p>9 segregation for extended periods of time. At</p> <p>10 Brook House, he was repeatedly referred to the mental</p> <p>11 health team and repeatedly discharged from that team's</p> <p>12 case load. No one bothered to do the basic checks to</p> <p>13 find out why he had missed so many appointments.</p> <p>14 Karen Churcher and Sandra Calver were both resolved to</p> <p>15 say that attendance at medical appointments was a matter</p> <p>16 of patient's choice, irrespective of vulnerabilities.</p> <p>17 His non-attendance was described in terms of wasted</p> <p>18 hours and resources of the mental health team, rather</p> <p>19 than symptomatic of a seriously unwell man. Neither</p> <p>20 contemplated that he could lack mental capacity to make</p> <p>21 decisions about accessing medical treatment or speak up</p> <p>22 for himself about his detention or conditions of</p> <p>23 detention. There was no practice to do so. They didn't</p> <p>24 know how to do so. Ms Calver accepted, and rightly so,</p> <p>25 that this was a serious failure in knowledge and care.</p> <p style="text-align: center;">Page 99</p>
<p>1 The only treatment following his suicide attempt was</p> <p>2 advice to him on how to snap an elastic band around his</p> <p>3 wrist to help him cope with stress. It is not hard to</p> <p>4 begin to understand that this cannot be treatment of the</p> <p>5 kind necessary for him.</p> <p>6 You will recall Dr Bingham's evidence that detention</p> <p>7 has the effect of forcing victims of torture to relive</p> <p>8 their past torture as if it was happening to them again.</p> <p>9 There is no doubt, from D801's narrative to</p> <p>10 an independent expert, Dr Sen, that he suffered</p> <p>11 article 3 inhumane and degrading treatment at</p> <p>12 Brook House, and Dr Sen summarises:</p> <p>13 "He could not eat and was throwing up all time. He</p> <p>14 just stayed inside his room and didn't want to socialise</p> <p>15 with anyone. The food tasted to him as if he was eating</p> <p>16 a pair of glasses, like it was burning. He didn't wish</p> <p>17 to explain anything to the authorities, just stayed away</p> <p>18 from the food, and the whole experience felt to him like</p> <p>19 walking on fire. Every single day felt as if there was</p> <p>20 biting on his skin and he physically felt the pain."</p> <p>21 D1275. But for this inquiry, the true nature of the</p> <p>22 ill-treatment suffered by D1275 at Brook House would</p> <p>23 never have come to light. He was so severely unwell</p> <p>24 during the time he was there that he couldn't even</p> <p>25 describe his experiences to anyone in a coherent way and</p> <p style="text-align: center;">Page 98</p>	<p>1 D1275 was just left to languish. But for the</p> <p>2 tenacity of Naomi Blackwell, a caseworker at GDWG, he</p> <p>3 could have remained in detention indeterminately in</p> <p>4 an environment that discriminated against him because</p> <p>5 the Home Office has refused to make provision for</p> <p>6 independent advocacy for people who lack mental</p> <p>7 capacity. By the time GDWG found him, he had been in</p> <p>8 detention for nearly 400 days, even though the</p> <p>9 Home Office knew long before that he could not be</p> <p>10 removed. He would remain in detention for 616 days, 442</p> <p>11 at Brook House, before he was able to access lawyers and</p> <p>12 secure release. Dr Hard said in oral evidence that it</p> <p>13 was inevitable that a vulnerable detainee, subjected to</p> <p>14 this kind of length, would suffer harm and, in fact,</p> <p>15 even someone who didn't have these issues would find it</p> <p>16 difficult and would deteriorate in an environment like</p> <p>17 this.</p> <p>18 Sandra Calver accepted serious omissions in this</p> <p>19 case, causing him significant ill-treatment.</p> <p>20 His immediate hospitalisation on release under the</p> <p>21 Mental Health Act for nearly half a year clearly</p> <p>22 demonstrates the extent of his mental deterioration and</p> <p>23 how unsuited he was for immigration detention. We all</p> <p>24 now know too familiarly the footage from 14 June 2017</p> <p>25 where he was cruelly and casually mocked by</p> <p style="text-align: center;">Page 100</p>

25 (Pages 97 to 100)

<p>1 DCM Nathan Ring and DCO Derek Murphy with derogatory</p> <p>2 remarks, including "div", "scrotum" and the more</p> <p>3 chilling and recurring phrase that has been used at</p> <p>4 Brook House, "If he dies, he dies". All this while he</p> <p>5 was suffering the acute effects of a spice attack.</p> <p>6 A nurse present for the mockery didn't challenge it, in</p> <p>7 fact, joined in with, "Homey is after your coke". The</p> <p>8 evidence before the inquiry shows that it was widely</p> <p>9 known that he was vulnerable and being exploited as</p> <p>10 a guinea pig for spice. No one did anything to stop it.</p> <p>11 No one reported it. They just watched it happen and</p> <p>12 some joined in to mock him. It was callous, but allowed</p> <p>13 to be repeated because of a culture of impunity and</p> <p>14 dehumanisation that pervaded Brook House, which</p> <p>15 normalised this kind of behaviour and suppressed</p> <p>16 dissent.</p> <p>17 He still is not able to speak about his experience</p> <p>18 at Brook House. When his solicitor Hamish Arnott tried,</p> <p>19 he became distressed. This fragility of his mental</p> <p>20 state, still, is a product of the intense mental</p> <p>21 suffering he experienced in prolonged immigration</p> <p>22 detention and an article 3 breach is inescapable in his</p> <p>23 case.</p> <p>24 D1713 is a victim of torture, sexual and physical</p> <p>25 abuse with pre-existing PTSD before entering Brook House</p> <p style="text-align: center;">Page 101</p>	<p>1 nothing to prevent him from re-experiencing, over and</p> <p>2 over again, his torture in the form of intrusive</p> <p>3 flashbacks.</p> <p>4 Not one nurse carrying out ACDT reviews thought to</p> <p>5 refer him for rule 35 assessment, despite repeated</p> <p>6 disclosure of torture, flashbacks and self-harm. Whilst</p> <p>7 detained, he was the target for derogatory and demeaning</p> <p>8 comments. One DCO compared him to locking up a dog. He</p> <p>9 felt humiliated, scared, "Like I was not being seen or</p> <p>10 treated as a human being". He was powerless to do</p> <p>11 anything because, "We were all scared of the</p> <p>12 consequences of speaking out, we were living in fear.</p> <p>13 Brook House was like hell". He is now scared to go to</p> <p>14 sleep at night, scared to close his eyes, fearing that</p> <p>15 the experiences that he had at Brook House would flash</p> <p>16 through his mind. Detention at Brook House spawned</p> <p>17 a severe episode of depression and has had a lasting</p> <p>18 effect which an independent expert, Dr Galappathie, has</p> <p>19 said has a poor prognosis for recovery.</p> <p>20 D2158's experience is very similar. He was not</p> <p>21 pre-screened before detention, despite being of a victim</p> <p>22 of torture or sexual abuse. He was detained unlawfully</p> <p>23 for the whole time he was at Brook House because there</p> <p>24 was no power to detain someone like him. Although he</p> <p>25 was liable to be returned to Germany under the</p> <p style="text-align: center;">Page 103</p>
<p>1 in March 2017. He is a classic illustration of the</p> <p>2 lasting mental harm caused by a complete deprivation of</p> <p>3 safeguards. No questions were asked at health screening</p> <p>4 to identify any past history of trauma or torture.</p> <p>5 Within hours of being at Brook House, he was asking to</p> <p>6 see a GP because he was experiencing flashbacks from</p> <p>7 being detained. Although he disclosed self-harm</p> <p>8 ideation and torture to Dr Chaudhary, no rule 35(3)</p> <p>9 report was raised and no rule 35(1) was raised.</p> <p>10 Dr Chaudhary could not give a coherent answer for why</p> <p>11 this was the case. He said he thought he needed to wait</p> <p>12 and see if D1713 actually deteriorated, which plainly is</p> <p>13 not what the rules say.</p> <p>14 We now know, of course, that Dr Chaudhary didn't</p> <p>15 understand what the rule 35 safeguard required of him as</p> <p>16 a doctor or why, which, as Dr Hard said, put detainees</p> <p>17 like D1713 directly in harm's way.</p> <p>18 The Home Office treated his self-harm, trauma and</p> <p>19 past torture as self-declared, of no value as far as the</p> <p>20 Adults at Risk policy was concerned. This reflected, of</p> <p>21 course, the culture of disbelief built into the evidence</p> <p>22 levels of the risk, but in circumstances, also, where</p> <p>23 the Home Office failed to ensure the safeguards linked</p> <p>24 to it actually functioned.</p> <p>25 Again, the only treatment was ACDT, which did</p> <p style="text-align: center;">Page 102</p>	<p>1 Dublin Regulations, the tension could only be applied to</p> <p>2 someone like him if he was at significant risk of</p> <p>3 absconding, and he was not.</p> <p>4 Once detained, again, there were no rule 34</p> <p>5 appointments, there were no rule 35 appointments. In</p> <p>6 the meantime, he suffered worsening heart palpitations</p> <p>7 and nightmares and often felt like someone was putting</p> <p>8 their hands around his throat and he struggled to</p> <p>9 breathe. The sounds of doors opening, banging and the</p> <p>10 sounds of keys would make his whole body shake and he</p> <p>11 would feel an electric shock in his body. He couldn't</p> <p>12 convey the intensity of his mental anguish and physical</p> <p>13 suffering because, each time he went to healthcare, he</p> <p>14 was not given an interpreter. So the rule 35 assessment</p> <p>15 he finally got from Dr Oozeerally was cursory and</p> <p>16 careless and didn't address the impact of detention on</p> <p>17 him as a victim of torture, who was suffering recurring</p> <p>18 trauma symptoms and heart palpitations. His report was</p> <p>19 one of three quarters of the rule 35 reports at</p> <p>20 Brook House at the time which failed to address the</p> <p>21 impact of detention. The Home Office relied on that to</p> <p>22 keep him in detention, so that he could suffer even</p> <p>23 more.</p> <p>24 When he commenced a period of food refusal because</p> <p>25 he felt he had no alternative, this was dismissed as</p> <p style="text-align: center;">Page 104</p>

26 (Pages 101 to 104)

<p>1 a dietary issue with no investigation into his</p> <p>2 escalating trauma symptoms and deteriorating mental</p> <p>3 health. Whilst detained, he was kicked by different</p> <p>4 custody officers on two occasions and also bullied and</p> <p>5 demeaned. The violence was unprovoked, doled out</p> <p>6 casually with the intent of intimidating, demeaning and</p> <p>7 humiliating.</p> <p>8 He couldn't complain, he didn't know how, and he was</p> <p>9 afraid to because, at night, he often heard other</p> <p>10 detainees screaming in pain after lock-in. He thought</p> <p>11 they were being physically assaulted by officers. He</p> <p>12 didn't want it to happen to him. Such was the culture</p> <p>13 of fear detainees were subjected to at Brook House.</p> <p>14 Finally, D1473, his mistreatment at Brook House is</p> <p>15 graphically illustrated by the prolonged and excessive</p> <p>16 restraint he suffered for some five and a half hours</p> <p>17 during an attempted unlawful removal whilst at</p> <p>18 Brook House. Whilst the force used -- the waist</p> <p>19 restraint belt was applied by Tascor officers, it was</p> <p>20 initiated on Brook House premises with the knowledge and</p> <p>21 apparent supervision of G4S and Home Office staff.</p> <p>22 There was simply no justification for this</p> <p>23 restraint, it was unplanned, because there was no risk</p> <p>24 assessment to suggest he should be restrained for</p> <p>25 removal. He was compliant throughout the removal</p> <p style="text-align: center;">Page 105</p>	<p>1 normalisation of the use of force in the centre. It was</p> <p>2 reckless, inhumane and degrading, especially when</p> <p>3 deployed for prolonged periods of time. The entrenched</p> <p>4 failure of the Home Office and its contractors to even</p> <p>5 appreciate and recognise this is illustrated by the</p> <p>6 PSU's response to the complaint made by D1473 concerning</p> <p>7 his restraint, categorising it as a "minor misconduct".</p> <p>8 On behalf of all of these individuals, I endorse</p> <p>9 Ms Harrison's submissions on the need for urgent interim</p> <p>10 recommendations so as to bring to an end, finally, the</p> <p>11 deprivation of safeguards which continue to this day to</p> <p>12 currently affect detainees in Brook House. This has to</p> <p>13 stop and it has to stop now.</p> <p>14 Thank you very much.</p> <p>15 THE CHAIR: Thank you very much, Ms Luh.</p> <p>16 Thank you.</p> <p>17 I appreciate you keeping to that time. Much</p> <p>18 appreciated. We are going to break for lunch now and</p> <p>19 I am still going to keep us to 2.00 to make sure we</p> <p>20 don't slip from the timetable. Thank you, see you at</p> <p>21 2.00.</p> <p>22 (1.05 pm)</p> <p>23 (The short adjournment)</p> <p>24</p> <p>25 (2.00 pm)</p> <p style="text-align: center;">Page 107</p>
<p>1 process from start to finish and presented no actual</p> <p>2 risk to anyone. And more importantly, it is another</p> <p>3 case where it should never have happened, because D1473</p> <p>4 was not removable at the time. He had outstanding</p> <p>5 representations on article 8 grounds and he was</p> <p>6 recognised as an Adult at Risk, level 3, and manifestly</p> <p>7 unsuitable for detention and on ACDT.</p> <p>8 Mr Shaw, in 2014, in a report prepared by the</p> <p>9 Advisory Panel on Non-compliance Management, identified</p> <p>10 the use of a waist restraint belt in these circumstances</p> <p>11 as inimical to the person's dignity. The duration and</p> <p>12 effects of this use of force against D1473 actually</p> <p>13 caused mental and physical suffering. In his own words:</p> <p>14 "It was terrifying and humiliating from start to</p> <p>15 finish. I was treated like an animal you were</p> <p>16 transporting. The terror was indescribable."</p> <p>17 His is but one of many cases concerning routine</p> <p>18 misuse of a waist restraint belt to facilitate the</p> <p>19 discharge of vulnerable detainees to Tascor officers.</p> <p>20 Other examples include the removals of 1234 and D2054,</p> <p>21 both forcibly restrained whilst naked and subsequently</p> <p>22 placed in waist restraint belts on handover to Tascor.</p> <p>23 The routine use of passive restraints in these</p> <p>24 circumstances, with no prior consideration of the risk</p> <p>25 of vulnerabilities of the person, reflected the general</p> <p style="text-align: center;">Page 106</p>	<p>1 THE CHAIR: Thank you. Mr Armstrong, thank you.</p> <p>2 MR ARMSTRONG: Now I am going to work out which of these</p> <p>3 microphones work. It sounds like that one is.</p> <p>4 Thank you, chair. I hope -- does that sound like</p> <p>5 it's working to you?</p> <p>6 THE CHAIR: It does to me.</p> <p>7 Closing statement by MR ARMSTRONG</p> <p>8 MR ARMSTRONG: Chair, my purpose this afternoon is to try to</p> <p>9 persuade you to be clear and definitive in your findings</p> <p>10 and to be bold in your recommendations. I do that</p> <p>11 because this inquiry is unique, it has not been done in</p> <p>12 this area before, the Home Office didn't want it, and</p> <p>13 they probably won't do it again.</p> <p>14 There have, of course, been investigations, there</p> <p>15 have been years of them -- Yarl's Wood, Oakington,</p> <p>16 Shaw -- I know that you know about all of those.</p> <p>17 There has also been years of litigation, there have</p> <p>18 been inquests, we have heard about Jimmy Mubenga and</p> <p>19 Prince Fosu, but there has been nothing like this.</p> <p>20 There has certainly not been the volume and range and</p> <p>21 intensity of the oral evidence you have had. Litigation</p> <p>22 in this area is almost always judicial review or</p> <p>23 tribunal and it almost never has much in the way of oral</p> <p>24 evidence.</p> <p>25 Inquests have a bit more, but they are necessarily</p> <p style="text-align: center;">Page 108</p>

27 (Pages 105 to 108)

<p>1 limited in their scope and they certainly don't have the</p> <p>2 assistance that you have had from the solicitor and</p> <p>3 counsel to the inquiry teams, who have worked as hard as</p> <p>4 they have worked for as long as they have worked.</p> <p>5 So you are in this unique position.</p> <p>6 It is also, of course, the fact that none of that</p> <p>7 previous work prevented what we have seen in 2017 in</p> <p>8 Brook House. And it also appears that, even when</p> <p>9 Panorama came out in September 2017, as happened</p> <p>10 previously with Yarl's Wood and Oakington, the secret</p> <p>11 recording itself was not enough to stop things. Serious</p> <p>12 problems continued. And you have heard evidence post</p> <p>13 the relevant period about what has happened when</p> <p>14 pressures have been put back on the system, including</p> <p>15 things like Dublin removals and small boats and you have</p> <p>16 heard evidence, even from Mr Hewer last week, about</p> <p>17 constant watches, there were two constant watches in the</p> <p>18 centre and still it appears in 35(2) reports. So those</p> <p>19 problems remain. All of that is, of course, with the</p> <p>20 spotlight of this inquiry on it.</p> <p>21 A key question of concern, certainly for those</p> <p>22 I represent, is what happens when that spotlight is</p> <p>23 taken away again, and how much and to what extent do</p> <p>24 things slide because, certainly in this area, things</p> <p>25 always slide.</p> <p style="text-align: center;">Page 109</p>	<p>1 PTSD, and you may remember how he was on the stand,</p> <p>2 struggling to give his evidence.</p> <p>3 The parade of unreconstructed men, the DCOs, unled</p> <p>4 and unguided in their attitudes.</p> <p>5 One or two people tried to stand up to it, but they</p> <p>6 got nowhere. So you heard from Owen Syred, you heard</p> <p>7 of, and we have seen evidence from, David Waldock, and</p> <p>8 of course there is also, in all of this, the women, the</p> <p>9 senior women, in fact, Stacie Dean, Michelle Brown,</p> <p>10 I think, in my submission, broken, too, in their way,</p> <p>11 not here, including for reasons that -- Michelle Brown,</p> <p>12 you understand the reasons for that, and we have seen</p> <p>13 their histories of being stressed, having periods of</p> <p>14 time off work, and telling you how and when they raised</p> <p>15 matters and you can see how far those got.</p> <p>16 You have seen their emails, you have seen the</p> <p>17 response or the lack of it, including when raised</p> <p>18 directly by senior people, directly with</p> <p>19 Jerry Petherick, in January 2018, in the Stacie Dean</p> <p>20 example, and one has to remember, if it is like that for</p> <p>21 them, if those people, at their level, cannot get change</p> <p>22 or movement, what must it be like being -- or if they</p> <p>23 are reacting or experiencing that from Brook House, what</p> <p>24 on earth must it be like for the detained people</p> <p>25 themselves?</p> <p style="text-align: center;">Page 111</p>
<p>1 Mr Riley gave evidence yesterday, he spoke of</p> <p>2 change. But he, too, has been forced to speak of</p> <p>3 change. He was abandoning statements yesterday under</p> <p>4 questioning from Mr Altman that he made as recently as</p> <p>5 the beginning of this inquiry in his witness statement</p> <p>6 when more was being put to him.</p> <p>7 So we have, certainly from this side of the room,</p> <p>8 a degree of skepticism, because we have been here so</p> <p>9 much more -- so many times before. As that -- when that</p> <p>10 inertia stays, when that inertia entrenches, what</p> <p>11 happens is the number of victims mount because they</p> <p>12 remain in detention and the victims that we already have</p> <p>13 wait for change or wait for a solution. So I am afraid</p> <p>14 I am here to say only you can do something about it.</p> <p>15 Only you can try to achieve sustained and reliable</p> <p>16 change, so that this does not happen again.</p> <p>17 I also say that, related to that, only you have the</p> <p>18 material, because you have had the breadth and the depth</p> <p>19 of the evidence and that starts with Callum Tulley's</p> <p>20 footage and then it moves into the sheer grinding</p> <p>21 awfulness of the granular detail that you have heard and</p> <p>22 have sat through, so the inadequate systems, the</p> <p>23 inadequate management, the inadequate staff, the parade</p> <p>24 of broken men, remember you -- Mr Lee talked about his</p> <p>25 client D643, the former army officer struggling with</p> <p style="text-align: center;">Page 110</p>	<p>1 You have heard a lot about their unique and</p> <p>2 vulnerable characteristics and it is, again, we say,</p> <p>3 only you who can do something about it. Because, if not</p> <p>4 you, then who? And if not now, then when?</p> <p>5 I do just want to note the chronology because it is</p> <p>6 not just now nearly 20 years since Yarl's Wood and 17</p> <p>7 since Oakington, it is six years since Callum Tulley was</p> <p>8 concerned about what he was seeing to contact the BBC in</p> <p>9 the wake of Medway. It is four and a half years since</p> <p>10 Panorama came out.</p> <p>11 It cannot be said that the Home Office has not had</p> <p>12 the time to do something about this. We have to ask,</p> <p>13 why haven't they acted? And we'll see some answers to</p> <p>14 that in a moment.</p> <p>15 We say there is just one shot at this, and we</p> <p>16 certainly have to assume there is only really going to</p> <p>17 be one shot at this, and I am afraid it is you.</p> <p>18 The -- not fiddling with it; we say, fundamentally</p> <p>19 altering it.</p> <p>20 Now, what do we say that you have seen -- and you</p> <p>21 have sat through all of this, and I am not going to go</p> <p>22 through all of the evidence, I don't have the time to do</p> <p>23 the evidence, you have sat through every witness --</p> <p>24 I think it may be just you and Zaynab, in fact, and,</p> <p>25 I think, one other, who has seen every single witness in</p> <p style="text-align: center;">Page 112</p>

<p>1 the room, so you know what they have said and you have 2 that.</p> <p>3 From our point of view, the key point that I would 4 emphasise, and we presage this in our opening, is the 5 toxicity, the unique toxicity, of immigration detention. 6 Now, "toxicity" is a word that has been used a lot, 7 counsel to the inquiry has referred to the contagion of 8 toxicity, and I do want to say something about the 9 language that we have heard.</p> <p>10 I am not going to go back through it, I am not going 11 to repeat it, but I am just going to say keep in mind, 12 of course, its extent and its intensity, and it has been 13 shocking even for those who look at these things. 14 Professor Bosworth told you last week, on 29 March, she 15 said it is obviously completely corrosive, and it was, 16 you know, the widespread nature of those sorts of 17 comments that are picked up on the undercover footage 18 that is genuinely shocking, and it clearly was not being 19 addressed by management, it was widespread and, you 20 know, I think played quite a large part in the physical 21 manifestation.</p> <p>22 Remember when you are looking at the language, none 23 of that would be acceptable, even in the high-security 24 prison estate where you are dealing with extremely 25 dangerous men, and this is not the high-security prison</p> <p style="text-align: center;">Page 113</p>	<p>1 importance of language, but where you have language that 2 robs people of their fundamental humanity, and that 3 that -- and the "dehumanising" is the word that they are 4 all using, then that does take us a long way, we say, to 5 establishing that the treatment was inhumane. And 6 I make another point here, which is a point that 7 Ms Harrison has already made this morning, that both in 8 phase 1, when we heard from detained people directly, 9 but also in phase 2, when we had the read-in evidence 10 from detained people, men spoke of their experience of 11 being -- "I felt like an animal", "I was being treated 12 like I was an animal" and it may very well be that those 13 men spoke in those terms without realising the legal 14 significance of the language that they were using, but 15 it does have a legal significance because it is 16 dehumanising. That is what they are describing, being 17 treated like an animal. So that is also very highly 18 relevant in article 3 terms.</p> <p>19 The second point I want to emphasise, moving on from 20 language, is the extent to which we say this obviously 21 goes -- and we just want to knock this on the head -- 22 much wider than that which -- than Panorama showed. 23 There has been this discussion, and it is perhaps not 24 a very helpful discussion, about whether it is bad 25 apples or a bad barrel, and there was that exchange</p> <p style="text-align: center;">Page 115</p>
<p>1 estate, this is not even a prison. There are people 2 that we have been looking at in this inquiry who have 3 never been anywhere like this before, gentle men, 4 guileless men, but even those who have been in a prison 5 environment before, a wide variety of people, they, too, 6 often scared, often mentally unwell. They may have 7 committed offences, but those offences may just be 8 documents offences, and they may also well be people 9 who -- and I will come back to this -- will, in fact, 10 end up staying in the UK. All of them are experiencing 11 all of this pretty much all of the time with nothing 12 being done about it, the use of the language not being 13 reported, not being corrected and not being stopped.</p> <p>14 That is corrosive, as Professor Bosworth says and it 15 is dehumanising. "Dehumanising" is another word that 16 has been used a lot in this inquiry. It has been the 17 premise for much of the questions from your counsel. 18 No one seriously disagrees about the characterisation of 19 that. But it is worth emphasising the use of the word 20 "dehumanising", because we are fundamentally in 21 an inquiry about article 3 ill-treatment, and article 3 22 ill-treatment is about treatment that is inhumane and, 23 if you have language that is dehumanising, you will get 24 to a position where it renders something inhumane and we 25 can look at authorities in due course about the</p> <p style="text-align: center;">Page 114</p>	<p>1 between Mr Altman and Professor Bosworth last week about 2 it, and we could debate about how many apples it takes 3 to make a barrel. It isn't everyone in Brook House, but 4 it is wider than Panorama, and it is certainly wider 5 than those people who were dismissed as a result of 6 Panorama, and you can see that because we have to add in 7 a number of other groups, and that includes the people 8 that you see on the unbroadcast footage, the people that 9 you see on the body-worn camera footage. All of that is 10 the footage, incidentally, that Mr Brockington didn't 11 bother to watch before he gave his evidence about it 12 being a supposed minority, despite his organisation 13 being responsible for producing much of that footage and 14 producing it late.</p> <p>15 You have to add in all of that. You have to add in 16 all of the people who didn't report the ill-treatment 17 and who were complicit, in that sense. And then you 18 have to add in the growing list of others who also seem 19 on the evidence, and we say, to be guilty of very 20 serious behaviour. You have within that list -- and 21 just to name a few of them, Luke Instone-Brewer must be 22 pretty close to the top of that list, in my submission. 23 You have seen an enormous quantity of evidence that he 24 was supplying spice to detained people and that he was 25 making a lot of money supplying spice to detained people</p> <p style="text-align: center;">Page 116</p>

<p>1 and you have seen that evidence be multi-sourced. You  2 have seen the intelligence that staff had and that  3 Stacie Dean and Michelle Brown were talking about, you  4 have seen all of that material, Mr Livingston took him  5 through it, but you have also seen that chime with  6 a completely different source of evidence, which is my  7 client, D687. He has talked about the detail of that  8 and how he was supplying it and the way that it was done  9 and the mechanics of how it was done and how it was  10 £50.02 in order to identify -- that level of detail.  11 And when that kind of evidence knits together, it shows  12 you, in my submission, that it is true. What that tells  13 you is that Mr Instone-Brewer was doing this or behaving  14 in these ways in 2014/2015 and raising concerns with  15 staff then.  16 It was raised again specifically with Mr Petherick  17 in January 2017, but he was left in place at Brook House  18 until he left himself in July 2017.  19 You will -- you may remember, chair, when he was  20 being challenged about this, the slightly cocky way, we  21 say, in which he gave his evidence, laughing as he  22 started his evidence. My submission is we can see very  23 clearly who he was and what he was and draw the  24 conclusions accordingly.  25 We also have on this list his friend, Mr Fagbo, he</p> <p style="text-align: center;">Page 117</p>	<p>1 David Waldock complaint at the same time she is turning  2 up in the GDWG materials, where people are talking about  3 how she was trying to stamp on things she thought were  4 second visits. There is no possibility of collusion  5 between GDWG and David Waldock. You see similar things  6 with Mr Purnell -- Mr Lee has talked about that again  7 this morning -- and the extreme racism that he  8 exhibited, and you see that that is being produced by  9 D643 but it was also in Callum Tulley's materials.  10 Again, multi-source material that all knits together  11 to show -- powerfully, we say -- that the allegations  12 are true. Mr Tomsett, top of the leader board, as the  13 most complained-about officer at Brook House, which is  14 something, given how many others were competing for that  15 and how reluctant people were to complain in the first  16 place. Promoted to DCM by Steve Skitt. All of that  17 material pointing in the same direction, all of them  18 taking part all of the time with this casual language.  19 And I'll just talk about that again. Where do you go  20 when you have used the F word, then they go to the  21 C word, then they go to the N word and you think, where  22 else can they go after this? And then you get  23 Sean Sayers comes out with a new phrase that seems to  24 have taken hold in this inquiry, and you see, again,  25 just how toxic and degrading it has become.</p> <p style="text-align: center;">Page 119</p>
<p>1 was also friends -- who were also friends. Both he and  2 Mr Fagbo were friends with Jules Williams, and I am  3 emphasising these people because both of those two came  4 into contact -- we see it in his early witness  5 statements. Again, my client, D687, these were the  6 people he was bumping into. Jules Williams was also  7 friends with him and you have these insights as the  8 evidence emerges, you have these insights which come out  9 of the detail, like Jules Williams and the complaint  10 that was made about him, and he was asked about it in  11 his evidence, mucking about with a banana, apparently  12 aimed at a gay female member of staff.  13 When you look at people who are behaving like that,  14 and he is a member of the SMT and you look at what that  15 is showing the people below him, and then you just  16 imagine for a moment the dexterity which you think he  17 brings, or might bring, to the pain and suffering or  18 concerns of detained persons, you get a real insight  19 into how dehumanising and difficult this environment  20 was. It is awful stuff. And on it goes. We see  21 Gayatri Mehraa, Graham Purnell, Darren Tomsett, all of  22 these names coming up in lots of different aspects of  23 the evidence, all names with extensive poor behaviour  24 and inadequacies recorded against them and, again,  25 multi-sourced. We see Gayatri Mehraa turning up in the</p> <p style="text-align: center;">Page 118</p>	<p>1 But, now, what you do have, we say, is a significant  2 percentage of the staff list. And you have,  3 a significant percentage of that list, some of the  4 behaviour that is described here, some of them are still  5 working at Brook House. So a number of staff implicated  6 in serious wrongdoing -- it has already been said this  7 morning -- Chris Donnelly, Steve Loughton, Steve Dix,  8 Steve Skitt, all implicated to greater or lesser  9 degrees, still working, and that is a real concern about  10 achieving proper change here.  11 The point about how wide this is and how culturally  12 broad or otherwise it is, you can also take from Callum  13 himself. He saw all of this in 2015 and 2016, which is  14 why he approached the BBC in January 2016. He then  15 waited for more than a year, he took notes, and they  16 checked whether it was still all happening, they went  17 through the editorial process and realised it was still  18 happening and so started filming.  19 He told you -- on 30 November, he said:  20 "Answer: [I know] why the inquiry are interested in  21 the relevant period ... is because of my filming ..."  22 Then he said this:  23 "Answer: ... but to me it's -- the years and months  24 before that were just as relevant, if not more relevant,  25 because at least I was able to capture some of the abuse</p> <p style="text-align: center;">Page 120</p>

<p>1 during -- between March and -- between April and August.</p> <p>2 You know, to be honest, it's not the things I saw whilst</p> <p>3 secretly filming undercover which trouble me most,</p> <p>4 because at least I filmed it so the world can see it.</p> <p>5 But it's the stuff that I witnessed before I started</p> <p>6 wearing secret cameras. I know you're going to ask me</p> <p>7 about one incident in particular. You know, that's the</p> <p>8 hardest stuff, because those officers have gotten away</p> <p>9 with it and it seems G4S are only being held accountable</p> <p>10 for the months of April to August, and I hope that's not</p> <p>11 going to be the case ..."</p> <p>12 The point this comes down to, he didn't just get</p> <p>13 lucky with what he filmed between April and August.</p> <p>14 That was representative of the period he had seen for at</p> <p>15 least the preceding year. I said this in my opening and</p> <p>16 I will say it again: this is not just a snapshot; it is</p> <p>17 indeed a panorama.</p> <p>18 Mary Bosworth also told you on 29 March -- we can</p> <p>19 argue about the numbers, but there are clearly systemic</p> <p>20 issues here. We say they are deep ones and they are</p> <p>21 long-standing ones.</p> <p>22 Now, just while I talk about Callum Tulley's</p> <p>23 evidence, I want to make one other point. The inquiry</p> <p>24 has heard a lot from him. He has given evidence over</p> <p>25 four days, so, in fact, he has been pressed harder and</p> <p style="text-align: center;">Page 121</p>	<p>1 and not to acknowledge and not to reflect.</p> <p>2 But we have still had people -- we still had the</p> <p>3 senior people, we still had people like Mr Neden</p> <p>4 persisting in claiming that Callum should have reported,</p> <p>5 that he could have relied on the systems, and then</p> <p>6 saying that people were harmed because Mr Tulley did not</p> <p>7 do that.</p> <p>8 Chair, I just want to note that. Others represent</p> <p>9 Callum, but I do want to note that on behalf of those</p> <p>10 I represent. All of that is obvious nonsense. Those</p> <p>11 kinds of statements are entirely reprehensible, and we</p> <p>12 say two things should flow from it.</p> <p>13 First, we say you should reject it expressly. We</p> <p>14 say Mr Tulley's actions in bringing all of this to light</p> <p>15 have been entirely exemplary and we should all be</p> <p>16 grateful for them. It cannot sensibly be suggested that</p> <p>17 he did anything other than the right thing. 20 years</p> <p>18 old, 20 years old, and he managed to stand up in the</p> <p>19 face of all of this when other people, who were much 7</p> <p>20 older, much more experienced and whose job it was to do</p> <p>21 this stuff, stayed silent. We say the inquiry should</p> <p>22 record that and record its gratitude. He stood up when</p> <p>23 the system which he had happened to join crushed so many</p> <p>24 others.</p> <p>25 But secondly, we should just reflect for a moment in</p> <p style="text-align: center;">Page 123</p>
<p>1 for longer than any other witness. You have also had</p> <p>2 the benefit of his notes, his full footage, including</p> <p>3 during unguarded moments, we all remember the time in</p> <p>4 the toilet, and my submission is that he has answered</p> <p>5 the questions that were asked of him clearly, openly and</p> <p>6 precisely. I imagine that, like the BBC, we will -- and</p> <p>7 I imagine the BBC will also do the same -- invite you to</p> <p>8 accept him as being a witness of truth, unlike a number</p> <p>9 of other people who gave evidence to you.</p> <p>10 But, the inquiry has also seen this ongoing number</p> <p>11 of allegations still mounted, sometimes even here in</p> <p>12 oral evidence by the DCOs and the DCMs he filmed, who</p> <p>13 have persisted in this range of allegations that he</p> <p>14 doctored or dubbed footage. You may remember the</p> <p>15 exchange between Mr Altman and Mr Connolly about this,</p> <p>16 where he was asking, whether Mr Connolly was saying:</p> <p>17 "Question: Is that a serious proposition,</p> <p>18 Mr Connolly? When we are all done here and we have all</p> <p>19 moved on and the chair retires to write her report, is</p> <p>20 this how you want to be remembered?"</p> <p>21 And it was only after that, that Mr Connolly finally</p> <p>22 abandoned this implausible point and went, "No,</p> <p>23 actually, no, I don't". That is what it takes, that is</p> <p>24 the inertia we are seeing, in order to get them to move</p> <p>25 off these attempts to minimise and say, "It wasn't me",</p> <p style="text-align: center;">Page 122</p>	<p>1 relation to those who persist in these baseless</p> <p>2 allegations and nonsensical allegations against him,</p> <p>3 record that, too, and bear in mind what that means for</p> <p>4 the chances of sustained or reliable change. And this</p> <p>5 is just propping up the submission I make to you about</p> <p>6 being bold, because that is what we are facing down,</p> <p>7 this persistence of holding the line, because that</p> <p>8 doesn't look like people who are seriously interested in</p> <p>9 changing, people who are seriously interested in</p> <p>10 examining their own actions or inactions or taking</p> <p>11 responsibility for them. Instead, they are determined</p> <p>12 to minimise, and we say the people who maintain those</p> <p>13 fictions as an attempt to cover their own responsibility</p> <p>14 should be called out on it.</p> <p>15 Also, chair, the longer that goes on, the longer</p> <p>16 they hold that position, all they are doing is holding</p> <p>17 up the real change that the system requires and, as they</p> <p>18 do that, the victims mount and the victims wait.</p> <p>19 But returning to what we saw with the DCOs, can</p> <p>20 I also just make this point very clear. It is entirely</p> <p>21 hopeless to suggest that it stops with them, or even</p> <p>22 with G4S more generally. That is, of course, who Verita</p> <p>23 were looking at; they were looking at G4S primarily.</p> <p>24 But it obviously goes up to the Home Office, too,</p> <p>25 because they are ultimately the detainer, they are the</p> <p style="text-align: center;">Page 124</p>

<p>1 contracting department with the enforcement powers and</p> <p>2 we have to look at where all of this comes from. If we</p> <p>3 are looking at leadership and void of leadership and so</p> <p>4 on, what leadership or tone are they showing and</p> <p>5 setting? We say that is very obvious. You see it</p> <p>6 everywhere you look. Start at the bottom end and look</p> <p>7 at the likes of Vanessa Smith in that February 2018</p> <p>8 Hibiscus training session, laughing along, using some of</p> <p>9 the same language, certainly not reporting the language</p> <p>10 as Hibiscus did, and you will remember, chair, that was</p> <p>11 13 separate upheld allegations of misbehaviour in</p> <p>12 relation to that incident and the language was serious.</p> <p>13 Hibiscus report it. Nobody else does. That was</p> <p>14 five months after Panorama where they were supposedly</p> <p>15 looking at this stuff seriously because Panorama had</p> <p>16 just come out and it was two years after Medway when</p> <p>17 they were supposed to be looking at these things very</p> <p>18 seriously.</p> <p>19 When she gave evidence to you, Vanessa Smith</p> <p>20 couldn't say why she didn't report it, but that, as</p> <p>21 I think he accepted yesterday, did undermine what</p> <p>22 Mr Riley told us in his witness statement about having</p> <p>23 the confidence that, had they seen it, officers would</p> <p>24 have reported it. And they didn't. Because they did</p> <p>25 see it, five months after Panorama, and still didn't</p> <p style="text-align: center;">Page 125</p>	<p>1 see a number of things. Nathan Ward talked of his cold</p> <p>2 functionality and you may think -- a matter for you, of</p> <p>3 course, but you may think that you saw some of that in</p> <p>4 the way he gave evidence.</p> <p>5 You have more direct evidence of that in the</p> <p>6 evidence of James Wilson and GDWG. You remember the</p> <p>7 meeting in August 2017. Now, I want to just touch on</p> <p>8 that briefly. What on earth was the problem with GDWG,</p> <p>9 you may think? Gentle people trying, politely and</p> <p>10 appropriately, to help people who we can see obviously</p> <p>11 needed that help. They were filling in the gaps in</p> <p>12 a system that obviously had many, many gaps. Yes, they</p> <p>13 are a campaigning organisation, for many years, for the</p> <p>14 end of immigration detention, but they do have force in</p> <p>15 that point. There are absolutely grounds for that</p> <p>16 campaign.</p> <p>17 What was the response -- what was the response of</p> <p>18 the Home Office to them? And you have Mr Wilson's oral</p> <p>19 evidence where he said this:</p> <p>20 "That was a dynamic that I felt was increasingly</p> <p>21 there. I was particularly -- I was vividly aware of</p> <p>22 that in that meeting, the dynamic. I remember the</p> <p>23 meeting very vividly. I remember it was Steve Skitt and</p> <p>24 Paul Gasson who were in the meeting. They were nearest</p> <p>25 the door. I was on my own. They were very, very</p> <p style="text-align: center;">Page 127</p>
<p>1 report it. And that was put to him. Mr Riley got --</p> <p>2 told you that he got a daily update from the inquiry,</p> <p>3 but didn't appear to get an update on that issue, about</p> <p>4 one of his own officers. He hadn't read the material,</p> <p>5 he hadn't read the investigation report, and he said</p> <p>6 this -- Mr Altman put to him:</p> <p>7 "Question: Presumably, Mr Riley, none of that is</p> <p>8 anything you would expect of a Home Office officer?</p> <p>9 "Answer: No, it isn't.</p> <p>10 "Question: Do you think that undermines your</p> <p>11 confidence in Home Office attitudes or a willingness to</p> <p>12 report things or do you think this is just a one-off?</p> <p>13 "Answer: I would hope that that is a one-off."</p> <p>14 Then, "Well, on what basis do you think it is</p> <p>15 a one-off?", is what follows from that, because -- and</p> <p>16 it means this: when Mr Riley thought about what needed</p> <p>17 to be done, and what needed to change, he did it not</p> <p>18 knowing that Vanessa Smith or immigration officers were</p> <p>19 behaving in this way, and that can't be a promising</p> <p>20 basis for sustained or meaningful change or reform.</p> <p>21 Moving on from her, you can also look at Mr Gasson.</p> <p>22 We start moving up the scale and look at Mr Gasson.</p> <p>23 Mr Gasson, it is said -- we are told, doesn't often come</p> <p>24 out of his room, doesn't like to mix with detained</p> <p>25 people, but when he does turn up in the evidence, we can</p> <p style="text-align: center;">Page 126</p>	<p>1 agitated. Very. As I put it, I felt that they were</p> <p>2 toying with me, they were threatening me with something,</p> <p>3 with something a very immediate threat to our access.</p> <p>4 I remember it being -- in my recollection, it was a dark</p> <p>5 and rainy day. I remember walking out of the centre</p> <p>6 feeling shaken by the meeting, and I had had meetings</p> <p>7 before when they had been difficult, but I was really</p> <p>8 shaken by that meeting."</p> <p>9 That evidence is supported by the contemporaneous</p> <p>10 email that he wrote, and that you have seen, where he</p> <p>11 talks about, "I've just had a gruelling meeting,</p> <p>12 drop-ins are on a knife edge, it sounds draconian, but</p> <p>13 this is serious", and you may have picked up that he</p> <p>14 didn't give as much detail the first time he gave</p> <p>15 evidence on this, which was in his witness statement for</p> <p>16 the judicial review which produced this inquiry, but the</p> <p>17 reason why he was saying less at that stage is also</p> <p>18 something that he explained in that witness statement,</p> <p>19 which he was scared of losing drop-ins at that stage,</p> <p>20 back in 2018, when those proceedings began. He was</p> <p>21 still very worried about what might happen if he</p> <p>22 challenged G4S or the Home Office.</p> <p>23 Both Mr Gasson and Mr Skitt were challenged about</p> <p>24 this and were asked about what they did, and both of</p> <p>25 them simply gave the manifestation of bullies who had</p> <p style="text-align: center;">Page 128</p>



<p>1 just slightly been caught out and were now sullenly 2 staring at their feet in the head's office, giving 3 grudging apologies, saying, "Well, if we were hostile, 4 we didn't mean to be".</p> <p>5 By way of, also, further emphasis on this, remember 6 it has been referred to a couple of times already but 7 that Naomi Blackwell statement. She gave evidence and 8 you have got the witness statement in the materials, 9 about, in a very sober, very restricted way, talking 10 about an incapacitated detained person who was obviously 11 very vulnerable and who, it turned out, was not only 12 unlawfully detained, but was being detained in breach of 13 article 3.</p> <p>14 Now, the knowledge of that witness statement, the 15 way G4S and others came to know of that witness 16 statement, must have come from the Home Office because 17 it was the Home Office that was the party to the 18 litigation.</p> <p>19 When that comes to light, what do they do? They 20 don't respond saying "Oh, this is very serious, we have 21 a vulnerable individual in detention who maybe shouldn't 22 be in detention. How have we missed this?", they attack 23 GDWG, was their response. "How dare they write the 24 statement". Remember, then, how GDWG come to be 25 examined and described in all of those meetings, and you</p> <p style="text-align: center;">Page 129</p>	<p>1 It also chimes with other material, it chimes with 2 Lee Hanford in his Verita interviews, and in his oral 3 evidence, talking about G4S having been criticised for 4 being too empathetic. Ben Saunders was asked about that 5 evidence and he agreed that he also had that take. 6 Ben Saunders was, of course, trying to please the 7 Home Office and he was said to be good at it, but he did 8 that by showing little or no empathy.</p> <p>9 He told us -- we heard that he stayed in his room as 10 well as Mr Gasson staying in his room, not being 11 visible, and that is important because it is, of course, 12 much easier to mistrust and it is much easier to 13 mistreat and much easier to dehumanise if you do it from 14 a distance. If you separate yourself out, you will find 15 it much easier to mistreat.</p> <p>16 So that is where we saw -- when you look at all of 17 that evidence, that is what you see about the approach 18 of the Home Office. But is that really very surprising, 19 that you are finding those sorts of uncompassionate 20 attitudes from the Home Office? When you look at things 21 like the overall political rhetoric in this area, the 22 overall agenda of the Home Office and you see that in 23 all sorts of places too. So you look at the contract, 24 and you see the absence of relevant provisions, so there 25 is nothing in there on welfare, nothing specific on</p> <p style="text-align: center;">Page 131</p>
<p>1 will remember the phrase "The problem is one of trust". 2 The problem is one of trust. Immediately characterising 3 this as an "us and them" situation, GDWG are a "them" 4 not an "us", they are on the wrong side of that line, 5 and all of that is, of course, stifling the production 6 of evidence that, in seeking to stifle the production of 7 evidence that was very desperately needed, but in 8 an article 3 context, because if you are stifling the 9 production of an evidence in an article 3 context, you 10 are breaching article 3.</p> <p>11 Now, as well as, it may be noted, in August 2017, 12 driving or helping drive the IMB to a degree of 13 hostility and distrust towards GDWG. That is pretty 14 serious and pretty telling stuff. And it was the 15 Home Office at least as much as it was G4S. And you 16 will remember the evidence of Mr Haughton who thought 17 the steer -- he even told you that the steer he had had 18 with regard to GDWG was unfortunate and was a shame, but 19 it came from the Home Office and from Ben Saunders.</p> <p>20 All of that material, chair, points in the same 21 direction. It certainly doesn't point to 22 a compassionate approach. In fact, I don't think we can 23 see, in the relevant period, any evidence of any 24 Home Office official behaving in a compassionate way 25 towards a detained person.</p> <p style="text-align: center;">Page 130</p>	<p>1 welfare, there is nothing on checking use of force in 2 schedule G, you look at the way schedule G works or 3 doesn't work, you look at the focus that everybody 4 describes on immigration throughput. We have looked 5 a lot at things like the KPIs and the complete absence 6 of any KPI, and suicide and self-harm, despite 60 7 incidents in the relevant period.</p> <p>8 We cannot see how that system could sensibly have 9 work because, in order to have a KPI, it requires all 10 these steps in the chain for Barry Timms to find out, in 11 order to report it, and then to get sufficient 12 information to characterise it as a procedural breach, 13 and then somebody to check whether that judgment is 14 correct. Mr Gasson is asked about that. He cannot 15 remember doing it, doesn't know how it worked. 16 Mr Castle didn't know how it worked and couldn't 17 remember the system either. And the reason they can't 18 is because there wasn't one because it wasn't happening.</p> <p>19 The only inference you can draw from that is because 20 nobody really cared about whether G4S was failing in its 21 monitoring of suicide and self-harm arrangements.</p> <p>22 I would just ask briefly about that. How is that 23 happening now? Because the KPIs and the contract now, 24 how does that now work? How have they improved those or 25 filled in those gaps in the system?</p> <p style="text-align: center;">Page 132</p>

<p>1 Again, we have had two people on constant obs. Have 2 they self-harmed? Has that become a KPI? Has it become 3 a rule 35(2) report? Dr Oozeerally tells us he has 4 never done one, et cetera.</p> <p>5 You have also got, in all of this, the use of force. 6 Obviously a critical issue for this inquiry. You know 7 that the use of force reports were done much later, 8 sometimes by the same person who was involved in the use 9 of force. Steve Webb did that.</p> <p>10 Just dealing with D687 himself, the use of force on 11 him, or the key one, is 13 May. The use of force review 12 form is done on 31 July, two and a half months later. 13 Tick box, not even picking up the fact that BWC -- 14 body-worn camera -- footage wasn't used, even though the 15 box was ticked for it. You will remember how important 16 that is because Mr Collier told you how important it 17 was. If you don't review it, if you don't pull people 18 up on it, then they won't write their reports correctly, 19 they won't write their reports accurately, they won't 20 learn, and nothing will change.</p> <p>21 Chair, in my submission, the use of force in this 22 case was a car crash. So much of it was badly done, 23 but, again, nobody seemed to pick it up. No 24 Scrutiny Committee meetings, nobody is picking up the 25 fact that Steve Webb is both being involved and doing</p> <p style="text-align: center;">Page 133</p>	<p>1 inhumane and that is what it flows from.</p> <p>2 It is also, of course, the Home Office that built 3 a category B prison on the fiction of a 72-hour 4 detention period, and so they didn't bother building 5 much in the way of outside space, very little in the way 6 of outside activities. Everything in that, too, says 7 "We don't care". Mr Riley yesterday was asked about the 8 culture of the Home Office and he told you:</p> <p>9 "Answer: ... We live in a society where the debate 10 on migration and enforcement is polarised and entrenched 11 and that doesn't help either. And it is a difficult 12 operating environment."</p> <p>13 Who do we think drove that, Mr Riley? Where do we 14 think that came from? Who do we think is polarising the 15 debate on migration and enforcement?</p> <p>16 So that is what I say about the Home Office.</p> <p>17 On the other side of this, of course, we have the 18 detained people themselves and I gave you in our opening 19 a list of characteristics and vulnerabilities, mental 20 ill-health, English not as first language -- I know you 21 have all of those points. Much harder to build 22 relationships -- which is the normal way in which you 23 run establishments of this kind, is by building 24 relationships. It is much harder to build relationships 25 when you have those characteristics.</p> <p style="text-align: center;">Page 135</p>
<p>1 the review, and doing them two months later.</p> <p>2 Then tie in, all of that shows no real interest in 3 welfare, but of course you see it in all of these other 4 places, like no 35(2) reports, for years. That is 5 astonishing and nobody picks up it. Article 3 findings 6 in respect of this detention centre, article 3 findings 7 more generally not being handed back, nobody can tell 8 the system for feeding that back to the people involved.</p> <p>9 What on earth is going on? But, moreover, what kind 10 of message is that sending? What is that saying to the 11 DCO on the wing who has never done anything like this 12 before, who is paid £25,000 flat rate a year with no 13 chance of an increase, understaffed, in the noise, 14 firefighting, and is unguided and unled? Is that saying 15 to that DCO, spend more time, engage more, try to 16 understand what is happening with this vulnerable 17 individual? Of course it is not. And where will he 18 look, then, for help and support? He will look at 19 people above him and look at how they are behaving or 20 expressing themselves.</p> <p>21 Chair, the Home Office -- I have talked about 22 political rhetoric. The Home Office wanted a hostile 23 environment. They got one. This is what it looks like. 24 They need to own this.</p> <p>25 The consequence of that is it is degrading and it is</p> <p style="text-align: center;">Page 134</p>	<p>1 I do want to just briefly summarise some of the 2 characteristics for D687 himself. You have seen a bit 3 of him around, he was at the early stages of the 4 inquiry, a cheeky, likeable man -- I hope he will 5 forgive me for saying so. He finds it quite hard to 6 watch. Turns up in court and finds himself on the 7 video, which is part of the reason why he has not been 8 here as much, because -- and he had recurrent depressive 9 disorder, PTSD, he is suspected of undiagnosed learning 10 difficulties and bipolar disorder. Been in the UK 11 nearly all of his life. He might well have had British 12 citizenship, but for the fact that he was in care and 13 social services didn't apply for him -- so the rest of 14 his family got citizenship and he didn't -- and he was 15 in care because he had suffered childhood abuse. It is 16 not -- he's not had an easy time, hasn't D687. Schooled 17 here, family here, being told regularly, "Fuck off 18 home", but feels that he is home. His suicide and 19 self-harm, clearly there for years, clearly serious, 20 well recorded. Remember the scarring, which only came 21 out in this inquiry, because, when his solicitors saw 22 the unreleased footage that nobody had seen before, they 23 saw him doing something and said, "What are you showing 24 the officer, there?" And then he showed them and that 25 is how the scarring came out for the first time.</p> <p style="text-align: center;">Page 136</p>

<p>1 So he has always found it difficult to express</p> <p>2 himself about those things and, by May 2017, two years</p> <p>3 and three months in immigration detention, in that</p> <p>4 patch, and a year and a half of which had been at</p> <p>5 Brook House, and that is, of course, very significant</p> <p>6 because he has had all of the stuff we are looking at</p> <p>7 for that period of time.</p> <p>8 He was significantly suffering as a result of that,</p> <p>9 which is not very surprising, because all of the medical</p> <p>10 evidence you have had, all of the independent doctors in</p> <p>11 particular, have told you how detention impacts.</p> <p>12 They have told you about the indeterminate nature of</p> <p>13 detention in particular and how that impacts, and D687</p> <p>14 had done a lot of that and, throughout that time, he has</p> <p>15 been bumping into the likes of Luke Instone-Brewer, who</p> <p>16 he has described in his early witness statements, and we</p> <p>17 can imagine how that was and we can imagine how those</p> <p>18 interactions were, and Vanessa Smith, who he tells he is</p> <p>19 writing a suicide note, but doesn't open an ACDT, or</p> <p>20 Dr Oozeerally, who doesn't open an ACDT either and</p> <p>21 doesn't do a 35(2) report. And he had just, at that</p> <p>22 point, told this individual -- for the first time, he</p> <p>23 had opened up about his childhood abuse and the story of</p> <p>24 his life there. Where does it get him? What does that</p> <p>25 tell him? He opens up and nothing happens, so it tells</p> <p style="text-align: center;">Page 137</p>	<p>1 two DCMs who are wearing BWC but don't turn it on. They</p> <p>2 are both individuals who abuse D687 in the course of the</p> <p>3 use of force. One of them is responsible for the "We'll</p> <p>4 just wait for it. If you do put it on, we will wait for</p> <p>5 a minute until you pass out and then we will cut you</p> <p>6 down", said by a DCM. Humanity, chair, at that point,</p> <p>7 has left the building.</p> <p>8 Then it -- Mr Collier says they should have engaged</p> <p>9 more. Force may not have been required if they had.</p> <p>10 Then they used the trick with the cigarette lighter,</p> <p>11 they take him to the ground, he's got four or five men</p> <p>12 on top of him whilst he's still got a ligature around</p> <p>13 his neck. They cuff him. He's subdued and in cuffs, so</p> <p>14 he doesn't appear to be a threat to anybody, but at that</p> <p>15 point he has a pain-inducing inverted wrist hold</p> <p>16 applied, and he cries out in pain. We also know that he</p> <p>17 turns up -- when he gets to hospital later in Dorset</p> <p>18 that night, when he has got to the Verne, he has got</p> <p>19 bruising to his ribs which has not been explained.</p> <p>20 So, chair, in relation to him, we say in relation to</p> <p>21 D687, he was degraded in breach of article 3 before he</p> <p>22 entered that toilet, but when you -- that is -- he's</p> <p>23 a very good example of what Brook House can do to you,</p> <p>24 particularly over a sustained period of time, but if you</p> <p>25 add in a domestically unlawful use of force,</p> <p style="text-align: center;">Page 139</p>
<p>1 him the system really doesn't care. And remember</p> <p>2 Dr Hard here, because these interactions -- he told you,</p> <p>3 these actions being regularly dismissed has a negative</p> <p>4 impact on mental health, and D687, we say, is</p> <p>5 the paradigm of that. You may not need Dr Hard's</p> <p>6 evidence to understand that.</p> <p>7 Just put it all together and imagine what two years</p> <p>8 and three months of that must be like. Being denied the</p> <p>9 identity that you feel and believe to be yours, not</p> <p>10 being taken to the funeral of his brother and his</p> <p>11 grandmother. Remember here the contemporaneous notes,</p> <p>12 Callum's video diary, and he's deteriorating, and where</p> <p>13 does it end up? In a disabled toilet with a ligature</p> <p>14 around his neck. He goes into the disabled toilet, too</p> <p>15 broken even to lock the door properly, "I have had</p> <p>16 enough, bruv, I want to go, bruv", that is what he tells</p> <p>17 you. That is what we hear on the video. And</p> <p>18 Brook House has reduced him to that. That has degraded</p> <p>19 him, that has dehumanised him, that has broken him. And</p> <p>20 where does it end up? It ends up with a use of force</p> <p>21 which, in domestic legal terms, Mr Collier cannot</p> <p>22 justify, and -- because it is not planned. There is no</p> <p>23 healthcare present, despite the ACDT, despite the</p> <p>24 ligature. There is no BWC footage, despite it being</p> <p>25 a duty director who is in charge that day, and there are</p> <p style="text-align: center;">Page 138</p>	<p>1 an unjustifiable use of force into that mix on top of</p> <p>2 that, then that is the breach and that is where it all</p> <p>3 absolutely goes over threshold with that final, slightly</p> <p>4 chaotic, thoughtless act, unplanned, as it were, by</p> <p>5 Duty Director Haughton.</p> <p>6 Can I also just bear in mind what D687 has said</p> <p>7 about all of that, and the number of times he has told</p> <p>8 the story about what happened then before the footage</p> <p>9 came out? And when the footage does come out and we</p> <p>10 have been able to examine it with the detail that you</p> <p>11 have been able to examine it with, it does show that he</p> <p>12 was right, in terms of what he was describing, and it</p> <p>13 shows also that the PSU was wrong about that. We</p> <p>14 haven't got time to go through the difficulties of what</p> <p>15 the PSU does and the way that it does it, not checking</p> <p>16 things unless -- "No, we don't check things. Unless you</p> <p>17 can tell us what date it was, and which individual it</p> <p>18 was, we won't do it". We will not weigh in -- I will</p> <p>19 dismiss the allegations of racial abuse, because I will</p> <p>20 not weigh, because it is not in front of me, what</p> <p>21 Panorama is showing about racist abuse, but he is</p> <p>22 clearly right -- D687 is clearly right about that and we</p> <p>23 say the PSU was wrong because of the narrowness of</p> <p>24 the approach that they took, but that PSU dismissal</p> <p>25 degraded D687 yet further.</p> <p style="text-align: center;">Page 140</p>

<p>1 So those are the findings that we invite you to 2 reach, chair. There is some law to deal with here about 3 the correct approach. I am not going to go through that 4 in any detail, we have CTT's note on it. We may have 5 some points of difference, but I think they will be 6 minor difference. What I say about that is essentially 7 this.</p> <p>8 You will need to reach findings about what happened, 9 you will need to reach findings that inform an article 3 10 assessment. That will mean looking at what happened, 11 but also why it happened, and when you come to look at 12 why it happened, you will need to look at things like 13 the motivation of the abuser, any justification for it, 14 the language which surrounds it, whether that is 15 intended to degrade, whether it is racist because that 16 sounds particularly heavily in an article 3 assessment, 17 and D687 had all of that, but then you will need to look 18 at things like, even from an individual breach point of 19 view, even the individual treatment point of view, 20 things like official indifference or the failure to 21 operate safeguards is also relevant to whether or not 22 you get to an article 3 threshold, so that will require 23 you to examine the systems, the training and the 24 resources. Even on that individual assessment, one will 25 have look at both what happened and why it happened and</p> <p style="text-align: center;">Page 141</p>	<p>1 So whether it is five-minute rule 34 assessments or 2 whether it is rule 35(1) and 35(2) reports or the 3 reliance on part Cs or the absence of use of force 4 scrutiny or the absence of staff or staff culture making 5 systems ineffective because they don't believe what is 6 being said about suicide and self-harm ideation, all of 7 those are capable of being article 3 systems breaches 8 and all of those are impacting, we say, on the people 9 you are hearing from, including, to a large extent, 10 D687. So we say there will need to be findings and we 11 invite you to do that in relation to all of those 12 matters.</p> <p>13 Now, where, then, does that take you? I started 14 this by saying I was going to invite you to be bold in 15 your recommendations. What does that entail? Now, back 16 to this point: we say that the problems here are too 17 legion and they are too manifest and they are too 18 long-standing and too entrenched to call for anything 19 short of fundamental change. Otherwise, you are facing 20 too much inertia. Look at how long these go back, 21 20 years to Yarl's Wood, look at how the Home Office had 22 to be dragged kicking and screaming to do it; it 23 required an order. They said in the judicial review, 24 "There is nothing here to be found, we don't need to do 25 this". We don't, in particular, need to have witness</p> <p style="text-align: center;">Page 143</p>
<p>1 that will take you into systems issues.</p> <p>2 When you then come to look at whether there are 3 systems breaches. Again, I am going to leave this to 4 written submissions, but you are concerned here with 5 whether there were inadequacies in the system which 6 materially increased the risk of an article 3 breach or, 7 to put it another way, would a system without these 8 inadequacies have had a real prospect of producing 9 a different outcome? Now, I am slightly borrowing that 10 phrase from the operational side of article 3, but it 11 must be the same.</p> <p>12 Now, what counsel to the inquiry is saying, that 13 there will need to be something that ties a system 14 breach to an individual breach, so there will need to be 15 a system that produces a consequence, there will need to 16 be an impact. We say you won't need that because you 17 can be future looking and say, "Is there an inadequate 18 system that might produce an outcome of that kind?", and 19 that would be an article 3 breach and, therefore, you 20 should look at it, but it is very difficult. I am not 21 sure I need to get that far, because it is very 22 difficult to look at all of the systems that you have 23 been examining through the course of this inquiry, 24 without finding somebody who that will have had 25 an impact on it -- that will have had an impact on.</p> <p style="text-align: center;">Page 142</p>	<p>1 compellability in order to get Yan Paschali -- we don't 2 need the powers to hear from Yan Paschali, or to hear 3 from the others, or from Connolly, or from Nathan Ring, 4 or any of those individuals. You did need to hear from 5 all of those individuals to understand how bad it was, 6 you did need to hear from all of those individuals, and 7 the -- and you needed to have that enforcement power 8 available to you. So the Home Office was wrong about 9 that. And, as it has continued to be wrong about many 10 things -- and I have already said Phil Riley was still 11 revising his remarks yesterday on rules 35(1) and (2) 12 and on part C. He was also, yesterday, when he sought 13 to reassure you that it was now a changed Home Office 14 under him, he told you that "We have done "-- he said: 15 "Answer: ... [chair], we have done an awful lot of 16 work over the last four years -- three years, four 17 years -- in learning from the Wendy Williams report ..." 18 Which was a slightly astonishing piece of timing, 19 given that Wendy Williams had issued her Windrush 20 progress report five days earlier, when she said that -- 21 which contains 13 expressions of disappointment in the 22 progress that has been made in relation to Windrush. 23 Only eight of her 30 recommendations have been acted on. 24 Much more progress was required and there was limited 25 evidence that a compassionate approach had been embedded</p> <p style="text-align: center;">Page 144</p>

<p>1 consistently.</p> <p>2 So none of that is giving a great deal of</p> <p>3 reassurance, you may feel.</p> <p>4 Mr Brockington also sought to reassure you change is</p> <p>5 being made, "It is only a minority", et cetera,</p> <p>6 et cetera. It's not immediately clear to me how he was</p> <p>7 seeking to persuade you or be persuasive in</p> <p>8 circumstances where he had not read the Mary Bosworth</p> <p>9 report, he had not read the transcripts, he hadn't</p> <p>10 listened to the key bits of evidence and he sought to</p> <p>11 come along and tell you what he knew when you have heard</p> <p>12 all of that material at great length. Again, not</p> <p>13 a terribly promising start, but what those attitudes</p> <p>14 tell you is that these are not organisations that</p> <p>15 welcome change. These are organisations that tell you</p> <p>16 what they think you want to hear in order to make the</p> <p>17 issue go away. And they will need again -- I have said</p> <p>18 this already -- to be dragged, kicking and screaming,</p> <p>19 into any serious alteration.</p> <p>20 They have also told you, a number of them have told</p> <p>21 you, Mr Riley in particular has told you, and told you</p> <p>22 in some detail, that further change is waiting for the</p> <p>23 Nationality and Borders Bill, and you can be reassured</p> <p>24 that because -- big changes coming in relation to that</p> <p>25 and they will do something after that, but you don't</p> <p style="text-align: center;">Page 145</p>	<p>1 put prompts on ACDT forms that then link it into the</p> <p>2 35(2) report, we can do all of those things, energise</p> <p>3 the IMB or the other monitors, but we submit that none</p> <p>4 of that is likely to be enough. All of those things</p> <p>5 have been done or said before and all of them are</p> <p>6 capable of sliding when the spotlight moves away, and</p> <p>7 they will fade as the energy fades, or when you get the</p> <p>8 pressure -- small boats, Dublin -- remember the 2020 IMB</p> <p>9 report and the Observer and Liberty materials telling</p> <p>10 you what it is like yet -- what it is like certainly in</p> <p>11 2020, and what Mary Molyneux told you. They were</p> <p>12 clearly not coping in 2020 with suicide and self-harm,</p> <p>13 is what she told you.</p> <p>14 Ian Castle was asked about that IMB report. We said</p> <p>15 that -- treating the whole of the detention estate</p> <p>16 inhumanely and he said he couldn't disagree.</p> <p>17 The numbers are down at the moment, but Mr Hewer</p> <p>18 told us, unsurprisingly, in his oral evidence, that he</p> <p>19 expected an increase. What will happen when that</p> <p>20 increase comes? Mary Molyneux, again, she told you</p> <p>21 that, "The Home Office kept" -- this is at the time of</p> <p>22 the Dublin Convention situation:</p> <p>23 "The Home Office kept bringing these men in. The</p> <p>24 Home Office were aware of the problem. The Home Office</p> <p>25 knew this was happening -- the numbers, and the numbers</p> <p style="text-align: center;">Page 147</p>
<p>1 have to look at that very closely to be pretty concerned</p> <p>2 too. Do we think that a Home Office that is currently</p> <p>3 proposing offshore processing of asylum seekers is</p> <p>4 seriously committed to migrant welfare? Do we think</p> <p>5 an Ascension Island Brook House is going to be better</p> <p>6 than this one? What do we think the scrutiny is likely</p> <p>7 to be there -- like there? What do we think</p> <p>8 an Ascension Island IMB is likely to be like? What do</p> <p>9 we think that that degree of removal from the world will</p> <p>10 do for the situational psychology of that potential</p> <p>11 environment?</p> <p>12 So we say one has to be -- one has to be fundamental</p> <p>13 in what one does.</p> <p>14 We can work down the list of the other things. And</p> <p>15 I will just do mine, briefly. One can adjust the</p> <p>16 contract, as it is said it has been done, but, as I have</p> <p>17 already said, things like KPI problems appear to remain.</p> <p>18 We can increase the staffing. I remember your question,</p> <p>19 chair, about moving the ratios around because, in the</p> <p>20 same way as you move the ratios around in open prison</p> <p>21 and closed prison, think about the fact that immigration</p> <p>22 detention has a different purpose and has different</p> <p>23 needs and has a different cohort. We can do that. And</p> <p>24 we can introduce better work or better activities, we</p> <p>25 can train staff in mental health and capacity, we can</p> <p style="text-align: center;">Page 146</p>	<p>1 of self-harm."</p> <p>2 And then she said the reply that she got was all</p> <p>3 about process. "We have the right, we have the</p> <p>4 process", and then she said, "There was just a total</p> <p>5 disconnect and not, in my view, acknowledgement of the</p> <p>6 problem". That is what they do, that is what the</p> <p>7 Home Office seems to do, on that evidence, they plough</p> <p>8 on.</p> <p>9 Now, the other thing I just mention, that I would</p> <p>10 single out for special mention, is that, yes, you could</p> <p>11 look at what you can do to change the culture. But in</p> <p>12 order to change the culture of the number of witnesses</p> <p>13 told you, you would need clarity of purpose and</p> <p>14 a recalibration of the purpose in favour of detained</p> <p>15 person welfare.</p> <p>16 Professor Bosworth talked about that, she talked</p> <p>17 about how hard it was for DCOs in circumstances when the</p> <p>18 purpose of the detention was not clear to them. The</p> <p>19 Jill Dando Institute said the same thing. You have more</p> <p>20 clarity of purpose in a prison because it is about</p> <p>21 punishment and rehabilitation and release, so you know</p> <p>22 what that is for, but immigration detention is much more</p> <p>23 difficult, and it is difficult for this reason, because</p> <p>24 it does need openness and honesty about what it is</p> <p>25 really about. The problem with immigration detention is</p> <p style="text-align: center;">Page 148</p>

<p>1 there is just no point in pretending it is about a short  2 period of detention just in order to affect removal  3 because we know that is not, in fact, what is happening,  4 as soon as you look at the release statistics you see  5 the numbers are very low. The only reason the release  6 numbers are anywhere is because, essentially, when you  7 look at the numbers, you have places like Poland and  8 Romania, where there is a probability of removal, but in  9 relation to all the tricky countries, if I can put it  10 informally, when you look at places like Sudan, Syria,  11 Afghanistan, Iraq, Iran -- also, coincidentally, the  12 countries where the people coming from there are most  13 likely to be most damaged -- the removals in relation to  14 those countries are very low. The latest statistic,  15 below 5 per cent for all of those. So this isn't really  16 about removal, and all that is happening is the  17 Home Office is pretending it is and, once it does that,  18 as it ploughs on, believing, or wanting to believe, that  19 it is, in fact, about removal and that all of these  20 people are off and all these people are charlatans and  21 they are maintaining claims to remain that are not real,  22 then that fosters the abuse, because as long as you  23 maintain that, that you are on the way out, it informs  24 the language of, "Why don't you fuck off home?".  25 The -- so, yes, look at that. Yes, see if we can do</p> <p style="text-align: center;">Page 149</p>	<p>1 the community.  2 But what you are also being told is, "Why not do  3 time limits?". Now, I understand that it would be said  4 this is outside of the terms of reference, but is it?  5 Because the terms of reference say, "examine the reasons  6 for the mistreatment and the experience", and the  7 reasons for the experience, at least in part, is a lot  8 of people are telling you, the detained people are  9 telling you, that indeterminate detention is making the  10 experience worse for them, at the same time as  11 Mary Bosworth tells you it is making it harder to  12 respond to them because it is undermining the clarity  13 and the purpose of immigration detention. So one does  14 have to reflect what the evidence is telling us, and  15 that is what it is telling us.  16 Even Jerry Petherick said in his oral evidence:  17 "I think the real issue -- and you are right, I am  18 not a clinician at all, but my experience would say that  19 the real issue that impacted on detainees' wellbeing and  20 mental health was their sense of not knowing -- the  21 uncertainty of the situation."  22 When you have that consistency of evidence all  23 saying the same thing across these different kinds of  24 witnesses, then we need to do something about that, we  25 need to take it seriously and we certainly need to</p> <p style="text-align: center;">Page 151</p>
<p>1 that. Yes, see if we can bring some honesty and  2 transparency to bear about what the real purpose of the  3 function of immigration detention actually is, but are  4 we going to achieve that, are we going to get there with  5 that, is that a realistic thing that we can alter, given  6 the political rhetoric and everything else that we have  7 around this area? And the problem that we have and the  8 people I represent have, is that, absent something  9 really hard and robust and fundamental, we can do all of  10 the work around those softer issues, but it won't  11 actually produce the outcome that we need.  12 What you need to do is just get much shorter periods  13 of immigration detention or no immigration detention at  14 all. Professor Bosworth has told you, and it is very  15 interesting the timing of all this, that the pandemic  16 has shown that much larger numbers can be managed in the  17 community. We have not -- there is no evidence that we  18 have seen that suggests that the pandemic and large  19 numbers of people being managed in the community has  20 produced an escalation in absconding or offending.  21 There is no evidence of that and, if there was, we would  22 expect the Home Office to produce it because the burden  23 of proof in detention is on them.  24 Absent that, we are entitled to infer that very  25 large -- much larger numbers of people can be managed in</p> <p style="text-align: center;">Page 150</p>	<p>1 record it.  2 Equally, why isn't indeterminate detention a method  3 policy practice or management arrangement, that causes  4 or contributes to any identified mistreatment? That is  5 something that you are tasked with looking at within  6 your terms of reference. It seems to us that it is  7 amply wide enough for indeterminate detention to be  8 a contributing practice and, therefore, within the terms  9 of reference.  10 Equally, your scope determination, 6 January,  11 confirms you can make any recommendation you like, and  12 you were clear in the scope determination that you would  13 be flexible and go where the evidence takes you. That  14 is where we say the evidence has taken you. Too many  15 people from too many different stripes are saying the  16 same thing. You are unconstrained, we say. Again, we  17 say look at the scale of what we've seen. You should  18 respectfully do all you can about it. If not you, then  19 who, and if not now, then when? And don't succumb to  20 the siren song of Mr Blake, who told you -- who's not  21 now in the room to hear me say this, but Mr Blake said  22 in opening, "Don't go into the politics. The things  23 that Brook House require is mundane. Don't do that".  24 It is impossible to avoid politics. We are talking  25 about immigration here. Certainly stay off the mundane,</p> <p style="text-align: center;">Page 152</p>

<p>1 certainly let's go beyond mundane.</p> <p>2 So a couple of other things very briefly. If</p> <p>3 Brook Houses are to continue, the mentally ill need to</p> <p>4 be out. They just need to not be in Brook House, they</p> <p>5 need to be not in detention. Not just those who can</p> <p>6 produce a certain calibre of medical report that just</p> <p>7 results in the Home Office then complaining about there</p> <p>8 being too many medical reports, "We don't like the</p> <p>9 medical reports because they all say these people are</p> <p>10 ill". Well, there may be a reason why they say that.</p> <p>11 We know that you can't do therapeutic work in the</p> <p>12 centre. All of the doctors say that. And not just the</p> <p>13 mentally ill, all of the vulnerable need to come out --</p> <p>14 the trafficking victims, torture victims, all of them.</p> <p>15 Bring into the systems those who understand the</p> <p>16 experience of detention, and that may be GDWG, but it</p> <p>17 also means the former detained people themselves because</p> <p>18 that will bring them closer, that will foster</p> <p>19 understanding, it will foster empathy and care, and it</p> <p>20 will do more to understand the detained person</p> <p>21 experience that has not, so far, been well understood.</p> <p>22 And stop, absolutely stop, using this building to detain</p> <p>23 people for any length of time beyond the 72 hours for</p> <p>24 which it has been designed.</p> <p>25 Chair, there are other longer lists of</p> <p style="text-align: center;">Page 153</p>	<p>1 people in their care. He regrets not having done more</p> <p>2 to counteract these behaviours at the time. He would</p> <p>3 like to commend the bravery and resilience of those</p> <p>4 formerly detained persons who have provided evidence to</p> <p>5 the inquiry.</p> <p>6 As Mr Syred said in his opening statement to the</p> <p>7 inquiry, he welcomes the inquiry's scrutiny, and</p> <p>8 continues to be hopeful that the inquiry's findings and</p> <p>9 recommendations will lead to significant improvement for</p> <p>10 those who are detained within immigration detention</p> <p>11 centres like Brook House, but also for the people who</p> <p>12 work in these centres. This closing statement is</p> <p>13 focused on issues that concern staff and management at</p> <p>14 the centre, which is where Mr Syred feels that he can</p> <p>15 add the most value.</p> <p>16 It will address six areas as follows: first,</p> <p>17 dysfunctional leadership; second, recruitment; third,</p> <p>18 training; fourth, career progression and professional</p> <p>19 standards; fifth, the impact of staff -- sorry, the</p> <p>20 impact on staff of working at Brook House; and sixth,</p> <p>21 balance.</p> <p>22 First, dysfunctional leadership. Part of the reason</p> <p>23 for addressing this area first is because the leadership</p> <p>24 is responsible and accountable for the behaviours within</p> <p>25 the centre. But also to highlight at the outset</p> <p style="text-align: center;">Page 155</p>
<p>1 recommendations and they are contained in the fourth</p> <p>2 witness statement of Anna Pincus, who I represent in the</p> <p>3 GDWG, but there is also more from BID, from</p> <p>4 Detention Action, from Medical Justice. You have long</p> <p>5 lists of recommendations, and I can't improve on all of</p> <p>6 those. You have all of those and I will put them in our</p> <p>7 written submissions, but there is a reason why all of</p> <p>8 those people agree. They all know their own bits of</p> <p>9 a system and they all agree, and there is a reason why</p> <p>10 they agree. And I conclude simply by saying, again, go</p> <p>11 where the evidence takes you. Now is the time. Be</p> <p>12 bold.</p> <p>13 Thank you very much.</p> <p>14 THE CHAIR: Thank you, Mr Armstrong. Thank you.</p> <p>15 Mr Stanton, do you require a lectern or anything?</p> <p>16 MR STANTON: No, I'm fine, thank you.</p> <p>17 THE CHAIR: Okay, thank you.</p> <p>18 Closing statement by MR STANTON</p> <p>19 MR STANTON: Chair, I will be giving the closing statement</p> <p>20 on behalf of Owen Syred, who is in attendance today and</p> <p>21 is sat beside me.</p> <p>22 At the outset, Mr Syred would like to say that he</p> <p>23 has followed the evidence of the inquiry closely, and</p> <p>24 has been disgusted at the actions and attitudes of some</p> <p>25 staff which demonstrated a lack of humanity towards</p> <p style="text-align: center;">Page 154</p>	<p>1 an issue that Mr Syred believes runs throughout the</p> <p>2 whole of Brook House, including the senior leadership,</p> <p>3 namely, the lack of clarity and awareness about the fact</p> <p>4 that immigration detention is not a punitive measure but</p> <p>5 a means of facilitating immigration controls.</p> <p>6 There are some features of immigration detention at</p> <p>7 Brook House which are clearly punitive without any</p> <p>8 obvious justification, such as being locked in a room</p> <p>9 with strangers for 11 hours a day.</p> <p>10 There is also a very obvious tension between the</p> <p>11 caring element of ensuring the welfare of detained</p> <p>12 persons and the reality of immigration detention,</p> <p>13 including the need, on occasion, to use force. It was</p> <p>14 striking the number of occasions that staff spoke when</p> <p>15 giving oral evidence about their empathy with detained</p> <p>16 persons, which Mr Syred believes is, on the whole,</p> <p>17 genuine, only to be confronted with recordings of their</p> <p>18 actions and statements which evidenced authoritarian,</p> <p>19 aggressive, abusive or uncaring behaviour.</p> <p>20 Some staff appeared visibly shocked while giving</p> <p>21 evidence and being confronted by their own behaviour.</p> <p>22 Mr Syred believes the lack of clear direction from</p> <p>23 senior leaders as to the purpose of an immigration</p> <p>24 detention centre, most particularly, that it is not to</p> <p>25 operate as a punitive measure, is at the heart of the</p> <p style="text-align: center;">Page 156</p>

<p>1 problem, coupled with the fact that the majority of</p> <p>2 staff were inexperienced and without adequate training.</p> <p>3 Mr Syred has always been aware that there were two</p> <p>4 camps within the DCO and DCM staff, those like Mr Syred,</p> <p>5 who believed that their role and priority was to ensure</p> <p>6 the welfare of detained persons, and those who believed</p> <p>7 that Brook House should be run more like a prison.</p> <p>8 However, having engaged with the inquiry proceedings,</p> <p>9 Mr Syred now realises that this fault line also ran</p> <p>10 through the senior leadership team.</p> <p>11 The inquiry has heard how there was a lack of</p> <p>12 cohesion among the senior leadership team. Lee Hanford</p> <p>13 referred to the "toxic" relationship between senior</p> <p>14 management, to an element of chaoticness, to the fact</p> <p>15 that the relationship between the centre director,</p> <p>16 Ben Saunders, and his deputy, up to 2015,</p> <p>17 Duncan Partridge, had broken down and that other staff</p> <p>18 knew there were two camps on site.</p> <p>19 The statement of Michelle Brown refers to a clear</p> <p>20 lack of trust within the senior management team.</p> <p>21 Mr Syred believes that Ben Saunders was out of his</p> <p>22 depth and did not command the respect of his senior</p> <p>23 leadership team, which was in part due to his social</p> <p>24 care background. There were many within the senior</p> <p>25 leadership team who saw Mr Saunders as too soft and</p> <p style="text-align: center;">Page 157</p>	<p>1 An example of the ineffectiveness of the senior</p> <p>2 leadership team is the failure to support Mr Syred when</p> <p>3 he reported the fact that he was being bullied,</p> <p>4 following his report of a racist incident. You will</p> <p>5 recall, chair, that a poster which contained photographs</p> <p>6 of staff so that they could be identified within the</p> <p>7 centre had been defaced next to Mr Syred's image with</p> <p>8 the words "Grass" and Post-It notes were also placed</p> <p>9 over his locker stating "[N-word] lover" and "Grass".</p> <p>10 Such an appalling example of bullying in support of</p> <p>11 a member of staff who had engaged in racist behaviour</p> <p>12 ought to have resulted in an immediate, visible and</p> <p>13 unequivocal response from senior leadership, including</p> <p>14 clear communication to the workforce that this type of</p> <p>15 behaviour is unacceptable, an investigation to identify</p> <p>16 those responsible and a review of processes, procedures</p> <p>17 and training so that the staff were in no doubt of their</p> <p>18 responsibility to call out inappropriate behaviour, and</p> <p>19 that the more senior the member of staff, the greater</p> <p>20 their responsibility to call it out.</p> <p>21 Instead, nothing was done, other than the provision</p> <p>22 of hollow expressions of support. The fact that</p> <p>23 inappropriate behaviour was not routinely challenged by</p> <p>24 the senior leadership team and managers led to staff</p> <p>25 feeling empowered to behaviour inappropriately because</p> <p style="text-align: center;">Page 159</p>
<p>1 wanted to see the centre run more like a prison, such as</p> <p>2 Duncan Partridge, Steve Skitt, Jules Williams and</p> <p>3 Ian Danskin(?). The prison approach was too ingrained</p> <p>4 within many of the senior leadership team and this</p> <p>5 filleted down through the whole organisation and</p> <p>6 resulted in the promotion of individuals who shared</p> <p>7 these values and contributed to the "us and them"</p> <p>8 culture. Attempts to lighten the prison-style</p> <p>9 environment were opposed and the less austere atmosphere</p> <p>10 at Tinsley House was referred to by some senior</p> <p>11 managers, DCMs and DCOs as "Disney House".</p> <p>12 Mr Syred believes that Brook House suffers from</p> <p>13 an identity crisis for which the senior leadership team</p> <p>14 bear a significant responsibility. In addition to this</p> <p>15 specific and profoundly damaging failure, the staff at</p> <p>16 Brook House were generally not well led. Brook House is</p> <p>17 not a particularly large work force, and almost all</p> <p>18 staff are required to be physically present to carry out</p> <p>19 their work. It should not have been difficult to</p> <p>20 instill a positive supportive team ethos and to</p> <p>21 communicate important messages such as the importance of</p> <p>22 freedom to speak out and to create and reinforce</p> <p>23 positive shared values.</p> <p>24</p> <p>25</p> <p style="text-align: center;">Page 158</p>	<p>1 they knew there would be no consequences.</p> <p>2 The lack of proper recruitment, training and</p> <p>3 induction processes, which will be mentioned in more</p> <p>4 detail later in this statement, was also a significant</p> <p>5 failure of the senior leadership team, as was the lack</p> <p>6 of presence and visibility and any real insight and</p> <p>7 awareness of what was happening on the shop floor.</p> <p>8 There were no proper mechanisms for feeding the views</p> <p>9 and experiences of DCOs and DCMs into the senior</p> <p>10 leadership team and, worse, suggestions for improvement</p> <p>11 and expressions of concern were actively suppressed.</p> <p>12 An example of this within Mr Syred's first statement</p> <p>13 that ironically occurred at a staff forum concerns</p> <p>14 Mr Syred's attempt to discuss what he considered had</p> <p>15 been an unnecessary use of force to facilitate</p> <p>16 a transfer which had caused injury to a detained person</p> <p>17 and to suggest that, in future, officers who may have</p> <p>18 a positive relationship with a detained person be</p> <p>19 afforded an opportunity to explain and persuade the</p> <p>20 detained person to transfer without the need for use of</p> <p>21 force. This is the same type of engagement that the</p> <p>22 inquiry's expert witness Jon Collier indicated when</p> <p>23 giving evidence was not happening enough at Brook House.</p> <p>24 However, Mr Syred was told by Ian Danskin, who was</p> <p>25 chairing the staff forum, that it wasn't for discussion.</p> <p style="text-align: center;">Page 160</p>

40 (Pages 157 to 160)



<p>1 The inquiry has heard a lot from staff witnesses 2 about the fact that bad language was rife within the 3 centre. Some staff continued to seek to justify its 4 use, whereas others had come to realise that, whatever 5 poor language and abuse they faced while working at 6 Brook House, it was not acceptable to respond in kind. 7 Given the relative inexperience and lack of training of 8 many of the staff, it is understandable that they 9 responded in this way. However, it was the job of the 10 senior leadership team to ensure that staff behaved 11 professionally through training, messaging, monitoring 12 and role modelling and, again, in this regard they 13 failed.</p> <p>14 Second, recruitment. If staff are not interested 15 and concerned at the conditions and circumstances in 16 which people are detained, and do not have an interest 17 and concern for the individuals that they are caring 18 for, then they will not be motivated to do a good job. 19 Motivational fit needs to become a central plank of the 20 recruitment process and more emphasis should be placed 21 on identifying people who will take pride in their 22 roles.</p> <p>23 Mr Syred experienced verbal abuse and was sworn at 24 and assaulted on a number of occasions for relatively 25 modest pay but he stayed because he enjoyed the work,</p> <p style="text-align: center;">Page 161</p>	<p>1 started, once reality had dawned. This is a huge waste 2 of recruitment and training resource and another aspect 3 of a flawed recruitment strategy.</p> <p>4 Mr Syred believes that there is a need for a much 5 more robust assessment process to identify and attract 6 people with the right skills who are interested in 7 undertaking the role for the right reasons. The 8 assessment process should continue both through the 9 initial training course and a properly assessed, not 10 just time-served, probationary period.</p> <p>11 Third, training. The inquiry has been repeatedly 12 told that the initial training course did not prepare 13 staff for the realities of the job, which, similar to 14 the failure to accurately advertise the role to identify 15 the right candidates, makes no sense because time and 16 money is wasted on training staff, who often leave 17 shortly after starting once they become aware of the 18 reality of Brook House. On any level the role of a wing 19 DCO as someone who is required to safeguard the welfare 20 of approximately 100 detained persons, together with 21 only one or two colleagues, taking account of physical 22 and mental health issues, the ACDT process, drugs issues 23 and incidents of violence and bullying, as well as 24 contending with verbal abuse and threats of violence, is 25 an extremely challenging position and to perform the</p> <p style="text-align: center;">Page 163</p>
<p>1 particularly the interaction with detained persons, and 2 he felt that he was making a difference. He is not 3 alone in this view and, with more effort, a higher 4 number of candidates with these values could be 5 identified.</p> <p>6 Assessment days for recruitment were often staffed 7 by people such as Graham Purnell and Derek Murphy, both 8 of whom face allegations of violent behaviour against 9 detained persons. This is yet another example of the 10 inappropriate emphasis and value placed on control and 11 restraint and the macho culture at Brook House.</p> <p>12 Mr Syred applied to run an assessment day and was turned 13 down, which illustrates that the values he promoted and 14 his caring approach to detained persons were not 15 regarded by the senior leadership team as attributes to 16 look for in new recruits.</p> <p>17 There is a need to identify and attract staff who 18 will treat the role as a career and not as a stopgap for 19 something else, as was too often the case and which 20 resulted in staff who were content to do the bare 21 minimum. Some suggestions of how this can be achieved 22 are made in a later section in this statement.</p> <p>23 The inquiry has heard from a number of staff 24 witnesses that the reality of the role was nothing like 25 advertised and that many staff left soon after they</p> <p style="text-align: center;">Page 162</p>	<p>1 role properly there needs to be significantly more and 2 better training.</p> <p>3 Given the high levels of incidents of self-harm and 4 mental illness, it is a particularly shocking failure 5 that more training and insight into mental health was 6 not provided to the staff. Some staff have told the 7 inquiry that they received no mental health training. 8 Mr Syred believes that they are mistaken in this regard; 9 however, the fact that many staff do not recognise that 10 they received mental training at all speaks volumes.</p> <p>11 Mr Syred has been a little puzzled at some 12 criticisms of staff during inquiry proceedings for 13 comments made while engaging in role play scenarios, 14 because the whole point of role play training is for it 15 to be as realistic as possible. The language used by 16 detained persons could sometimes be threatening and 17 abusive and there is a need for this to be reflected in 18 the training.</p> <p>19 Mr Syred suggests that there should be more scenario 20 based training and that staff should be confronted in 21 group learning sessions with how and how not to behave 22 in the difficult and challenging circumstances that they 23 will inevitably encounter.</p> <p>24 Mr Syred will also recommend there should be 25 an opportunity during the initial training course for</p> <p style="text-align: center;">Page 164</p>

<p>1 engagement between trainees and detained persons, 2 perhaps former detained persons if they would be willing 3 to take part in such a programme, to better help 4 trainees to see detained persons as individuals, to gain 5 a better insight into the impact of detention and to 6 establish and build empathy.</p> <p>7 Staff must be better equipped to meet the complex 8 needs of detained persons. The range of needs is huge, 9 from short term stays by people who have overstayed 10 their visa and wish or do not object to a return, to 11 people who suffer from serious mental health issues and 12 may have suffered torture and persecution. There are 13 also significant numbers of detained persons who are 14 liable to behave aggressively or violently or to 15 self-harm.</p> <p>16 Mr Syred felt it necessary to undertake additional 17 training at a two-day course on immigration law 18 delivered by Amnesty International to gain a better 19 understanding of the legal issues involved in 20 immigration and so that, as a DCO, he was better able to 21 engage with detainees who were subject to the legal 22 process of removal or deportation. As a result of this 23 interest and commitment, Mr Syred was able to assist 24 a detained person who had been described by officials 25 from his home country as an abomination because of his</p> <p style="text-align: center;">Page 165</p>	<p>1 provided is the fact that Mr Syred was never trained in 2 the operation of rule 35, which represents a significant 3 failure given the importance of this provision, as has 4 been emphasised in the inquiry proceedings. It was only 5 when he started working in welfare several years after 6 he had started at Brook House that he learned about the 7 requirements and the significance of the rule.</p> <p>8 Fourth, career progression and professional 9 standards. There needs to be an opportunity to progress 10 within the DCO grade, so that the centre can build 11 a reservoir of experienced and committed practitioners 12 as well as managers. Mr Syred had no ambition to become 13 a DCM; however, it was the only way to achieve career 14 progression. He wanted to carry on and develop his role 15 as a welfare officer, which allowed him to assist people 16 on a daily basis. Mr Syred believes that the 17 introduction of a senior DCO role to allow for career 18 progression, development and job satisfaction would 19 improve standards within immigration detention centres 20 and also greatly improve staff retention.</p> <p>21 The lack of financial remuneration for experience 22 and commitment to the role also needs to be addressed. 23 As a 10-year served DCO, Mr Syred was earning the same 24 salary as a new recruit with no experience, which was 25 a source of frustration and needs to be addressed in</p> <p style="text-align: center;">Page 167</p>
<p>1 sexuality; and Mr Syred spoke about this in his evidence 2 before the inquiry.</p> <p>3 It is accepted that it is not the role of staff at 4 immigration detention centres to advise detained persons 5 about their claims. However, given the context of 6 immigration detention, and the length of time that some 7 detained persons spent at Brook House, there is a need 8 for better training on the basic principles of 9 immigration law in order to effectively carry out the 10 role of DCO and DCM.</p> <p>11 Training is also largely based on the National 12 Offender Management Service training, which is designed 13 for prisons and not immigration detention centres. The 14 rules governing the running of a prison and 15 an immigration detention centre are different and there 16 are a number of other factors that make the role of 17 a prison officer and that of a DCO and DCM very 18 different, including the uncertainty around the length 19 of detention, the mixed population of detained persons 20 who have been convicted of serious criminal offences 21 with overstayers with no previous experience of 22 detention, and freedom of association and movements, at 23 least during the day, which requires a different set of 24 skills to manage.</p> <p>25 An example of the inadequacy of the training</p> <p style="text-align: center;">Page 166</p>	<p>1 order to retain people with the right skills and 2 experience.</p> <p>3 As an example of the benefits of experience, 4 Mr Syred's reaction when he first started working at 5 Brook House was to become offended by abusive comments 6 or aggressive behaviour by detained persons. However, 7 he came to recognise that it was the detained persons 8 who were locked up while he was not, and to see past 9 such behaviours as isolated incidents, realising that 10 the detained person was in a stressful situation or 11 perhaps having a bad day. The inquiry's counsel team 12 have highlighted this imbalance of power and the duty on 13 staff to behaviour professionally at all times, even in 14 the face of abusive or aggressive behaviour. However, 15 it can be particularly difficult for inexperienced or 16 immature staff to do so, particularly without effective 17 and reinforced training and the availability of 18 experienced role models, such as Mr Syred.</p> <p>19 DCOs and DCMs should be recognised as a specialist 20 profession, not the cheap cousin of prison officers. 21 A recognised qualification tailored to immigration 22 detention centres should be developed and become 23 mandatory for those seeking to work in the centres. 24 This would provide staff with a sense of pride and 25 professional duty.</p> <p style="text-align: center;">Page 168</p>

<p>1 Fifth, the impact of working at Brook House on</p> <p>2 staff. Professor Bosworth spoke about the secondary</p> <p>3 trauma experienced by DCOs and DCMs when confronted by</p> <p>4 the trauma suffered by detained persons, and many</p> <p>5 officers and managers have been adversely affected by</p> <p>6 their experiences at Brook House. The evidence of</p> <p>7 Professor Katona has prompted Mr Syred to reflect about</p> <p>8 the challenges of seeking to support people in dire need</p> <p>9 without the appropriate knowledge, training and support,</p> <p>10 and the detrimental impact on how staff cope and work</p> <p>11 with people with mental illness.</p> <p>12 Working at Brook House, you are exposed to</p> <p>13 high-levels of aggression, abuse and violence, and</p> <p>14 Mr Syred has been assaulted on a number of occasions.</p> <p>15 There is a need to be hyper vigilant to respond to drug</p> <p>16 misuse, violence and threatening behaviour, and this can</p> <p>17 cause mental health problems for staff, particularly</p> <p>18 when the training and support is inadequate. Mr Syred</p> <p>19 has been diagnosed with post-traumatic stress disorder</p> <p>20 and when he tried to raise his own mental health issues,</p> <p>21 the management of Brook House wouldn't listen.</p> <p>22 The strain of working at Brook House led some</p> <p>23 officers to hide their lack of confidence with bravado</p> <p>24 or to act out of character in order to fit in. The</p> <p>25 inquiry heard a particularly distressing example of this</p> <p style="text-align: center;">Page 169</p>	<p>1 Lee Hanford told the inquiry that the behaviours you</p> <p>2 see from the majority of staff, their relationships with</p> <p>3 detainees were excellent. A number of officers and</p> <p>4 managers have told the inquiry about the efforts they</p> <p>5 made to build relationships with detained persons and to</p> <p>6 look after their needs. The inquiry has already heard</p> <p>7 evidence of officers seeking to support detained persons</p> <p>8 by helping them with forms and documents needed for</p> <p>9 immigration cases and assisting with access to legal</p> <p>10 representatives and charities.</p> <p>11 Mr Syred can recall numerous examples of caring and</p> <p>12 supportive behaviour by staff, such as a welfare officer</p> <p>13 colleague, Nikki Madgwick, who arranged for a detained</p> <p>14 person's dog to be cared for by a canine charity;</p> <p>15 James Begg, safer custody manager, who provided detained</p> <p>16 persons with his contact number so that they could</p> <p>17 contact him 24/7 if they had thoughts of self-harm;</p> <p>18 Ramon Giraldo, a highly respected and well liked</p> <p>19 colleague who worked tirelessly to provide activities</p> <p>20 for detained persons with the limited resources</p> <p>21 available to him; Michelle Brown, who attended Surrey</p> <p>22 Accident and Emergency with an Egyptian national who</p> <p>23 required specialist treatment for mental health issues</p> <p>24 and stayed at hospital all night to support him; and</p> <p>25 Mr Syred's colleagues in welfare, who all went the extra</p> <p style="text-align: center;">Page 171</p>
<p>1 when Mr Sanders gave his evidence. Staff were also</p> <p>2 frustrated by staff shortages, the lack of support from</p> <p>3 senior management and by colleagues who were not pulling</p> <p>4 their weight, leaving staff who took the role seriously</p> <p>5 to become overwhelmed and dispirited by not having</p> <p>6 sufficient time to do their jobs properly.</p> <p>7 Sixth, balance. Mr Syred's main aim as a core</p> <p>8 participant is to tell the inquiry what it was really</p> <p>9 like at Brook House. The inquiry has seen and heard</p> <p>10 about the worst of Brook House but there is also another</p> <p>11 side which was not shown in Panorama or drawn out in the</p> <p>12 inquiry hearings. It was a small minority of staff who</p> <p>13 conducted themselves as Yan Paschali and Derek Murphy</p> <p>14 did. By and large, staff at Brook House behaved well</p> <p>15 and treated residents with care, dignity and compassion.</p> <p>16 There are no recordings of officers and detainees</p> <p>17 chatting, having a coffee, sharing a joke or playing</p> <p>18 pool. However, these were everyday occurrences at</p> <p>19 Brook House.</p> <p>20 In his evidence in December of last year, Mr Syred</p> <p>21 told the inquiry:</p> <p>22 "When you worked on a wing with guys, you got to</p> <p>23 know them, they got to know you. It felt like you were</p> <p>24 almost a community. Believe it or not, I had some very</p> <p>25 funny times joking and laughing together."</p> <p style="text-align: center;">Page 170</p>	<p>1 mile on a daily basis.</p> <p>2 There are also many officers who Mr Syred believes</p> <p>3 were caring individuals who were shown in the BBC</p> <p>4 recordings behaving inappropriately, for example</p> <p>5 Charlie Francis, Steve Webb, Calvin Sanders and</p> <p>6 Clayton Fraser. Mr Syred has known some of them for</p> <p>7 years and witnessed them trying to do their best. In</p> <p>8 his evidence to the inquiry, Mr Syred described</p> <p>9 Clayton Fraser as someone who he had "always witnessed</p> <p>10 being quite caring, considerate; to me that was quite</p> <p>11 really out of character but I do believe that was</p> <p>12 probably more just to fit in, just to be accepted and</p> <p>13 it's a very common thing".</p> <p>14 The inquiry has understandably focused on a small</p> <p>15 selection of the recordings made by Callum Tulley.</p> <p>16 However, they do not present a balanced picture of life</p> <p>17 within Brook House, which is a point recognised by</p> <p>18 Professor Bosworth in her expert evidence to the</p> <p>19 inquiry. It is important to Mr Syred that the inquiry</p> <p>20 has a balanced view of what Brook House was like and</p> <p>21 that it should find some way of recognising the many</p> <p>22 positive interactions that took place between staff and</p> <p>23 detained persons. Mr Syred is conscious of the</p> <p>24 distressing experiences that many detained persons</p> <p>25 experienced. However, not all allegations made by</p> <p style="text-align: center;">Page 172</p>

<p>1 detained persons are accurate; for example, the witness 2 statement of D390 submitted to the High Court that 3 referred to the use of batons by staff in circumstances 4 where video evidence demonstrated that this was not the 5 case. There were other examples, and a careful 6 examination of the availability facts is needed when 7 assessing the merits.</p> <p>8 Mr Syred would also ask the inquiry to take account 9 of the fact that there have been significant 10 improvements in the conditions at Brook House between 11 2009, when Mr Syred first joined, and the relevant 12 period in 2017, so that recommendations can be made for 13 the future, having regard to relevant past developments.</p> <p>14 In his first witness statement, Mr Syred states: 15 "When Brook House first opened in 2009, it was 16 a dreadful place. 90 per cent of the detainees were 17 foreign national criminals and it was infested with 18 drugs. There were also problems with prostitution, 19 bullying and gambling. It was a very menacing 20 atmosphere which you could cut with a knife."</p> <p>21 Some of the factors that Mr Syred believes 22 contributed to the problems in the first few years were 23 the fact that the overwhelming majority of residents 24 were time-served prisoners; the failure to allow the 25 centre time to bed in -- almost immediately it was</p> <p style="text-align: center;">Page 173</p>	<p>1 do if they feel they are able to have a positive impact 2 on the circumstances of detained persons and their 3 families, and they are able to positively influence 4 management of the centre.</p> <p>5 Second, the act of locking someone up for 11 hours 6 each day, either alone or with one or more other 7 detained persons, is stressful and damaging to mental 8 health and wellbeing. It is also punitive nature and 9 cannot be said to be in any way necessary to ensure 10 lawful immigration controls. There is no reason that 11 detained persons could not be provided with their own 12 key, with wing officers being able to access rooms which 13 are locked from within where necessary. This is 14 a practice adopted in other countries, notably Norway, 15 and the current low numbers of people in immigration 16 detention would be an ideal time to trial it in the UK.</p> <p>17 One has only to imagine how it would feel to be 18 locked in a room for such a long period of time each day 19 to begin to appreciate the levels of anxiety the 20 practice causes. The fears of detained persons about 21 being locked up at night were very obvious to Mr Syred. 22 Staff would spend considerable time persuading people to 23 be locked up together with a stranger and when detained 24 persons refused they would be taken to the Care and 25 Separation Unit.</p> <p style="text-align: center;">Page 175</p>
<p>1 opened, it was filled with residents -- and an even less 2 experienced workforce than in 2017; less recreational 3 activities were available and the fact that all wings 4 were open to each other, which caused considerable 5 disruption and violence.</p> <p>6 The atmosphere changed completely from 2009 to 2017, 7 and you could not compare the two periods. The main 8 reason that conditions and behaviour improved was 9 because staff were able to build positive relationships 10 with detained persons, and Mr Syred suggests a continued 11 focus in this area will lead to further improvements.</p> <p>12 Finally, Mr Syred would like to suggest two other 13 broad areas for improvement. First, an independent 14 state-run service to better ensure the welfare of people 15 in immigration detention. In Mr Syred's view, the role 16 of a DCO and DCM is far too important for it to be left 17 to a private company whose priorities are to profit and 18 shareholders. Mr Syred also has concerns about the need 19 of any private company to protect their corporate image 20 and the disincentive this brings, conscious or not, to 21 seek to identify poor practices and areas of concern by 22 thorough investigation and external reporting, so that 23 issues can be addressed and improved. In Mr Syred's 24 experience, staff rarely have loyalty to profit 25 companies. However, they will take pride in what they</p> <p style="text-align: center;">Page 174</p>	<p>1 For people who have difficulty sleeping, which is 2 very common in those who are experiencing stress or 3 anxiety, it would be far better for them to have access 4 to communal areas and to be able to undertake 5 an activity, rather than lying in bed with negative 6 thought patterns. Staffing levels would need to 7 increase, but not significantly, and the additional cost 8 would be a small price to pay for the potentially 9 significant improvements to the wellbeing of those in 10 immigration detention.</p> <p>11 A final final point, picking up on what Mr Armstrong 12 said about a hostile environment. Mr Syred can confirm 13 that he was encouraged to make known the hostile 14 environment to detained persons.</p> <p>15 Thank you, chair.</p> <p>16 THE CHAIR: Thank you very much, Mr Stanton.</p> <p>17 Mr Kelly, we are going to be hearing from you next 18 but I am going to suggest that we take our 15-minute 19 break and we will hear from you when we return at 3.45.</p> <p>20 MR KELLY: That is fine.</p> <p>21 THE CHAIR: Thank you very much. 3.45. 22 (3.30 pm)</p> <p>23 (A short break)</p> <p>24 (3.46 pm)</p> <p>25 THE CHAIR: Mr Kelly, thank you.</p> <p style="text-align: center;">Page 176</p>

<p>1 Closing statement by MR KELLY</p> <p>2 MR KELLY: Thank you very much, chair.</p> <p>3 I propose to just deal effectively in a thumbnail</p> <p>4 sketch with the submissions that we are making, because</p> <p>5 we will be making full written submissions later dealing</p> <p>6 with all of the points.</p> <p>7 The very first point I would like to make is that,</p> <p>8 in section 2 of the Inquiries Act 2005, it provides at</p> <p>9 subsection (1) that an inquiry must not "rule on, and</p> <p>10 has no power to determine, any person's civil or</p> <p>11 criminal liability". It is an inquiry, not a court of</p> <p>12 law. No one is on trial.</p> <p>13 Subsection (2) provides that an inquiry is "not to</p> <p>14 be inhibited in the discharge of its functions by any</p> <p>15 likelihood of liability being inferred from facts that</p> <p>16 it determines or recommendations that it makes". The</p> <p>17 use of the word "inferred" clearly refers to subsequent</p> <p>18 litigation, thereby reinforcing the point.</p> <p>19 In respect of article 3, it of course prohibits</p> <p>20 torture, inhumane treatment and punishment. We say, in</p> <p>21 short, that there is no credible evidence that either</p> <p>22 Nathan Ring nor Stephen Webb, as individuals, engaged in</p> <p>23 such conduct. The thrust of the allegations against</p> <p>24 them is the use of foul language on limited occasions.</p> <p>25 Brook House, it has to be said, was an exceptionally</p> <p style="text-align: center;">Page 177</p>	<p>1 and indeed created an atmosphere leading to frustration</p> <p>2 and aggression, all of which contributed to the problems</p> <p>3 this inquiry is examining.</p> <p>4 Professor Mary Bosworth also identified the length</p> <p>5 of time detainees were held in centres such as this as</p> <p>6 a problem, which, among other things, contributed to the</p> <p>7 detainees' poor mental health. If people are subject to</p> <p>8 a regime where they don't know how long they will be</p> <p>9 detained, it is hardly surprising that there will be</p> <p>10 anger and frustration.</p> <p>11 Brook House was overcrowded. There is a significant</p> <p>12 amount of evidence that Brook House was overcrowded and</p> <p>13 that was certainly not helped by putting in a third bed</p> <p>14 in many cells in early 2017 -- the so-called 60 extra</p> <p>15 beds. The independent investigation into concerns about</p> <p>16 Brook House by Kate Lampard and Ed Marsden used three</p> <p>17 words about it.</p> <p>18 THE CHAIR: Sorry, Mr Kelly, I think we have lost your</p> <p>19 microphone. Could you just give us a moment and we will</p> <p>20 get that fixed. (Pause)</p> <p>21 MR KELLY: Is that working?</p> <p>22 THE CHAIR: That is better, thank you.</p> <p>23 MR KELLY: Thanks.</p> <p>24 Do you want me to repeat the last bit or have you</p> <p>25 got that?</p> <p style="text-align: center;">Page 179</p>
<p>1 difficult environment for everyone involved --</p> <p>2 detainees, employed custody officers and other employees</p> <p>3 alike. It was on virtually all accounts a building with</p> <p>4 physical inadequacies, with poor facilities, a building</p> <p>5 which suffered from overcrowding, and a place which was</p> <p>6 under-resourced and understaffed.</p> <p>7 Looking at just some of those things, briefly, it</p> <p>8 could be said to be a poor environment and there was</p> <p>9 certainly uncertainty as to how long the detainees would</p> <p>10 be kept prisoner in Brook House and that contributed, we</p> <p>11 say, to its problems. The cells were not kept clean,</p> <p>12 there was poor ventilation, some exercise areas were</p> <p>13 closed, the exercise space was far too limited, and that</p> <p>14 is just according to Jeremy Petherick of G4S.</p> <p>15 Mr Singh from Her Majesty's Inspectorate of Prisons</p> <p>16 had this to say:</p> <p>17 "But I think one of the major ones is the fact that,</p> <p>18 you know, this is in relation to Brook House in</p> <p>19 particular, it is a centre which looks and feels like</p> <p>20 a prison and is designed like a prison."</p> <p>21 As we have said many times, that is inappropriate</p> <p>22 for a detainee population.</p> <p>23 The length of detention was uncertain or, put</p> <p>24 another way, detainees were subject to indefinite</p> <p>25 detention. That had a serious impact on the detainees</p> <p style="text-align: center;">Page 178</p>	<p>1 THE CHAIR: If you could start again -- you were going to</p> <p>2 start talking about the independent investigation by</p> <p>3 Kate Lampard, if you want to start there. I think we</p> <p>4 lost you then. Thank you.</p> <p>5 MR KELLY: The independent investigation into concerns about</p> <p>6 Brook House by Kate Lampard, and Ed Marsden in 2018</p> <p>7 described it as "overcrowded and unsettled".</p> <p>8 Brook House was under-resourced. Footage of</p> <p>9 Callum Tulley looking for an evacuation chair but there</p> <p>10 were not any to be had, nor were there any where they</p> <p>11 were supposed to be. In any event, Brook House didn't</p> <p>12 have enough evacuation chairs.</p> <p>13 There was a group complaint submitted by detainees</p> <p>14 regarding the lack of internet access. There was a lack</p> <p>15 of translators, long queues to use IT equipment or</p> <p>16 access to the welfare office. There was no clean</p> <p>17 bedding often, no cleaning equipment provided, officers</p> <p>18 unable to provide basics such as toilet roll, not enough</p> <p>19 showers for the number of detainees, poor internet, poor</p> <p>20 phone signal, malfunctioning phones and poor quality</p> <p>21 food.</p> <p>22 Brook House was also understaffed. As Nathan Ring</p> <p>23 put it:</p> <p>24 "The Home Office contract was, I believe, very</p> <p>25 prescriptive, particularly in terms of how many hours</p> <p style="text-align: center;">Page 180</p>

<p>1 G4S were prepared for. Staff on the ground, however,</p> <p>2 generally felt that Brook House was understaffed. On</p> <p>3 a good day, we were lucky to have 50 officers in the</p> <p>4 whole centre. On evenings, you might be lucky to have</p> <p>5 six DCOs and two DCMs. It left staff on the ground of</p> <p>6 the centre often feeling vulnerable, overworked and</p> <p>7 uneasy."</p> <p>8 However, there was a high turnover of staff and,</p> <p>9 because a lot of the candidates were inexperienced, some</p> <p>10 candidates never came back following the training course</p> <p>11 or decided that, after a month of working in the role,</p> <p>12 it was not what they expected. It was the residential</p> <p>13 side which suffered the most with retaining staff.</p> <p>14 The counsel to the inquiry, Mr Altman, on the first</p> <p>15 day seemed to recognise this when, in opening, he said:</p> <p>16 "You may want to consider whether the range of</p> <p>17 staffing problems described contributed to</p> <p>18 dissatisfaction amongst detained persons and a growing</p> <p>19 feeling of hopelessness and frustration among them,</p> <p>20 which, in turn, had an impact on the levels of</p> <p>21 self-harm, substance misuse and violence at</p> <p>22 Brook House."</p> <p>23 The more challenging or non-compliant detained</p> <p>24 persons became in consequence of their environment, the</p> <p>25 more some staff resented them for the additional work</p> <p style="text-align: center;">Page 181</p>	<p>1 lay in the indefinite nature of the detention. That was</p> <p>2 the root of all the problems -- the fact that it was</p> <p>3 designed and supposedly intended to house people for</p> <p>4 short term, pending their removal from the</p> <p>5 United Kingdom -- and I personally, and I think many</p> <p>6 others in this room are still in the same position,</p> <p>7 whether it was 28 days, 72 days or 72 hours and, if so,</p> <p>8 when that changed, are none the wiser after the evidence</p> <p>9 heard but, whatever it was, through Home Office failings</p> <p>10 and inefficiency the detention of its residents</p> <p>11 stretched to many months in some cases.</p> <p>12 The Home Office in the form of Mr Phil Riley</p> <p>13 characterised the notion of detention for no more than</p> <p>14 72 hours in Brook House as an "urban myth". That</p> <p>15 uncertainty as to how long an individual might be</p> <p>16 deprived of his liberty led inevitably to frustration on</p> <p>17 the part of those detained. This was recognised by</p> <p>18 Jeremy Petherick on Day 34, when he said:</p> <p>19 "The real issue that impacted on detainees'</p> <p>20 wellbeing and mental health was their sense of not</p> <p>21 knowing what was happening with them and the</p> <p>22 frustrations of their progress towards their release</p> <p>23 either into the United Kingdom or their repatriation,</p> <p>24 and so the major impact on their wellbeing was the</p> <p>25 uncertainty of the situation they found themselves in."</p> <p style="text-align: center;">Page 183</p>
<p>1 and stress this added to their lives. Understaff and</p> <p>2 overwork were also reported to affect staff morale in</p> <p>3 a direct sense.</p> <p>4 Much has been said about the use of foul language.</p> <p>5 However, we cannot treat Brook House as a normal</p> <p>6 workplace like an office. Swearing was, on the</p> <p>7 evidence, a common method of communication and was not</p> <p>8 intended to be offensive. In many cases it appears that</p> <p>9 such swearing was speaking to detainees in the common</p> <p>10 language in use by staff, including in fact</p> <p>11 Callum Tulley and detainees on occasions. As Mr Ring in</p> <p>12 his evidence said, such language often was a coping</p> <p>13 mechanism for many in Brook House.</p> <p>14 Now, when it comes to the inquiry considering the</p> <p>15 role of Callum Tulley, you should bear in mind the</p> <p>16 evidence of officers such as Yan Paschali, who described</p> <p>17 Callum Tulley as always fishing for stories. He told</p> <p>18 you how he, Mr Paschali, responded by making up stories</p> <p>19 and how he embellished the stories. You should also</p> <p>20 bear in mind Callum Tulley's own evidence that he only</p> <p>21 turned his camera on when he thought he would capture</p> <p>22 interesting material. That footage should not be</p> <p>23 treated as intrinsically representative of everyone at</p> <p>24 Brook House.</p> <p>25 The true ill-treatment and cruelty at Brook House</p> <p style="text-align: center;">Page 182</p>	<p>1 The problem, in our submission, is the system. It</p> <p>2 would be an error to scapegoat the former employees and</p> <p>3 put events down to a few bad apples. Such an approach</p> <p>4 would do nothing to address the issues which have given</p> <p>5 rise to the need for this inquiry, and would not address</p> <p>6 what has been dealt with by a variety of different</p> <p>7 witnesses. In short, such an approach would be no more</p> <p>8 than a cop out with little credibility.</p> <p>9 The two men we represent, Nathan Ring and</p> <p>10 Stephen Webb, if guilty of anything, are guilty of</p> <p>11 little more than a few facetious comments, silly</p> <p>12 comments, which were made in what they thought were</p> <p>13 private conversations. In short, the staff must not be</p> <p>14 portrayed as the scapegoats; nor are they</p> <p>15 self-evidently responsible for immigration or</p> <p>16 deportation policy. They merely worked in</p> <p>17 a dysfunctional system.</p> <p>18 It is, we submit, on the evidence clear that many of</p> <p>19 the problems with Brook House were and are due to</p> <p>20 indefinite detention as a policy, combined with housing</p> <p>21 detainees in what in effect was a prison, with extremely</p> <p>22 limited facilities, understaffed, under-resourced, badly</p> <p>23 managed, and the responsibility for that should be laid</p> <p>24 where it belongs: at the door of the Home Office and its</p> <p>25 contractors, here G4S.</p> <p style="text-align: center;">Page 184</p>

46 (Pages 181 to 184)

<p>1 Thank you, chair. I am glad to say that I have</p> <p>2 finished well within time.</p> <p>3 THE CHAIR: Thank you very much, Mr Kelly.</p> <p>4 Mr Jacobs.</p> <p>5 Closing statement by MR JACOBS</p> <p>6 MR JACOBS: Chair, I represent Charlie Francis and I am</p> <p>7 instructed by Howe &amp; Co. Charlie Francis was a DCO at</p> <p>8 Brook House from 2012 and during the relevant period,</p> <p>9 and he appears in the Panorama programme. I don't</p> <p>10 propose to deal with the evidence at length today, and</p> <p>11 will do that in more detail in the written submissions.</p> <p>12 Mr Francis gave evidence on Day 23, 3 March 2022.</p> <p>13 He became a core participant on the previous day, so you</p> <p>14 don't have opening submissions in respect of him.</p> <p>15 Mr Francis would like the inquiry to know that he is</p> <p>16 watching today on the live link -- he cannot be here</p> <p>17 this afternoon.</p> <p>18 It is important that I say from the outset that</p> <p>19 Mr Francis does not seek to excuse his behaviour towards</p> <p>20 D1527 and D728, as shown on the Panorama programme. He</p> <p>21 accepted in his evidence that he was shocked when he saw</p> <p>22 that programme and couldn't believe, he said, that he</p> <p>23 was seeing himself.</p> <p>24 Generally speaking, my client was a capable and</p> <p>25 competent DCO. He had no antipathy towards those</p> <p>Page 185</p>	<p>1 now?" He said that, at the time, he used those words</p> <p>2 believing he was bringing D1527 out of a state of</p> <p>3 anxiety, "to bring him back to reality", in his words.</p> <p>4 He confirmed in his evidence, when asked by</p> <p>5 Mr Altman, that he now understands that he was unable</p> <p>6 then to distinguish between a detainee who was capable</p> <p>7 of rational actions and a suicidal man who was suffering</p> <p>8 from mental illness. Mr Francis received no training in</p> <p>9 mental health or PTSD awareness. In the absence of such</p> <p>10 training, he believed at the time that he was able to</p> <p>11 distinguish between those who he believed were genuine</p> <p>12 people who wished to harm themselves and those who he</p> <p>13 thought at the time were attention seeking. Mr Francis'</p> <p>14 position, looking back and reflecting, is that, had he</p> <p>15 been appropriately trained by G4S, he would have acted</p> <p>16 entirely differently towards D1527.</p> <p>17 The same lack of awareness in relation to mental</p> <p>18 health issues apply to my clients exchanges with D728 on</p> <p>19 6 July 2017. The video footage shows my client arguing</p> <p>20 with this detainee who had been trying to frustrate</p> <p>21 officers by covering the observation hatch with tissue</p> <p>22 paper and had been complaining about lack of access to</p> <p>23 medication. Mr Francis was heard to say to the</p> <p>24 detainee, "If I have to come back again, you won't be</p> <p>25 going anywhere today. You will be staying down here</p> <p>Page 187</p>
<p>1 detained at Brook House and told the inquiry that he</p> <p>2 treated detainees as human beings. He also told the</p> <p>3 inquiry in his evidence that he intervened on two</p> <p>4 occasions to save detainees who had tried to kill</p> <p>5 themselves, and the detail of that is detailed in his</p> <p>6 witness statement.</p> <p>7 DCM Webb referred to Mr Francis when he gave</p> <p>8 evidence on Day 26, and he said:</p> <p>9 "Charlie was a good officer, he was a very good</p> <p>10 officer who I relied on a lot and I am sorry that he got</p> <p>11 tied up in what I said."</p> <p>12 The core participant Syred, who is to my right,</p> <p>13 Owen Syred said, when asked about the officers on E wing</p> <p>14 who were macho and cliquy, he said:</p> <p>15 "Yes, most of the guys apart from one, Charlie,</p> <p>16 I knew very well. He was always very good with</p> <p>17 detainees."</p> <p>18 Mr Francis is shown on the Panorama programme making</p> <p>19 inappropriate remarks towards D1527 on 25 April 2017 and</p> <p>20 using inappropriate language towards that detainee in</p> <p>21 the aftermath of the Paschali choking incident,</p> <p>22 an incident which my client has described in his</p> <p>23 evidence as "horrific". My client accepts that he used</p> <p>24 the words, "Are you going to continue being a tool? Are</p> <p>25 you a man or a mouse? Are we getting bored with this</p> <p>Page 186</p>	<p>1 permanently, do you understand?" And after they were</p> <p>2 out of the detainee's earshot, Mr Webb used derogatory</p> <p>3 language saying he would like to punch the detainee. He</p> <p>4 made it clear in his evidence that the detainee couldn't</p> <p>5 have heard that, and Mr Francis replied "If you don't,</p> <p>6 I will".</p> <p>7 Mr Francis accepts there is no excuse for his</p> <p>8 behaviour but, again, he was not able to understand that</p> <p>9 D728 was a man who had significant mental health</p> <p>10 problems. Mr Francis' primary problem here is that he</p> <p>11 was not properly trained to deal with detainees with</p> <p>12 mental health and PTSD issues and that is a systemic</p> <p>13 failing at Brook House.</p> <p>14 Neither was my client trained or equipped to deal</p> <p>15 with the negative macho-aggressive culture that had been</p> <p>16 allowed to develop and fester at Brook House.</p> <p>17 Sarah Newland in her Verita interview referred to</p> <p>18 a large cadre of DCMs who are testosterone-filled and Mr</p> <p>19 Francis stated in his evidence that there were two</p> <p>20 categories of staff members at Brook House, some in his</p> <p>21 words were "very hard-nosed uncaring types without</p> <p>22 compassion or softness", and he confirmed that that</p> <p>23 certainly included Yan Paschali, who in his view</p> <p>24 shouldn't have been working on E wing. The second</p> <p>25 category were officers who, like my client and Mr Syred,</p> <p>Page 188</p>

<p>1 were more human, more sympathetic and more placid men.</p> <p>2 In Mr Francis' case, the former group prevailed over</p> <p>3 the latter. Mr Francis agreed in his evidence that he</p> <p>4 was one of those who was easily led by more dominant</p> <p>5 staff members. He was led into behaviour by other</p> <p>6 officers but did not instigate that behaviour. The</p> <p>7 Reverend Ward has made the same point in his evidence to</p> <p>8 the inquiry. He described my client as someone who did</p> <p>9 not have bad intent but an example of someone who was</p> <p>10 caught up in the culture of Brook House. He goes on to</p> <p>11 say that, in both incidents in which Mr Francis is</p> <p>12 featured in the Panorama programme, he took</p> <p>13 inappropriate action and used inappropriate and</p> <p>14 offensive language when in the company of more dominant</p> <p>15 staff members.</p> <p>16 But, chair, this is as far as it goes. It is</p> <p>17 important to note that Mr Francis, when giving evidence,</p> <p>18 clearly and categorically rejected any suggestion that</p> <p>19 he tried to cover up Paschali's conduct or that his</p> <p>20 reluctance to give a police statement over and beyond</p> <p>21 the information that he had given in detail to G4S</p> <p>22 represented any attempt to protect Paschali from</p> <p>23 prosecution.</p> <p>24 We respectfully say there is no proper basis for the</p> <p>25 inquiry to make any finding along the lines that my</p> <p style="text-align: center;">Page 189</p>	<p>1 with G4S, my client received no mental health training.</p> <p>2 Indeed my client may have believed he was actually doing</p> <p>3 some good by speaking harshly to detainees. He talks in</p> <p>4 his statement about trying to snap someone out of</p> <p>5 an emotional or vulnerable state.</p> <p>6 Dr Hard told the inquiry on Day 39 that staff didn't</p> <p>7 understand D1275's mental health problems and he</p> <p>8 confirmed they were not concerned about his welfare as</p> <p>9 such, rather they were frustrated by the presentation of</p> <p>10 symptoms. The nurse in the room behaved no differently.</p> <p>11 The inquiry witness Bosworth, Professor Bosworth,</p> <p>12 dealt with this issue on Day 40. She said that the</p> <p>13 training given to DCOs was pretty minimal and focused on</p> <p>14 security. It did not enable staff to see the residents</p> <p>15 as highly vulnerable, but rather dangerous and</p> <p>16 difficult. She recommended that mental health training</p> <p>17 have a focus on secondary trauma training for DCOs, as</p> <p>18 that would enable them to conduct their duties with</p> <p>19 empathy and recognise that the dehumanisation,</p> <p>20 aggression and losing control of emotions that we have</p> <p>21 seen in the evidence can be symptoms of secondary trauma</p> <p>22 in the detention centre staff themselves.</p> <p>23 There appears to have been no mental health element</p> <p>24 in C&amp;R training. Jon Collier told the inquiry that the</p> <p>25 test criteria used to medically evaluate the</p> <p style="text-align: center;">Page 191</p>
<p>1 client was involved in any cover up, aside to what is</p> <p>2 said about the inquiry not being able to make findings</p> <p>3 in relation to liability, but that is an important point</p> <p>4 for my client.</p> <p>5 We agree, and we say that there is broad agreement</p> <p>6 amongst the core participants' representatives, that the</p> <p>7 evidence has shown that the problem at Brook House was</p> <p>8 not one of bad apples or, as Mr Brockington for G4S</p> <p>9 suggested, "isolated incidents". The problems at</p> <p>10 Brook House in the relevant period arose from systemic</p> <p>11 failings, as Dr Patterson has said "a corrupted</p> <p>12 culture", and ultimately it was the responsibility of</p> <p>13 G4S and the Home Office to secure the welfare of</p> <p>14 detainees at the facility and the systems in place at</p> <p>15 Brook House failed to do this.</p> <p>16 Chair, like Mr Stanton before me, I will address you</p> <p>17 on six issues, six areas. The first area, which I have</p> <p>18 already touched on, is lack of mental health training.</p> <p>19 Mr Francis stated in his witness statement that, when he</p> <p>20 attended DCO refresher courses, he would say that</p> <p>21 officers needed to receive psychological training to</p> <p>22 understand and respond to what detainees were</p> <p>23 experiencing. He states that he was not alone in</p> <p>24 thinking this and he recalls others on his shift saying</p> <p>25 the same thing but, despite having raised this issue</p> <p style="text-align: center;">Page 190</p>	<p>1 appropriateness and safety of C&amp;R techniques employed in</p> <p>2 an IRC does not include consideration of mental illness</p> <p>3 or vulnerabilities such as history of torture and</p> <p>4 trauma.</p> <p>5 Chair, this is a matter of some concern. Mentally</p> <p>6 ill detainees subjected to these procedures in the</p> <p>7 relevant period are likely to have found the experience</p> <p>8 terrifying and to have been retraumatised by it, but</p> <p>9 none of this was in the thinking of G4S or the</p> <p>10 Home Office. So we say that the inquiry should</p> <p>11 recommend that all IRC staff receive mandatory mental</p> <p>12 health awareness training, including PTSD training from</p> <p>13 a recognised and independent source, such as HMIP.</p> <p>14 Chair, the second issue is that Brook House involved</p> <p>15 a unique situation for which the training given to DCOs</p> <p>16 was inadequate and Mr Francis' evidence highlighted the</p> <p>17 fact that it was no ordinary detention facility. He</p> <p>18 stated in his evidence that there were DCOs who left</p> <p>19 Brook House shortly after completing their training</p> <p>20 because they realised they had not been properly trained</p> <p>21 to deal with the condition there and a particular</p> <p>22 problem, as Mr Kelly touched on before I spoke, and as</p> <p>23 Mr Lee submitted in his submissions in relation to D643,</p> <p>24 who was at Brook House for 558 days, is that some</p> <p>25 individuals believed they would be staying at</p> <p style="text-align: center;">Page 192</p>



<p>1 Brook House for two weeks or two months but ended up 2 staying there for two years. In reality, Brook House 3 must have seemed like a place of internment for many who 4 were there. Unsurprisingly, this created levels of 5 exasperation and desperation and many detainees would 6 eventually lash out and resort to self-harm.</p> <p>7 Professor Bosworth said in her evidence on Day 40 8 that this issue affects staff because it makes their 9 role unclear. She said:</p> <p>10 "If you don't know how long someone is there for, it 11 is hard to motivate yourself to invest in them as 12 a person."</p> <p>13 She said this factor affected staff culture and led 14 to desensitisation as a mechanism for dealing with 15 people who staff members were unable to help.</p> <p>16 Another problem which Mr Francis highlighted in his 17 evidence was the mixing of often dangerous and violent 18 criminal deportees in cells with vulnerable asylum 19 seekers or overstayers, and we saw this on the Panorama 20 programme. My client said this led to intimidation and 21 bullying of the non-criminal detainees. There were also 22 high-levels of the drug spice that came through the 23 doors largely unchecked, and my client confirmed in his 24 evidence that he received no training on substance abuse 25 and would dread the prospect of violence, which was</p> <p style="text-align: center;">Page 193</p>	<p>1 My client stated in his evidence that the E wing 2 segregation -- that is the wing on which he worked -- 3 was used to manage distressed behaviour, including 4 self-harm and suicidal ideation, certainly not for the 5 purpose of providing treatment. Dr Hard stated that 6 E wing detainees were primarily being managed by 7 detention staff with very little clinical input.</p> <p>8 Sandra Calver gave evidence that some people did indeed 9 deteriorate as a result of being on that wing.</p> <p>10 So much of the detention in the relevant period in 11 2017 was unlawful detention. People were being kept in 12 conditions where they hadn't been properly assessed 13 when, if they had been assessed, they would have been 14 released under the DCO and under the Adults at Risk 15 policy.</p> <p>16 I should say a little something about that policy. 17 There is a problematic element to it because it involves 18 as balancing exercise between risk factors and so-called 19 immigration factors which has been criticised, but there 20 is an underlying presumption that detention will not be 21 appropriate if a person is considered to be at risk 22 through having experienced traumatic events, or where 23 there is a medical or professional or observational core 24 of evidence that an individual is suffering in the way 25 that they have a condition such as a mental health</p> <p style="text-align: center;">Page 195</p>
<p>1 potentially likely when the effects of the drug wore 2 off.</p> <p>3 It is quite clear, chair, that Mr Francis' evidence 4 is that Brook House was dysfunctional with unique 5 systemic problems for which no proper training of staff 6 was given to Mr Francis and other DCOs.</p> <p>7 The third issue is that detainees, many of those at 8 Brook House, were simply not suitable to be deputy in 9 detention in the first place. That affected my client's 10 working conditions and that is an issue that has been 11 exposed by the Panorama programme. No amount of 12 training could have equipped my client to deal with 13 those detainees whose experiences of past torture or 14 whose mental health conditions were such that they were 15 incapable of being managed in detention.</p> <p>16 Dr Hard said on Day 39 that rules 34 and 35 were not 17 properly operated in the relevant period. We have heard 18 that, in early operating and nursing screening on 19 arrival, healthcare failed to take account of the 20 specific needs of the detainees. So DCOs like my client 21 were charged with looking after individuals who had 22 already been failed by healthcare. Dr Hard agreed with 23 the view taken by Medical Justice that the arrangements 24 at Brook House made it impossible to comply with 25 rules 34 and rule 35.</p> <p style="text-align: center;">Page 194</p>	<p>1 condition that would be likely to render them 2 particularly vulnerable to harm if they are placed in 3 detention or remain in detention. Yet that system 4 didn't work because it was let down by a culture of 5 disbelief by healthcare at Brook House.</p> <p>6 So Mr Francis' position is not only was he 7 inadequately trained to deal with detainees who were 8 lawfully present at Brook House, but he was required 9 through systemic failures to deal, whilst untrained, 10 with numerous detainees who suffered from mental health 11 conditions which, under the Secretary of State's own 12 policies, rendered them unsuitable for administrative 13 detention.</p> <p>14 Chair, the fourth issue is that Brook House was 15 understaffed at the time and run for profit by G4S. 16 This was a contributing factor to the situation in 17 Brook House which affected my client and which is shown 18 in the Panorama documentary -- the financial motivation 19 of the institution that which was charged with running 20 the facility. We saw evidence yesterday that the tender 21 delivered 35 cost savings compared to the original 22 budget.</p> <p>23 In my submission, my client was required to work in 24 an inhuman environment where removal and security were 25 prioritised over health and safety, and nothing</p> <p style="text-align: center;">Page 196</p>

<p>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.</p> <p>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:</p> <p>"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."</p> <p>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:</p> <p>"I would go home after a 12-hour shift and we would come back later, six hours after that, and do the same</p> <p style="text-align: right;">Page 197</p>	<p>defaced with words such as "Snitch" and "Grass".</p> <p>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.</p> <p>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.</p> <p>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</p> <p style="text-align: right;">Page 199</p>
<p>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."</p> <p>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.</p> <p>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.</p> <p>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</p> <p style="text-align: right;">Page 198</p>	<p>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.</p> <p>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.</p> <p>On Day 40, the professor agreed that this dehumanisation contributes to the risk of abuse. She said:</p> <p>"The only moral narrative about IRCs from the</p> <p style="text-align: right;">Page 200</p>

<p>1 Home Office's point of view is either one in relation to</p> <p>2 security, dangerous criminals or a moral narrative; they</p> <p>3 don't deserve to be here (interference)."</p> <p>4 This narrative, the Home Office's narrative, led to</p> <p>5 desensitisation or dehumanisation of staff members.</p> <p>6 Karen Churcher said it was the Home Office's view that</p> <p>7 detainees with mental health difficulties were better</p> <p>8 off in detention, rather than being released from</p> <p>9 detention. Lee Hanford says that the Home Office</p> <p>10 criticised G4S staff for showing too much empathy.</p> <p>11 On Day 40, what Professor Bosworth said is that the</p> <p>12 Home Office must have known what was going on but her</p> <p>13 understanding is that they did not concern themselves</p> <p>14 with detention. Dr Hard has agreed that people</p> <p>15 suffering from PTSD may go on to suffer from secondary</p> <p>16 psychosis in detention, owing to the stresses of being</p> <p>17 there and traumatised.</p> <p>18 Chair, Mr Francis was required to work within</p> <p>19 a toxic culture at Brook House, but the entire system</p> <p>20 was dysfunctional. The Home Office were aware of and</p> <p>21 caused this disfunctionality. Essentially, the</p> <p>22 Home Office's view was that they found Brook House too</p> <p>23 cumbersome to bring about any meaningful change and, as</p> <p>24 Mr Altman put to the witness, the corporate witness</p> <p>25 yesterday, they simply sat on the problem; and I endorse</p> <p style="text-align: center;">Page 201</p>	<p>1 recommendations are made: one, that the Home Office</p> <p>2 exercises a greater degree of oversight of IRCs to</p> <p>3 ensure that contractors operate in a transparent fashion</p> <p>4 so that we don't see a repeat of those incidents on the</p> <p>5 Panorama programme; that contracts with IRC operators</p> <p>6 are varied or drafted to contain provisions requiring</p> <p>7 prioritisation of the welfare of detainees; that those</p> <p>8 contracts are varied or drafted to contain provisions</p> <p>9 requiring mandatory staffing levels; that all IRC staff</p> <p>10 receive mandatory mental health awareness and PTSD</p> <p>11 training from a recognised and independent source, such</p> <p>12 as HMIP; that all IRC staff are provided with</p> <p>13 counselling and other facilities to manage secondary</p> <p>14 trauma and stress levels; that those who are unsuitable</p> <p>15 for detention, as Dr Hard recommends, are screened out</p> <p>16 at an early stage in which the Home Office engages with</p> <p>17 independent medical advisers to assess individuals prior</p> <p>18 to admission to an IRC; that segregation is no longer</p> <p>19 used as a means of managing those with mental health</p> <p>20 problems; that effective complaints whistleblowing</p> <p>21 procedures are implemented in all IRCs with a specific</p> <p>22 focus on dealing with the abuse of detainees; that</p> <p>23 policies are brought into effect to bring about the</p> <p>24 change to the culture within the Home Office in relation</p> <p>25 to immigration detainees; and, finally, that the</p> <p style="text-align: center;">Page 203</p>
<p>1 what Ms Morris said this morning, that at best all the</p> <p>2 Home Office are doing is tweaking around the edges.</p> <p>3 So in relation to the findings that we ask you to</p> <p>4 make, I endorse what Mr Armstrong has said, that you</p> <p>5 must make bold and robust findings, because we don't</p> <p>6 want another inquiry to sit here in five years' time</p> <p>7 dealing with the same points.</p> <p>8 Ultimately, while my client behaved unacceptably</p> <p>9 towards detainees, he was at the centre of a perfect</p> <p>10 storm where DCOs were not trained to deal with mentally</p> <p>11 ill detainees at a facility in which men were often</p> <p>12 detained for apparently indefinite periods, in which</p> <p>13 detention of those with mental health problems was very</p> <p>14 often unlawful, in which vulnerable asylum seekers and</p> <p>15 visa overstayers were required to share rooms with</p> <p>16 dangerous criminals, in which there was a drugs and</p> <p>17 violence problem, and in which segregation was used as</p> <p>18 a means of managing vulnerable detainees. Furthermore,</p> <p>19 the facility was run by an organisation that prioritised</p> <p>20 profit over safe staffing and the welfare of detainees.</p> <p>21 On top of all of this, Brook House was overseen by</p> <p>22 a government department that had sought to stigmatise</p> <p>23 and marginalise immigration overstayers, failed asylum</p> <p>24 seekers and criminal deportees.</p> <p>25 So we ask on Mr Francis' behalf that following</p> <p style="text-align: center;">Page 202</p>	<p>1 practice of apparently indeterminate detention is</p> <p>2 brought to an end, with detainees being informed of</p> <p>3 a fixed date when their detention will end, in the event</p> <p>4 that they cannot be returned to their countries of</p> <p>5 origin.</p> <p>6 I agree with Mr Armstrong that this does fall within</p> <p>7 the terms of reference of this inquiry.</p> <p>8 Chair, I am aware of the time. I think I have ended</p> <p>9 at the right time. Unless I can assist further, those</p> <p>10 are my submissions.</p> <p>11 THE CHAIR: Thank you very much, Mr Jacobs.</p> <p>12 I am grateful for all of the submissions I have</p> <p>13 heard today and we will be returning tomorrow at 10.00</p> <p>14 am for the remaining submissions.</p> <p>15 Thank you very much.</p> <p>16 (4.33 pm)</p> <p>17 (The inquiry adjourned until 10.00 am the following day)</p> <p>18</p> <p>19</p> <p>20 I N D E X</p> <p>21</p> <p>22 Closing statement by MR ALTMAN .....1</p> <p>23 Closing statement by MS HARRISON .....13</p> <p>24 Closing statement by MS MORRIS .....49</p> <p>25 Closing statement by MR GOODMAN .....54</p> <p style="text-align: center;">Page 204</p>

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