**BROOK HOUSE INQUIRY**

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**Closing submissions of Bhatt Murphy**
**Core Participants**

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## I. Introduction

1. Five years ago, on 7 September 2017 the BBC' *Panorama* programme aired a documentary entitled "*Undercover: Britain's Immigration Secrets*" ("the *Panorama* programme"). It showed footage recorded secretly by a young man, Callum Tulley, who worked as a detention custody officer working at Brook House, an immigration detention centre operated by G4S located just behind Gatwick Airport. The covertly recorded material showed appalling and repugnant scenes: a detained person with mental health issues being ridiculed and physically assaulted, an officer describing to a room of other staff his assault on a detained person, detained persons being spoken of in derogatory, dehumanising terms using racist language, a collective decision not to record use of force. The misconduct filmed secretly at Brook House involved custody officers, healthcare staff and manager. Further, in the period over which events were recorded there were no concerns raised by the Independent Monitoring Board (IMB) or Home Office staff located at Brook House, nor by Her Majesty's Inspectorate of Prisons (HMIP).

2. In opening submissions made on behalf of Medical Justice, D801, D1275, D1713, D2158 and D1473 ("the Bhatt Murphy CPs"), we highlighted the two main tasks for the Inquiry in its Evidence Phase:

    a. **First**, to bring to light the full facts of what happened at Brook House and identify the dangerous policies, practices, and management arrangements that caused or contributed to mistreatment and who is responsible for this. This fact-finding is important to inform what remedial course of action is necessary to prevent recurrence;

    b. **Second**, to give former detained persons an important opportunity to confront those responsible for their mistreatment and abuse on an equal footing. An important part of restorative justice is to be able to question and hold to account not just the frontline staff who perpetrated acts of violence, physical and abuse, humiliation, medical neglect and disregard of their suffering and denial of their human dignity, but also the absent complicity and complacency of managers who run the detention centre or sit in the corporate officers of G4S, and of civil servants and ministers who

have been entrusted with the exercise of a draconian power that deprives people of their liberty without need for prior independent scrutiny or authority.

3. This latter point has been a priority for both Medical Justice and the formerly detained people that Bhatt Murphy represents in the Inquiry.

   a. Each of the five formerly detained people represented by Bhatt Murphy has told the Inquiry in their witness evidence that they wanted to participate because they want to ensure that the mistreatment and abuse they experienced is not repeated. This has been at some personal cost for them as they have had to relive these traumatic and life changing experiences to achieve that purpose. Putting their experience and their wishes at the heart of this Inquiry in the hearings is what the Chair promised and must now deliver with the Inquiry's findings and recommendations.

   b. Medical Justice wants an end to the impunity with which the power of administrative detention has been used for so long on a mundane and regular basis, and allowed individuals to be held for indeterminate periods without charge or trial. They know all too well from their clients' experience, their interactions with detention staff and engagement with the Home Office that sacking a handful of custody officers, albeit guilty of grave misconduct, does not begin to identify or address the root causes or contributory factors in the mistreatment that occurred, and was allowed to go unchecked for much longer than the period captured on film by Mr. Tulley.

4. There have been previous abuse scandals – also exposed because of undercover reporting – at Oakington in 2005, at Yarl's Wood in 2004, 2014 and 2015 and Harmondsworth in 2014. Those scandals tell similar accounts of misuse of force and segregation on vulnerable people, the use of derogatory and racist language toward people held under administrative detention powers, and the complicit silence signified by the absence of complaints and whistleblowing. Independent reports had been commissioned, recommendations made, but none of those resulted in the change needed to prevent the abuse scandal at Brook House in 2017. Even the investigations carried out thus far specifically into what happened at Brook House in 2017 did little to prevent the abuse at

the centre in 2020, and avoid the finding made by the Independent Monitoring Board that the whole detained population was exposed to risks in inhumane treatment.

5. Medical Justice's recently published report, *Harmed not Heard*[1] shows that the complete deprivation of safeguards in the system still do not protect those unsuitable for detention because of mental illness and past histories of torture and trauma from being exposed to harm in detention and, in too many occasions, suffering actual harm.

6. We commend the Inquiry for the rigour with which it has sought to fulfil its functions, commensurate with the importance of the rights at stake under Article 3. Once the Inquiry went beyond the Panorama programme itself, it has uncovered - through unbroadcast BBC footage, CCTV, body worn and hand-held camera footage, pages of transcripts and reams of documents - truly shocking patterns of inhumane and degrading treatment of detainees. Central to which is:

   a. the overuse and misuse of force and segregation often without lawful authority or justification,
   b. the normalised of the infliction of pain, suffering and humiliation, even whilst the detained person is naked, or so emaciated the man could barely hold his own body weight,
   c. the pervasive derogatory and violent verbal abuse and racism to them or about them,
   d. underscored by an underlying lack of any empathy even when at their most distressed and vulnerable- even if life threatening situations.

7. It has been profoundly disturbing to witness repeated physical abuse, the severe mental anguish, and denial of human dignity in the footage, transcripts and oral evidence of officers. It has been harrowing to hear the direct evidence of detained persons who were brutalised by the toxic environment marked by violence, chaos, disrespect, disregard and callous indifference to fundamental rights and human suffering. It has also been disconcerting to listen to detention custody officers who, even in oral evidence, maintained patently untrue accounts or claimed no memory in the face of incontrovertible

[1] https://medicaljustice.org.uk/wp-content/uploads/2022/04/2022_HarmedNotHeard_Final.pdf April 2022

evidence of misconduct and cover up, and who have sought to deflect responsibility to Callum Tully, accusing him of misrepresenting them, inciting them, or failing himself to report the misconduct. Several of these officers, whose misconduct was not caught on camera has only been fully exposed by this Inquiry but they *remain in post*. Some like Stephen Dix have been promoted. Ben Saunders, the Director of Gatwick IRCs during the relevant period, was allowed to resign and work elsewhere for another private contractor Mitie involved with immigration enforcement.

8. It is abundantly clear from the evidence heard and seen by the Inquiry that what happened were not isolated incidents. Both Owen Syred and Callum Tulley described alarming incidents of abuse well before April 2017. Owen Syred and Rev. Nathan Ward spoke of a culture of desensitisation, dehumanisation and disbelief that had become entrenched since it first opened in 2009. Medical Justice, Freedom from Torture and Gatwick Detainee Welfare Group also spoke of endemic failure of detention safeguards in preventing and reducing the numbers of vulnerable people who are put in detention and remain there for indeterminate periods of time without being identified as unsuitable for detention. Healthcare witnesses confirm these failures in the oral evidence they give and importantly confirm that they are not only based on established practices and customs, preceding the relevant period, but also adopted across the detention estate.

9. The Inquiry's experts are also ad idem on the underlying causes of the abuse and mistreatment captured on BBC Panorama being systemic failures and dysfunctions, not isolated incidents perpetrated by a group of rogue officers:

   a. Mr. Collier, the Inquiry's use of force expert, considered that what we have seen even now to be the tip of the iceberg, and that the fact that so many incidents of brutal uses of force were only identified through covert camera footage is indicative of the extent to which a culture where force is normalised, and is not reported, challenged (and at times covered up) took root[2].

   b. Professor Bosworth, the Inquiry's expert on institutions and cultures, said that the prisonisation of immigration detention – in the way the detention centre looked, the

[2] Jon Collier 1st report, §670, INQ000111_0160

policies, practices and management arrangements adopted and operated, the staff seeing themselves as prison officers whose role was to secure the centre from threats – desensitised staff and allowed the dehumanisation and racist othering of detained people as criminal, dangerous people who need to be controlled and disciplined.[3]

c. Dr. Hard, the Inquiry's clinical expert, said it was *"impossible"* not to draw a causal connection between the mistreatment of detained people, the routine misuse of force and segregation and the *"complete failures"* of the systems safeguards, particularly Rules 3, 34, 35 and 40 of Detention Centre Rules 2001, to guard against harm being caused to detained people.[4] The systems failures led to high numbers of vulnerable people not being identified as vulnerable and kept in an environment that has a known negative impact on mental health so that behaviours like self-harm, distress, mental health problems, are treated as challenging behaviour and an inappropriate response that leads to escalating mental health problems and increased risks of self-harm. He agreed[5] with Medical Justice's Dr. Bingham that it was *"a perfect storm."*[6]

10. Both Dr. Hard and Professor Bosworth pointed to the draconian nature of administrative detention, the absence of any time limit to detention and the use of it, as the evidence shows, as a punitive measure in circumstances of a complete deprivation of safeguards, as the fundamental and underlying causal factor for the mistreatment. They are not alone in this view; it is one given by the full spectrum of witnesses to the Inquiry, from specialist NGOs, such as Medical Justice, Gatwick Detainee Welfare Group, Freedom from Torture, Detention Action, Bail for Immigration Detainees, Inquest, to G4S senior manager and former managers, to professional bodies like the British Medical Association, to oversight bodies such as the HMIP and the IMB, Mr Shaw (a reviewer commissioned by the Home Office to scrutinise the welfare of vulnerable detained people in detention) and Parliamentary committees.

[3] See for example, Professor Bosworth, 29 March 2022, 13/23-25, 14/1-2, 39/18-22; 46/10-12.
[4] Dr Jake Hard 28 March 2022, 117/20-25, 118/1-11, 119/1-11.
[5] Dr Jake Hard 28 March 2022, 177/20-25, 178/1-15, 20-25.
[6] Dr Rachel Bingham 14 March 2022 55/1-15.

11. The Inquiry should not ignore or disregard that the use of this draconian power of administrative detention is the starting point for understanding what happened, why it happened, and so that real, tangible and effective change can be brought about finally. The Terms of Reference require the Inquiry to grapple with this. Doing so is not to stray in the political arena. How the detention power is used, the safeguards against its misuse and the length of detention are all clearly matters of policy, practice and management arrangements. That is why there is a suite of detention policies, rules and casework instructions governing the way in which Home Office caseworkers, detention custody officers, and IRC healthcare professionals ought to function and perform. Whether these policies, practices and management arrangements governing the exercise of the detention power caused or contributed to any identified mistreatment fall squarely within the Inquiry's Terms of Reference, and underpins the purpose of an Article 3 investigation.

12. In our system of justice, lessons are not learnt unless you are willing to confront and accept misconduct, wrong-doing and failings that harm others:

    a. Peter Neaden and Jerry Petherick, both G4S senior corporate managers, did not accept their own culpability or responsibility for the dysfunctional senior management team at Brook House, of which they were aware from 2014, but at least they recognised that there must have been serious failure on the part of G4S because this abuse and mistreatment occurred. Not so its Managing Director, Gordon Brockington, with his prepared script, his dissembling, evasion and denials. His evidence alone exposes G4S as not a fit and proper company and one which should not have been after 2017 – and should not now be - entrusted with public functions in the containment and care of prisoners or detained persons.

    b. The evidence of senior Home Office officials – Ian Cheeseman, Philip Schoenenberg and Philip Riley - confirm a state body that is driven by political imperatives to sacrifice welfare on the alter of enforcement and administrative convenience that relegates safeguarding of detained persons to a virtual footnote in a contract . That puts cost cutting over safety and care. It also confirmed the utter disinterest in criticisms of its actions, the failure of its polices and practices, whether by oversight bodies, judges, coroners or its own appointed reviewer (Stephen Shaw), and is cavalier about its legal duties and the adverse impacts on those it

detains and in apparently indifferent to ensuring the necessary changes to prevent repeated abuse and mistreat re occurring.

c. Phil Riley did not look much beyond limited contractual tweaking and increase in staff numbers. Was unable to accept that the original corner cutting contract that baked in dangerously low staffing levels, a harsh regime and impoverished conditions would have impact on welfare – maybe other operations but not welfare. Phil Riley, without irony, asserted that the Home Office had taken "every step we could take proportionately to deliver a safe environment" and claimed that the rule 35 system has now been improved and even that there was no systemic failure in 2017.

d. This is of real concern. The same wilful denial of HO responsibility and cannot be reconciled with the evidence that the Inquiry has heard and to which Mr Riley even now is oblivious. This is important because it is the mind-set of men like these who will be responsible for considering and implementing any recommendations this Inquiry makes.

13. Their attitude and analysis of the events at Brook House provides key evidence for the Inquiry's crucial function in its next phase – to identify

a. why mistreatment and abuse was allowed to *re-occurred* in 2017, again only exposed by uncover reporting
b. whether and how the detention system, regime, policy and practices sanctioned or allowed it to occur,
c. why lessons have not been learnt from past abuse scandals indeed even from this one 5 years on, and
d. what effective remedial action can now be taken, particularly in the wake of another abuse scandal in BH 2020 : where the IMB found the cumulative effect of their concerns amounted to inhumane treatment of the entire population.

14. Fundamental remedial action needs to be urgently taken. Its already far too late. The evidence obtained by the Inquiry post-Panorama has in no way diminished this imperative. If anything, it has only grown more pressing:

a. Dr Hard described a "deprivation of safeguards" to protect detained persons from harm was a significant factor in 2017, which is continuing;

b. The institutional culture of bullying and intimidation, according to Michelle Brown one of its long-serving G4S Mangers is also continuing;

c. The IMB report on the inspection period between January and December 2020 found high incidences of vulnerability, mental illness and self-harm and a clear correlation between this and the increased of prison-based methods including ACDT, use of force and segregation as a first resort to managing vulnerable detained persons, and continued dysfunctions in the Rule 35 process. The letter from the IMB to the Home Office is telling:[7]

> *"Our evidence indicates that a series of issues are collectively and cumulatively having an unnecessary, severe and continuing impact on detainees, particularly those facing removal on charter flights, as well as across the detainee population as a whole. We believe that the cumulative effect of these concerns amounts to inhumane treatment".*

15. All this shows beyond doubt that contractual tweaks and increased staff, even with a much lower detained population, did not prevent inhumane conditions occurring and serve as the breeding ground for continued excessive and unlawful use of segregation and force on highly vulnerable people. PPG – the current healthcare contractor – could not commit to remedial action on the recalcitrant systems failures in safeguards without direction and resources from the Home Office to do so. Serco's Steven Hewer could give no assurances that another situation like that identified by the IMB in 2020 as inhumane. That, he says, is only within the control of the Home Office.

16. Given this, the Inquiry needs to identify a fundamentally different approach to bring about fundamental change where previous investigations and reviews have failed to

[7] DL0000140_001113-116

achieve - not because it is bold or political but because it is the only rational and logical consequence of where the evidence has taken this Inquiry.

17. We have in the next Section set out a summary of the findings that we urge the Inquiry to make about the system and in respect of the breaches of Article 3 experienced by our individual Core Participants. We also set out proposals for remedial action, many build on and develop the recommendations that Medical Justice has made over more than 15 years in their published reports, consultation responses and engagement with the Home Office.

18. Fundamental to our proposals is the urge on the Inquiry to press for alternatives to detention, which are available and must be found because current detention policy is failing. In any event, the use of this draconian power to detain needs to be constrained and controlled within clearly defined and strict limits; the detention of people who are vulnerable in particular by reason of a past history of torture, trauma and mental illness must end.

19. None of these are radical conclusions. They are the findings and recommendations that have been made on a recurring basis by Parliamentary committees, oversight bodies, and Stephen Shaw.[8]

20. No civilised society should tolerate anything else.

21. This Inquiry should also conclude that Brook House must not be used as an immigration removal centre, further to the clear view of HMIP and the expert evidence of Professor Bosworth that it is simply an "*inappropriate environment*".

[8] Annex 1 to Emma Ginn's witness statement, BHM000041.

## II. Summary of Our Submissions

22. We invite the Inquiry to make the following findings in answer to the Terms of Reference:

### (1) Has there been mistreatment of complainants and who is responsible?

23. Each of the individual formerly Core Participants was subjected to a system of immigration detention that was deprived of functional safeguards capable of identifying them and effectively removing them from detention. Instead, each was held in immigration detention and suffered inhuman and degrading treatment contrary to Article 3 ECHR. Detailed submissions on each individual Core Participant are in **Section X**.

24. Each of them was unlawfully detained, and but for that unlawful detention, would not have been exposed to the risks of and actual harm experienced. Therefore, the ultimate responsibility for the mistreatment is the Home Office.

25. All of them also suffered neglect from healthcare, which lacked the knowledge and understanding the statutory safeguards, what they do, when they are used, and how they are used, failed to act in accordance with their primary duties of care to detained people as patients, and were desensitised to the suffering of each of them. Perhaps the starkest examples of this are the experiences of D801 who was without any psychiatric care for 34 days despite it being identified as urgent and necessary, and D1275 whose severe mental disorder was left undiagnosed and untreated and dismissed as challenging behaviour. This is both the responsibility of the Home Office, for its oversight and monitoring of safeguards, and G4S Healthcare for its management arrangements and operation on the ground.

26. No custody officer intervened to prevent D1275 from being exploited as a guinea pig for spice by reason of his vulnerabilities. He was subject to casual and degrading verbal abuse and mockery by Derek Murphy and Nathan Ring when he was at his most vulnerable but this was allowed to continue without any protest from healthcare or other custody officers. Officers were only disciplined after the BBC Panorama programme aired. D2158 and D1713 experienced casual violence and witnesses inappropriate force being used on vulnerable detained persons. D1473 suffered a misuse of force by the application of a Waist Restraint Belt that was unlawful, unnecessary and unjustified but

no detention custody staff or healthcare professional in the detention centre sought to intervene to prevent its use. Their experience reflects a desensitised and dehumanised culture that suppresses dissent for which G4S senior management must take responsibility, but the Home Office must as well for prisonising the centre.

**(2) Did methods, policies, practices and management arrangements (both of the Home Office and its contractors) caused or contributed to any identified mistreatment?**

27. **Yes** for all the reasons set out in **Sections V (Policy, Structural and Operational Breaches of Safeguards), VI (Prisonisation and Toxic Culture), VII (Misuse of Force) and VIII (Suppression of Dissent)**. Our submissions on who is responsible is set out in **Section IX**.

**(3) Will any changes to these methods, policies, practices and management arrangements help to prevent a recurrence of any identified mistreatment?**

28. **Yes to a limited extent**. Rule 3 of the Detention Centre Rules impose a duty on the state to create and operate a humane and safe detention environment. The recommendations made in **Section XI** set out changes that are necessary to prevent a recurrence of the mistreatment identified in these submissions.

29. However, as Professor Bosworth told the Inquiry, these changes will not eliminate the risk of mistreatment and only minimise it, which is why on behalf of the Bhatt Murphy Core Participants, it is our respectful submission that the use of administrative detention for immigration enforcement purposes needs to be phased out, or at least significantly curtailed. We set out the rationale for this in **Sections IX and XI**.

**(4) Did any clinical care issues cause or contribute to any identified mistreatment?**

30. **Yes**, for all the reasons outlined in **Section V** and in the submissions on behalf of individual formerly detained Core Participants. Medical Justice's witnesses, Theresa Schleicher, Dr. Rachel Bingham, Dr. Brodie Paterson and Professor Cornelius Katona provide powerful evidence to this effect. This is supported by the Inquiry's own clinical expert, Dr. Hard.

**(5) Will any changes to clinical care help to prevent a recurrence of any identified mistreatment?**

31. **Only to the limited extent** that it is possible to correct the dysfunctions in the statutory safeguards so that it is possible to promptly identify people who are vulnerable to harm in detention at the earliest opportunity. This cannot happen by tweaking healthcare arrangements. It requires a decisive injection of resources and clear instructions to healthcare (not a lame two page letter setting out the rules) to direct them on the important responsibility they have to advocate for and protect detained people from suffering a deterioration or harm. See further **Section XI**.

32. But the fundamental problem is that the safeguards did not prevent high numbers of highly vulnerable people from being identified prior to being detained in the first place.

**(6) Are the complaints and monitoring mechanisms provided by the Home Office and external bodies adequate in respect of any identified mistreatment?**

33. **No**. None of the complaints and monitoring mechanisms – whether the PSU, HMIP or IMB – identified the mistreatment before it was exposed publicly on air by BBC Panorama. In **Section IX**, we provide our analysis of why this is the case.

34. In **Section XI**, we provide a detailed list of proposals for change that we invite the Inquiry to adopt in its recommendations.

35. In the light of the forceful view expressed by Dr. Hard, supported by Medical Justice's experience and the evidence of healthcare witnesses, there is a need for urgent change to be brought about now, before the Inquiry has finalised its report, so that at the very least, as the Chair identified, people who are vulnerable to harm are not subject to this unnecessarily in circumstances where the evidence is clear as to the deprivation of statutory safeguards to protect them and the grave consequences of such deprivation.

36. The steps that can and should now be taken as a matter of urgency are as follows:

    a. Additional resources need to be urgently made available so that initial GP appointments within the first 24 hours of a person entering detention can be of a sufficient length to be capable of completing a medical examination that can result in a Rule 35 report;

b. R35 appointments should be automatic and delays must be eliminated or reduced. This will require additional and sufficient resources to be made available urgently so that the number of Rule 35 appointments are not capped at 1 or 2 a day. Rather resources need to be made available so that appointments are made available immediately where there is a need;

c. Instructions need to be given to GPs and healthcare staff that the threshold trigger for a Rule 35(1) or Rule 35(2) does not require evidence that a person cannot be satisfactorily managed in detention through other means, contrary to the misdirection set out in the templates for those two limbs of Rule 35. This is a necessary urgent first step to ending the application of a satisfactory management threshold to responding to mentally ill detained people, which has already been found by Mr. Shaw to be contrary to good psychiatric care and an affront to civilised values.

d. Opening an ACDT because of risk of self-harm or suicide should result in a R35(2) report, or at least sufficient assessment and consideration of one, and further a consideration of a R35(1) report, with a view to a speedy detention review for consideration of release;

e. GPs and healthcare professionals should be given clear instructions that they should be able to review a person's circumstances and not impose limits to the number of Rule 35 reports they need to do. The fact that the Home Office refuses to release further to a Rule 35 report should not act as a deterrent or barrier to raising a further Rule 35 report. So far as the healthcare professionals are concerned, a Rule 35 report should be raised whenever and however often the need arises but has not resulted in release.

f. Segregation due to self-harm and suicide risk should likewise trigger Rule 35 report and release.

37. The Home Office's and is contractors' resistance to learning lessons also mean that it is crucial for the Inquiry to have an implementation phase so that the progress of the recommendations that this Inquiry will make can be reviewed. We cannot wait for the

next brave young man willing to carry out undercover reporting before mistreatment and abuse is exposed again. It needs to stop, and it needs to stop now.

## III. Article 3: Principles and Application

38. The following principles relating to Article 3 are well-established in the Strasbourg jurisprudence and can be summarised as follows:

39. Article 3 enshrines one of the most fundamental values of democratic society. It prohibits in absolute terms torture or inhuman or degrading treatment or punishment, irrespective of the circumstances and the victim's behaviour (*Rooman v Belgium*, App, 18052/11, para. 141).

### (1) Treatment contrary to Article 3

40. The CTI's note focusses on physical and verbal mistreatment. But it is understood to be common ground that the Inquiry is also concerned with mental mistreatment, including suffering which flows from naturally occurring illness, physical or mental, where it is, or risks being, exacerbated by treatment, whether flowing from the conditions of detention, or other measures, for which the authorities can be held responsible as well as the provision and adequacy of medical treatment. This is clear from the Grand Chamber's judgment in *Rooman*, which the CTI refers to in their note at and which is set out above in the Grand Chamber's judgment at para. 143-147.

41. This underpins and informs the Inquiry's task under paragraph 3 of the Terms of Reference and the Inquiry will recognise the significance of these obligations in the context of the consensus of medical opinion and clinical research that mental illness cannot be effectively and appropriately treated in an IRC nor can it even be appropriately managed.[9] That is why it has always been and continues to be an imperative for policy to prevent detention of those with mental illness or secure prompt release once identified as suffering from mental illness.

42. In order for treatment to fall within the scope of Article 3 ECHR it must attain a minimum level of severity. The assessment of this minimum is, in the nature of things, relative: it depends on all the circumstances of the case, such as the nature and context of the treatment, the manner and method of its execution, its duration, its physical or mental

[9] See Professor Mary Bosworth's *Mental Health Literature Survey Sub-Review*, annexed as Appendix 5 to Stephen Shaw's 1st report in 2016, INQ000060_0307; Dr. Rachel Bingham witness statement, §§35-36,46-60, BHM000033; Professor Cornelius Katona witness statement, §§70-80, and in respect of specific mental disorders §§90-102, BHM000030

effects and, in some instances, the sex, age and state of health of the victim (*Rooman v Belguim* para. 141).

43. **Torture**: Torture can be psychological as well as physical. A single incident can amount to torture if serious or cruel enough, and a threat of physical torture can amount to mental torture depending on the severity of the pressure exerted and the intensity of the mental suffering caused.

44. **Inhuman treatment**: By contrast, inhuman treatment does not need to be deliberate or intended to cause suffering, *Ireland v United Kingdom* (1980) 2 EHRR 25, and there is no requirement that the suffering be inflicted for a purpose.

45. The Court defined "inhuman treatment" and "degrading treatment" in *Kudla v Poland* (2000) 35 EHRR 198 at para. 92 to include treatment that "*caused either actual bodily injury or intense physical or mental suffering*".

46. **Degrading treatment**: Treatment is considered to be *"degrading"* when it arouses in the victim feelings of fear, anguish or inferiority capable of breaking his or her moral and physical resistance, or when it is such as to drive the victim to act against his or her will or conscience. Although the question whether the purpose of the treatment is to humiliate or debase the victim is a factor to be taken into account, the absence of any such purpose cannot conclusively rule out a finding of violation of Article 3 (*Kudla*, para. 141).

47. In the context of deprivation of liberty any "*recourse to physical force which is not strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3 ECHR*": *Keenan v United Kingdom* (2001) 33 EHRR 38, para. 112.

48. Measures depriving persons of their liberty inevitably involve an element of suffering and humiliation. That being stated, Article 3 requires the State to ensure that all prisoners are detained in conditions which are compatible with respect for their human dignity, that the manner of their detention does not subject them to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in such a measure: *Rooman,* para. 142 and *Kudla,* para. 92.

49. Given the practical demands of imprisonment, their health and well-being are adequately secured by, among other things, providing them with the requisite medical assistance. The Court has emphasised that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them: *Rooman* para. 143.

**(2) Suffering associated from mental illnesses**

50. The suffering which flows from naturally occurring illness, whether physical or mental, may in itself be covered by Article 3, where it is, or risks being, exacerbated by conditions of detention for which the authorities can be held responsible. Hence, the detention of a person who is ill in inappropriate physical and medical conditions may in principle amount to treatment contrary to Article 3 ECHR: *Rooman,* para. 144.

51. The suffering associated with relapse in mental health could in principle, fall within the scope of Article 3: *Bensaid v UK* (2001) 33 EHRR 10, at para. 37 and the ECtHR has emphasised that where the authorities decide to detain a person with disabilities, they should demonstrate special care in guaranteeing such conditions as correspond to the person's individual needs resulting from his disability: *Jasinskis v. Latvia*, no. 45744/08, para. 59, 21 December 2010; *Price v. the United Kingdom*, para. 30.

52. States have an obligation to take particular measures which provide effective protection of vulnerable persons and include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge (see *Z and Others v. the United Kingdom* [GC], no. 29392/95, para. 73, ECHR 2001-V). Any interference with the rights of persons belonging to particularly vulnerable groups – such as those with mental disorders – is required to be subject to strict scrutiny, and only very weighty reasons could justify any restriction (*Alajos Kiss v. Hungary*, no. 38832/06, para. 42, 20 May 2010).

53. The Inquiry has powerful evidence from a number of sources of the feeling of anguish and inferiority that occurs as a result of the inevitable suffering of deterioration in mental illness. This comes directly from the detained people, G4S staff and the clinical experts Professor Katona, Chair of the Royal College of Psychiatrists and Dr Bingham.

**(3) Article 3 in a detention context**

54. In determining whether the detention of an ill person is compatible with Article 3 of the Convention, the Court takes into consideration the individual's health and the effect of

the manner of execution of his or her detention on it. It has held that the conditions of detention must under no circumstances arouse in the person deprived of his liberty feelings of fear, anguish and inferiority capable of humiliating and debasing him and possibly breaking his physical and moral resistance (*Selmouni v. France* [GC], no. 25803/94, para. 99, ECHR 1999 V). On this point, it has recognised that detained persons with mental disorders are more vulnerable than ordinary detained persons, and that certain requirements of prison life pose a greater risk that their health will suffer, exacerbating the risk that they suffer from a feeling of inferiority, and are necessarily a source of stress and anxiety. It considers that such a situation calls for an increased vigilance in reviewing whether the Convention has been complied with (*Sławomir Musiał v. Poland,* no. 28300/06, para. 96, 20 January 2009).

55. In addition to their vulnerability, the assessment of the situation of these particular individuals has to take into consideration, in certain cases, the vulnerability of those persons and, in some cases, their inability to complain coherently or at all about how they are being affected by any particular treatment: *Rooman*, para. 145.

56. The Court must also take into account of the adequacy of the medical assistance and care provided in detention. A lack of appropriate medical care for persons in custody is therefore capable of engaging a State's responsibility under Article 3. In addition, it is not enough for such detained persons to be examined and a diagnosis made; instead, it is essential that proper treatment for the problem diagnosed should also be provided, by qualified staff: *Keenan paras.* 115-116 and *Rooman,* para. 146.

57. In this connection, the "adequacy" of medical assistance remains the most difficult element to determine. The Court reiterates that the mere fact that a detained person has been seen by a doctor and prescribed a certain form of treatment cannot automatically lead to the conclusion that the medical assistance was adequate. The authorities must also ensure that a comprehensive record is kept concerning the detained person's state of health and his or her treatment while in detention, that diagnosis and care are prompt and accurate, and that where necessitated by the nature of a medical condition supervision is regular and systematic and involves a comprehensive therapeutic strategy aimed at adequately treating the detained person's health problems or preventing their aggravation, rather than addressing them on a symptomatic basis. The authorities must also show that

the necessary conditions were created for the prescribed treatment to be actually followed through. Furthermore, medical treatment provided within prison facilities must be appropriate, that is, at a level comparable to that which the State authorities have committed themselves to provide to the population as a whole. Nevertheless, this does not mean that every detained person must be guaranteed the same level of medical treatment that is available in the best health establishments outside prison facilities: *Rooman*, para. 147.

58. Where the treatment cannot be provided in the place of detention, it must be possible to transfer the detained person to hospital or to a specialised unit: *Rooman*, para. 148.

59. The jurisprudence cited above, and by the CTI and considered above concerns prisons. It applies to to the context of administrative detention under immigration powers subject to one fundamental modification, which is the question of the legality of underling detention and the option for release not normally in issue in the context of prison sentence. The starting point for evaluating the minimum threshold of severity is different where someone has been lawfully deprived of their liberty by an order of the court, and where the detention arose from an unlawful exercise of administrative detention powers. Where the detention was unlawful because it was in breach of the state's policies and safeguards related to protect vulnerable people in detention, that finding is obviously highly material to the assessment of whether there was a violation of Article 3 during the period that a person was unlawfully detained and their suffering is not incidental to a legitimate measure. Furthermore, if the person is unlawfully detained then any touching is a trespass to the person and any use of force, reasonable or otherwise is an assault.

60. Whilst every case is fact-sensitive, there are six decided domestic cases in which the Article 3 threshold for inhuman and/or degrading has been found to have been breached by the immigration detention of mentally ill individuals without deliberate physical mistreatment – the first five were reviewed by Jeremy Johnson QC in the first Shaw Review in 2016: *R(S) v SSHD* [2011] EWHC 2120, *R(BA) v SSHD* [2011] EWHC 2748, *R(HA (Nigeria)) v SSHD* [2012] EWHC 979, *R(D) v SSHD* [2012] EWHC 2501, *R(MD) v SSHD* [2014] EWHC 2249. Subsequently *ARF v SSHD* [2017] EWHC 10 (QB)[10] also

[10] I NQ000060 :Stephen Shaw ('Review into the Welfare in Detention of Vulnerable Persons', Cm9186, January 2016) which included a review of the Article 3 cases by Jeremy Johnson QC. An updated review was published in July 2018 (Cm9661).

involved a finding of an article 3 breach. In a seventh case *VC v SSHD* the Home Office conceded in 2020 the appeal to the Supreme Court on the basis that the facts disclosed an article 3 breach. VC was held in BH for several months in 2015. The common features of these cases included (i) serious deterioration in mental illness (both exacerbation of pre-existing illness or as is in *R(MD) v SSHD* being caused by detention itself); (ii) inability to deliver effective medical treatment; iii) inappropriate management through segregation and use of force to address mentally disturbed behaviour ; vii) self-neglect and compromised inter-personal relations causing humiliation in the eyes of the individual or third parties. A table addressing the key facts and findings in these cases is attached hereto at Annex 1.

**(4) Positive Duty under Article 3 – Systems and Operational**

61. The importance of the obligation is underscored by key features of the protections in Article 3 ECHR which are stringent. They are absolute and non-derogable[11]. They also imposed on the state non-delegable duties (those duties cannot be contracted out). States are obliged not only to prohibit and punish ill-treatment but also to forestall its occurrence: it is insufficient merely to intervene after its infliction, when the physical or moral integrity of human beings has already been irremediably harmed. Consequently, States are bound to put in place measures that pre-empt perpetration of ill-treatment. Therefore states must take positive steps to prevent actual breaches and potential breaches of the prohibition against torture and inhuman and degrading treatment.

62. The positive duties on the state including (i) to have in place a clear and effective legal framework and procedure to prevent a breach (the 'systemic duty'): *Savage v South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681 and *VC* para 113-114, 118, and (ii) an operational duty to prevent a breach in the individual case.

63. The state must not violate the physical and psychological integrity and the human dignity of persons deprived of their liberty and is required to take preventive measures to preserve human dignity: *Premininy v Russia* (44973/04) (2016) 62 E.H.R.R. 18, *Mouisel v France* (67263/01) (2004) 38 E.H.R.R. 34 and *Keenan v United Kingdom.* In particular,

[11] Non-derogable means those rights from which state parties to the European Convention on Human Rights cannot derogate they comprise the right to life, the right not to be subjected to torture, inhuman and degrading treatment, the right not to be subject to slavery, and the prohibition on retrospective criminal punishment.

detained persons are in a vulnerable position and the authorities are under a duty to protect them: *Edwards v United Kingdom* (2002) 35 EHRR 19 para 56.

64. Here, whether the state did so through its policies, practices and arrangements at Brook House reflects the Inquiry's tasks contained in paragraphs 2 and 4 of the Terms of Reference. In accordance with those terms, the Inquiry is tasked not only with making findings of operational failures in individual cases but also failures in systems level arrangements which were either a cause or a contributory factor t the operational breaches occurring in the first place.

65. The positive duties under Article 3 ECHR mean that the lack of system or the system as operated by the SSHD will be unlawful if it creates an unacceptable risk of breach of Article 3 ECHR : *R (Munjaz) v Mersey Care NHS Trust* [2006] 2 AC 148.

**(5) Institutional Racism and connection with Article 3**

66. CTI's note does not specifically address institutional and personal racism, but is plain where evidenced by explicit racist language or derogatory racial or xenophobic stereotyping, this inherently undermines the dignity of the person and alone may constitute degrading treatment in breach of Article 3. Racism is recognised to be a special form of affront to human dignity.[12] It will certainly be an exacerbating factor if treatment occurs in the context of institutional racism.

**(6) Inhumane treatment of the whole detained population in 2017**

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

68. We invite the Inquiry to find that the conditions in 2017 and 2020 bear striking similarities in respect of key features including high numbers of vulnerable detained persons, high incidence of self-harm and cases of suicidal risks, the routine use of

[12] *East African Asians v The United Kingdom* (1973) 3 EHRR 76 and *Cyprus v Turkey* (2002) 35 EHRR 731 para. 306.

segregation and force to respond to self-harm and the complete dysfunction of the Rules 34 and 35 safeguards with the same harmful consequences. Our evidence indicates that a series of issues are collectively and cumulatively having an unnecessary, severe and continuing impact on detained persons, particularly those facing removal on charter flights, as well as across the detained person population as a whole. We believe that the cumulative effect of these concerns amounts to inhumane treatment".

69. This link was made by several of the witnesses in their written and oral evidence to the Inquiry:

g. Medical Justice's witnesses;
h. Nathan Ward;
i. Professor Bosworth;
j. Lee Hanford

70. We emphasise this because not all of the Bhatt Murphy Core Participants were subject to overt physical ill-treatment or ill-treatment of the severity to which D1527 was subject. Nevertheless, all of them have been subject to mistreatment which was at least degrading, if not inhuman, in breach of Article 3 ECHR.

71. We remind the Inquiry that in granting judicial review May J recognised at para. 63 that the allegation made by D1257 go much wider than events shown in the Panorama programme and the full extent of Article 3 abuse needs to be investigated.

## IV. Relationship between Article 3 ECHR and domestic detention powers, policy and safeguard

72. The executive power to administratively detain for indeterminate periods without charge or trial for immigration purposes is well recognised as one of the most extraordinary draconian powers exercised by the state over the individual[13].It is normally only used in times of war or public emergency[14]. Whilst it is not the task of this Inquiry to look at immigration detention more widely, it is the job of the Inquiry to understand what caused and contributed to the mistreatment and abuse at Brook House during the relevant period. The Inquiry, therefore, cannot ignore the nature of immigration detention for a number of reasons:

a. Its terms of reference require it to investigate relevant detention policy and practice;

b. It is relevant to understanding the profound underlying weaknesses in the legal protections and safeguards for detained persons' rights, and the attitude to those rights (or lack of them) both within the Home Office and on the ground in the detention centre.

c. It is obviously also relevant to the detained persons' own experience.

d. The clinical literature is clear – that immigration detention per se has a negative impact on a detained person's mental health, that impact intensifying and worsening the longer the person is in detention. That is clear from Professors Bosworth's sub-review for Stephen Shaw's 2016 *Review into the Welfare of detainee in Immigration Detention published.*[15] It is echoed by Dr. Bingham and Professor Katona. As well as length of detention, the causes of mental deterioration resulting from detention itself include pre-existing trauma such as torture or other forms of ill-treatment.

[13] *R v Home Secretary ex parte Khawaja* [1984] AC 74 per Lord Bridge at 122 E-F. In *Lumba*, Lord Brown at para 341 endorsed Lord Bingham's well known statement that "freedom from executive detention is arguably the most fundamental and probably the oldest, the most hard won and the most universally recognised human rights."
[14] In *SSHD v Pankina* [2011] QB 376 Sedley LJ has commented that the introduction of administrative detention here represented a "dramatic constitutional innovation", "unprecedented in peacetime".
[15] INQ000060.

e. detention policy being applied in a rigorous and conscientious way application in practice is an essential component of lawful detention and detention which is compatible with Article 5 ECHR: *Lumba v SSHD* [2011] UKSC 12, [2012] 1 AC 245 para. 34-36, and 68 and summarised in *R (HA) Nigeria* [2012] EWHC 979 para. 143.

73. Consistent with the state's positive Article 3 obligations, the Inquiry should expect to, but will not see:

**a.** rigorous and robust enforcement of detention policy and the safeguards in policy and practice, as well as the highest standards of governance, oversight, management and vigilance in ensuring compliance.

**b.** effective functioning of key safeguards that guard against the detention of vulnerable people in the first place, or their prompt release if detained. That is a primary objective of Rule 34 and 35 of the Detention Centre Rules, which enable the objects of the Adults at Risk policy to reduce the numbers in detention of vulnerable people to be fulfilled. The evidence of a complete deprivation of these safeguards, such that vulnerable people are not identified, and not released, if identified, is not to be treated as just an operational failure in an individual case. It is a reflection of the fundamental defects in the system: promises to meet the recommendations of Shaw 1 (2016) to improve protection for vulnerable detained persons and reduce the numbers of vulnerable people in detention, just have not been fulfilled. On the contrary, the Home Office took the opportunity further to Mr. Shaw's review to redraw a policy so it directed even more so away from release and in favour of immigration factors, resulting in very many fewer people benefiting from the strong presumption against detention;

c. policies operating proactively to prevent prohibited harm[16], rather than the "wait and see" approach that is shown in the evidence heard and seen by the Inquiry.

[16] *R v Secretary of State for the Home Department ex parte Limbuela* [2005] UKHL 66 at §§8-9, 61-72, 78 87 and 102; *BA (Nigeria) v Secretary of State for Home Department* [2011] EWHC 2748 (Admin), §§183-185.

## V. Article 3: Systems Breaches

74. Mistreatment, abuse and fundamental disrespect for human dignity of the kind seen on Panorama does not occur overnight, or over a matter of days or weeks. Individual G4S officers may have inflicted the actual physical blow in the cases of many detained people. But the evidence received by the Inquiry lay bare multiple layers of systems deficiencies in both policy and practice, across the highest level of policy and rules, to the structural and contractual arrangements and the measures used for implementation, to the day to day management and control of detained persons.

75. This section will address the structural and operational defects in the detention policy and arrangements that created an environment that put detained people at high risk of, and in many circumstances, caused, harm, including humiliation, degradation of their physical and mental integrity and dignity and lasting psychiatric injury.

### (1) Context: Immigration Enforcement and the Hostile Environment Policy

76. Stephen Shaw recognised in his 2005 investigation into Racism and Mistreatment at Oakington that:[17]

> *The very purpose of immigration detention is to exercise coercive power over foreigners prior to their removal from the country. It is perhaps not a surprise that this function, combined with the attitude towards asylum-seekers and other would-be immigrants of some sections of the media, can become a breeding ground for racist and abusive word and deed.*

77. This is an issue which cuts across all of the Inquiry's Terms of Reference. As we said in our opening statement, this Inquiry cannot ignore the nature of the detention power or who it is applied to when considering how Brook House came to be described for so many of the witnesses as a toxic, desensitised and dehumanised environment that permitted physical violence, verbal abuse and racism to be directed at detained persons with impunity. In the years that followed from Mr. Shaw's Oakington report, attitudes of intolerance toward asylum-seekers and other would-be immigrants intensified and

[17]Inquiry into allegations of racism and mistreatment of detainees at Oakington Immigration Reception Centre and while under escort, Shaw (2005),BHM000043_0781.

became co-opted into the rhetoric and thinking behind the design of immigration policy by politicians at the highest level of government.

78. When opening Brook House in March 2009, the then-Home Secretary Jacqui Smith emphasised that:[18]

> *I am committed to removing more foreign lawbreakers faster than ever before, that's why the opening of this Immigration Removal Centre is so important... The message is clear – whether you're a visa overstayer, a foreign criminal or failed asylum seeker, the UK Border Agency is determined to track you down and remove you from Britain.*

79. In May 2012, the then-Home Secretary, Theresa May, formalised this approach by coining it a *"hostile environment"* policy, the aim of which was *"to create, here in Britain, a really hostile environment for illegal migration ... What we don't want is a situation where people think they can come here and overstay because they're able to access everything they need ... "*[19] The public messaging included in 2013, the hiring of billboard vans advertising *"Go home or face arrest"*. The campaign was controversial but sent a clear message to the general public: that it was permissible to ostracise migrants from British society, and indeed, encouraged. The *"hostile environment"* was then codified in law through the Immigration Acts of 2014 and 2016, to restrict access to and introduce more stringent checks on the abilities of migrants to access work, welfare support, healthcare, housing and bank accounts.[20] The measures introduced into statute divided migrants into categories of the "deserving" and the "undeserving", often judged arbitrarily by whether a person was able to show, by documentary proof, their right to remain in the UK. For the undocumented, the policy's goal was to make life so unbearable that they would choose to leave the UK voluntarily, and if not, be forcedly removed, irrespective of whether they may have a right to remain notwithstanding the absence of documentation. This whole approach of dividing people into the deserving

[18]Nathan Ward 1st witness statement, dated 10 November 2021, DL0000141_0008 §21. Press release link at: https://www.wired-gov.net/wg/wg-news-1.nsf/0/FB6FE92BDEE224128025757D00444829?OpenDocument (accessed on 14 April 2022).
[19] The Daily Telegraph, "We're going to give illegal migrants a really hostile reception", 25 May 2012, cited in DL0000141_0008 §21.
[20] See "Windrush Lessons Learned Review: independent review by Wendy Williams" dated March 2020, referred to in DL0000141_0009 footnote 7.

and undeserving, documented and undocumented, was identified by Wendy Williams[21] as a critical factor in the Windrush scandal, with British citizens even being caught up in it.

80. The "*hostile environment*" policy drove an increase in removals as a way to reduce illegal migration and cap net migration. This was done through an increased use of Charter flights, which allows for removals in numbers to a country, and the use of immigration detention to contain groups of people subject to Charter flights in one place.[22] Charter flight removals were coupled with the use of no-notice removal windows, whereby detained people would be given 72 hours' notice that they could be removed without further warning over the next three months, instead of being given an exact date of removal and the use of no notice removal windows.

81. The Home Office choose Brook House as one of its main centres to put this policy of no-notice Charter Flights removals into practice.[23] The political narrative of hostility therefore underpinned the centre's very existence, development and its operation. Lee Hanford, the interim director of Brook House confirmed this, linking the Home Office's approach to no-notice removals directly to the hostile environment policy:

> *"there was a point in time, I think it would be about 2014, around that period of time, where there was a view from government in relation to: removal centres are removal centres, so all engagement should be about removal ... the rhetoric from the government at the time, ... it was quite – the rhetoric was, you know, generally all about removals."*[24]

82. The menacing hostility toward cohorts of detained persons – as opposed to dignity and humanity- was embedded into the arrangements and culture of Brook House, well before the abuse and ill-treatment of detained persons was captured on film by BBC Panorama.

[21] Windrush Lessons Learned Review (2020): https://www.gov.uk/government/publications/windrush-lessons-learned-review
[22] Nathan Ward 1st witness statement, DL0000141_0009-0010 §25.
[23] See comments by Ben Saunders in G4S' 360 Degree Contract Review dated 24 June 2014, CJS000768_0002 referenced in DL0000141_0009-0010 para 25 and footnote 8.
[24] Lee Hanford 15 March 2022 88/19-23 and 89/7-10.

Rev. Nathan Ward described its ever-presence when he was at Brook House in 2013 and 2014.[25]

83. It is of no surprise that when large groups of people of the same nationality are moved to Brook House in the lead up to a planned Charter flight,[26] this had the effect of singling these nationalities out and reinforcing the idea that these people were the "undeserving" and undesirable ones under the rubric of the "hostile environment" policy, because why else would they be selected to be subject to non-notice Charter flight removals? When the political narrative is so woven into the fabric of the centre, there is, according to Rev. Ward, *"a strong likelihood that the institutional will itself become "hostile" and abuse will occur."*[27] And the evidence before the Inquiry clearly showed that it did.

84. The Home Office reinforced the idea that those detained at Brook House were undeserving through its contractual arrangements with G4S, which were geared to ensure removals were not hampered by contract failures, and where penalties were placed on anything that prevented deportation, such as not producing a detained person for an immigration interview on time or not presenting them when required for escort. The Home Office also reinforced this by applying pressure on G4S to prioritise removals and according to Mr. Hanford, criticising G4S staff when it appeared that they were *"showing too much empathy, supporting detainees in their appeals and the likes."*[28]

85. The Inquiry heard evidence from Mr. Hanford that the Home Office would make deliberate decisions to withhold information about charter flights from even G4S, telling only a few custody staff about the actual details, and instructing them to lie about the plans in order to ensure that the flight went ahead.[29] Custody officers' role were, in this way, constrained and reduced to managing detained persons who were subject to removal; there was nothing else they could do – they were oppressed by the threat of contractual penalties for failed removals and were unable to respond with any compassion to anxieties and distress of detained persons who lived a *"day by day"*

[25] Nathan Ward 1st witness statement, DL0000141_0009-0010 §§25-27.
[26] Lee Hanford 15 March 2022 86/5-9.
[27] Nathan Ward 1st witness statement, DL0000141_0010 §26.
[28] Lee Hanford's Verita interview, VER000266_0022 See also Lee Hanford 15 March 2022 88/19-23.

[29] Lee Hanford 15 March 2022 87/11-25 and 88/1.

existence of fear that their removal would suddenly be enforced.[30] All this, Mr. Hanford said, served as a *"significant contributing factor"* to the increased use of force at Brook House.[31] His evidence is consistent with that contained in HMIP's 2016 report on Brook House[32], which also noted an increase in the use of force at the centre.

86. Although Mr. Hanford's evidence concerned his time at Brook House (and he left the centre in June 2016), there is no evidence before the Inquiry that suggests that this causal link between no-notice Charter flight removals (driven by the hostile environment policy) and the increased use of force on detained persons at Brook House was broken at any point in 2017, and indeed during the relevant period. The IMB's report on Brook House in 2017 reported no-notice charter flights as an area of concern that *"can lead to inhumane treatment. They leave detainees in a limbo of uncertainty with the psychological stresses that brings. There is not proper time to allow for farewells to family, and others in the UK, the return of property or to make firm arrangements in the returning country – which might be completely new to some detainees."*[33] That report also reported an increase in the use of force in Brook House during 2017.

87. The use of no-notice removal was only halted further to the Court of Appeal declaring in 2020 the policy governing this type of removal as unlawful for fundamentally impairing detained persons' rights of access to justice and the courts and as a result, exposing them to risk of harm on removal.[34] Even after that judgment, the Home Office has continued to use Charter flights to effect removals in numbers in pursuit of a key plank of the hostile environment policy.

88. The most recent example of the inhumane consequences of this approach is well documented in the IMB's 2021 report about the situation at Brook House in 2020, discussed below at Section IX on Home Office responsibility.

**(2) Policy Context: the defective design and operation of detention safeguards**

[30] Lee Hanford 15 March 2022 86/5-25 and 87/1-3.
[31] Lee Hanford, 15 March 2022, 87/3-10.
[32] HMIP Report on an unannounced inspection of Brook House IRC (2016),HMIP000552_0025§1.54.
[33] IMB Annual Report for reporting Year 2017, (Published May 2018), VER000138_0023 §11.2.
[34] See *R (FB) (Afghanistan) v Secretary of State for the Home Department; R (Medical Justice) v Secretary of State for the Home Department* [2020] EWCA Civ 1338.

89. The various statutory powers of immigration detention[35] have in common that, provided the broad statutory conditions for detention are met (liability to removal or deportation, plus in some cases service of a decision to remove), there are no *express* statutory limits on the exercise of the power by the Defendant. As pointed out by Sedley LJ in *Pankina v SSHD* [2011] QB 376 at [13], detention pursuant to immigration powers was a *"dramatic constitutional innovation ... unprecedented in peacetime."*

90. The European Court of Human Rights has reiterated that the detention of migrants must be accompanied by effective safeguards for those concerned and *"is acceptance only in order to enable states to prevent unlawful immigration while complying with their international obligations", in particular the 1951 Geneva Convention relating to the Status of Refugees and the European Convention on Human Rights*". States' legitimate concern to foil the increasingly frequent attempts to circumvent immigration restrictions must not deprive asylum-seekers of the protection afforded by these conventions: *Amuur v. France, 25 June 1996, § 43, Reports of Judgments and Decisions 1996-III.* Article 3 ECHR requires the state to ensure that detention conditions are compatible with respect for human dignity, that the manner and method of execution of the measure do not subject the detained persons to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention, and that given the practical demands of imprisonment their health and well-being are adequately secured: *M.S.S. v Belgium and Greece* App no 30696/09 §§218 and 222.

91. The statutory power to detain is a broad one but is limited by detention policies published by the Home Office – currently the Adults at Risk ("AAR") policy and Detention Services Orders - and secondary legislation, in the form of the Detention Centre Rules 2001. Ms. Theresa Schleicher, Casework Manager for Medical Justice, outlines at some length the history to the development of the AAR policy framework in her first witness statement, which the Inquiry is asked to read.[36] Most notable is the long-standing recognition by the Home Office – and by Parliament – of a need for safeguards in

[35] Most notably, para 16(2) of Schedule 2 to the Immigration Act 1971 ("the 1971 Act"), used to detain pending administrative removal, and various powers to detain pending deportation in para 2 of Schedule 3 to the 1971 Act and (for automatic deportation cases) section 35 of the UK Borders Act 2007 ("the 2007 Act").
[36] Theresa Schleicher 1st Witness Statement, dated 3 February 2022, §§26-112, BHM000032_0008-0038. The summary of the Shaw Review,INQ000060, published in January 2016, is set out at §§114-122, BHM000032_0038-41. (Shaw 1st Report)

detention capable of ensuring that vulnerable people who may be adversely impacted by detention are identified promptly and are not detained at all, or are promptly released from detention once identified. The Home Office's duty of inquiry and the detention gatekeeper are primary means by which consideration of safeguards are meant to be applied prior to detention, and Rules 34 and 35 of the Detention Centre Rules 2001 are the primary statutory mechanisms following detention that enable the AAR policy to be implemented.

92. However, it is clear from the evidence received by the Inquiry that there has been (and remains) what Dr. Hard called a *"complete failure of the systems designed to protect vulnerable detainees"*. The systems failures referred to by Dr. Hard concerned both the AAR policy framework and the safeguards under Rules 34 and 35 of the Detention Centre Rules 2001. The failures were both structural and operational, and more importantly, they are long-standing and well known to the Home Office.

93. All of the clinical witnesses, Dr. Hard, the Inquiry's clinical expert, Dr. Rachel Bingham, the clinical advisor for Medical Justice and Professor Cornelius Katona, who convenes the Royal College of Psychiatrists' Refugee and Asylum Mental Health group, were unified in their evidence that this failure of the systems safeguards *"led to abuse and ill-treatment of detainees"* of the kind we saw repeatedly in both the broadcasted and unbroadcasted footage from the BBC.[37] Freedom from Torture's experience supported this analysis.[38]

94. None of the IRC healthcare witnesses – including in particular Sandra Calver, the Head of Healthcare or Dr. Hussein Oozeerally, the lead GP, could suggest the contrary.

95. This was also confirmed by Ian Cheeseman, the senior civil servant in the Home Office responsible for the design of the AAR policy, whose evidence revealed how political pressure to demonstrate "toughness" on immigration and focus on effecting removal fundamentally undermined the way in which the AAR policy was formulated. Of particular note was his candid acceptance that the AAR statuary guidance and policy did

[37] Dr. Jake Hard 28 March 2022 143/21-23, 145/1-7, 147/1-8. See also Dr Rachel Bingham 14 March 2022 Professor Cornelius Katona witness statement dated 3 February 2022, BHM000030.
[38] Witness statement of Sile Reynolds, FFT000001 and exhibit FFT000012.

not accord with the recommendations of Stephen Shaw in his 1st Review in 2016.[39] He did not dispute that the end product achieved the opposite to what it was intended to do, and as a result more (not fewer) vulnerable people entered the immigration detention estate, and were (and are) directly exposed to risks of serious harm and mistreatment of the kind described by many of the former detained people Core Participants, including D801, D1275 and D2077. His evidence is critical for understanding of the political imperatives and the institutional culture and practice within the Home Office which has dictated and dominated detention policy since at least 2012.

**(a) Structural deficiencies in the Adults at Risk policy**

96. Although the AAR policy is said to be the centre piece of the response to the findings and recommendations made by Stephen Shaw in his January 2016 report, Review into the welfare in detention of vulnerable persons, it is important to note that Mr. Shaw never recommended the design of a brand new policy. Rather, his recommendations had focused on ways to improve the existing policy, Enforcement Instructions and Guidance Chapter 55.10 ("EIG 55.10") so that it could function effectively and achieve its purpose of reducing the number of vulnerable people ending up in detention and being detained for shorter periods of time.

97. EIG 55.10 used a category-based approach, whereby people falling in prescribed categories of vulnerability – such as torture, trafficking, pregnancy, severe mental illness – would not normally be suitable for detention *"save in exceptional circumstances"*. This approach proceeded on assumption that for certain categories of vulnerable people, detention *per se* would be harmful, and that harm would be exacerbated by prolonged detention, the uncertain duration of detention and the uncertainties surrounding the person's immigration or asylum case.[40]

98. The problems pinpointed by Mr. Shaw about EIG 55.10 concerned missing categories of vulnerabilities, such as people who suffered from post-traumatic stress disorder or were victims of sexual violence or transsexual. He was also concerned about the detention per se of pregnant women, the lack of an upper age limit for detention, and the failure to

[39] Ian Cheeseman, 16 March 2022, 184/16-19.
[40] See summary of findings in Professor Mary Bosworth's *Mental Health Literature Survey Sub-Review*, annexed as Appendix 5 to Shaw 1st report, INQ000060_0307.

recognise the dynamic nature of vulnerability which might be injuriously affected by detention.[41]

99. EIG 55.10 depended on the Detention Centre Rules 2001 operating effectively, which Mr. Shaw found they did not. He concluded that the combination of EIG 55.10 and Rules 34 and 35 the Detention Centre Rules 2001 failed to protect vulnerable detained persons, and that the design and operation of the Rule 35 safeguard needed to change fundamentally to ensure its effectiveness in achieving its protective objective. His ultimate conclusion was that: [42]

> *"there is too much detention; detention is not a particularly effective means of ensuring that those with no right to remain do in fact leave the UK; and many practices and processes associated with detention are in urgent need of reform."*

100. Publicly, Home Office ministers and senior civil servants held out that the AAR policy was produced to meet Mr. Shaw's recommendations of strengthening the approach to safeguarding *"those whose care and support needs make it particularly likely that they would suffer disproportionate detriment from being detained , and will therefore be considered generally unsuitable for immigration detention unless there is compelling evidence that other factors which relate to immigration abuse and the integrity of the immigration system, such as matters of criminality, compliance history and the imminence of removal, are of such significance as to outweigh the vulnerability factors."* [43] This was said to be the foundation of section 59 of the Immigration Act 2016, the enabling provision that directed the Home Office to produce a policy setting out the steps to be taken to strengthen the operation for those who are particularly vulnerable to harm in detention.[44] The introductory paragraphs to the AAR statutory guidance repeat this intention, stating at §6[45] that *"the intention is that fewer people with a confirmed*

[41] See Recommendations 9-16 of Shaw 1st Report, INQ000060_0195-196..
[42] Shaw 1st Report, INQ000060section 11.1.
[43] See statement of then Immigration Minister James Brokenshire at https://hansard.parliament.uk/Commons/2016-01-14/debates/16011448000010/ImmigrationDetentionVulnerablePersons at footnote 31, Theresa Schleicher 1st witness statement, BHM000032_0042.
[44] *R (Medical Justice) and Others v Secretary of Ste for the Home Department* [2017] EWHC 2461 (Admin) at §§149-151.
[45] Adults at Risk statutory guidance, §6, BHM000019_0005.

*vulnerability will be detained in fewer instances and that, where detention becomes necessary, it will be for the shortest period necessary."*

101. The evidence that the Inquiry has heard and received in writing quite starkly shows the contrary: that the AAR policy has not actually been designed to achieve a reduction in the number of vulnerable people being detained, and has not in practice done so. Many of the AAR policy's key features in fact do not reflect the recommendations made by Mr. Shaw[46] and are the exact opposite of what he recommended. Mr. Cheeseman, the key architect of the AAR policy, was unable to defend any of the flaws identified to him during his oral evidence on 16 March 2022. Nor was he was able to provide any coherent explanation for the retrograde steps taken in the AAR policy:

102. **First, there is no mechanism within the policy by which vulnerabilities can be consistently identified *prior* to a decision is made to detain a person so that the person can be screened out for detention at all**. Mr. Shaw considered that a *"gatekeeper for detention"* could be used to screen vulnerabilities pre-detention, so that vulnerable people who may be harmed by being detained do not end up in detention at all. [47] He contemplated that such a mechanism would involve undertaking risk assessments and evidence gathering before a decision is made to detain. [48]

103. The Home Office did implement a detention gatekeeper, but what was implemented does not reflect the purpose identified by Mr. Shaw. The detention gatekeeper that has been implemented is heavily reliant on accurate information being provided by immigration case workers. Gatekeepers do not communicate directly with individuals subject to consideration of detention, and do not invite relevant evidence, particularly clinical evidence of vulnerability, to be submitted for consideration prior to detention. The gatekeeper also has no ability to make clinical assessments on the likely impact of detention, [49] and even where such evidence is available, it is applied inconsistently in decision-making. In his second report, Mr. Shaw found that *"the gatekeeper function had not prevented entry to the detention estate"* of vulnerable people *"where it appeared that detention was not suitable."*[50] That is hardly surprising given the gatekeeper does not

[46] Ian Cheeseman 16 March 2022 184/16-19, 189/8-16.
[47] Shaw 1st Report 2016, §§4.90-4.91 and recommendation 20, INQ000060_0101.
[48] Shaw 1st Report 2016, §§4.90-4.91 and recommendation 20, INQ000060_0101.
[49] Shaw follow up report 2018, §4.16 CJS0073862_0089.
[50] Shaw follow up report 2018, §4.18 CJS0073862_0090.

seek out relevant information in all cases about a person's vulnerability. Mr. Shaw also found that the failure of the gatekeeper to function effectively was also because Home Office staff were *"under significant pressure to maximise the number of removals"* and to prioritise this over the identification of vulnerable people.[51] The failure of the gatekeeper function is, thus, yet another clear illustration of the consequences of a single-tracked focus on the part of the Home Office of a hostile pursuit of removal at the expense of its obligations to arrange and operate a system that effectively safeguards against harm to vulnerable people in detention.

104. At Brook House, the absence of any effective pre-detention screening mechanism meant that during the relevant period and beyond, a significant number of people with past histories of torture, trauma or pre-existing mental ill-health were detained without any consideration of the likely impact of detention on them before exposing them to the known risks of harm. The risks of harm to them were compounded by the complete failures in the operation of the statutory safeguards under Rules 34 and 35 Detention Centre Rules 2001 to ensure prompt identification of vulnerability and consideration of release, discussed further below.

105. **Second, the Home Office abandoned the category-based approach to determining suitability of detention, whereby a strong presumption against detention would be afforded to vulnerable people, save in very exceptional circumstances was removed.**

106. The strength of that presumption was based on (a) the acceptance of clinical research and literature that establish that those with a history of past torture or trauma, or pre-existing mental illnesses are likely to suffer harm if detained, without needing to demonstrate in an individual case that such likely harm would eventuate[52]; and (b) the operation of a "very exceptional circumstances" threshold, which imposed a "high hurdle" to be overcome before the presumption against detention could be displaced in respect of people who are otherwise considered unsuitable for detention.[53] On that policy approach,

[51] Shaw follow up report 2018, §4.21 CJS0073862_0090.
[52] See witness statement of Professor Cornelius Katona, BHM000030, witness statement of Dr Rachel Bingham, BHM000033, RCPsych Position Statement 02/21, BHM000027 and summary of findings in Professor Mary Bosworth's *Mental Health Literature Survey Sub-Review*, annexed as Appendix 5 to Stephen Shaw's 1st report in 2016, INQ000060_0307.
[53] *R (Das) v Secretary of State for the Home Department* [2014] EWCA CIv 45 at §68, cited at footnote 4 of Theresa Schleicer 1st witness statement, dated 3 February 2022, BHM000032_0010.

in principle, mere immigration factors, such as having entered the UK illegally, having overstayed or refusing to leave voluntarily could not on their own constitute "very exceptional circumstances".[54]

107. The AAR policy marked a fundamental shift from this protective approach. Under the AAR policy, the identification of vulnerability does not automatically engage the strong presumption against detention. Rather, it is treated as a risk factor. Presenting with such a risk would not in itself be enough for a person to be treated presumptively as not suitable for detention, and would only do so if (a) the detained person is able to produce evidence of risk independent of his self-declaration; (b) the evidence demonstrates a likelihood of harm if the person remains in detention; and (c) the immigration factors – such as non-compliance, and public protection concerns – do not outweigh the risks of harm caused by detention.

108. Thus for example, whereas previously, a person identified as a victim of torture through a Rule 35(3) report alone was sufficient to trigger the strong presumption that the person would not be detained unless "very exceptional circumstances", existed. By contrast under the AAR policy, a Rule 35(3) report with independent evidence of torture is not treated as sufficient to demonstrate risk of harm or attract strong presumption against detention. The person would have to additionally show by way of professional evidence that his experience of torture would likely lead him being harmed in detention. Even if likely harm is shown, the policy affords the Home Office to displace a presumption against detention if outweighed by general immigration enforcement factors.

109. This is a fundamental weakening of the policy protections intended to prevent harm from being actually caused to vulnerable people. It unavoidably promotes a "wait and see" approach because a detained person is unlikely to produce the evidence of likely harm until the harm has already been occasioned upon him in detention, and cannot secure his release until that has happened.

110. Mr. Cheeseman did not disagree with this analysis, and accepted that the approach taken in the Adults at Risk policy – particularly the imposition of an evidential burden on the

[54] Rix LJ at §34 of *R (AM) v Secretary of State for the Home Department* [2012] EWCA Civ 521, affirmed by the Court of Appeal in *Das*, and referred to at footnote 5 of Ms. Schleicher's 1st witness statement BHM000032_0010.

detained person to demonstrate predictable likely harm – does not reflect Mr. Shaw's recommendations.[55]

111. These matters had been pointed out to the Home Office by Medical Justice in the consultation on the initial proposals and in subsequent correspondence and meetings.[56] This was also the subject of submission by the Royal College of Psychiatrists ("RCPsych") [57] to the second Shaw Review and in a detailed RCPsych Position Statement in 2021.[58] Similar concerns have been raised by ICBI and the IMB

112. **Third, and perhaps the starkest way that the policy does not reflect the Shaw recommendations is the retention in all but name, of the threshold of "satisfactory management" so that vulnerable people suffering from mental illness are, by default, kept in detention contrary to good psychiatric care, instead of being treated as presumptively unsuitable to be detained**.

113. Mr. Shaw called for the abandonment of the "*satisfactory management*" threshold for justifying the detention of the mentally ill under EIG 55.10. He said this approach – which permitted the continued detention of the mentally ill so long as their mental illness could be "managed" (albeit not treated) in detention – was contrary to *good psychiatric care* and *"an affront to civilised values"*.'[59] These are strong words and their force should be recognised by the Inquiry. Professor Katona emphasises its importance and as reflecting the clinical consensus in the Royal College of Psychiatrists.[60]

114. The Home Office's use of that policy threshold to maintain the detention of mentally ill detained persons had, prior to the 2016 Shaw Review, contributed to a series of six court judgments finding individual detained persons having suffered severe ill-treatment in breach of Article 3 ECHR, identified and analysed in the Article 3 sub-review undertaken by Jeremy Johnson (now a High Court judge) for the Shaw Review.[61] In three of these cases, the detained person had been held at Brook House when he suffered inhuman and

[55] Ian Cheeseman 16 March 2022 184/16-19, 189/8-16.
[56] Theresa Schleicher 1st witness statement, BHM000032_0044-0045

[57] Professor Cornelius Katona witness statement, §34, BHM000030_0018-0019.
[58] Professor Cornelius Katona witness statement, §61, BHM000030_30
[59] Shaw 1st Report, §§4.35-4.36, INQ000060_0090.
[60] Professor Cornelius Katona witness statement, §25, BHM000030_0013-0014
[61] See the sub-review at Appendix 4 to Shaw first report, INQ00060_0271_0304

degrading treatment. The factors that the Court identified as contributing to an Article 3 breach in each of these three cases have some striking similarities in terms of the systemic and operational failures that feature in the cases of formerly detained Core Participants who were at Brook House during the relevant period and are the subjects of the Inquiry's investigation:

a. *R (HA) v Secretary of State for the Home Department* [2012] EWHC 979 (Admin) concerned a severely unwell man who exhibited bizarre and paranoid behaviour whilst in immigration detention and self-neglected. He did not receive medical treatment. Instead, he was subjected to ACDT, and segregation as ways of managing his disturbed behaviour. Although a Rule 35(1) report confirmed that detention was likely to be injurious to his health, and healthcare took the view that he required hospital treatment, the Home Office maintained his detention for several months on the basis that his self-neglect required him to remain in detention so that, purportedly, he could receive medical attention and care albeit in hospital. The High Court found this to be *"manifestly unreasonable"*[62] approach; it not only prolonged HA's immigration detention, it also exposed him to further periods of segregation and to the use of force. The combination of these experiences led the High Court to find that HA's treatment in immigration detention, including at Brook House, to amount to both inhuman and degrading treatment under Article 3 ECHR.

b. *R (D) v Secretary of State for the Home Department* [2012] EWHC 2501 (Admin), concerned a man who was suicidal and suffered from auditory hallucinations whilst in detention. He was deprived of any psychiatric input or access to anti-psychotic drugs, and deteriorated to the point of losing his mental capacity to instruct lawyers or to challenge his detention and conditions of detention. Although the Home Office was fully aware of his need for and inability to access necessary medication and that the IRC environment was not conducive to his mental health, his detention was maintained repeatedly in detention reviews. The High Court found that his ill-treatment amounted to Article 3 inhuman and degrading treatment[63], and that this

[62] *R (HA) v Secretary of State for the Home Department*, §171.
[63] *R (D) v Secretary of State for the Home Department*, §183.

ill-treatment was *"premeditated … in the sense that those with responsibility for the well-being of detainees [at Brook House and Harmondsworth] knew that D had a history of mental illness and persisted in a medical regime for him which involved neglect (particularly in relation to the taking of anti-psychotic medication and denial of access to a psychiatrist) and recourse to what were in effect disciplinary sanctions under rules 40 and 42 which were unsuitable for a person with his condition."*[64]

c. *R (VC) v Secretary of State for the Home Department* [2018] EWCA Civ 57 concerned a man who suffers from bipolar schizoaffective disorder and psychosis. He was detained for nearly a year, the latter six months of which was at Brook House. Whilst there, he presented with hallucinatory and psychotic symptoms, delusions of grandeur, having erratic sleep pattens, self-neglecting himself.[65] He was segregated on several occasions to manage his disturbed behaviour. Whilst in segregation, he was observed as rambling, unpredictable and unable to understand why he had been removed from association. He was recorded as having little insight into his mental illness.[66] Two Rule 35(1) reports were raised during VC's detention. Both concluded that his mental illness was severe and long-standing and his health would be injuriously affected by continued detention. The one raised whist VC was in Brook House, stated that his health had deteriorated, exacerbated by the detention environment, which was not conducive to the management of his mental health condition, that he did not seem to have capacity to make decisions, posed risks to staff, other detained persons and himself (through neglect) and that required hospital treatment. The Home Office, however, maintained his detention on the assertion that although the stress of detention was impacting negatively on his mental health and he was unfit for detention, the GP had not stated explicitly that he was currently not fit for detention, and in any event there were very exceptional circumstances to justify his continued detention given the high risks of absconding.[67] The Court of Appeal found that the Home Office had misapplied the "satisfactory management" policy threshold when refusing to release VC when the

[64] *R (D) v Secretary of State for the Home Department*, §175.
[65] *R (VC) v Secretary of State for the Home Department* [2018] EWCA Civ 57 at §27(7).
[66] *R (VC) v Secretary of State for the Home Department* [2018] EWCA Civ 57 at §27(8).
[67] *R (VC) v Secretary of State for the Home Department* [2018] EWCA Civ 57 at §27(11).

Rule 35 report made it clear that he had deteriorated whilst detained and that his health was likely to be injuriously affected further by continued detention; the Home Office wrongly treated the threshold as met only where the detained person was hospitalised. But the Court of Appeal found made no Article 3 findings. It as only when VC's case reached the Supreme Court in 2020 that the Home Office conceded that VC had suffered both inhuman and degrading treatment in breach of Article 3 ECHR as a consequence of being subjected to prolonged detention for an indeterminate period of time.[68]

115. Although there is no reference to "satisfactory management" in the AAR policy, it is plain that it has very much remained a core part of the policy's operation despite Shaw's recommendations. Indeed the templates created by the Home Office for Rules 35(1) and 35(2) make plain that that policy threshold remains very much in practice.

a. Section 5(ii) of the Rule 35(1) template[69] asks the doctor *"Can remedial action be taken to minimise the risks to the detainee's health whilst in detention? If so, what action and in what timeframe?"* Section 5(iv) of the same template asks the doctor: *"How would release from detention affect the detainee's health? What alternative care and / or treatment might be available in the community that is not available in detention?"*

b. Section 3(ii) of the Rule 35(2) template[70] asks the doctor *"Is the detainee being managed under Assessment Care in Detention Teamwork (ACDT) arrangements? If not, why not?"* and section 3(iii) asks *"Can the suicide risk be managed / reduced satisfactorily through ACDT, medication and/ or appropriate interventions such as talking therapies?"*

116. In blatantly explicit ways, these questions direct doctors to consider whether someone can be satisfactorily managed in immigration detention notwithstanding having a serious mental illness or suicidal intentions despite this having no connection with the wording of Rules 35(1) and (2) and what those rules, on the face of their wording require. This is

[68] 1st witness statement of Hamish Arnott dated 25 January 2022 at §142 BHM000042_0041.
[69] HOM002591_0019.
[70] HOM002591_0024.

clear also from the evidence of practice at Brook House given by both Dr. Chaudhary[71] and Dr. Oozeerally.[72]

117. Ms. Simcock put the issue to Mr. Cheeseman who did not (and could not realistically) dispute that that is what has happened. Instead, he answered *"I suppose that's one way of looking at it"*[73] and *"I suppose that could be one way of interpreting it."*[74] When Ms. Simcock pointed out to Mr. Cheeseman that these questions also discourage doctors to complete Rule 35(1) or Rule 35(2) reports on the basis that there is no need if the detained person can be satisfactorily managed in detention by alternative measures, he said *"I must confess, I hadn't considered that before, but I suppose it does."*[75]

118. None of the other Home Office witnesses disagreed or provided any further explanation as to why a policy threshold that was found to be contrary to good psychiatric care and *"an affront to civilised values"* by Mr. Shaw ended up being incorporated back into the Adults at Risk policy, when that policy was meant to implement key remedial reforms of past failures to protect vulnerable detained persons. Nor could any of them explain why it remains in use in the templates of the only statutory reporting mechanisms for identifying and reporting on concerns about the unsuitability of detention of adults at risk to the Home Office and for triggering a detention review, despite the templates not setting out the wording of the Rule 35 criteria.

119. **Fourth, there is no provision of independent advocacy for people who suffer from severe mental ill-health or cognitive impairments such as learning disability and may lack mental capacity.**

120. This unlawful and systemic failure to provide a means by which those with mental illness can be assisted to effectively participate in relevant decision making has not only created barriers to their being able to appropriately access medical treatment in detention, but, in many cases, also prevented them from being able to challenge their detention, conditions of detention and to access legal advice and assistance to help them to do this.

[71] Dr. Saeed Chaudhary 11 March 2022 193/1-23, 195/1-10, 200/5-9, 199/1-12.
[72] Dr. Husein Oozeerally 11 March 2022 60/1-6, 52/7-23.
[73] Ian Cheeseman 16 March 2022 203/2.
[74] Ian Cheeseman 16 March 2022 204/5-7.
[75] Ian Cheeseman 16 March 2022 203/11-16.

121. This systems gap is long-standing and has been known to the Home Office for some years.[76] It was material contributing factor to the ill-treatment suffered by a man called VC, in breach of Article 3 ECHR, during his immigration detention from June 2014 to May 2015, as discussed above. VC only came to the attention of lawyers because he contacted Gatwick Detainee Welfare Group by telephone. Ms. Naomi Blackwell recounted in her witness statement, prepared for VC's eventual judicial review application, described their first encounter and his bizarre and paranoid presentation, whereby he would veer from laughter to dismay in quick succession and his speech was tangential.[77] VC was referred by GDWG's Ms. Blackwell to Bhatt Murphy Solicitors, who then got the Official Solicitor involved to act as VC's litigation friend. It was only once a litigation friend was in place that Bhatt Murphy was able to take all the necessary steps to investigate the basis of his detention, and bring judicial review proceedings to bring an end to the inhuman and degrading treatment that he suffered whilst detained at Brook House.

122. The Court of Appeal found, in its 2018 judgment, that in continuing to detain VC after a Rule 35(1) report had deemed him unfit to be detained, the Home Office discriminated against him in breach of the Equality Act 2010 on grounds of his disability because it failed to make any provision for independent mental health advocacy to facilitate VC to make representations about his detention, segregation and treatment in detention.[78] The Home Office contested VC's judicial review claim all the way to the Supreme Court, and along the way, actively threatened GDWG with penalties, including of access to detained persons at Brook House, for getting involved in and facilitating VC to access legal representation to bring an end to his Article 3 mistreatment. This is a salutary insight into the extent to which the Home Office and G4S considered that they were able and entitled to deter oversight and scrutiny of their conduct.

123. Even after the *VC* judgment was handed down, the Home Office took no steps to remedy the unlawful discriminatory failure to make independent advocacy provision available to mentally incapacitated detained persons. A further judgment was handed down by the

[76] Professor Cornelius Katona witness statement, §§119-124, BHM000030_0051-0053
[77] Ms. Naomi Blackwell's witness statement prepared for VC's judicial review proceedings, dated 22 October 2015, BHM000038_0002 §3, exhibited as Exhibit NB1 to Naomi Blackwell's witness statement for the Inquiry, dated 25 January 2022, BHM000040.
[78] 1st witness statement of Hamish Arnott, §§140-146, BHM000042_0040-45.

Court of Appeal in 2019 in the cases of *R (ASK) v Secretary of State for the Home Department*; *R (MDA) v Secretary of State for the Home Department [2019] EWCA Civ 1239*, making the same findings of discrimination concerning two mentally unwell detained persons who similarly suffered a deterioration in their mental health whilst detained and were unable to access any assistance to challenge their detention, segregation or their treatment in detention.[79]

124. Four years on from the *VC* judgment, and seven years on from when VC suffered inhuman and degrading treatment in breach of Article 3 ECHR at Brook House, there is still no independent advocacy provision in place to provide an effective means by which detained persons who may lack mental capacity by reason of their mental illness or learning disability can challenge their detention, conditions of detention and treatment in detention. That the Home Office considers itself able to disregard judgments of the Court even now is a graphic example of the extent of institutional impunity that it both enjoys and perpetuates however serious the consequences of its illegality and systems failure.

125. Mr. Cheeseman, who, until his retirement in November 2020, was responsible for the implementation of remedies in response to the Court of Appeal judgment in *VC*, could not identify how this lacuna was addressed. He pointed to DSO 04/2020 on mental vulnerability as evidence of the Home Office's efforts to belatedly address the findings of the Court of Appeal[80] but was unable to articulate how DSO 04/2020 began to address the discrimination identified in the *VC* judgment in the absence of an independent advocacy system. He readily accepted that the DSO was not implemented in conjunction with any independent advocacy system, which was *"key"* to addressing the systems gap identified by the Court of Appeal.[81] The only explanation he could give was that the development of the advocacy system was complex and could not be introduced alongside the DSO in 2020. He asserted that the Home Office *"were coming under pressure from the courts"* to get the DSO on identification and support in place,[82] but that, at least at the time he retired in November 2020, work on an advocacy process was ongoing.

[79] 1st witness statement of Hamish Arnott, §162(e), BHM000042_0051.
[80] Ian Cheeseman 16 March 2022 205/21-25 to 206/1.
[81] Ian Cheeseman 16 March 2022 207/3-7.
[82] Ian Cheeseman 16 March 2022 207/8-25 to 208/1-5.

126. None of the other Home Office witnesses were able to assist the Inquiry any further on this or were able to confirm that there is an ongoing process for developing an independent advocacy system. Nor were the IRC healthcare witnesses, who were not even aware of the concerns identified by the Court of Appeal in *VC* or in *ASK / MDA* as to the discriminatory and unlawful gap in the detention safeguards to protect the interests and welfare of detained persons who may lack mental capacity by reason of severe mental illness or cognitive impairment.

127. The discriminatory effect of this systems gap is exacerbated by the lack of any knowledge on the part of either IRC healthcare or custodial staff of the steps that should be taken in the case of a detained person who may lack mental capacity. The first witness statement of Ms. Theresa Schleicher of Medical Justice sets out a detailed list of problems with the DSO, including the absence of any clear referral pathway to ensure that someone who appears to lack mental capacity is identified, and the failure to recognise the impact of mental incapacity on detained persons' ability to raise concerns about their detention and other immigration enforcement issues.[83] As explained by Ms. Schleicher, the discrimination can only realistically be cured by the implementation of an effective independent advocacy system.[84] Although Dr. Hard, the Inquiry's clinical expert, thought that IRC healthcare ought to take more proactive responsibility for identifying mental capacity in the context of medical treatment, he agreed in oral evidence that it would be inappropriate to rely only on IRC healthcare, particularly where mental incapacity can affect detained persons' ability to challenge their detention or advance their immigration cases. He agreed that it would be important to have independent advocates to avoid further complication or conflict in the role of IRC healthcare.[85]

128. There was (and remains) no mitigation for the absence of an independent advocacy system to safeguard those who suffer from severe mental illnesses and cognitive impairment from mistreatment. The Inquiry has heard evidence on behalf of D1275 about the impact of this discriminatory lacuna on him during the 422 days that he was at Brook House and 616 days in immigration detention. More will be said about D1275's experience at Brook House in the context of the abuse he suffered. In the present context,

[83] Theresa Schleicher 1st witness statement, §§178-182, BHM000032_0062-64.
[84] Theresa Schleicher 1st witness statement, §111,BHM000032_0037.See also Theresa Schleicher 14 March 2022.
[85] Dr. Jake Hard 28 March 2022 157/1-13.

it is clear from the evidence received by the Inquiry that the absence of independent advocacy directly contributed to his inhuman and degrading treatment:

a. He was unable to access any mental health assessments at all in the 422 days that he was detained at Brook House and the 616 days he was detained under immigration powers, and therefore received no medical intervention for his mental ill-health. He repeatedly missed mental health appointments – 13 in total[86] - because he lacked mental capacity to make decisions about attendance at these appointments, and no one from the healthcare unit bothered to ask the most basic questions as to whether he had mental capacity to engage with healthcare.

   Sandra Calver said in oral evidence that there was (and still is) no process by which issues of mental capacity are explored when medical appointments are missed, and attendance at medical appointments was (and still is) purely a matter of patient choice.[87] Karen Churcher, a senior mental health nurse working at Brook House during the relevant period, said the same,[88] and was under the misapprehension that mental capacity issues did not concern nurses, but rather were the GP's role.[89]

b. D1275's mental capacity also affected his ability to understand his rights concerning his detention and conditions of detention or to know that he could seek legal advice and assistance concerning his detention, his immigration case or his treatment in detention. He was therefore unable to do anything to challenge his prolonged (and unlawful) detention. Although a detention custody staff member appeared to recognise that he may have no mental capacity to attend appointments with lawyers or access legal advice and assistance[90], no steps were in fact taken at all throughout his time at Brook House to assist him to do so. By the time Naomi Blackwell of Gatwick Detainee Welfare Group ("GDWG") happened upon D1275 in early November 2017[91], he had been detained unlawfully at Brook House for more than 6 months, and in immigration detention generally for a year.[92].

[86] Hamish Arnott witness statement, §42, BHM000042_0012.
[87] Sandra Calver 1 March 2022 180/4-7.
[88] Karen Churcher 10 March 2022 64/8-14.
[89] Karen Churcher 10 March 2022 65/23-25 to 66/1-6.
[90] CJS004978.
[91] Witness statement of Naomi Blackwell dated 25 January 2022, BHM000040.
[92] He was detained on 19 October 2016 under immigration powers.

In her witness statement, Ms. Blackwell described the challenges she faced in arranging a face to face meeting with him, which were overcome only because of her tenacity, and not because she received any assistance from G4S or the Home Office. In fact, the Inquiry heard evidence of the threats that GDWG received from the Home Office and G4S for helping detained persons access lawyers, even though Ms. Blackwell was just doing her job. It was only after D1275 was referred by GDWG for legal advice and assistance to Hamish Arnott of Bhatt Murphy Solicitors that his detention and treatment in detention was finally investigated, with the Official Solicitor acting as his litigation friend, and judicial review proceedings brought to secure his release from immigration detention.

c. Prior to accessing lawyers, D1275 was exploited because of his severe mental illness and used as a guinea pig for testing spice. He was also subject to verbal abuse by custody officers on several occasions, as discussed in further detail below. An independent Medico-Legal Report obtained by Bhatt Murphy from consultant psychiatrist Dr. A Ragunathan[93] in February 2018, diagnosed D1275 as having either bipolar affective disorder with psychotic symptoms or a psychotic illness with mood abnormalities.[94] Dr. Ragunathan was of the view that his detention at Brook House perpetuated his mental disorder and he was deprived of appropriate care and support for his mental disorder in detention.[95]

129. The Inquiry has evidence from Dr. Rachel Bingham of Medical Justice to the effect that the discriminatory lacuna has continued to contribute to the serious mistreatment of detained persons after the relevant period and as recent as in 2021 / 2022.[96]

130. There is plainly an urgent need for remedial action to be taken in the form of the implementation of a system of independent advocates. The Inquiry should consider making an interim finding to that effect.

[93] Dr. Ragunathan's report dated 9 March 2018, HOM011262.
[94] Dr. Ragunathan's report dated 9 March 2018, §4.4, HOM011262_0017.
[95] Dr. Ragunathan's report dated 9 March 2018, §4.13, HOM011262_0020.
[96] Dr. Rachel Bingham witness statement dated 3 February 2022, §96, BHM000033_0036-37.

**(b) Operational Deficiencies: Mismatch between policy and practice**

131. For more than 20 years, Home Office policy had recognised - at least in principle – that those who have suffered from torture and other forms of ill-treatment are particularly vulnerable to harm if detained or remain in detention. This was clearly acknowledged as long ago in the 1998 White Paper, *"Fairer, Faster, Firmer"*[97] and was given effect through detention policy and the implementation of the Detention Centre Rules 2001[98] pursuant to section 153 of the Immigration and Asylum Act 1999.

132. Over the course of the two evidence phases, the Inquiry has had occasion to consider different parts of the Detention Centre Rules. The particular rules that we would like to draw the Inquiry are:

133. Rule 3, which identifies the "Purpose of detention centres" as follows:

> *3 - (1) The purpose of detention centres shall be to provide for the secure but humane accommodation of detained persons in a relaxed regime with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environment, and to encourage and assist detained persons to make the most productive use of their time, whilst respecting in particular their dignity and the right to individual expression.*
>
> *(2) Due recognition will be given at detention centres to the need for awareness of the particular anxieties to which detained persons may be subject and the sensitivity that this will require, especially when handling issues of cultural diversity.*

134. Rule 33, which sets out the healthcare arrangements for the IRC, stipulates that there must be at least *"a medical practitioner, who shall be vocationally trained as a general practitioner and a fully registered person within the meaning of the Medical Act 1983"* (Rule 33(1)) and *"a health care team (of which the medical practitioner will be a member) which shall be responsible for the care of the physical and mental health of the detained persons at that centre."* (Rule 33(2)).

135. Rule 34, which sets out the duty and process for medical examination upon admission and thereafter:

[97] Theresa Schleicher 1st Witness Statement, §26, BHM000032_0008.
[98] CJS006120.

*34 – (1) Every detained person shall be given a physical and mental examination by the medical practitioner (or another registered medical practitioner in accordance with rules 33(7) or (10)) within 24 hours of his admission to the detention centre.*

*(2) Nothing in paragraph (1) shall allow an examination to be given in any case where the detained person does not consent to it.*

*(3) If a detained person does not consent to an examination under paragraph (1), he shall be entitled to the examination at any subsequent time upon request.*

136. Rule 35, which contains the core statutory reporting mechanisms for bringing those detained persons who may be vulnerable and whose detention may be unsuitable to the attention of the Home Office so that their detention can be reviewed:

*35 – (1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.*

*(2) The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.*

*(3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.*

*(4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.*

*(5) The medical practitioner shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements) which appear necessary for his supervision or care.*

137. Rules 34 and 35 work in tandem to the key safeguard on detention in ensuring that vulnerability is identified under the AAR policy and those identified to be vulnerable can have a review of their detention and be released. This is why Rule 34 requires that a medical examination be undertaken within the first 24 hours of a person's arrival at an IRC. Its purpose is not only to identify immediate medical needs but more importantly, to facilitate an IRC doctor to carry out clinical assessments that may identify *concerns* or *suspicions* of likely harm in detention or as a result of continued detention. Where such vulnerabilities are identified, these can be notified to the Home Office under one of the

three limbs of Rule 35, as is appropriate, so that the person's detention can be reviewed under the AAR policy. The dual purpose of Rule 34 is clear from the Detention Services Operating Standards Manual[99], published in September 2011 by the Home Office, and established in court judgments since 2006.[100] Its connection with Rule 35 is also clear from the same court judgments.

138. Notification of vulnerabilities under one of the three limbs of Rule 35 is a statutory duty on the IRC doctor. It is non-derogable, that is, where the threshold for a Rule 35 report is met, under one of the three limbs, the doctor *shall* (not *may*) complete a Rule 35. The wording of the duty on the doctor under each of the three limbs of Rule 35 is unambiguous and mandatory, and does not afford the doctor any discretion as to whether to raise a report or not once the trigger threshold is met. This is emphasised in a Detention Services Order, which has always accompanied Rule 35 since the Detention Centre Rules came into force in 2001 and is the applicable DSO during the relevant period. In respect of R35(2), the DSO explains that the trigger can be informed not only by first hand examination of the patient but also from what *"they know from current management of the detainee under the ACDT process"*.[101]

139. Although Rule 35 itself does not stipulate a requirement on the part of the Home Office to undertake a review of detention on receipt of a report under the rule, this requirement is contained in *DSO 09/2016: Detention centre rule 35* (6 December 2016).[102] The DSO, at page 13, stipulates a timescale for a response to a Rule 35, *"as soon as possible but no later than the end of the second working day after the day of receipt."*[103] If a Rule 35 report does not contain sufficient information to understand the medical concern and meaningful consideration of the report is not possible, then the Home Office caseworker is directed to contact IRC healthcare for further information.[104] That remains the approach in the current version of the DSO.

[99] See page 36, paragraph 15 of the manual, accessed on 20 April 2022 at: https://www.gov.uk/government/publications/detention-services-operating-standards-manual
[100] *R (D and K) v Secretary of State for the Home Department* [2006] EWHC 980 (Admin) at §§50-53. See also *R (EO and Ors) v Secretary of State for the Home Department* [2013] EWHC 1236 (Admin), *R (SW) v Secretary of State for the Home Department* [2018] EWHC 2864 (Admin) and *R (KG) v Secretary of State for the Home Department* [2018] EWHC 1767 (Admin).
[101] DSO 09/2016: Detention centre rule 35,HOM002591_0009-0010.
[102] DSO 09/2016: Detention centre rule 35,HOM002591.
[103] DSO 09/2016, HOM002591_0013.
[104] DSO 09/2016, HOM002591_0014.

140. The systemic defects in the Rules 34 and 35 safeguards are well-known and long-standing, and have been reported by many including Medical Justice, Parliamentary committees, by Stephen Shaw, the Home Office's appointed independent reviewer and by the Courts[105]. The failures are at every stage of the safeguarding process including:[106]

a. health screening failing to elicit a history of torture and prompt a Rule 35 assessment;
b. Rule 34 medical examinations not being completed at all, or partially with either no physical or mental state examination, and therefore not triggering Rule 35 reports;
c. Rule 35 reports failing to identify a significant number of torture survivors, body maps not completed documenting scarring, reports being completed by nurses, and reporting failing to consider impact of detention on the person's health;
d. Few Rule 35(1) or 35(2) reports being done even in circumstances of known self-harm or mental state deterioration in detention;
e. the Home Office failing to respond to Rule 35 reports at all or within prescribed timeframes. When responses were provided, the Home Office disputing the credibility of the account despite the medical evidence and maintaining detention without considering the evidence or impact of detention on the detained person's health adequately or at all. The "very exceptional circumstances" strong presumption was not applied properly to secure the release of vulnerable people.

141. The failures are also evident from looking at the Home Office's own data on Rule 35 reports and the rate of release, set out in Tables 1-3 to Theresa Schleicher's 1st witness statement.[107] It is apparent form the Home Office's own figures that:

a. there is a high volume of Rule 35 reports, principally focussing on claims of torture (Rule 35(3)) rather than on suicide risks (Rule 35(2)) or concerns about the impact of continuing detention (Rule 35(1)).

[105] See for example *R (D and K) v Secretary of State for the Home Department* [2006] EWHC 980 (Admin); *R (EO and Ors) v Secretary of State for the Home Department* [2013] EWHC 1236 (Admin).
[106] Theresa Schleicher's 1st witness statement §§49-71, BHM000032_0014-21.
[107] Theresa Schleicher's 1st witness statement, BHM000032_0048-51.

b. At Brook House, no Rule 35(2) reports were raised at all for the two years preceding the relevant period and during 2017. Only 2 Rule 35(1) reports were raised in 2015, 11 in 2016 and 8 in 2017. Nearly all Rule 35 reports were under the third limb.

c. Even where a Rule 35(1) report was raised, the person did not always get released. In 2017, for example, only 2 out of 8 detained persons with a Rule 35(1) report were released as a result of a report stating that they were likely to be injuriously affected by detention.[108] During the two quarters of 2017 (April to September 2017) covering the relevant period for the Inquiry, the breakdown of Rule 35 reports showed that only one of five people who received a Rule 35(1) report were released as a result of the Home Office being informed that their health was likely to be injuriously harmed by continued detention.[109]

d. Data from Freedom of Information Act requests made by Medical Justice suggest that the patterns of defects in the Rule 35 safeguards persisted at Brook House post-2017.[110] The data in 2018 and 2019 showed similar patterns of very few Rule 35(1) reports, no Rule 35(2) reports, and consistently low release rates in response to Rule 35(3) reports.

142. There can be no doubt that the Home Office was fully aware of the persistent and systemic deficiencies in the Rule 35 safeguard well before this Inquiry shone a spotlight on this issue again during its evidence phases. Emma Ginn of Medical Justice confirms that Home Office official, as long ago as 2010, recognised the "*disconnect*" between the purpose of a Rule 35 report and Home Office decision-making.[111] Theresa Schleicher described repeated calls by Medical Justice for the Home Office to undertake an audit of Rule 35 reports to investigate the underlying factors causing the whole safeguarding process to be dysfunctional for more than a decade.[112] Medical Justice and others engaged in repeated "*largely pointless*" Home Office consultations on Rules 34 and 35[113] and face to face meetings with the Home Office including Phil Schoenberger in an

[108] Table 2, Theresa Schleicher 1st witness statement, BHM000032_0051.
[109] Table 2, Theresa Schleicher 1st witness statement, BHM000032_0051.
[110] Table 3, Theresa Schleicher's 1st witness statement, BHM000032_0052-53.
[111] Emma Ginn witness statement dated 9 February 2022, §61, BHM000041_0021
[112] Theresa Schleicher 1st witness statement, §§56-57, BHM000032_0016
[113] Emma Ginn witness statement, §53, BHM000041_0019

attempt to effect improvements to the safeguards.[114] But in the absence of concrete improvements, Medical Justice produced the *Second Torture* research report in 2012.[115]

143. It is apparent from the evidence before the Inquiry that no progress was made to do so on the part of the Home Office because the 2015 Parliamentary Joint Inquiry into the Use of Immigration Detention in the UK also expressed shock at reports of medical staff not knowing that Rule 35 existed or how it should be operated, and Home Office caseworkers ignoring vulnerabilities raised through Rule 35 reports for the purposes of considering release. That inquiry made strong recommendations that the Home Office ensure that both staff in detention (custodial and healthcare) and immigration caseworkers are properly trained on the purpose and application of Rule 35 so that the safeguard can work as it should. At the time, the Home Office told the Parliamentary inquiry that it would wait to implement any recommendations until after Mr. Shaw had reported on his review of the welfare in detention of vulnerable people.

144. By the publication of Mr. Shaw's report in January 2016, he had observed such *"a sense of frustration"* [116] across the spectrum of organisations and professionals ranging from NGOs to professional organisations like the British Medical Association to detention staff and caseworkers about the ongoing systemic deficiencies in the Rule 35 safeguard that he considered that there was no point attempting an audit of the reports to identify the underlying causative factors. He also did not believe that introducing better training for doctors and immigration caseworkers who are responsible for responding to Rule 35 reports would make a difference. The fundamental problem was, according to Mr. Shaw, that *"the Home Office does not trust the mechanisms it has created to support its own policy."*[117]

145. Mr. Shaw recommended that the Home Office *"immediately"* consider an alternative to the current rule 35 mechanism.[118]

146. This recommendation, the Inquiry heard, was not implemented. Mr. Cheeseman, the only witness put forward by the Home Office who has insight into policy-making, could not

[114] Emma Ginn witness statement, §§ 60-65, BHM000041_0021-0025
[115] Theresa Schleicher 1st witness statement, §§58-61, BHM000032_0017
[116] Shaw 1st Review, §§4.108-4.116, INQ000060_0104-0108
[117] Shaw 1st Review, §4.118, INQ000060_0108
[118] Shaw 1st Review, recommendation 21, INQ000060_0108

provide an explanation for this other than to say that the Home Office did not agree to implement every recommendation of the Shaw Review but accepted its "broad thrust".[119] That answer is wholly unsatisfactory as on its own, it shows little acknowledgment on the part of the Home Office of the systemic problems with the key safeguard to ensuring a functioning and effective protective detention policy for vulnerable people, the impact of those systemic problems on the welfare of detained persons (which was the whole point of the Shaw Review) and again reflects the extent of institutional impunity that the Home Office believes it enjoys and perpetuates irrespective of the consequences for vulnerable detained persons.

147. Against this backdrop, it is hardly surprising that the Inquiry's clinical expert, Dr. Hard, found *a complete deprivation of safeguards at Brook House in 2017.*[120] What even Medical Justice did not expect was evidence of the scale of the systems failures of the safeguards and the misdirection by the Home Office of the application of safeguards by healthcare exposed in this Inquiry.

### (i) Failure of the Rule 34 safeguard

148. The evidence before the Inquiry confirm that Rule 34 medical examinations have become entirely disconnected from the safeguarding purpose of the rule, that is to provide the evidence base for a Rule 35 report and for a review of the suitability of detention in an individual case.

149. When asked why this was the case, Sandra Calver, Head of Healthcare for Brook House during the relevant period (and to date), said that these initial GP appointments were only allocated 5 minutes.[121] Dr. Hard expressed surprise at this arrangement, which at best can only achieve a *"a very very cursory appointment;"*[122] it is *"impossible"* to fulfil the requirements of a Rule 34 examination or to complete a Rule 35 report in that limited amount of time allocated.[123] Despite Dr. Oozeerally's pedantry about the wording of Rule 34 not defining the extent of the physical and mental state examination[124], his description

[119] Ian Cheeseman 16 March 2022 181/11-25
[120] Dr Jake Hard, 28 March 2022, 178/20-25.
[121] Sandra Calver's Verita interview at Q&A 33-36, VER000275_00004. See also Sandra Calver 1 March 2022 208/16-25 to 209/1-15
[122] Dr Jake Hard 28 March 2022 19/1-4
[123] Dr Jake Hard 28 March 2022 19/17-25, 20/6-14
[124] Dr Husein Oozeerally 11 March 2022 9/9-13, 10/14-20, 24-25, 11/1-9, 18-20

of the initial GP appointment confirms that Rule 34 medical examinations were (and still are) not done in the way they are intended to be done: *"It's almost like triage."*[125] He confirmed that *"you couldn't possibly do a full mental health examination,"*[126] and that a proper assessment for the purposes of a Rule 35 report would take about 45 minutes, or more with an interpreter, not something that could possibly be completed in the 5-minute slot. [127]

150. Because insufficient time has been allocated to initial GP appointments, a practice developed whereby a further GP appointment is booked for people who disclose vulnerabilities or medical conditions requiring further investigation.[128] But these second GP appointments *"wouldn't be the next day"* [129]; instead detained people whose vulnerabilities require a Rule 35 assessment would have to wait for 2-4 weeks before they could get an appointment with a GP with a view to carrying out that assessment.[130]

151. Dr. Bingham of Medical Justice gave evidence that this practice of booking a second GP appointment and the delay in detained people being seen for a Rule 35 report was inappropriate. Rules 34 and 35 are intended to work in tandem to identify people at the earliest opportunity – within 24 hours of a person entering detention – so that they can be routed out of detention as soon as possible before any harm is done. Delays mean that people vulnerable to harm in detention are, instead, exposed to risks that the harm will actuate, and they may deteriorate whilst waiting for a Rule 35 appointment.[131] Dr. Hard agreed with Dr. Bingham.[132]

152. Ms. Calver did not initially recognise that there was anything wrong with these arrangements because *"this is the same as it's been throughout all of the other IRCs as well,"*[133] which shows that the systems defect was both far more pervasive across the detention estate, *and* known to the Home Office. Neither Ms. Calver nor Dr. Oozeerally could recall any concerns being raised with them from the Home Office about these

[125] Dr Husein Oozeerally 11 March 2022 9/18
[126] Dr Husein Oozeerally 11 March 2022 9/13-15
[127] Dr Husein Oozeerally 11 March 2022 9/6-16
[128] Sandra Calver 1 March 2022 208/19-21, 209/11-13
[129] Dr Husein Oozeerally 11 March 2022 18/18-25, 19/1-5
[130] Dr Husein Oozeerally 11 March 2022 20/9-12
[131] Dr Rachel Bingham 14 March 2022 27/11-25, 28/1-8
[132] Dr Jake Hard 28 March 2022 17/6-20
[133] Sandra Calver 1 March 2022 209/1-2

arrangements of 5-minute slots for initial GP appointments were incapable of fulfilling the objective of the Rule 34 safeguard and needed to be remedied.

153. Once Ms. Simcock explained the statutory purpose of Rule 34, to pick up vulnerabilities, like torture, PTSD and other mental health symptoms might be worsened by detention at the earliest opportunity after a person enters detention, Ms. Calver accepted that a functional Rule 34 examination, carried out promptly within 24 hours, would need to be much longer than 5 minutes if it was to operate as intended, as an important safeguard for deciding whether vulnerable detained people should remain in detention. She accepted that the failure to operate the Rule 34 safeguard promptly and properly necessarily meant people who should not be detained, remained in detention and were exposed to and suffered harm by being detained. [134]

154. It is of course better that Ms. Calver now recognises that the fundamental defects in the way that Rule 34 has been operating at Brook House. However, her belated recognition is of little comfort to vulnerable detained people who were detained at Brook House during the relevant period and were not being identified as such because the Rule 34 safeguard was dysfunctional, and as a direct consequence of this, were exposed to and experienced harm to detention.

155. What is worse is that her evidence confirms that the dysfunction in the Rule 35 safeguard has now been carried over and embedded in the new contractual arrangements at Brook House under the new contractor, PPG in the form of 10-minute initial GP appointments[135], which are still patently insufficient to ensure the kind of physical and mental state examination necessary to determine whether a Rule 35 report should be raised. This is plainly not a question of training; the structural arrangements in place are incapable of ensuring compliance with the Rules 34 and 35 safeguard. As the Court in *D and K* had said, the responsibility for ensuring the safeguard functions is with the Home Office, who is obliged to put in place the resources and instructions to give effect to the rule.[136]

[134] Sandra Calver 1 March 2022 212/8-25, 213/1-16.
[135] Sandra Calver 1 March 2022 209/1-15
[136] *D and K v SSHD*, §53: "*This in fact, as I see it, is precisely one of the reasons why Rules 34 and Rule 35 are framed as they are – the obligation being on the detaining authorities in this regard to provide the medical attendance which may in turn, in some cases, lead to a report capable of being independent evidence of torture*".

156. When asked whether she considered this to be a fundamental systems issue, Ms. Calver said that it was not for her to say, and that *"there probably needs to be a further explanation from Home Office as what they – the full extent they want from a rule 34 appointment."*[137]

157. Both Luke Wells and Dr. Sarah Bromley, the corporate witnesses for PPG, said they were not told by the Home Office of the ongoing systems failure in the Rule 34 safeguard when they made their witness statements on 7 February 2022 (Mr. Wells[138]), and 16 February 2022 (Dr. Bromley[139]). Both said they only became aware of the problem after listening to Ms. Calver's evidence and that of Dr. Hard, the Inquiry's clinical expert.[140] Whilst Dr. Bromley recognised that unless there is a radical change to the arrangements for initial GP appointments so that the Rule 34 safeguard can actually achieve its objective, neither she nor Mr. Wells was willing to make any commitments on behalf of PPG to remedy this systemic gap. [141] Mr. Wells indicated that there would be scope within the contract for PPG to negotiate around the amount of time that doctors would spend on site[142], but could not confirm that steps would be taken to do that. Dr. Bromley also made vague statements that PPG would be willing to *"explore what we can do effectively with the resources we have got."*[143] But additional resources are required to make fundamental structural changes to the way Rule 34 is operated. This can only come from the Home Office in conjunction with NHS England.

158. When asked about the dysfunction of the Rule 34 safeguard on the last day of Evidence Phase 2, Phil Riley, Director of Detention and Escorting Services, acknowledged the deficiencies highlighted in oral evidence but provided no explanation for why these have been going on for so long. Nor did he provide any indication that additional resources will now be made available to PPG to ensure that Rule 34 medical examinations can realistically be completed by medical practitioners and that steps would be taken to eliminate the disconnect between the Rule 34 and 35 safeguard so that they can work as

[137] Sandra Calver 1 March 2022 211-19-25 to 212/2.
[138] Luke Wells first witness statement. PPG000169.
[139] Sarah Bromley first witness statement. PPG000172.
[140] Luke Wells 31 March 2022 171/24-25 to 172/1-2, 174/3-13 ; Sarah Bromley 1 April 2022 161/19-25, 162/1-10, 163/3-5, 164/21-25, 165/1-13
[141] Luke Wells 31 March 2022 182/9-15; Sarah Bromley 1 April 2022 166/16-24
[142] Luke Wells 31 March 2022 176/15-17.
[143] Sarah Bromley 1 April 2022 167/20-25

intended, in tandem, to identify detained people who are vulnerable to harm in detention, at the earliest opportunity after they enter the detention centre, so that the suitability of their continued detention can be reviewed as soon as possible before any harm is done to them.

159. In considering recommendations to address this systemic defect, the Inquiry is asked to bear in mind the evidence of Dr. Bromley, that absent additional resources, which can only come from the Home Office, *"it is likely that [Rule 34] will continue to be breached, particularly as the numbers ramp up in Brook House."*[144] This breach does not stand alone; given its connectivity to Rule 35, this ongoing breach impacts on the ability of other safeguards to function to ensure that the protective purpose of the AAR policy is actually fulfilled and the system and operational duties under Article 3 ECHR are met so as to prevent the known risk of harm particularly for those with pre-existing vulnerability.

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**(ii) <u>Defects in Rule 35 safeguards</u>**

***Failure to refer for a Rule 35 assessment***

160. The Inquiry heard no evidence that contradicts the long-standing casework experience of Medical Justice concerning detained persons not being referred automatically for Rule 35 appointments where they disclose histories of torture, self-harm, suicide attempts, depression or other pre-existing mental ill-health. The example of D2033, identified to Dr. Oozeerally in oral evidence by Ms. Simcock[145], was a clear illustration of this. As were other examples given from Medical Justice's casework database, summarised at §§47-50 of Theresa Schleicher's second witness statement.[146]

161. In addition to the significant waiting times for a Rule 35 appointment already discussed above, Medical Justice's uncontradicted evidence was also that all too often, Rule 35 assessments were only done at the request of detained persons or their solicitors and not identified by healthcare even when disclosures were made at the initial health screening of torture and other vulnerabilities including a history of self-harm. Dr. Hard also noted this in his analysis of the material that he was provided by the Inquiry.[147] This inevitably

[144] Sarah Bromley 1 April 2022 168/1-7
[145] Dr Husein Oozeerally 11 March 2022 16/15-25, 17/1-25, 18/1
[146] Theresa Schleicher 2nd Witness Statement, 3 February 2022, §§47-50. BHM000031_0016-0020
[147] Dr Jake Hard 28 March 2022 22/10-15

added to delays in detained people being able to access the Rule 35 safeguard promptly and at the earliest opportunity. It also raised an additional concern of shifting the burden on the detained person to make the request, which is wrong in principle[148] and in practice depends on the detained person being aware of his rights, having means to do so as well as the confidence, ability and language skills to advance those rights. Chrissie Williams, then the clinical lead at Brook House, told the Inquiry that although detained people were given a leaflet with basic information on the provision of healthcare in the IRC, that leaflet did not contain information to explain the Rules 34 and 35 safeguards, what they say, what their purposes are, and how to access the safeguards. In these circumstances, the ability of detained people to access the Rule 35 safeguard was arbitrary and left to chance, whilst they remain in detention, subjected to prolonged exposure to deterioration in their mental health in breach of Article 3 ECHR.

162. The case of D801 is a paradigm illustration of this. He was someone who should never have been detained in the first place, given that he had a pending appointment to submit a fresh claim for asylum and had produced detailed medico-legal reports on the high risks of suicide if he were to be re-detained (having been detained once already in 2015) and forcibly removed. On entering Brook House on 1 March 2017, he disclosed to a nurse at the initial health screening that he had experienced past torture in Sri Lanka, suffered from PTSD and regular flashbacks as a result, and had attempted two failed suicide attempts by overdose whilst in the community.[149] The nurse at the screening appointment clearly was concerned about him, because an ACDT was opened on his arrival and he saw a psychiatrist the next day. But any and all of this information disclosed at the health screening ought to have resulted in an urgent referral for a Rule 35 assessment with a view, at a minimum, to raising a Rule 35(3) report (because of D801's disclosure of past torture), if not a Rule 35(1) or Rule 35(2) report (because of D801's disclosure of suicide attempts, self-harming ideation and active trauma symptoms that are likely to worsen in detention). However, no Rule 35(3) report was ever contemplated in D801's case, nor was a Rule 35(2) report.

163. Whilst in detention, and in circumstances where the statutory safeguards totally failed him, D801 suffered a significant deterioration, and quite rapidly. Dr. Iona Steen, who

[148] *D and K v SSHD* [2006] §53.
[149] See entry on 1 March 2017 in the medical records for D801, HOM032191_0001.

saw D801 10 days after he was first detained, noted that he had become so distressed he was no longer able to speak about his past or his current circumstances.[150] He continued to deteriorate rapidly thereafter, attempting to take his own life by using a shoe lace to hang himself. Even that did not prompt a Rule 35 report under any of the three limbs. A Rule 35(1) report only came two weeks after the attempted suicide, on the very last day of D801's month-long detention, and only after Dr. Belda, an IRC psychiatrist, stated in no uncertain terms that D801 was not fit for detention. The harm that D801 suffered from being detained for 34 days is clear from the clinical assessment of Dr. Piyal Sen, who concluded in a report of 1 March 2021 that the detention served as a *"re-traumatisation experience"* and continues to plague him even now.[151]

164. Dr. Chaudhary attributed the backlogs to accessing Rule 35 appointments to the fact that there was only one allocated Rule 35 appointment slot a day during the relevant period.[152] Be that as it may, this evidence does not explain why detained persons such as D801 and D1713 never got referred for a Rule 35 report despite disclosure of a history of torture, self-harm and other vulnerabilities, and so never even got onto a waiting list for a GP appointment.

165. Dr. Oozeerally proffered an alternative theory, that the backlog for Rule 35 appointment was not because of flaws in the structure arrangements for Rules 34 and 35 (i.e. 5 minute initial GP appointments, and limited slots for Rule 35 reports per week), but rather because of the *"misuse"*[153] of the safeguard by detained persons and NGOs wishing to advance a political agenda, which diverted precious resources away from GPs to provide primary healthcare to detained people. Dr. Oozeerally's evidence on this point should be rejected. There is no other evidence before the Inquiry that would suggest that the Rule 35 safeguard was not working because it was being misused. That was not a problem that Mr. Shaw identified in his January 2016 report. Neither the HMIP nor IMB identified that as the cause for the dysfunction in the Rule 35 safeguard. Nor had Ms. Calver or any Home Office witness. This reflects poorly on Dr Oozeerally and is indicative of his compromised professional and ethical position as the lead IRC doctor. It also reflects the

[150] See letter from Dr. Iona Steen dated 14 March 2017, §27, HOM028547_0003-0004.
[151] Witness statement of D801 dated 26 January 2022 at §80, BHM000034_0026.
[152] Dr Saeed Chaudhary 11 March 2022 241/11-21
[153] Dr. Oozeerally 1st witness statement, dated 30 November 2021, §§78-79, DR000001_0010.

extent to which the culture of disbelief that permeates Home Office policy had infected the system.

166. The obvious and only credible and coherent explanation for the backlog is that identified by Dr. Hard: that an *"understanding of why the Detention Centre Rules are here in the first place seems to historically have been lost along the way"*[154] and along with it, the role of healthcare to ensuring that detention safeguards function properly and are a priority in circumstances where they are critical to ensuring that people who should not be detained by reason of the risk of harm to them in detention are notified to the Home Office with the possibility of being removed from the environment.[155] Instead, safeguarding was seen as a *"footnote"*.[156]

***Dysfunctions of Rule 35(1) and Rule 35(2) safeguards***

167. Dr. Hard expressed shock at the very low number of Rule 35(1) reports that were completed during the relevant period, particularly when that is considered against the high numbers of opened ACDTs (248) and the numbers of constant watch cases (60) for the same 5-month period.[157] He found it equally, if not more shocking, that no Rule 35(2) reports were ever produced during that same period in circumstances where removal from association and segregation were being routinely used in response to self-harm and suicidal ideation. Indeed, according to the Home Office's own statistics, no Rule 35(2) report was completed at all for the whole of 2017, or indeed for the two years preceding and even to date. Dr. Hard *"can't fathom why"* even in constant watch open ACDT cases, no Rule 35(1) or Rule 35(2) was raised. *"It just doesn't make any sense to me"* and is *"a significant concern."*[158]

168. His clinical concerns correlate with the casework experience of Medical Justice. Their case studies from the relevant period show repeat concerning patterns of doctors and healthcare professionals failing to act to ensure the Rule 35(1) safeguard was used to notify the Home Office of obvious deterioration on the mental health of detained people, especially when this manifested in active expression of suicidal intentions, symptoms or

[154] Dr Jake Hard 28 March 2022 24/1-7
[155]. Dr Jake Hard 28 March 2022 17/1-5
[156] Dr Jake Hard 28 March 2022 180/1-6
[157] Dr Jake Hard 28 March 2022 58/4-7
[158] Dr Jake Hard 28 March 2022 78/22-25 to 79/1-4

diagnoses of depression, intensifying trauma symptoms such as flashbacks, poor and disturbed sleep, recurring nightmares or even psychosis.[159] Medical Justice's review of available Rule 35 reports for the relevant period revealed at least half a dozen cases where the Rule 35(3) report recorded active suicidal thoughts and plans from the detained person, no Rule 35(2) was raised.[160] This is even in cases where the Rule 35(3) report noted that the detained person had expressed thoughts of ending his life and actually attempting to carry this out,[161] and where the detained person is on constant watch.[162]

169. The failure to operate the Rule 35(1) or Rule 35(2) safeguard is not merely unlawful as a breach of a statutory rule. The Inquiry will recall that the rules are not an end in themselves, but rather and importantly, there to ensure that the detention is lawful, and the AAR policy is properly applied so that the vulnerable are identified and released before they suffer risks of or actual harm. There is a direct causative link between the functioning of the safeguards, the legality of the detention and the risk of Article 3 ill-treatment. As Dr. Hard pointed out, *"without these safeguards being used to their full force, at the earliest opportunity, then it appears that … the only consequence [is] that people are likely to come to more harm."*[163]

170. When healthcare witnesses were asked to give an explanation for the alarmingly low numbers of Rule 35(1) and the absence of any Rule 35(2), their answers betrayed a similarly shocking lack of understanding of the thresholds for Rule 35(1) and (2) reports that caused concern with the Parliamentary Joint Inquiry on the Use of Detention in 2015, two years before the abuse at Brook House was captured on film by Callum Tulley:

171. Sandra Calver's written evidence described the threshold for Rule 35(1) as requiring the detained person to have *"a severe or unstable medical condition, which means they are not suitable for detention."*[164] She thought that the threshold for Rule 35(2) required someone to be *"severely suicidal and not suitable for detention."*[165] Her understanding of both thresholds was plainly wrong. She was right to accept that the wording of the

[159] Theresa Schleicher 2nd witness statement, dated 28 January 2022, §§71-77, BHM000031_0029; Dr. Rachel Bingham witness statement, §§120-127, BHM000033_0046-48.
[160] Dr. Rachel Bingham witness statement, §118,BHM000033_0045.
[161] See for example the case of D2442, summarised at §118(a) of Dr. Bingham's witness statement, BHM000033_0045.
[162] Sandra Calver 1 March 2022 235/11-21
[163]. Dr Jake Hard 28 March 2022 54/24-25, 55/1-3
[164] Sandra Calver 1st witness statement dated 9 November 2021, §117, DWF000009_0020.
[165] Sandra Calver 1st witness statement, §117, DWF000009_0020.

rules did not stipulate such high thresholds[166] and also right to accept that her flawed approach was *"risky"* and *"dangerous"* because it allowed detained people to become so unstable that detention had already actually harmed them[167] before anything was done to bring their suffering to the attention of the Home Office.

172. When asked how she came to this fundamental misunderstanding of the rule, the answers she gave were revealing as to the role of the Home Office in misdirecting healthcare professionals as to how to operate the statutory safeguards. Ms. Calver told the Inquiry that she never got any training or information from the Home Office on the Rule 35 safeguard, either on what it said or when to make a referral for a Rule 35 report to a doctor on behalf of a detained person.[168] She also received no training that assisted her to understand how the Rule 35 safeguard was connected with the AAR policy. Instead she and her staff were *"advised by the Home Office"* to raise a Part C (not a Rule 35) when they come across detained people who appeared to suffer from a mental health condition or impairment or PTSD. This was even though she was aware that Part Cs do not trigger a detention review on the part of the Home Office.[169]

173. When asked whether she was concerned about these instructions, she told the Inquiry that she did have (and still has) concerns that nurses did not (and do not) have a good understanding of Rule 35(1) or (2)[170] and that she has been pushing for better training since before 2017 with the Home Office policy team[171] but to no avail. To date, she and the nursing staff still have only ever had any training on Rule 35(3)[172] but not on the other two limbs of the rule. There was, in her view, a significant gap in knowledge, and one that persists to date.[173]

174. It is clearly of significant concern that the Head of Healthcare has had such a fundamental misunderstanding of the Rule 35 safeguards for more than a decade (Ms. Calver having become a manager at Brook House since 2009). But what is of even more concern is Ms. Calver's evidence that the Home Office was fully aware that higher thresholds were

[166] Sandra Calver, 1 March 2022, 218/25 to 219/1-7.
[167] Sandra Calver, 1 March 2022, 218/1-24.
[168] Sandra Calver, 1 March 2022, 192/15-21.
[169] Sandra Calver, 1 March 2022, 201/9-18, 202/1-4.
[170] Sandra Calver, 1 March 2022, 230/18-25.
[171] Sandra Calver, 1 March 2022, 226/1-11.
[172] Sandra Calver, 1 March 2022, 152/1-11, 228/13-25.
[173] Sandra Calver, 1 March 2022, 230/18-25.

being applied to when Rules 35(1) and 35(2) reports were done, was content for these fundamentally flawed and dangerous thresholds to be applied to the operation of the Rule 35 safeguard[174], and moreover, actually misdirected Ms. Calver and her staff not to refer for Rule 35(1) or (2) reports, and instead use Part Cs.

175. Ms. Calver's evidence to this effect is echoed by the evidence of Dr. Chaudhary, one of the two primary GPs at Brook House. He told the Inquiry that whilst he would accept that the wording of the rules set a low threshold for triggering a report, the training he received from the Home Office on Rule 35 directed him to look at the questions in the template, and not at the rule itself. The first time he had occasion to read the wording of the rule itself was when he gave oral evidence on 11 March 2022.[175] It was his belief, based on the training he got from the Home Office and the practice that was adopted at Brook House, that the questions set out in the template for Rules 35(1) and 35(2), designed by the Home Office, narrow the scope of those two limbs of Rule 35.[176] He described the questions in the templates as *"the kind of leading questions that kind of make me understand that this document was really, if we were unable to treat or help to manage patients within the immigration centre, that we would need to be filling that out. And, in practice, it didn't automatically mean that they would be released."*[177] No one from the Home Office who has read his Rule 35 reports has ever sought to disabuse him of this fundamentally erroneous understanding about the way Rule 35(1) and (2) ought to operate.

176. Although Dr. Oozeerally was unwilling to accept that, as someone *"quite experienced"* in undertaking Rule 35 assessment[178], he had misunderstood what Rule 35(1) and Rule 35(2) required of him, it is apparent from his evidence that he also operated under the misdirection of the Home Office not to raise a Rule 35(1) report if *"those patients were able to be managed within that detention environment"*[179] because that is what the template questions told him to do. Similarly in respect of Rule 35(2), Dr. Oozeerally also believed that if he thought that he was managing the patient in detention[180], through an

[174] Sandra Calver, 1 March 2022, 220/15-19, 24-25, 221/1-11, 222/15-21.
[175] Dr. Saeed Chaudhary, 11 March 2022, 202/12-18.
[176] Dr. Saeed Chaudhary, 11 March 2022, 193/1-17, 195/1-10, 200/5-9.
[177] Dr. Saeed Chaudhary, 11 March 2022, 193/18-23, 199/1-12.
[178] Dr. Husein Oozeerally, 1st witness statement dated 30 November 2021, §72, DR000001_0009.
[179] Dr. Husein Oozeerally 11 March 2022 60/1-6.
[180] Dr. Husein Oozeerally 11 March 2022 52/7-23.

open ACDT, he would not complete a Rule 35(2). Indeed, although Dr. Oozeerally accepted that someone at high risk of suicide on constant watch would undoubtedly meet the criteria for a Rule 35(2)[181], he had not ever done a Rule 35(2)[182] in the whole time that he worked at Brook House (that is since December 2014).

177. Like Ms. Calver, Dr. Oozeerally told the Inquiry that no one at the Home Office had ever raised with him any concerns about not seeing many Rule 35(1) reports and no Rule 35(2) reports. He said *"they would have been aware of it, right? Even at the teachings [sic], they were fully aware of that. That was never raised. And they would have been aware of the number of ACDTs as well. So that information would have been in front of them."*[183]

178. That the Home Office bears the responsibility for the dysfunction of the Rules 35(1) and (2) safeguards is also clear from the evidence of Ian Cheeseman, who until November 2020, was the senior civil servant responsible for the Adults at Risk policy. In his evidence about his knowledge of the overall low numbers of Rules 35(1) and 35(2) reports, he told Inquiry that they would not necessarily have concerned him because *"I would have assumed that the absence of rule 35(1) reports was because people were using rule 35(3) reports to report rule 35(1)s, effectively, and as far as rule 35(2) was concerned, I was aware that the ACDT process had effectively – well, ran alongside rule 35(2) but had in some ways kind of replaced the reporting need because Part Cs were used to report cases of suicide and self-harm, of suicidal ideation and self-harm, and that any conversation needed by caseworkers to consider cases under the Adults at Risk policy would be getting through through Part Cs or by other communication methods."*[184] When Phil Riley was asked about the same issue, he did not dispute that this was the case, and could offer no alternative explanation to the evidence given by Ms. Calver and Dr. Oozeerally as to the Home Office's role in misdirecting healthcare staff to disapply statutory safeguards under Rules 35(1) and (2) of the Detention Centre Rules 2001.

[181] Dr. Husein Oozeerally 11 March 2022 47/10-14.
[182] Dr. Husein Oozeerally 11 March 2022 53/16-17.
[183] Dr. Husein Oozeerally 11 March 2022 61/9-18.
[184] Ian Cheeseman 16 March 2022 200/15-25 to 201/1-7.

179. The Inquiry should be seriously concerned that the state authority with duties to design and operate an Article 3 compliant immigration detention system with appropriate and effective safeguards is proactively misdirecting its contractors and staff to use Part Cs and to disapply the statutory safeguards put in place for the purpose of preventing vulnerable detained people from suffering inhuman or degrading treatment in detention in breach of Article 3 ECHR. More is said below as to why Part C is a patently inferior mechanism and cannot be a substitute for an effective and functioning Rule 35 safeguard.

***Ineffective Rule 35(3) safeguard***

180. None of the healthcare witnesses, including Dr. Chaudhary and Dr. Oozeerally could explain why nearly three quarters of the Rule 35(3) reports reviewed by Dr. Hard contained no information on the impact of detention, and many more reviewed by Medical Justice showed that the doctors did not consider detention harmful unless there were symptoms of psychosis, even though in many cases such symptoms would indicate an advanced stage of deterioration, which any proper vulnerability screening would aim to prevent."[185] DSO 09/2016 provides a process by which the Home Office could ask the doctor who completed the Rule 35 report for further clarification or information, particularly when there was crucial missing information in the report relevant to the review of detention.[186] But the Inquiry received no evidence of any attempt by the Home Office to use this process to seek clarification. Instead, the available responses to Rule 35(3) reports show that the absence of any comment on the impact of detention by the doctor was relied on by the Home Office to find detention to not have posed any risk to the detained person, and so maintain detention on the false premise that the detained person had not been and was unlikely to be harmed by continued detention.

181. The Inquiry heard evidence from Dr. Bingham on how the Home Office's approach is wholly incongruous with established clinical literature which states that someone who has suffered a past history of torture would be at risk of harm in detention[187]. As she explained, leaving a torture victim in an environment known to trigger and exacerbate his trauma symptoms causes *"extreme distress and suffering, because flashbacks being*

[185] Dr. Rachel Bingham's witness statement §§109, 113-117, BHM000033_0043-44.
[186] Pages 13-14 of DSO 09/2016, under the heading "Actions by Home Office responsible officers",HOM002591_0013-0014.
[187] Dr. Rachel Bingham's witness statement §103, BHM000033_0038-39, and the literature cited within that paragraph. See also transcript of her oral evidence; Dr Rachel Bingham 14 March 2022 8/3-25 to 9/1-5.

*exacerbated, it's not just a symptom that, you know, happens in passing. That's a reexperiencing of torture. So what's happening in the person's experience there is going to be as if they are being tortured again."*[188]

182. D801's description of his experience of remaining in detention because the Home Office failed to consider the impact of detention on him starkly illustrates what Dr. Bingham was describing in oral evidence:

> *He could not eat and was throwing up all the time. He just stayed inside his room and did not want to socialise with anybody. The food tasted to him as if he was 'eating a pair of glasses, like it was burning.' He did not wish to explain anything to the authorities and just stayed away from food. The whole experience felt to him 'like walking on fire.' Every single day felt as if it was biting on his skin and he physically felt the pain.*[189]

183. Dr. Hard agrees with Dr. Bingham's concerns, and considers that where the Home Office accepts, on the basis of a Rule 35(3) report, that the person is a victim of torture, that, should *"simply be a red flag to that person remaining in detention, full stop."* But, as is clear from the evidence before the Inquiry during the relevant period, that was not the case. Indeed, that had not been the case even at the time of Mr. Shaw's January 2016 review, and remained problematic when he completed his 2018 review. This is also apparent from the Home Office's low release rates for Rule 35(3) reports. All this further confirms to the Inquiry that, at least during the relevant period – if not for longer - a great many detained people with a past history of torture were instead kept in detention for far longer than they should be and were forced to relive their torture repeatedly

184. The healthcare witnesses made various attempts to point to the availability of IS91 RA Part Cs, ACDT and constant watch to suggest that the failures of the statutory safeguards under Rules 34 and 35 were somehow compensated for by other measures. This is patently unsupported by evidence before the Inquiry, and Dr. Hard, Dr. Bingham and Professor Katona all roundly rejected these as appropriate substitutes for functional primary statutory safeguards under the Detention Centre Rules 2001.

[188] Dr Rachel Bingham 14 March 2022 8/10-22.
[189] Witness statement of D801, §58, BHM000034_0021.

***Part C not a substitute for a functioning statutory Rule 35 safeguard***

185. The Inquiry should be seriously concerned by description of this dangerous practice of replacing the rule 35 system mandated by law with a system of sending part C forms to a different branch of the Home Office:

a. Part Cs do not have any statutory underpinning and thus, unlike Rule 35, there is no statutory or policy mechanism which obliges the Home Office to consider the content of a Part C by reference to the key question of whether (a) the document shows that the individual is an Adult at Risk; and (b) the decision to detain should or can be maintained in the circumstances, applying the Adults at Risk statutory framework.

b. The High Court had already roundly rejected the Home Office's contention that Part Cs could be used instead of Rule 35 reports as a reporting mechanism on vulnerabilities.[190] It is *"not a trigger for thought about suitability for detention and weighing the counter-vailing factors."*

c. The fact that the High Court's finding was not acted upon by the Home Office or conveyed in any form to Brook House staff by the Home Office does not excuse the continuation of this dangerous practice; it rather indicates the way in which the Home Office disregards legal judgments and its legal obligations to ensure that the immigration detention system functioned with effective safeguards. This aspect of the institutional culture within the Home Office is addressed by Emma Ginn in her witness statement[191] and as explanation for why such "*problems have remained so intractable*".

186. Healthcare witnesses, and in particular Drs. Oozeerally and Chaudhary, made generalised assertions as to the purported effectiveness of Part C. These assertions are simply not borne out from the uncontradicted evidence before the Inquiry from formerly detained persons. The records of individual Core Participants quite obviously show the opposite: its use, in place of the Rule 35 safeguard, actually prolonged the detention of vulnerable

[190] *R (Medical Justice and 7 Ors) v SSHD* [2017] EWHC 2461 (Admin) per Ouseley J at §166.
[191] Emma Ginn witness statement, §§67-69, BHM000041_0023-0024

people, delayed their release, and precipitated a deterioration in their mental health. For example,

a. In the case of D1538, Part Cs were issued on 9 occasions on 11 April, 19 April, 27 May, 28 May, 3 June, 5 July, 6 July, 7 July and 13 July. But none of those Part Cs prompted nay consideration of release, let alone actual release.[192]

b. In the case of D801, four Part Cs were sent to the Home Office, including one following his failed suicide attempt by ligature, but none of these part Cs prompted any review of D801's detention or his actual release.[193] In fact he remained at Brook House for another two weeks after the Part C was sent notifying of his suicide attempt.[194]

c. Medical Justice, which had reviewed the Home Office and medical records of 28 clients who had been detained at Brook House during the relevant period, could not identify a single case in which a Part C – in place of a Rule 35 report under any limb – led to a detained person's vulnerabilities being acknowledged and the detained person released as a result.

187. That Part Cs patently do not work in practice at all as a substitute for the Rule 35 safeguard is also apparent from the evidence of the Home Office's own witness, Phil Schoenberg, who until 2018 was the Head of DEPMU, the HO unit where Part Cs are sent. When asked why Part Cs went to DEPMU which did not undertake detention reviews, Mr. Schoenberg said that *"Part C is really by way of an update so that they have got a method for receiving information, recording information and making it available to everybody."*[195] DEPMU's role is only to *"update the Part C"* onto the "CID" database[196]; it has no power to make any decisions as to whether detention should continue or end.[197] What happens thereafter is anyone's guess[198] as there is no process by which DEPMU is obliged to notify the detained person's caseworker and to ensure

[192] Alex Goodman Closing Submissions on behalf of Duncan Lewis CPs 5 April 2022 81/7-9.
[193] Shu Shin Luh Closing Submissions on behalf of Bhatt Murphy CPs 5 April 2022 97/20-25.
[194] See IRC Medical Records of D801, HOM032191 and GCID Case Record Sheet, HOM032190.
[195] Philip Schoenenberger 23 March 2022 80/20-24.
[196] Philip Schoenenberger 23 March 2022 85/19-22.
[197] Philip Schoenenberger 23 March 2022 86/9-16.
[198] Philip Schoenenberger 23 March 2022 85/19-22.

that a review of detention is carried out if the Part C contains information that raise concerns about suitability of detention.[199]

188. Thus, even if there were the occasional example of an individual for whom a Part C prompted a detention review, and release, it is apparent from the evidence before the Inquiry that that would only be by chance. The use of Part Cs in place of the Rule 35 statutory safeguard *"overlooks the founding principle that if you have got the rules, then those are the things that should be used in order to prompt a review of detention"* because the importance of the safeguard is that *"it requires a response"* and does not leave it up to the person receiving it.[200]

189. A policy operated in this way by the Home Office is in clear breach of both the systems and operational duty under Article 3 ECHR to ensure that it does not expose detained people to *a significant risk* of torture, inhuman or degrading treatment.[201] Here, the evidence before the Inquiry does not only demonstrate exposure of detained people to such a significant risk but also actual harm being caused in the many case studies produced by Medical Justice and in the evidence of individual formerly detained Core Participants. What's more, the Home Office has been fully aware of this for many years[202] and is directly responsible for the harm caused although it has [203] and continues to deny responsibility and any form of accountability for this systemic failure of detention policy and safeguards. [204]

***ACDT is not an alternative safeguard***

190. It is patently clear from the evidence that the Inquiry has heard that ACDT cannot be described in any way, shape or form as a substitute for a functional statutory safeguard under Rules 34 and 35 of the Detention Centre Rules 2001. Even less so than Part C, ACDT is not an information-sharing mechanism between the detention centre and the Home Office about vulnerable people and their suitability for detention. It is a risk

[199] Philip Schoenenberger 23 March 2022 88/20-25 to 89/1-9.
[200] Dr. Jake Hard 28 March 2022 70/15-25 to 71/1-5.
[201] *R (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58 at §29 per Lord Bingham. See also §80 per Lord Hope.
[202] Emma Ginn witness statement, §§32-41 (reports), §§42-48 (Reviews) §§49-59 (consultations) §§60-65 (meetings) and §§66-69 (litigation), BHM000041_0012-0024
[203] Emma Ginn witness statement,§§70-80 BHM000041_0024-0028.
[204] Emma Ginn witness statement, §§84-94 BHM000041_0029-0034

management tool, which can be opened and closed by custody staff without any clinical input; levels of monitoring can be increased or decreased by custody staff, again without any clinical input.

191. We have seen those notes in cases of individual Core Participants. They are bare, basic, and the observations served little purpose. Take as an indicative example, D1713 who is a victim of torture, physical and sexual abuse. He was put on ACDT from the second day of his detention on 1 April 2017 after reporting depression, suicidal ideation, flashbacks, and a loss of appetite. He also disclosed a past history of torture, sexual and physical abuse to both Dr. Chaudhary and Daliah Dowd, a mental health nurse.[205] He told Dr. Chaudhary that he was scared to look in the mirror as he was going to harm himself if he did that. A note was made by Dr. Chaudhary that *"Pt [patient] tearful +++ (appears Genuine) says he feels scared."*[206] No Rule 35 report under any of the three limbs was contemplated. Instead, he was kept on ACDT for 11 days until 11 April 2017.

192. His observation records contained no actual information about his presentation, just bland information about the level of observations required for him.[207] The medical records of the ACDT reviews contained some more information but nothing that prompted any actions to safeguard him despite his disclosure of trauma symptoms. For example, the first ACDT review on 4 April 2017 noted that D1713 was tearful at the meeting. He told those present (mental health nurse Daliah Dowd, DCM Houghton, DCO McMillan) that he felt stressed out and was suffering from migraines, which were worst in the mornings. He told them that *"I might look big, but my emotions are f***** up."*[208] This did not prompt any assessment of his mental health and no ACDT action plans were documented. He was simply maintained on hourly observations *"with 2 conversations daily."* At the next ACDT review on 8 April 2017, he was asked about his past sexual abuse but was unable to speak about it. Again he reported difficulties coping with detention but no referral was made for a Rule 35 report under any of the limbs; no mental health assessment was undertaken; he was downgraded to observations every two hours with two conversations daily.[209] There was no reasons recorded for the downgrading of

[205] BHM000005_0004-0005.
[206] BHM000005_0004-0005.
[207] See for example CJS001318_0004 (dated 5 April 2017), CJS001304_0002 (dated 7 April 2017).
[208] BHM000005_0006.
[209] BHM000005_0007.

observations in the absence of any clinical assessments. Three days later, his ACDT was closed, again with no reasons recorded for that decision (or who made the decision).

193. D1713 never received any clinical assessment of his mental health whilst in detention despite being on ACDT for a significant period of the 19 days he was detained at Brook House from 31 March to 17 April 2017). In fact, he was detained under immigration powers for a total of 94 days and never received any clinical assessment of his mental health despite repeated disclosure of torture and abuse to health professionals. In the Rule 35(3) report that was eventually done on 6 May 2017 when D1713 was at Harmondsworth, he disclosed being burnt and hit with a machete and broken bottle and his toenails pulled out. It is not hard to see from that account the high likelihood of trauma, and extrapolate from that a high likelihood of Post-Traumatic Stress, which is known to worsen in a detained environment.[210]

194. The fact that nothing was done to investigate his clear trauma symptoms (stress, tearfulness, flashbacks, loss of appetite, suicidal ideation) in the face of ACDT reviews on its own demonstrates clearly that ACDT simply is not a safeguard against detained people suffering harm in detention.

195. In truth, ACDT is used as a means of perpetuating the Home Office's policy of purported "satisfactory management" of the mentally ill, a policy which is contrary to the clinical evidence and heavily criticised by Mr. Shaw as being contrary to *good psychiatric care* and *an affront to civilised values* and therefore needing to be discontinued immediately. The Home Office has not even made any attempt to hide that; the Rule 35(2) template explicitly directs doctors to consider satisfactory management of suicidal risks and self-harm by the use of ACDT.[211] This is despite clinical evidence that ACDT is not only an inadequate mans of management it may be positively harmful.[212]

196. Ms. Churcher's oral evidence confirms this as she described ACDT as *"a risk assessment and not treatment"*[213] and *"does not prevent deterioration."*[214] She was the lead mental

[210] Professor Cornelius Katona, BHM000030, witness statement of Dr Rachel Bingham, BHM000033, RCPsych Position Statement 02/21, BHM000027.
[211] HOM002591_0024.
[212] Professor Cornelius Katona witness statement, §§110-112, BHM000030
[213] Karen Churcher 10 March 2022 53/6-15.
[214] Karen Churcher 10 March 2022 57/14-19.

health nurse involved with D801. She had been present for at least two psychiatric reviews of D801, who was known to healthcare as having PTSD with flashbacks, having had two failed attempts at suicide in the community and needing hospitalisation for treatment. Yet all she and her mental health team did was put D801 on an ACDT (from day one of detention) without contemplating what is required for his treatment or invoking one of the Rule 35 statutory safeguards. There was no recognition that in the light of D801's presenting trauma symptoms, detention was inevitably going to have an adverse impact on his mental health. Whereas he was able to articulate a history of torture when he first entered detention on 1 March 2017, he was noted to have become disengaged and withdrawn in his ACDT review by 10 March 2017.[215] Although ACDT observations continued to note his withdrawn and disengaged demeanour, this did not prompt any clinical investigation. Avoidance and withdrawal are known core symptoms of PTSD[216] and should have alerted healthcare to the potential that his PTSD had become exacerbated by being in detention. Instead, his levels of observations were downgraded to once every two hours on 14 March 2017[217] because of his passivity and avoidance, on an erroneous assumption that that somehow indicated stability rather than deterioration. But of course just three days after this downgrade of ACDT observations, D801 attempted to kill himself using a shoelace to hang himself and using plastic knifes to hurt himself.[218]

197. When Karen Churcher, the senior mental health nurse at Brook House during the relevant period, was asked about his case, she accepted that given what was already known about D801's pre-existing PTSD, history of torture past suicide attempts, and the recommendation by Dr. Belda, the IRC psychiatrist, that he required in-patient mental health treatment, it ought to have been apparent that D801 was at risk of deteriorating, in detention, and Rule 35 reports under any and in fact all limbs should have been notified to the Home Office.

198. Ms. Calver was asked about D801 and why no Rule 35 safeguard was triggered in circumstances of his having been on ACDT for the whole time he was detained at Brook

[215] HOM032191_0005-0006.
[216] See page 6 of the NICE clinical guideline 26: Post-traumatic stress disorder (PTSD), 20005. Online at http://data.parliament.uk/DepositedPapers/Files/DEP2015-0545/NICE_guidelines_26.pdf, footnoted at Footnote 8 of Dr. Rachel Bingham's witness statement, BHM000033_0015.
[217] HOM032191_0007.
[218] HOM032191_0008.

House. Ms. Calver's answer was that ACDT as an *"operational"* [219] and not clinical tool *not owned by healthcare"*[220] It never occurred to Ms. Calver, the Head of Healthcare, that the need to manage someone on ACDT may indicate a deterioration in their mental health until it was put that way to her in questioning by Ms. Simcock[221] and should prompt a Rule 35 report under either the first or second limb.[222] She did not ever contemplate the use of the Rule 35 safeguard, even in a case of a detained person with an open ACDT who was on constant watch, even though she accepted that that would indicate a high risk of suicide.[223]

199. Dr. Oozeerally also could not see a possible connection between the circumstances in which an ACDT may be opened for an individual and the need to raise a Rule 35 safeguard with the Home Office because of clinical indicators that the person was unsuitable for detention. He did not even consider that ACDTs were within the GPs' remits as they were not trained in ACDT,[224] would not get involved in the process unless they were asked to do so by the mental health team,[225] and would not necessarily receive feedback on the result of ACDT reviews by the mental health nurses conducting the reviews.[226] But at the same time, he was unwilling to agree with Ms. Calver and Ms. Churcher that ACDT had no therapeutic value, but could not see why an open ACDT would necessarily prompt him, as an IRC doctor, to complete a Rule 35(2) report. Indeed, he boasted that he had never completed any Rule 35(2) reports ever in his time at Brook House. [227] Rather chillingly, he said that at least ACDT *"stop[s] someone actually killing themselves. … it's stopping --- it's managing that patient."*[228]

200. Dr. Oozeerally's evidence again encapsulates the extent to which healthcare professionals at Brook House had become blind to serious mental health problems presented amongst the detained population that they could not draw the connections between known core symptoms of trauma and the risks of deterioration in detention, or recognise the important and primary duty of care they owe to these patients to advocate

[219] Sandra Calver 1 March 2022 237/10-13.
[220] Sandra Calver 1 March 2022 237/14-18.
[221] Sandra Calver 1 March 2022 237/20-25.
[222] Sandra Calver 1 March 2022 238/1-5.
[223] Sandra Calver 1 March 2022 194/15-25 to 195/1-9.
[224] Dr. Husein Oozeerally 11 March 2022 49/10-12.
[225] Dr. Husein Oozeerally 11 March 2022 44/6-11, 16-22.
[226] Dr. Husein Oozeerally 11 March 2022 54/12-18.
[227] Dr. Husein Oozeerally 11 March 2022 53/12-17.
[228] Dr. Husein Oozeerally 11 March 2022 53/2-5.

for their swift removal from an environment known to harm people with pre-existing mental illnesses.

**(iii) Dysfunctional safeguards create and contribute to a culture of desensitisation and disbelief**

201. Dr. Hard considered that this unthinking and default use of ACDT in place of proper consideration of the need to use the Rule 35 safeguard *"speaks to the issue of desensitisation and normalisation, that my population is likely to do self-harm to this sort of level and we will just manage it with an ACDT rather than considering our founding principles of what's embodied with the rule 35."*[229]

202. Such desensitisation is hardly surprising when the entire framework under which healthcare professionals are expected to operate is driven by a state body that is more concerned about its hostile pursuit of immigration enforcement and removal at any cost, than about protecting detained people by designing and implementing safeguards that make it possible to remove those who are likely to be harmed from an environment that is known to cause harm and deterioration in people's mental health. Healthcare professionals are given no instruction that a primary (and key) aspect of their role is to identify people who are vulnerable and need to be removed from the detained environment. Instead, healthcare professionals are specifically misdirected to keep vulnerable people in detention and manage any mental health issues that may arise in that environment contrary to Mr. Shaw's strong advice against the use of satisfactory management to respond to mental illness in detained people.

203. When this unlawful policy approach is inculcated into practice, that in and of itself creates conditions for desensitisation because:

204. Healthcare professionals are not looking to prioritising identification of vulnerable detained persons so that it is possible for them to be removed from the environment known to be damaging and harmful to them. Trauma symptoms – such as flashbacks, nightmares, self-harm and suicidal ideation as well as hypervigilance and arousal – are not being recognised as symptomatic of PTSD. Ms. Calver, in her witness statement, did not even recognise the high prevalence of clinically significant levels of depression,

[229] Dr. Jake Hard 28 March 2022 80/9-14.

PTSD and anxieties amongst detained people, symptomatic of people who have expressed past histories of torture and trauma. Instead, she told the Inquiry in her witness statement that the *"most significant health problems"* were lots of stomach issues relating to change of diet, headaches and lack of sleep, and low level mental health issues, stemming from stress.[230] It was only in oral evidence, under questioning from Ms. Simcock that she accepted that PTSD was *"really a prevailing mental disorder amongst detainees,"*[231] but that it was not something that she or her staff were able to identify in 2017.

205. Questions are not asked about trauma symptoms even if a detained person discloses a past history of torture or other forms of serious ill-treatment. Consequently, consideration is not being paid to the psychological consequences of trauma in detention. Neither of the doctors considered it their role to diagnose PTSD or identify trauma and mental health symptoms within the context of Rule 35 reports. Both said that this was the remit of the psychiatrist or the mental health team. [232] Neither recognised that the issue was not just a matter of a diagnosis but a question of whether given the symptoms, they need to act in the interest of the patient to raise concerns about their continued detention and the need for release from immigration detention.

206. Even when trauma symptoms are identified and recognised, it does not occur to IRC healthcare professionals to take active steps to secure the detained person's release from detention, knowing that detention centres such as Brook House are not appropriate environments to promote recovery from mental ill-health,[233] Instead, they resort, by default, to "*managing*" the mental health condition for indeterminate period of time, even though, as Ms. Churcher said to Kate Lampard and Ed Marsden in her Verita interview: *"we can't open up a box that much because we don't know when they are going. We can't leave that open wound – we just manage at a surface level."*[234]

207. This is why suicidal and depressed detained people are told to use an elastic band around their wrist and snap it to release stress, even though this is nothing more than a coping

[230] Sandra Calver witness statement, 86, DWF000009_0015.
[231] Sandra Calver 1 March 2022 186/6-10.
[232] Dr Husein Oozeerally 11 March 2022 152/6-9; Dr Saeed Chaudhary 11 March 2022 187/1-7.
[233] Professor Cornelius Katona, §18, BHM000030_0009; Karen Churcher 2nd witness statement dated 4 March 2022 §31, DWF000022_0008; Sandra Calver 1 March 2022 191/3-23.
[234] Verita Interview of Karen Churcher, dated 11 May 2018, Q&A 68-69, VER00273_0005

mechanism, at best, that is not therapeutic, and is only about risk management.[235] No therapeutic alternative is offer, or indeed, is available.

208. This is why depression and trauma symptoms of sleep disturbances and nightmares are managed by anti-depressants, sleeping pills and anti-psychotics at increasing dosages without consideration of the crucial question of whether the person should even be in detention.

209. The absence of a means of appropriate and effective treatment of trauma and other mental illness in detention[236] means both mental illness deteriorates and inadequate and often harmful methods of management such as ACDT, segregation, control and restraint are deployed to manage the illness and the deterioration.[237] This is why ACDT is overused – with 248 ACDTs opened in the 5-month relevant period alone in 2017, with many opened and closed several times, and 60 cases on constant watch – because at least this stops detained people from dying (Dr. Oozeerally), even if it does not prevent deterioration in their mental ill-health (Karen Churcher). This approach to "managing" mental illness in detention without recognition of the need to consider release is also why there is a high incidence of self harm and a correlation with the use of segregation or force to address this and other symptoms of serious mental illness such as disturbed behaviours.

210. This context also re-enforces , a culture of disbelief also develops, whereby disclosures of past histories of torture are viewed as "misuse" of the Rule 35 statutory safeguard (Dr. Oozeerally) and distress, self-harm and suicidal ideation are seen as manipulative and attention-seeking or disruptive behaviour requiring intervention by way of custodial measures (such as segregation and the use of force, discussed further below), rather than a manifestation of vulnerability, requiring clinical investigation and removal from the environment that is causing or exacerbating the harm. [238] Mr. Shaw identified the

[235] Karen Churcher 11 March 2022 55/8-15.
[236] See Professor Mary Bosworth's *Mental Health Literature Survey Sub-Review*, annexed as Appendix 5 to Stephen Shaw's first report in 2016, INQ000060_0307; Dr. Rachel Bingham witness statement, §§35-36, BHM000033_0010 & §§46-60, BHM000033_0013- 0018; Professor Cornelius Katona witness statement, §§70-80, BHM000030_0036-39, and in respect of specific mental disorders §
[237] Professor Cornelius Katona, §114, BHM000030_0049
[238] Dr Bingham first witness statement, §§144-145, BHM000033_0055-56; Dr Bingham, 14 March 2020, 18/7-17. Professor Cornelius Katona, §§103-108, BHM000030_0046-47 . See Dr Husein Oozeerally 11 March 2022

frustration and despondence of IRC doctors at the rejection of Rule 35 reports and continued detention of detained people they considered to be vulnerable.[239] Dr. Chaudhary spoke too of not seeing much point in using a Rule 35(1) safeguard when it would not mean that the detained person is released.[240]

211. As Dr. Bingham said,[241]

> *So we are talking about a failure of safeguards to stop vulnerable people being in this environment. Then we are talking about an environment which has a known negative impact on mental health. So where behaviours like self-harm, like distress, like mental health problems are treated as challenging behaviour, so an inappropriate response, that leads to escalating mental health problems, increased risks of self-harm.* ***It's a perfect storm****, and, in that situation, we have people that are then unqualified to manage. Their only recourse is use of force, solitary confinement. They don't have the capacity to do a therapeutic intervention. So the possible responses are going to be inappropriate. I don't think it is possible to separate that from the abuses that we see.*

212. Nurse Jo Buss' evidence to this Inquiry captures this most starkly in respect of how this affected IRC healthcare. When asked her failure to challenge the highly derogatory comments made by officers in her presence about D1527, she repeatedly stated this "*washed over (her) like banter*"[242] . She said that type of situation was "*day to day*" that "*you almost become immune to what's going in there. You just do your job and go away*".[243] It was this cavalier indifference which spurred Nurse Buss to actively join in on the abusive comments made about and to D1527, saying, when outside his cell with other officers, "*he's an ass basically... he can't get what he wants*"[244]. This mirrors the perception of self-harming behaviour as deliberate and attention-seeking, rather than as a manifestation of vulnerability, held by custodial staff. Several days later, when discussing the incident with Callum Tulley, Nurse Buss doubled down on her analogy of

57/20-25, where he described self-harm not necessarily as a safeguarding concern but sometimes is used as a "coping mechanism" for a detained person.

[239] Shaw 1st Review, §§4.113-4.115, 4.120, INQ000060_0106-0118.

[240] Dr Saeed Chaudhary 11 March 2022 193/21-25 to 194/1-6.

[241] Dr Rachel Bingham 14 March 2022 55/1-15.

[242] Jo Buss 14 March 2022 136/22-23, 141/9-10.

[243] Jo Buss 14 March 2022 141/16-20.

[244] Jo Buss 14 March 2022 129/4-17.

D1527 acting like a petulant child: *"he had a massive hissy fit on the floor… a couple of hours later, he was as right as rain."*[245] This trivialising of D1527's serious mental health symptoms as merely behavioural was perpetuated through her inaccurate entry in the medical records that D1527 was simply "*angry and not engaging*"[246]. Indeed, even in her oral evidence to this Inquiry, she refused to accept the extent to which she had mischaracterised D1527's serious vulnerability. When pressed by Ms Simock as to whether she accepted he was in acute mental crisis at the time, she maintained he was simply "*angry*" and "*upset*"[247].

213. RMN Karen Churcher displayed a similarly indifferent and mocking attitude towards D1527's mental health issues. She was present at the 4 May 2017 incident when D1527 jumped on to the suicide netting in serious distress, threatening to jump whilst holding a plate shard. Ms Churcher was moreover D1527's mental health nurse and was well aware of his serious mental health issues and self-harming history, having attended, just two days earlier, a psychiatric review where he expressed suicidality and was diagnosed him with PTSD[248]. Notwithstanding this, Ms Churcher dismissed his motivation for being on the netting as down to not wanting to wash up a dirty plate, laughing with officers that: "*If he didn't have to do the washing up, he didn't have to go that far did he*"[249]. Even with the benefit of hindsight, in the preparation of her statement to this Inquiry, Ms Churcher maintained that the incident was down to "*nothing more than a dirty plate*" as D1527 was a "*highly stressed individual...it doesn't take much to upset him*"[250].

214. This culture of desensitisation and dehumansiation is allowed to continue because those in charge do not recognise that it is unacceptable. In oral evidence, Sandra Calver (still head of Healthcare at Brook House) sought to maintain that derogatory – and racist - comments made about detained persons by clinical staff may be permissible if said "*in a safe space*" as between colleagues as way to let off steam;[251] she did not seek to resile from calling them "silly comments"[252], and just "black humour."[253] Members of

[245] TRN0000100_0008 [226-229].
[246] CJS001002_0038.
[247] Jo Buss 14 March 2022 115/7-17.
[248] CJS005997_0042.
[249] TRN0000005_007 [27-35].
[250] DWF000022_0019 [91].
[251] Sandra Calver 1 March 2022 147/14-25, 148/1-10.
[252] Sandra Calver first witness statement, §109, DWF000009_0018.
[253] Sandra Calver witness statement, §153, DWF000009_0024.

healthcare, as trained medical professionals, governed by professional codes of conduct, are looked to as exemplars of appropriate care and treatment within the custodial context. Neither Calver – nor any of the nurses who gave evidence - could see that the use by healthcare of such dismissive and demeaning language, even if behind closed doors, reflects and reinforces the notion that such views hold value across the staff estate.

215. Dr Paterson[254] has addressed in detail the links between dehumanisation and the risk of mistreatment, including with respect to the failures of healthcare staff to fulfil their safeguarding roles in respect of mentally vulnerable detained persons. Professor Katona[255] also explores the connection, describing how: "*Failure to recognise these symptoms as manifestations of a mental disorder rather than as 'bad' behaviour creates a context in which resort to control and restraint is likely and inappropriate force tends to be deployed. This in turn risks exacerbation of the disorder especially if occasioned by a removal from association and into segregation*". He notes this was "*a recurrent theme in the cases where the Courts had found a breach of Article 3 ECHR.*

216. As Emma Ginn of Medical Justice points out[256], such an institutional culture of indifference can contribute to deaths in detention, as the death of Prince Fosu graphically illustrates. There, the Prison and Probation Ombudsman identified how a range of staff from across the Home Office, IRC, Healthcare and even IMB had apparently become "*de-sensitised to behaviour that at the very least suggested significant mental distress*".[257]

[254] Dr. Brodie Paterson witness statement, §§105-121, BHM000045_0024-28-29 [not yet adduced on BHI website]
[255] Professor Cornelius Katona witness statement, §§103-108, BHM000030_0046-47
[256] Emma Ginn witness statement, §125, BHM000041_0044-45
[257] PPO (2019) Independent investigation into the death of Mr Prince Fosu, a detainee at Heathrow Immigration Removal Centre on 30 October 2012, exhibited to Emma Gin's witness statement [the bundle of exhibits has not been disclosed or adduced]

## VI. Prisonisation and the Toxic Racist Culture at Brook House

### (1) Prison-Like Arrangements and Environment

217. It is uncontroversial that Brook House was built to the design of a Category B prison. This means that it was (and still is) a harsh physical environment: cell-like rooms, a concrete yard and cramped conditions. It was also reflected in how the centre was run, with Brook House operating a highly restrictive regime of extended lock ins and night patrol state, with limited opportunities for association or exercise. Witnesses to this Inquiry, from across the board, including former detained persons[258], G4S custody officers[259], managers[260], and professionals from independent oversight bodies[261], all agreed that Brook House looked and felt like a prison. Most agreed that there was little if anything that could be done to remedy the structural deficits in this environment[262]. The HMIP reiterated its long-standing position that it is an inappropriate environment for administrative detained persons on this basis[263]. Jerry Petherick, Managing Director of G4S Custodial and Detention Services, drew attention to the exacerbating impact of the misuse of Brook House far beyond its initial conception as a short-term holding centre, instead holding detained persons for lengthy periods. This further laid bare the deficits of its design and impoverished regime which, perversely, offered even less by way of purposeful activity or structure than compared to prison[264]. Lee Hanford, the Centre Director raised similar concerns to Kate Lampard over the physical design and regime of the centre being inimical to long-term detention[265]. It is also notable that it has no medical wing again reflecting its intended short-term nature of the facility.

218. Phil Riley, the Home Office's corporate witness, was alone in his evidence to the Inquiry that Brook House was not designed like a category B prison, insisting that the "*regime and the culture there was anything but prison-like*"[266]. This stands in direct tension with the evidence of Phil Schoenberg, who was responsible for the tendering process for

[258] D1618, 3 December 2021 64/1-6;
[259] Clayton Fraser, 28 February 2022 14/9-11; Chris Donnelly 23 February 2022, 77/8-12; Ioannis Paschali, 24 February 2022, 14/3-11
[260] Jerry Petherick, 21 March 2022, 94/6-14, 95/10-20, 98/25-99/1-2. Steve Skitt, 17 March 2022, 42/20-25, 43/15-17; Lee Hanford, 15 March 2022, 91/14-17
[261] Hindpal Singh Bhui, 24 March 2022, 154/1-7; HMIP 2016 report: HMIP000613_0020 [S36]
[262] Hindpal Singh Bhui, 24 March 2022,155/19-23; Jerry Petherick, 55/22-24, 56/1-7, 98/1-7
[263] Hindpal Singh Bhui, 24 March 2022, 155/19-23
[264] Jerry Petherick, 21 March 2022, 55-56 ; Lee Hanford, 15 March 2022, 96/23-25, 97/1-23
[265] VER000266_0005
[266] Phil Riley, 4 April 2022, 60/12-25, 61/1-7

Brook House, and who accepted that the way Brook House was run was inconsistent with the ethos and requirements of immigration detention under Rule 3 of the Detention Centre Rules 2001. Specifically, that the harsh regime of extended lock ups, with men spending nearly half of their time in detention locked behind their door, was contrary to the provision of humane accommodation, in a relaxed immigration detention regime, with as much as freedom of movement possible[267]. Mr Schoenberg candidly accepted that such a prison-like regime compromised on the welfare and dignity of men held there in order to save costs[268]. The clinical evidence of Dr. Bingham and Professor Katona, discussed in the Section V, highlight the general unsuitability of detention for those with a mental disorder or a past history of torture or trauma.

219. The effects of this punitive environment were heightened by the poor physical condition of the residential wings. These concerns were adumbrated in the HMIP reports including the 2016 report which noted the squalid and unclean conditions of the cells, poor ventilation and lack of privacy for sanitary facilities[269]. Such conditions constituted a fundamental assault on the privacy and dignity of those detained at Brook House[270]. Mr Shaw described them as "*not decent*" in his follow up review in 2018.[271] Hindpal Singh Bhui, the HMIP lead on immigration detention, criticised the lack of institutional will or response by the Home Office to the HMIP calls for 'concerted action' to improve these conditions in early 2017, despite the Inspectorate having raised recurrent concerns over cleanliness and ventilation since its first inspection in 2010[272]. Peter Clarke, the Chief Inspector of Prisons, also cautioned in his 2016 report that the proposed introduction of the 60 additional beds into the centre would lead to a further decline in living standards[273], as did Stephen Shaw in his 1st review.[274]

220. The Inquiry has already heard as to the cavalier introduction of the three-men rooms in the face of such concerns, which further intensified the cramped, prison-like conditions. This is another illustration of the Home Office's single-tracked focus on ramping up immigration removal, doing it on the cheap, all at the expense of the welfare and dignity

[267] Phil Schoenberger, 23 March 2022, 16/14-25, 17/1-4
[268] Ibid, 17/5-15
[269] HMIP 2016 report: HMIP000613_0020 [S36]
[270] Hindpal Singh Bhui, 24 March 2022, 154/21-22
[271] Stephen Shaw: follow-up report, July 2018, §2.76, CJS0073862_0032
[272] Hindpal Singh Bhui, 24 March 2022, 153/3-11, 155/1-4,13-23
[273] VER000117_00005
[274] Shaw 1st Report, §3.5, IN1000060_0045

of detained people: a crude austerity measure to reduce the '*blended rate of the cost per detainee place*'[275]. In their oral evidence, senior institutional witnesses from both G4S and the Home Office, including Lee Hanford[276], Peter Neden[277], Jerry Petherick[278], and Phil Riley[279] were reticent to accept the severe impact this had on the welfare of detained persons, even through the lens of Mr. Shaw's 2018 follow-up report which criticised the indecent introduction of these beds and recommended their urgent removal, along with the 'unacceptable' feature of the in-room, barely screened toilets[280] following the challenge in *Hussein*[281].

221. The design and operation of Brook House accordingly cultivated an intensely desolate environment for the vulnerable detained persons placed there. This was compounded by the general chaos and noise of the centre, affected by chronic under-staffing, violence and instability caused by the spice pandemic. Added to this were the high levels of frustration and distress faced by the many detained persons who were subjected to lengthy and open-ended periods of detention within a wholly unsuitable regime[282]. As described by Jacqueline Colbran, the chair of the Brook House Independent Monitoring Board in 2017, in her evidence to the Inquiry, all of these factors led to an inevitable '*coarsening*'[283] of the atmosphere at Brook House, and in the attitudes of staff towards detained people.

222. A key motif of the expert evidence of Professor Bosworth is the 'prisonisation' of immigration detention. Her use of this term has a specific and significant meaning in the context of this Inquiry. It denotes the effects of the structural arrangements in place at Brook House, which led staff to feel that they were "*working in an institution that was effectively a prison, with people who, therefore, criminal and dangerous*"[284]. This relates to the material conditions and layout of Brook House, as above, which Professor

[275] Lee Hanford first witness statement: §77, CJS0074048_0020
[276] Lee Hanford, 15 March 2022, 101/9-22
[277] Peter Neden, 22 March 2022, 50/11-12
[278] Jerry Petherick, 21 March 2022, 80/7-15, 90/12-16
[279] Phil Riley, 4 April 2022, 70/3-7
[280] Shaw follow-up report, §§2,74 & 2.77, CJS0073862_0032
[281] *Hussein v SSHD* [2018] EWHC 213 (Admin): IMB000204_0066.
[282] Lee Hanford, 15 March 2022, 99/13-15, 100/1-24
[283] Jacqueline Colbran first witness statement, §194, IMB000204_0066.
[284] Professor Bosworth, 29 March 2022, 13/23-25, 14/1-2

Bosworth finds created a "*very very harsh environment to be in*"[285] and was inimical to its purpose as an administrative detention centre.

**(2) Adoption of Prison-based policies, methods and practices**

223. Prisonisation, however, goes far beyond this. Contractual arrangements made by the Home Office for Brook House similarly prioritised security and removal over safeguarding the welfare of detained persons, and put a premium on price and profit over care and respect for fundamental human rights, manifested in chronic understaffing and poor staff retention, penalised failures to facilitate immigration enforcement and removal of detained persons and failed to sanction the high numbers of self-harm incidents, even when it occurs whilst the detained person is on ACDT.

224. Prison-based policies, methods and practices such as use of force and segregation were transposed crudely to the immigration detention context when they were patently inappropriate[286]. They are coercive custodial risk management tools, aimed at controlling and managing prisoners, hold no therapeutic value, and were not designed with recognition and awareness of the particular cohort of people and the inherent risks and needs of the IRC detained person demographic, a high proportion of whom are vulnerable to harm in detention.

225. Furthermore, the systemic failures in detention policy and detention safeguards to ensure that those at *particular risk of harm* are not detained at all or are promptly released if detained means that these generally inappropriate prison methods are routinely used on the most vulnerable, for example those with a past history of torture or trauma, or those who suffer from mental illness including PTSD, depression, anxieties or other serious mental illness, including psychosis , bi-polar disorder or schizophrenia. As Dr Bingham made clear in her evidence, the use of custodial processes such as segregation to manage mentally unwell detained persons not only fails to provide any form of clinical treatment, it is in fact *'worse than nothing'* as they are actively injurious to the mental health of those detained[287]. This is supported by the evidence of Professor Katona.[288] Dr Brodie Paterson also endorses this view with respect to the use of prison-based Use of Force

[285] Professor Bosworth, 29 March 2022, 33/11-16.
[286] Professor Bosworth, 29 March 2022, 12/4-25, 157/10-20
[287] Dr Bingham, 14 March 2022, 54/4-8
[288] Professor Katona witness statement, §§25, 52-54(v), 114, BHM000030_0013, 0026-27, 0049

("UoF") techniques in immigration detention, which he considers fail to recognise the specific vulnerabilities of this population or the unique context in which they are held [289].

226. Professor Bosworth is critical of the use of prison-based practices in IRCs for its failure to distinguish between the nature and use of immigration detention and prisons.[290] Unlike in prison, where those who are detained are usually held on remand or pursuant to a criminal sentence, those in administrative detention are held under discretionary immigration powers without any statutory time limit. They can face lengthy and often indefinite periods of detention. There is no 'moral narrative' of rehabilitative nor punitive purpose to their detention[291]. All of this is also set against the distinct complex vulnerabilities of the IRC detained person population, which manifest in high levels of mental illness and distress[292].

227. Adopting a prison-based model for IRCs such as Brook House, wrongly took "*people down a pathway which leads towards thinking about these places as punitive places and places for criminals and there's no real reason for that*"[293]. The effects of 'prisonisation' leads to immigration detained persons being labelled as "*risky and dangerous*" instead of inherently vulnerable.[294] That language seeped into training for custodial staff, which drew on prison-based training models and material to place an inappropriate emphasis on 'security' and risk management.[295] This extended to the use of terminology and concepts associated with counter-terrorism such as 'conditioning'[296]. All this purportedly gave officers justification for taking coercive actions against the detained population.[297] Both Professor Bosworth and Dr Paterson considered that these notions of security and risk, and of detained persons as criminals, is reinforced and given credence by the government's wider "hostile environment" immigration enforcement agenda, which seeks to cast all detained persons as "*dangerous foreigners we need to get rid of*" or who simply do not deserve to be here[298] because they threaten British values and security.[299]

[289] Dr. Brodie Paterson witness statement, §26, BHM000045_0005
[290] Professor Bosworth, 29 March 2022, 107/4-7.
[291] Professor Bosworth, 29 March 2022, 47/4-25; second report, §§3,20-3.21, INQ000123_0017
[292] Professor Bosworth, 29 March 2022, 34/19-20, 31/19-20;
[293] Professor Bosworth, 29 March 2022,31/2-6.
[294] Professor Bosworth first report, §3.16, INQ000064_0016
[295] Professor Bosworth first report, §3.10, INQ000064_0015; §§5.5-5.6, INQ000064_0029-0030.
[296] Professor Bosworth first report , §3.13, INQ000064_0015-_0016; Professor Bosworth second report, §2.72, INQ000123_0013
[297] Professor Bosworth, 29 March 2022, 83/9-14.
[298] Professor Bosworth, 29 March 2022, 47/14-25.
[299] Dr Brodie Paterson witness statement, §106, BHM0000534_0024-25.

The humiliation of being treated like a criminal is a common experience of those detained at Brook House.

228. G4S custodial staff consistently gave evidence to the Inquiry of being ill-equipped to deal with such high levels of serious mental illness, distress, self-harm and suicidal ideation in the detained population. They received no mental health training nor specialist training for working on E wing[300]. They did not know the difference between signs of serious mental ill-health, requiring urgent clinical support, and behaviour which was simply disruptive or 'manipulative'[301]. As DCO Yan Paschali put it in his evidence, he simply had no means of determining if a detained person was mentally ill or "*just lying or blagging or messing around*"[302]. Healthcare and the deficits in its understanding and expertise on how to deal with vulnerable detained persons could offer no guidance. In view of the combined effect of prisonisation, the perception of detained persons as dangerous and a threat, and in the absence of any therapeutic tools or training, it is wholly unsurprising that custodial staff resorted to the only measures they knew and had at their disposal: blunt prison-based risk management measures, such as the use of force, segregation, and ACDT monitoring, to manage even the most vulnerable detained persons.[303]

229. The evidence before this Inquiry starkly illustrates that force was used routinely as a measure of first resort to manage all incidents. More will be said about the UoF later in these submissions, but for present purposes, the Inquiry will recall the evidence of Yan Paschali, who was part of the core team routinely deployed for Control and Restraint ("C&R") interventions, estimating that he would be deployed up to four UoF incidents per day[304]. He told the Inquiry that force was the default and sole tool to manage all incidents, irrespective of the detained person's vulnerabilities: *"we were equipped – we were trained to restrain people. If someone commits an act of self-harm or shows aggression or violence you restrain them. That is what we are trained to do"*[305]. Jon Collier, the Inquiry's UoF expert, concurs, and points out that of the 43 UoF incidents he

[300] David Webb, 105/14-18, 106/4-9; Ioannis Paschali, 24 February 2022, 188/5-10, 29/12-16, Chris Donnelly, 23 February 2022, 133/15-18
[301] Chris Donnelly, 23 February 2022, 137/21
[302] Ioannis Paschali, 24 February 2022, 30/1-7
[303] Dr. Bingham, 14 March 2022 55/3-14
[304] Ioannis Paschali, 24 February 2022, 20/1-6
[305] Ioannis Paschali, 24 February 2022, 30/19-23

reviewed, the recurrent concerns that emerged were that force was not used as a last resort, there was insufficient de-escalation attempts in advance of the use of force, and the frequent target was mentally unwell detained persons[306]. This is supported by the clinical opinions of Dr Bingham and Dr Patterson who underline the entirely inappropriate and routine use of restrictive custodial practices against mentally unwell detained persons[307]. Dr Bingham considers the use of force in this context "*highly concerning…..potentially harmful*" and "*inimical to the clinical management and treatment of vulnerable detainees*"[308]. This reflects and supports Dr Patterson's view that the default use of coercive measures is "*extremely problematic*", inconsistent with good clinical practices and must be urgently addressed[309].

**(3) Desensitisation and dehumanisation saturated the culture**

**(a) <u>Dominance of a Macho-Aggressive Culture</u>**

230. The prisonisation of Brook House – especially the emphasis on security within staff training and language, and the casting of detained persons as dangerous criminals - invited a "*masculine, authoritarian response*"[310] and allowed a 'macho' staff culture to take root and dominate within the centre. It manifested in displays of brute machismo and casual disdain for detained persons, by groups of DCOs/DCMs who aligned themselves with traditional prison officers, stylising their jobs as security related and risky.

231. A hallmark characteristic of this 'macho' culture is the notion of the need to 'man-up'. This was an expectation expressly perpetuated by G4S managers at the centre such as Jules Williams[311] and Steve Skitt[312] Not only did this inform the suppressive culture which developed, but it inculcated the view amongst custodial staff that showing concern or care for detained persons was a sign of weakness, and that detained persons similarly needed to 'man-up'[313]. This was reinforced by the Home Office, which repeatedly

[306] Jon Collier, 30 March 2022, 15-16, 83/4-25, 84/1-10
[307] Dr. Rachel Bingham witness statement, §§133-171, BHM000033_0050-0066
[308] Dr Rachel Bingham witness statement, §133, BHM000033_0050
[309] Dr Brodie Patterson witness statement, §§46-47, BHM0000534_0010-11.
[310] Professor Bosworth, 29 March 2022, 63/6-14, 71/6-15
[311] Edmund Fiddy, 7 March 2022, 154/16-25, 155/1
[312] Luke Instone-Brewer, 8 March 2022, 35/8-23
[313] Darren Tomsett 7 March 2022, 27/2-22, TRN0000080_0002 [21]; Ioannis Paschali, 24 February 2022, 44/15-19,

criticised any demonstrative empathy shown by custodial officers toward detained persons[314].

232. This macho environment also manifested in a corrosive glorification of violence. The Inquiry is all too familiar with the extensive evidence of graphically violent language used between officers. In his oral evidence to the Inquiry, Yan Paschali accepted having bragged to Calum Tulley and DCM Murphy about having 'wrapped up' and 'choked' D1527[315], that he did not "*cringe at breaking bones*" and "*wouldn't be bothered*" if he killed someone[316]. He claimed that this was simply 'banter' to "*wind up*" Mr. Tulley [317]. The fact Paschali felt able to divulge such criminal conduct, with complete impunity, reflects an environment in which grandstanding about acts of casual violence (whether true of fabricated) was normalised and in fact actively praised. This is similarly reflected in the grossly violent, inciteful language used by DCO Connolly to his C&R team of officers whilst waiting in the stairwell on 17 May 2017: "*I'll go kick the fucker out… .fuck 'em. Christmas time we can fucking buzz 'em*"[318] and speaking of his involvement in a prison riot in the following terms: "*funny as fuck… .fucking dogs in. Fucking chewed him..he was like moaning and groaning… happy days eh?*"[319]. As the extensive footage before this Inquiry shows, this type language was not confined to a hardened cohort of officers: it was used widely and freely, in the presence of many DCOs who did nothing to stop or challenge such behaviour, but rather laughed along with it.

233. The Inquiry is asked to exercise great caution and scepticism when considering the accounts of various officers that they fed Mr Tulley 'tall stories' about their macho exploits to appease his curiosity. As observed by Mr Altman QC, Counsel to the Inquiry, in his course of questioning a G4S officer, "*everybody seems to want to tell tall stories*"[320]. These excuses are far too similar to be in any way believable[321].

[314] See Lee Hanford's evidence to Verita that some G4S were criticised by Home Office staff for "*showing too much empathy*" to detainees: VER000266_0022.
[315] TRN0000077_0042
[316] TRN00000042
[317] Ioannis Paschali, 24 February 2022, 165/23-25, 166/3,
[318] TRN0000085_0078 [2787-2796]
[319] TRN0000085_0024 [852-860]
[320] John Connolly, 2 March 2022, 178/13-14
[321] See also the BBC oral closing submissions: 6 April 2022 9/3-25, 10/1-8

a. Derek Murphy claimed that he was simply telling '*fairy stories*'[322] to Mr. Tulley when asked about footage showing him threatening to "*smash the fucking shit*"[323] out of two different detained persons in two separate incidents[324]. The Inquiry will recall of course that Owen Syred gave evidence that he had witnessed Derek Murphy punch a detained person square in the face[325]. DCM Murphy is frequently cited as a 'dominant' officer who used threats of violence about and towards detained persons.

b. Yan Paschali similarly said that he simply told Mr Tulley 'tall stories'[326] on every and any occasion this type of language was used to and in front of him as he was so impressionable. This included, conveniently, his boasting to Mr Tulley and Derek Murphy about his days as a prison officer when he had slashed prisoners' arms with razor-blades to make it look like they had self-harmed, kicked prisoners' heads in and smashed them against the sink so hard it broke[327].

c. John Connolly similarly sought to dismiss his bragging about violence captured on footage as mere '*tall stories*' said to Mr Tulley and the rest of the C&R officers to 'pass the time' [328].

234. Quite apart from the fundamental lack of credibility to these explanations given by former G4S staff members for the violent language used about detained persons, the language they deemed appropriate to use to tell "stories" itself is telling of the extent to which this glorification of violence took hold amongst staff.

235. This 'laddish' culture[329] was also perpetuated through the framework of C&R methods and training. Reverend Ward observed how the 'macho-aggressive' behaviours modelled by the NTRG, the prison-based unit which delivered all national C&R training, filtered

[322]Derek Murphy first witness statement, §8(a), INQ000121_0002; §17, ; Derek Murphy, 2 March 2022, 37/9-16_0005; Derek Murphy, 2 March 2022, 37/9-16
[323] TRN0000024_0003 [46]
[324] TRN0000092_0024 [721]
[325] Owen Syred, 7 December 2021, 125/4-17
[326]Second witness statement of Ioannis Paschali, §64, IPA000002_012 Ioannis Paschali, 24 February 2022, 159/17-22, 160/1-2,
[327] TRN0000039_0029
[328] John Connolly witness statement (undated version), §38(a), INQ0000120_0011; John Connolly, 2 March 2022, 178/10-12
[329] Clayton Fraser, 28 February 2022, 7/17

down to G4S staff and their UoF practices[330]. This was similarly reflected in the overt 'adrenaline' demonstrated by certain officers when using and discussing C&R, of which there are numerous examples in the Panorama footage[331]. Dominic Aitken, who had carried out research at Brook House during 2017, likewise spoke in his Verita interview of reports over officers who enjoyed the conflict and bravado surrounding C&R interventions[332]. This was reinforced by the fact that perceived figures of authority, such as John Connolly, a C&R trainer, were shown to openly use and sanction such violence themselves[333]. Mr Connolly himself casually accepted in his oral evidence that some of the officers he trained "*absolutely loved*" C&R, seemingly entirely unaware of his own part to play in normalising such macho attitudes [334].

236. This enjoyment of C&R engendered the perverse belief that the use of force was in fact a positive tool for de-escalation and crisis-management. A recurrent concept cited by former G4S staff in their evidence to this Inquiry was the use or threat of force to 'bring' or 'break' down a detained person's distressed behaviour. Yan Paschali reiterated this refrain several times in his oral evidence in reference to his threats to put D1527 to sleep, during his chokehold of the detained person, as being simply a strong command to shock him into compliance. He sought to claim that where a detained person is at 'level 10': "*you need to go in at level 11… you need to go in at a higher level to gain compliance and bring that down*"[335]. This reinforced the specious conception of unlawful heavy-handed C&R interventions as a conducive and appropriate response to manage vulnerable detained persons.

**(b) <u>Culture of Desensitisation</u>**

237. This 'macho-aggressive' culture – which encouraged desensitisation and dehumanisation of detained persons - did not develop in a silo. The conditions for desensitisation were already present in the dysfunctional structural arrangements put in place by the Home Office for deciding who is detained and who is not. As discussed in Section IV, it led to a significant number of highly vulnerable people entering detention because there were

[330] Reverend Ward first witness statement, §§230-232, DL0000141_0082.
[331] Ibid, DL0000141_0082 [§233].
[332] VER000257_0007
[333] "*If he fucks about, get him in here, fuck him up in the coroner, mash up in the corner*": TRN000085_0054 [1872-1874]
[334] John Connolly, 2 March 2022, 166/8-22
[335] Ioannis Paschali, 24 February 2022, 71/16-25,

no effective screening tool to prevent them from being detained in the first place, and once detained, there was what Dr Hard called a *"complete deprivation of safeguards"* incapable and unable to operate to identify and remove people who were inevitably going to be harmed by being detained from an environment known to have a negative impact on this population of detained people. The indeterminate nature of detention also fostered the conditions for desensitisation as it heightened the already high levels of distress and anxiety amongst detained persons and exacerbated pre-existing mental ill health, ideations of self-harm and suicide and other disturbed behaviour.

238. The conditions for desensitisation are further facilitated by the security narrative and prison arrangements around those detained since, as Professor Bosworth puts it, "*it is a lot easier to be desensitised towards people who you kind of think are not like you and you don't value*"[336]. The uncertain duration of detention seriously undermines the motivation of DCOs to invest in the care of those detained who may well be gone tomorrow.[337] Furthermore, in circumstances where custody officers lacked the tools or know-how to care for such a highly vulnerable detained population, the inevitable response, Professor Bosworth said, was to become desensitised, "*separating yourself emotionally from that is... the very easiest way to manage it*"[338].

239. Desensitisation was a necessary and critical means of self-preservation for custodial staff. In this way, it also acted as a mechanism by which staff could morally abdicate responsibility for their own actions, and played into a self-justificatory narrative for staff, whether conscious or not, as to why they did what they did[339]. Nathan Ring – part of the 'core' group of authoritarian DCMs the Inquiry has heard about – spoke of desensitisation as a vital protective tool: "*seeing the things we saw and had to deal with it, if you couldn't desensitise to a certain extent, it would probably have an effect on your mental health*" [340]. This was a sentiment echoed by various other witnesses in their evidence to this Inquiry[341], and one that Professor Bosworth and Dr. Paterson both

[336] Professor Bosworth, 29 March 2022, 46/10-12
[337] Professor Bosworth, 29 March 2022, 39/18-22
[338] Professor Bosworth, 29 March 2022, 45/22-24
[339] Professor Bosworth, 29 March 2022, 51/17-25, 52/1
[340] Nathan Ring, 25 Feb 2022 101/20-23
[341] Ioannis Paschali first witness statement, , §114, IPA000001_0015; Jo Buss, 14 March 2022, 139/2-4, 141/19-20; Dominic Aitken, 8 December 2021, 98/17-23, Daniel Small, 28 February 2022, 118/3-4

considered to be inevitable in the absence of a positive structure in place to build the resilience of officers[342].

240. An environment desensitised to the suffering of detained persons allowed the 'macho-aggressive' to flourish and normalised highly derogatory and even racist language, attitudes and behaviours, not only toward detained persons but also in the ways that officers spoke with one another. The unanimous evidence before this Inquiry from G4S officers was that 'bad language' was commonplace amongst staff and used from "*top to bottom*"[343]: from Directors, mangers, down to officers on the wings. In the view of Professor Bosworth, such derogatory language was "*genuinely shocking*" and widespread[344]. The spectrum of this language was broad: from swearing to the casually demeaning, all the way through to the overtly violent, abusive and degrading.

241. To provide just a snapshot of this type of language, the Inquiry has heard of the dialogue:

a. between DCO Harris and various other officers, in which he talks of gagging, injecting, and gassing detained persons: "*just fucking tape 'em and bag 'em….get the gas, chuck it in there...they're all knocked out...needle in*"[345].

b. of Stephen Webb saying, with reference to D728, a highly vulnerable detained person on constant supervision on E wing, that he will "*fucking punch the cunt*"[346].

c. of the graphic exchange between Derek Murphy and Yan Paschali, when they speak of "*softening up*"[347] detained persons, "*crack[ing]*" them "*in the ribs*" and "*drop[ping]*" a "*cunt*" [348] in a fight.

242. Virtually all G4S officers who gave evidence attributed the use of such derogatory and abusive language to everyday '*banter*'[349], done '*behind closed doors*' as a way of '*letting*

[342] Dr Brodie Paterson witness statement, §§93-98, BHM0000534_0021-22; Professor Bosworth, 29 March 2022, 42/18-25; 43/1-17
[343] Ioannis Paschali, 24 February 2022, 27/23-25,
[344] Professor Bosworth, 29 March 2022, 92/24, 93/2
[345] TRN0000084_0010
[346] To which Charlie Francis responds "*if you don't I will*": TRN0000017_0006 [54-56]
[347] TRN0000077_0005
[348] TRN0000077_0042-43
[349] See e.g. Ioannis Paschali, 24 February 2022, 166/4-5; Clayton Fraser, 28 February 2022, John Connolly, 2 March 2020, 171/18-21; Daniel Lake first witness statement, §44, BDP000002_0014; Charlie Francis first witness statement, §6(ii), HOW00001_0003

*off steam'* from the pressure of their job.[350] Others sought to justify their involvement in this language as a means of 'fitting in'. It was on this basis that Daniel Small sought to explain his use of highly racist language: *"think of it as a sheep in a herd. You know, I'm just following suit what everyone else did, just using the terminology that was used"*.[351] Likewise, social acceptance was what Kalvin Sanders claimed drove him to make up that he had assaulted D1527, stating that he felt that the only way for officers to *"pay any interest"* in him was by making up stories 'similar' to those he had heard.[352] The Inquiry should reject this as untrue and find that he did assault D1527. The fact however that Mr Sanders could consider it a credible excuse is indicative of the fact that he knew such pressures to exist.

243. The striking tenor of this evidence was that this type of language was just part of the general grain of staff dynamics and "*how the centre ran*" [353]. Whilst some officers accepted that, in retrospect, the language they had used or witnessed was inappropriate, all were clear that, at the time, it was ubiquitous and the norm. In turn, of course, the more staff witnessed or used this type of language without challenge, the more inured to its impact they became. This led, in the view of Professor Bosworth, to the '*extensive normalisation*'[354] of such highly abusive inappropriate and derogatory and attitudes about and towards detained persons. Dr Paterson agreed, describing how such sustained patterns of language and behaviour *"can gradually become embedded as part of the service culture subtly passed on to new members of staff via modelling rather than explicit endorsement as simply the '... way things have always been done around here"*[355]. This was not just a sub-culture among *"core groups"* of custody officers, but rather the dominant culture which, as per the evidence of Mr Tulley[356], inculcated new staff members with its inappropriate, abusive attitudes and practices.

244. That this culture was able to thrive, dominate and pervade the enter centre depended on the normalised complicity and silence of seemingly 'neutral' officers. That is, those

[350] Stephen Webb first witness statement, §85, MIL000003_0015 & §93(c), MIL000003_0018; Stephen Webb, 8 March 2022, 195/19-24
[351] Daniel Small, 28 February 2022, 149/22-25
[352] Kalvin Sanders, 4 March 2022, 126/12-14, 20-24; TRN0000097_0002
[353] Sean Sayers, 10 March 2022, 175/8-15
[354] Professor Bosworth, 29 March 2022, 81/13-17
[355] Dr Brodie Paterson witness statement, , §97, BHM000045_22
[356] Calumn Tulley first witness statement, §169, INQ000052_0043; endorsed by Professor Bosworth: 29 March 2022, 73/12-24.

present when such abusive language and behaviours were demonstrated and did nothing to challenge or report it. There are myriad individual reasons for this inaction (which will be explored further below): fear, bullying, self-protection. Overall, however, Dr Paterson considers that the *"saturating"* effect of this abusive culture led staff to redefine behaviour which they would normally classify as abusive if not criminal conduct as "*merely conformity*"[357]. Professor Bosworth endorsed this view in her evidence[358]. In acquiescing to the use of such derogatory language and behaviours as part of the status quo, all staff members therefore contributed to and perpetuated this climate of impunity in which racism, violence, and abuse was able to thrive.

### (c) Culture of Disbelief

245. Consequent to the desensitising effects of the Brook House environment, the 'culture of disbelief' also dominated, both within IRC custodial and healthcare staff. This manifested in an entrenched scepticism concerning symptoms of mental illness and self-harming behaviours exhibited by vulnerable detained persons. As Dr Bingham explained in her evidence, indicators of serious mental illness and distress were routinely re-characterised as non-compliant behavioural issues and managed by way of custodial measures, rather than requisite clinical intervention[359], particularly in the absence of any training, resources or instructions being given to officers to the contrary.

246. Staff disbelief around self-harming and suicidal behaviours was pervasive and multifarious. As Dr Paterson observes, by staff re-labelling distressed behaviour as instrumental, they were able to re-characterise their own punitive responses, i.e. as a legitimate restraint rather than violence, and as morally self-justified "*because of the bad choices or character which the victim themselves brought about*"[360]. The implication of vulnerable detained persons as in some way culpable, and deserving of coercive treatment, is illustrated in the causal disdain shown by officers such as Kalvin Sanders - "*if you're hurting yourself, you're attention seeking aren't you, you little prick*"[361] – and

[357]Dr Brodie Paterson witness statement, , §104, BHM000045_0024.
[358] Professor Bosworth, 29 March 2022, 77/11
[359] Dr Rachel Bingham witness statement, §§144-145, BHM000033_0055-56, Dr Bingham, 14 March 2020, 18/7-17.
[360] Dr. Brodie Paterson witness statement, §105, BHM000045_0024.
[361] TRN0000097_002 [40-41]

by the recurrent motif of self-harming as '*childish*' and a sign of male weakness [362], which Clayton Fraser said was the 'default' presumption[363]. Similarly, the perception of self-harming as a source of mere inconvenience and frustration[364] for officers, rather than a sign of a detained person's acute distress. These were views which indeed many G4S officers still sought to maintain, with firm resolve, in their oral evidence to this Inquiry. Chris Donnelly, for instance, saw nothing problematic in his evidence to the Inquiry that some detained persons threatened self-harm "*to help their case*"[365], refused food "*as a means of being released*"[366], and swallowed blades as an "*empty threat*"[367]. Similarly, Nathan Ring refused to recant on his view that D1527 had acted "*the way like one of my children would act*"[368]. These views were ingrained, perpetuated and normalised throughout the staff culture, with more junior or recently recruited officers unquestioningly accepting self-harming as instrumental, such as Daniel Small, who claims he simply "*cottoned on*" [369] to this impression from more senior officers.

247. This culture of disbelief led to a fundamental deprivation in the care and clinical safeguards afforded to highly vulnerable detained persons.

248. Because self-harming and distressed behaviour was trivialised as difficult, refractory or manipulative, genuine cries for help from detained persons were disbelieved, and treated with disdain. This was desensitisation to a whole new level of inhumanity. The evidence before the Inquiry showed that these punitive attitudes which custodial staff showed towards detained persons who self-harmed not only compounded their sense of powerlessness, but also put detained persons at increased risk of further self-harm.[370]

[362] See for instance the evidence concerning the D1527 incident on 24.4.17: Clayton Fraser: "*I would treat him with compassion, but I would think hes playing up….like a child developing*" 28 February 2022, 18/20-23; Paschali accepted he believed D1527 was acting like a 'child' and a '3 year old': 24 February 2022, 126/18-22; Charlie Francis: "*are you a man or a mouse*" "*come on stop being baby*" TRN0000002_0009 [57-65] ; Nathan Ring "*dummy*" comments TRN0000002_0005 [81-82] ; Nathan Ring, 25 February 2022, 79/15-20, 80/4-5, 81/15-25, 82/1-6

[363] Clayton Fraser, 28 February 2022, 18/24-25

[364] Nathan Ring, 25 February 2022, 72, 16-18, 118/24; Ioannis Paschali, 24 February 2022, 91/8-13

[365] Chris Donnelly, 23 February 2022, 137/1-5

[366] Chris Donnelly, 23 February 2022, 156/5-6

[367] Chris Donnelly, 23 February 2022, 161/19-21

[368] Nathan Ring, 25 February 2022, 79/15-20, see also 80/4-5, 81/15-25, 82/1-6

[369] Daniel Small, 28 February 2022, 117/8-18

[370] Dr Rachel Bingham witness statement, §152, BHM000033_0060

249. The treatment of D1527 by officers on 25 April 2017, when in the throes of a suicidal crisis, is an obvious example of the extent and effects of the overt contempt with which staff treated vulnerable detained persons.

250. This is similarly evidenced by the callous indifference shown by Chris Donnelly towards D687 on 13 May 2017, who was found with a ligature around his neck in the toilet: "*we'll wait for a minute until you pass out and then we'll cut you down*"[371]. D687 was clear in his evidence to this Inquiry that this comment added to his feeling of worthlessness[372]. Mr Donnelly evinced similar disdain when acting as the Supervising Officer in the C&R intervention on D687 to effect his attempted Charter Flight removal. Mr Donnelly, well aware that D687 had placed two razor blades in his mouth, openly goaded the detained person: "*doesn't matter about razor blades, swallow as many as you want*"[373]. When asked in his oral evidence why he did not initiate a clinical emergency – D687 being handed over to Tascor officers with blades still in his mouth – Mr Donnelly responded tersely: "*it was an escorted removal so we were obliged to present him. If he had swallowed a blade it would not have presented a huge problem. They pass straight through the body*"[374]. This is a chilling example of the extent to which concerns over detained person welfare, even active displays of self-harm, were entirely subordinated to the priority of removal.

251. The culture of disbelief – manifested in trivialising of self-harming and distressed behaviour as simply 'difficult' or 'refractory', and reinforced by the complete absence of therapeutic tools or training - also resulted in the default recourse to custodial measures, such as the use of force and segregation, to manage these incidents. Dr Bingham considers the numerous examples, on the evidence, of force being used as a first-line response to detained persons who had self-harmed or evidenced suicidal ideation[375].This includes, by way of indicative example[376]:

[371] TRN0000095_0033[1068]
[372] DPG000021_0073 [209]
[373] Chris Donnelly, 23 February 2022, 165/2-10; Footage S215002 [not yet adduced on BHI website]
[374] Chris Donnelly, 23 February 2022, 161/3-7
[375] Dr Rachel Bingham witness statement, §147, BHM000033_0056-0058; Dr Bingham, 14 March 2022, 50/12-18;
[376] See further examples of C&R responses to self-harming listed in Annex 3 to Dr Bingham's statement at BHM000033_0159-0165

a. the case of D2183 who, during a C&R intervention to effect his removal, cut his neck with a razor whilst on E wing[377]. The restraint proceeded notwithstanding, with D2183 being pinned with a shield, restrained prone on the floor and placed in handcuffs, with the single-tracked focus of effecting the Home Office's directions for his removal.

b. Even more stark is the case of D812 who was subjected to a planned C&R removal to E wing after his threats to self-harm[378]. This restraint proceeded even after he was lying on his bed with a plastic bag wrapped tight around his head. Rather than being treated as a clinical emergency, the bag was simply removed, and the restraint proceeded, with D812 pinned with a shield and restrained prone several times.

252. Dr Bingham is clear that the use of force in this context is wholly inappropriate and inimical to the good clinical management and treatment of self-harm, which requires an immediate therapeutic assessment of the patient's need and the implementation of therapeutic safeguards[379]. Recourse to blunt custodial tools to manage self-harming and distressed behaviours only serves to increase the risk of further self-harm and a deterioration of the detained person's underlying mental health symptoms[380].

253. Segregation, both under the R40/R42 safeguards and in a de facto way by relocation to E wing, was also inappropriately used to manage detained persons suffering from symptoms of mental illness, distress and at risk of self-harm. The default relocation to CSU of vulnerable detained persons who have been removed from the suicide netting[381], after attempts at self-harm or displays of obvious distress, illustrates the extent to which segregation was misused in this way:

a. The Inquiry has heard, for instance, about D275, who was relocated to CSU on R40 after being removed by the NTRG from the suicide netting on 17 May 2017, where he had remained for several hours with razor blades in his mouth[382]. The rationale

[377] UoF DCF-2 form: CJS005535 [not yet adduced on BHI website]
[378] UoF DCF-2 form: CJS005608 [not yet adduced on BHI website]
[379] Dr Rachel Bingham witness statement, §148, BHM000033_0056-0058.
[380] Dr Rachel Bingham witness statement, §152, BHM000033_0060; Dr Bingham, 14 March 2022, 55/5-9
[381] Annex 3 to Dr Bingham's witness statement: BHM000033_0150-_0151; BHM000033_0175-_0176; see also evidence of DCM Yates to the PSU that once a detainee was on the netting, they were always taken to CSU on R40 as their actions might 'incite' others: CJS001107_0014
[382] CJS001130_0002-0004; IMB000027_0001-5; IMB00111_0016 [neither IMB document yet adduced on BHI website]

for his removal was recorded as for the 'safety and security', D275 having caused 'disruption' to the unit by his actions[383]. Neither the custody staff or the healthcare staff involved recognised the extremity of his self-harming behaviour as indicative of the adverse impact of detention and the unsuitability of continued detention.

b. Dr Bingham also considers the case of D2830, who was removed to CSU under R40 after attempting to self-harm with razor blades on 12 July 2017, whilst on an ACDT on E wing[384]. He was subjected to a substantial restraint, on the alleged basis of preventing self-harm, before being relocated to CSU, during which he remained highly agitated. The use of segregation in such cases is representative of an environment which did not permit for the identification or treatment of vulnerable detained persons, mischaracterising their symptoms as behavioural issues which required a restrictive response.

254. The clinical evidence before this Inquiry is unanimous that segregation in this context, as a crude tool to contain distressed and at-risk behaviours associated with self-harming and suicidality, is wholesale inappropriate, failing to provide any form of clinical safeguarding or therapeutic benefit[385]. As Dr Bingham emphasised in her evidence, segregation is actively detrimental to those who suffer from mental illnesses, associated with the exacerbation of psychological symptoms, increased suicidal ideation and risk of self-harm[386]. In this way, the use of coercive measures, such as use of force and segregation, to manage symptoms of serious illness and self-harming behaviour, comprises a fundamental facet to the mistreatment of vulnerable detained persons as Brook House[387].

### (d) Dehumanisation

255. The evidence before this Inquiry has shown how easily, and rapidly, desensitised attitudes can harden into dehumanisation. It is not surprising, according to Professor Bosworth, that when staff 'switched' off from the emotional distress of detained persons,

[383] CJS000976_0002
[384] Dr. Rachel Bingham witness statement, §162, BHM000033_0064; DCF-1, CJS001650: [not yet adduced on BHI website].
[385] Dr Rachel Bingham witness statement, §158, BHM000033_0063 ; Dr Bingham, 14 March 2022, 54/4-8
[386] Dr. Rachel Bingham witness statement, §157, BHM000033_0062 ; Dr Bingham, 14 March 2022, 13/15-25, 14, 1-10
[387] Dr Bingham, 14 March 2022, 55/14-15

this "*obviously [led] to [the] dehumanisation*" of detained persons as not worthy of basic human respect, care, or empathy[388]. This is especially so given the prominent narrative of "us" and "them", hardwired into an "hostile environment" immigration policy which advocates an image of immigration detained persons as "dangerous criminals" who pose a threat to British values and culture[389]. Such rhetoric allows a 'moral distance' to be created, and provides justification for the "othering" of detained people as not human beings.

256. Many formerly detained persons have described their experience of Brook House in these terms: of feeling debased, humiliated, and less than human. D1713, for instance, speaks of feeling locked up '*like [an] animal[s]*', compounded by his demeaning treatment by a DCO who told him "*I would never lock up my dog but I would lock you up*"[390]. D687 states that "*we were treated like animals, less than human*" and that officers "*assumed we were all criminals and that meant we deserved everything that happened to us*"[391].

257. This culture of dehumanisation created the conditions for abuse and mistreatment. As Professor Bosworth states, staff "*lost their sense that people in their care were like them in a fundamental way, based on a share humanity*"[392].

258. It led to the verbal abuse of detained persons because they were seen as undeserving of basic care and respect. Derogatory language was not only routinely used by staff to speak about detained persons, but was deployed directly towards detained persons, as a form of punitive and deliberate abuse. The different types of coarse, demeaning, often outright violent, language directed at detained persons are too numerous to list. The feature common to all such abusive language used by staff, however, is a brutal indifference towards the welfare of detained persons. Professor Bosworth described such language towards detained persons was "*completely corrosive*" "*genuinely shocking*" and ubiquitous[393].

[388] Professor Bosworth, 29 March 2022, 50/20-25, 51/1-4
[389] Professor Bosworth, 29 March 2022, 47/14-25; Dr Paterson witness statement, §106, BHM000045 : not yet adduced on BHI website
[390] Witness statement of D1713, §22, BHM000018_0005 & §34, BHM000018_0009
[391] Witness statement of D687, §§58-59, DPG000021_0019.
[392] Professor Bosworth, 29 March 2022, 54/15-23;
[393] Professor Bosworth, 29 March 2022, 92/24-25, 93/1-3

259. This is starkly evidenced by Steve Webb's direct exchanges with D728, a highly vulnerable detained person on constant watch in E wing after attempting to ligature earlier that day. In response to his reasonable requests to have a shower, attend mosque, and to receive his medication, DCO Webb branded him a "*fucking idiot*"[394] and a "*fucking twat*"[395], before threatening him in the following terms: "*dick us about and well make your life a living fucking misery*"[396]. In response to D728 telling him he recently tried to kill himself, Webb chillingly responds: "*do you think I care? I ain't fucking in the mood*"[397]. This causal disdain for detained person's distress similarly plays out in the chilling refrain – "*if he dies, he dies*"[398] – used by various different officers. Their attempt at an explanation – that it was a quote from a movie[399] – is insulting and reflects just how violent the indifference[400] was toward detained persons and how entrenched was the failure to see this.

260. One particular context in which this phrase was used was against D1275 on 14 June 2017, when he was suffering from the effects of spice. He was a highly vulnerable detained person, with untreated mental health and capacity issues, who was being exploited by other detained persons as a guinea pig for spice. The litany of abuse directed at D1275 on this occasion, from various different staff members, whilst he lay convulsing on the floor, was delivered with the plain intent to humiliate and debase. Officers' comments included "*Div*"[401] "*Scrotum*"[402] "*knob*"[403] "*ball sack*"[404] "*does your face taste nice*"[405] "*look at the state of that... imagine brining that home to your mother*"[406]. The nurse present fails to challenge this language and in fact actively joins in, joking "*homie's after your coke*"[407].

[394] TRN0000017_0009 [89-90]
[395] TRN0000017_0007 [89]
[396] TRN0000017_0007 [41-42]
[397] TRN0000017_0010 [37-38]
[398] Derek Murphy: TRN0000092_040 [1231-1232] re D1275; TRN0000087_0016 [596] re D1914; Yan Paschali: CPS000025_0013 re D2159
[399] Derek Murphy, 2 March 2022, 82/22-25, 83/1-16; Dave Webb, 3 March 2022, 131/2-14,
[400] See also Nathan Ring calling a detained person who was on food refusal a "*prick*" and a "*penis*" who he will "*fucking cross ... off*" anyway: TRN0000079.
[401] TRN0000092_0041 [1447]
[402] TRN0000092_0046 [1482]
[403] TRN0000092_0041 [1445]
[404] TRN0000092_0047 [1515]
[405] TRN0000092_0039 [1194-1195]
[406] TRN0000092_0037 [1097-1098]
[407] TRN0000092_0039 [1197]

261. This echoes a similar incident when a nurse, conducting observations on D3202, who has been unconscious from spice intoxication and has just suffered a seizure, openly mocks him saying "*you've had a good old time haven't you?....Was that fun?*"[408].

262. In her written evidence, Sandra Calver sought to minimise the language used by nursing staff in these incidents as *"silly comments"*,[409] which only confirmed the far-reaching extent of dehumanisation to include even the healthcare professionals. That she conceded when questioned that this type of language used against detained persons was inappropriate, dehumanising and degrading[410]does not soften the gravity of the situation; a concession under cross examination, five years on from the relevant period, is easy to offer but does not itself signify any desire to lead a fundamental change to the entrenched culture that pervaded Brook House beyond the relevant period, as is apparent from the IMB's annual report on the IRC in 2020, discussed further in the submissions.

263. Verbal abuse went well beyond derogatory descriptions of detained persons to include routine grotesque violence. In an environment dominated by macho-aggression this is inevitable, but is patently unacceptable, abusive and degrading. This is illustrated in Yan Pashcali's ominous whisper to D1527, whilst strangling him, that he will "*put (him) to fucking sleep*"[411]. Similarly, by Sean Sayers' lurid threat to D720 (who he had just called a *"cunt"* and a "*fucking dick*") "*I'm going to skullfuck you like the little bitch you are*"[412]. The Inquiry is invited to reject outright the attempts by various officers to justify the use of their shocking language on the basis that it was allegedly consensual: part of a tit-for-tat of offensive remarks traded between officers and detained persons. Yan Paschali was adamant, for instance, in his evidence that detained persons gave as good as they got, that "*detainees swore at us, we swore at them... it was the norm*"[413]. Sean Sayers similarly sought to justify his graphic threat as banter, claiming he had a rapport with the detained person and that he had also been laughing [414]. This position however misconceives the custodial context in which such language is used, within which there is a pronounced power imbalance between officers and detained persons such that, even if a detained

[408] TRN0000083_0005 [149-150]
[409] Sandra Calver first witness statement, §109, DWF000009_0018.
[410] Sandra Calver, 1 March 2022, 145-147
[411] TRN0000002_0007 [49-51]
[412] TRN0000083_0038
[413] Ioannis Paschali, 24 February 2022, 60/25, 61/1; see also 62/22-25, 63/1-2
[414] Sean Sayers, 10 March 2022, 173-175

person may be seen to laugh at such abuse, any notion of consent was fundamentally vitiated[415]. The alternative justification attempted by Steve Webb[416] – namely that his use of aggressive language was part of a legitimate NTRG 'mirroring' technique, in which officers are taught to 'match' the level of aggressiveness of the detained person in order to de-escalate the situation – has already been firmly discredited by the evidence of Jon Collier (NTRG lead) who said he had never heard of this technique, which would be entirely inappropriate as a de-escalation measure[417].

264. The normalisation of such derogatory and abusive language about and to detained persons leads inevitably to risks of and actual physical abuse being inflicted on detained people, because, as Professor Bosworth said, in these circumstances, they are "*no longer kind of considered to be fully human or fully... deserving of decent treatment.*" [418] The physical mistreatment of detained persons is thus an extension of their dehumanisation. In this context, physical violence and abuse are not limited to acts of overt violence, such as Paschali's 'choke-hold' of D1527, Derek Murphy's punching of a detained person or Sean Sayers assault of D313[419], admittedly using his 'face' to stand up[420]. It also encompassed the concerning patterns of misuse of force as identified by Mr Collier, including the use of excessive force even on naked detained persons or when inflicting pain or carried out ineptly without intervention by managers[421]. It also included the misuse of coercive measures on vulnerable detained persons as a routine first resort to contain behaviours and risks consequent to mental illness; unthinking as it may be, this plainly constitutes reckless indifference to human suffering and a form of retribution inevitably experienced as punishment.

265. For instance, the use of high-level and prolonged restraint to respond to a detained person's self-harm attempt, such as those concerning D2183 and D812, can and should rightly be considered punitive and amounting to physical abuse, executed in direct response to the detained persons' self-harming behaviour.

[415] Professor Bosworth, 29 March 2022, 85/8-12
[416] Steve Webb, 8 March 2022, 200/21-23, 201/1-13
[417] Jon Collier, 30 March 2022, 186/1-25
[418] Professor Bosworth, 29 March 2022, 78/7-16
[419] Witness statement of D313, §§60-71, DI0000233_0014-15
[420] Sean Sayers, 10 March 2022, 166/19-25, 167/1-18
[421] Jon Collier, 30 March 2022, 15-16

266. In the same vein, the use of segregation as a deliberate containment strategy to manage a detained person's distressed or self-harming behaviour is plainly punitive. This includes, for instance, the removal to association of D1527 on 4 May 2017, having jumped on the suicide netting earlier that day when suffering from a psychotic episode. He was subsequently subjected to an apparently unplanned use of force to relocate him to E wing under R40, on the claimed basis of his refusal to relocate voluntarily and likewise to allegedly prevent self-harm as it was suspected he had a weapon in his pocket[422]. It is clear however from full consideration of evidence that the decision to remove D1527 to segregation was a premediated and direct response to his distressed behaviour on the netting, rather than to anything that took place thereafter. The UoF report prepared by DCM Dix states he explained to D1527, after he came off the netting, that he would need to go to CSU "*due to his behaviour*"[423]. In his oral evidence, DCM Dix confirmed this association: "*when someone is on the netting, then obviously the procedure was to get then to go to Rule 40*"[424]. The intentional and punitive use of segregation is further corroborated by DCM Dix's admonishment to D1527, during his relocation to E wing: "*the way you have gone about things – jumping on the netting – is not the right way… your problem is you go from okay to lose the plot in two or three seconds*[425]". Further yet, the footage captures D1527 being told by another officer "*if you start to do what you did last time, self-harming….obviously your behaviour will dictate how long you state here for*"[426]. It is plainly clear that D1527 was subjected to a planned removal from association with the express intention of disciplining him for his self-harming behaviour. Both the use of force to effect his removal – and the physical restriction of segregation itself – plainly amounts to serious physical mistreatment.

**(4) <u>Racism</u>**

267. In this toxic culture, racism – the worst kind of dehumanisation and afront to human dignity – thrived. It served as both the precipitant and the justification for unchecked

[422] DCF-2, CJS005530; DCF-1, CJS001026_0002
[423] CJS005530_0008
[424] Steve Dix 9 March 2022 56/1-3

[425] UOF 114.17 BWC B at 02:36-02:48; reference to BWF in Duncan Lewis closing submissions, 5 April 2022, 62/11-25
[426] UOF 114.17 BWC A at 01:58- 02:06; reference to BWF in Duncan Lewis closing submissions, 5 April 2022, 63/4-8

mistreatment and abuse, and reckless indifference to the mental suffering, humiliation and anguish of the detained population as a whole and individually.

268. Professor Bosworth forcefully concluded that Brook House was afflicted by institutionalised racism[427]. The seeds for this were sown in the very use and purpose of immigration detention. It is the view of Professor Bosworth that the risk of mistreatment, and in particular of institutional racism, is inherent in setting up such a system where foreign nationals are housed in a high-security prison for the sole purpose of removal[428]. She is not alone in this analysis.

269. In his 2005 report on Oakington, Stephen Shaw described how the coercive function of immigration removal, coupled with the wider effects of the hostile environment policy, can and does become a "*breeding ground for racist and abusive word and deed'.*[429] Evidence of pervasive racism had also been identified in G4S staff by the Mubenga Inquest in 2013 and in the Yarl's Wood undercover reporting in both 2004 and 2015[430]. Notwithstanding the focussed recommendations made within these investigations, the risk of institutional racism continues to take root and is ever-present.

270. The Inquiry will note in particular the evidence of Professor Bosworth that the close similarities between the events and practices at Oakington and Brook House pose the question of "*whether racism or violence can ever fully be eradicated from these kinds of institutions"*[431]. The conclusion which she arrives at, and which is fully endorsed by Medical Justice, is that such a risk cannot be eliminated: it is inherent within the coercive use and purpose of the IRC estate. In turn, the IRC custodial environment cannot be considered safe or legitimate and must, at the very least, if it is to continue to be used at all, be subject to a statutory maximum time limit for detention, to curtail the extent to which the harm it causes is inflicted. and to afford some constraint on its use that makes sense to those subject to it and working within it.

[427] Professor Bosworth, 29 March 2022, 97/10-12
[428] Professor Bosworth, 29 March 2022, 74/2-13 ; 98/5-7.
[429] Inquiry into allegations of racism and mistreatment of detainees at Oakington Immigration Reception Centre and while under escort, Shaw (2005), foreword, pg 3 HM000041 as quoted by Professor Bosworth in her second report, §1.7, INQ000123_0002-3. This report was also referenced in Emma Ginn's first witness statement Annex 3 - 70 BHM000041_0081
[430] Emma Ginn first witness statement, §107, BHM000041_0038; §14, BHM000041_0004-5; §§121-122, BHM000041_0043-44
[431] Professor Bosworth second report: §8.38, INQ000123_0033

271. Racism at Brook House played out on a continuum. On the one end was the frequent stereotyping detained persons on the lines of nationality and race, often on the basis of the perceived risk and dangerousness of certain groups. This was reinforced by the wider xenophobic narrative of government immigration policy which casts foreign nationals as criminals and outsiders who are deserving of punitive treatment[432]. As Professor Bosworth observes, racial stereotyping is an *"inevitable part"* of the IRC environment which, geared towards the holding of foreign nationals for the coercive purpose of removal, inculcates the message that *"these nationalities are people we don't want….these nationalities are dangerous"*[433]. The development of racialised logics at Brook House manifested in subtle and pervasive ways. For instance, in the tendency to label young black men a potential security threats, whilst older Asian men were considered comparatively low risk[434]. This particular stereotype would have, in the view of Professor Bosworth, left young black detained persons at enhanced risk of unjustified or excessive interventions[435]. There are various other instances of detained persons being referred to pejoratively by their nationality. For instance, after D1275 is removed to E wing to recover from the effects of his spice attack, having already endured significant verbal abuse and humiliation at the hands of staff, Nathan Ring states he is from Iran *"like the terrorist in 'Back to the Future"*[436]. Another detained person is referred to as a *"fucking Serbian cunt"*[437] . In his Verita interview, Steve Skitt made sweeping statements about the traits of detained persons, grouped together according to nationality, stating that Albanians have '*no respect'*, the Nigerian and Ghanaians were litigious, and the Chinese liked sharing rooms[438].

272. Professor Bosworth suggests that recourse to racist stereotypes is staff *"responding to the prompts that the institution is giving them"*[439], trying to make sense of their role within the IRC environment. This does not however detract from the fact that such casual stereotyping was commonplace and normalised throughout the staff culture as a seemingly legitimate proxy for understanding the detained persons in their care. As a

[432] Professor Bosworth, 29 March 2022, 47/14-25.
[433] Professor Bosworth, 29 March 2022, 36/5-14.
[434] Professor Bosworth first report, §8.7, INQ00064_0040.
[435] Professor Bosworth, 29 March 2022, 101/7-18.
[436] TRN0000092_00047 [1538]
[437] TRN0000029_0031: not yet adduced on BHI website.
[438] VER000248_0016
[439] Professor Bosworth, 29 March 2022, 36/15-19.

stark illustration of dehumanisation, such negative stereotyping increased both the risk and effects of mistreatment of detained persons.

273. On the other end of this continuum is racism of the most extreme and unchecked form, namely the overt use of racist language and attitudes. The Inquiry has heard for instance about the highly pejorative and recurrent racist language used by Daniel Small. This included various exchanges in which he stated there were "*too many blacks*"[440] in Cleveland, that Grenfell had resulted in "*a few less foreigners in England*"[441], and held forth on his dislike for Jamaicans, including: "*why are you in Britain? Fuck Off back. Cunt. No wonder if you're in shithole Jamaica*"[442]. In his evidence to the Inquiry, Daniel Small stated that he had used such language in order to fit in, given how prevalent the use of such racist language was amongst staff, including by SMT members[443]. He described in his oral evidence how "*the environment moulded you*"[444], echoing his previous comments to Mr Tulley that "*this job has made me racist*"[445]. Considering Small's insistent avowals that he was not racist, the extremity of the racist language he felt he had to have recourse to, in order to 'fit in' and gain social acceptance, is indicative of just how structurally embedded such racism was. Daniel Small however still failed to show insight, in his oral evidence, as to how the use of this language was racist, appearing to indicate that it wasn't as it was just 'banter' said in 'private rooms' and not directed at a detained person[446]. The fact such terminology is not directed to a subject who may take offence does not of course diminish its pejorative value. Further, Mr Small failed to recognise that, by sharing such views with other officers, he was actively reinforcing the use of racist language as a legitimate feature of the service culture.

274. Even more abject racism was however used by staff. The Inquiry had heard of at least three instances of custody officers - John Connolly[447], Graham Purnell[448], DCO Gurney[449] - using the "N" word directly to or about detained persons. This is far removed from causal stereotyping, concerning the most racially offensive slur conceivable. The

[440] TRN0000079_0010 [254]
[441] TRN0000068_0006
[442] TRN0000092_0050
[443] Daniel Small, 28 February 2020, 145-148.
[444] Daniel Small, 28 February 2020, 147/19
[445] TRN0000092_0050
[446] Daniel Small, 28 February 2020, 148/19-25
[447] John Connolly re D275: TRN0000085_0044 [1474]
[448] Graham Purnell against D643: see D643 witness statement: §76, DL0000228_0020
[449] See Owen Syred first witness statement: §§125-127, INN000007_0030

use of such term is deliberate and provocative – it is intended to shock and, when directed towards the intended subject, to demean and debase. There is good reason why Connolly doggedly denied, in his written and oral evidence, that he had uttered this racist phrase, even suggesting the BBC had dubbed it, before reluctantly conceding he had and there was no excuse for it[450]. The fact this language was used openly, and with complete impunity, is illustrative of the extreme dehumanising effects of the staff culture where, in effect, no form of abusive practice was off limits.

275. The pervasive nature of the racism is also starkly illustrated by staff attitudes towards their colleagues, for example:

a. John Connolly calling the Iman a cunt after he left the stairwell and plainly demeaning him in front of the other white staff present.[451] Notably this went unchallenged by any of the other officer.
b. Owen Syred was called a "N" lover by other G4S staff when he complained about the very use of this word by DCO Sam Gurney [452] Owen Syred gave evidence that Ben Saunders was aware of this and the intimidating ostracism he experienced but took no effective action whatsoever. [453]
c. Shayne Munroe, one of the very few black female DCOs, said in her evidence that she experienced both overt and covert forms of racism from her colleagues[454]. This included, in its most extreme form, being called a *"fucking black cunt"* by DCO Bonnie Spark[455]. The disciplinary investigation into this resulted in no substantive action being taken against Ms Spark, as the various officers present when the comment ws made later denied they had heard it. DCO Spark was later made a DCM.

276. The Inquiry must find that Brook House was afflicted by institutional racism applying the criteria of the MacPherson Inquiry[456] light of the evidence as to:

[450] John Connolly, 2 March 2022, 189/1-25, 190/1-11
[451] TRN0000085_0077 [2745]
[452] Owen Syred, 7 December 2021, 116/21-25, 117-118, 121/2-11; Owen Syred first witness statement §§125-128, INN00007_0030-21
[453] Owen Syred, 7 December 2021, 116/5-8, 117/2-6, 120/22-25, 121/1-25;
[454] Shayne Munroe first witness statement, §§50-51, INN000013_0016-17
[455] Shayne Munroe first witness statement, §55, INN000013_0018
[456] See Bhatt Murphy opening submissions, 25 November 2021, 25/8-25; 26/1-9; full report can be found at: DL0000176

a. the lack of urgency in investigating the incident and failing to see its relationship with race (§6.45(a))
b. evidence of negative stereotyping of racial groups by staff fostered through workplace culture (§6.45(b))
c. underreporting to the organisation by BAME individuals due to a perception that their cases would not be taken seriously (§6.45(c))
d. the lack of training within the organisation of racism awareness and race relations (§6.45(d))
e. the failure of the organisation to unequivocally recognise, acknowledge and accept the problem (§6.48, §6.51, §6.52, §6.58)
f. the use of racially insensitive language and terms by officers/staff without understanding as to how such language could be offensive (§6.3)

277. All of these factors are clearly in play and are compounded by the evidence of Mr Riley and the failure of the Home Office to even acknowledge never mind engage with the evidence of institutional and pervasive racism exposed by BBC Panorama and further uncovered in the evidence to the Inquiry. The same applies to the senior G4S corporate witnesses. The failure to "*unequivocally recognise, acknowledge and accept the problem*" reveals a startling complacency and institutional indifference to racism on the part of both the Home Office and G4S. This is despite the previous reports documenting evidence of racism[457], racist subcultures[458] and pervasive racism[459]. Dr Paterson examines this in his witness statement, in particular in respect of the development and impact of a corrupted staff culture in which such racist and derogatory language and behaviours exacerbate the risk and of and contribute to mistreatment.[460]

[457] See PPO Report on the Treatment of Detainees at Yarl's Wood IRC (2004) which subsequently recorded that, after 5 weeks of training as a DCO the undercover journalist reported on incidents of racism, including racial profiling racially derogatory language, xenophobia, and threats of violence that he had witnessed; exhibited to Emma Ginn's witness statement: [the exhibit bundle BHM000043 is not fully adduced]; see also witness statement of Emma Ginn, §14,BHM000041_0004-6; §95, BHM000041_0034.
[458] See PPO Inquiry into allegations of racism and mistreatment of detainees at Oakington Reception Centre (2005) that Shaw called "*a sub-culture of abusive comment, casual racism, and contempt for decent values*" at Oakington IRC; linked at Annex A - 70 of Emma Ginn's witness statement, see also §15, BHM000041_0006; §§96-100, BHM000041_0034-35
[459] Rule 43 Report of the Assistant Coroner into the death of Jimmy Mubenga (2013) which found evidence of "*a more pervasive racism within G4S*" (§§43-44), EG19 of Emma Ginn's witness statement exhibit bundle [BHM000043, not yet fully adduced]; see also first witness statement of Emma Ginn, §107, BHM000041_0038
[460] Dr Brodie Paterson witness statement, §§89-117, BHM000045_0020-27: not yet adduced on BHI website.

**(5) Over-reach of Healthcare**

278. Dr Bingham explained cogently in her evidence as to why healthcare staff must act, and be seen to act, independently from the wider operation of the IRC[461]. Within the context of a closed custodial environment, clinical staff are expected to exercise an independent safeguarding role in respect of the health and welfare of detained persons which sets them apart from matters of custodial management. They should, for instance, play no executive role in decisions concerning restrictive measures or wider immigration processes.

279. But the instructions and expectation from the Home Office were dominated by priorities concerning immigration enforcement and removal, and the management of people, regardless of their health and vulnerabilities, in detention to pursue that agenda. Against this backdrop, this separation of functions at Brook House came unstuck for healthcare professionals. This led to a conflict of dual loyalties of the worst kind, allowing the Home Office's priorities in immigration removal overwhelm and overcome the doctor's and nurses' primary duty of care to their patients.

280. With the focus honed in on immigration enforcement, healthcare staff – whether inadvertently or not - acquiesced to the use of custodial risk management tools as a form of first-line management for unwell detained persons. The clinical inappropriateness of such measures has already been explored above. For emphasis however, Dr Bingham was clear that there was "*no justification for managing somebody with mental health problems in a high degree of distress though these restrictive measures*"[462] These are custodial-led and designed mechanisms with absolutely no therapeutic value. They cannot used as a substitute for assessment and treatment of the underlying causes and exacerbating factors to the detained person's distress or related mental health issues.

281. Recourse to custodial processes to manage clinical issues fundamentally undermines the safeguarding role of healthcare. It means that clinical staff are participating, in the words of Dr Bingham, in an *"environment that hasn't allowed (this person) to be treated as a vulnerable person, to be treated as a patient"* but rather one which is actively "*hostile"* to their needs[463]. This is compounded by the dominance of removal as a contractual priority for the Home Office, and the reciprocal low priority afforded to issues of welfare

[461] Dr. Rachel Bingham witness statement, §§129-130, BHM0000033_0048.
[462] Dr Bingham, 14 March 2022, 49/15-17
[463] Dr Bingham, 14 March 2022, 49/17-20, 49/23-25, 50/1-4

of vulnerability. It is easy to understand how, in this context, healthcare would have developed conflicting loyalties: operating in an environment where their clinical role was viewed as entirely subordinate, and in fact a distraction to, the end-point of removal. The far easier route, rather than attempting to pro-actively provide care for and safeguard these detained persons, was simply to defer to the custodial processes designed only to contain their risk pending removal.

282. These factors militated towards a healthcare unit which had in essence been actively encouraged to, and did, abdicate their duty of care owed to their patients. This is illustrated by the various examples of healthcare failing to exercise their safeguarding role in respect of UoF interventions by raising clinical concerns contra-indicative to restraint. The omissions of Nurse Buss in respect of D1527, who failed to intervene, call out, shout, or do anything to stop Yan Pashcali's assault are obvious and in complete dereliction of her protective clinical role.

283. The treatment of D2159 is also instructive. He was an acutely vulnerable detained person on constant watch for prolonged food and refusal. D2159 was subject to a planned C&R removal to E wing on 5 April 2017 on grounds of his deteriorating clinical state. The Inquiry has seen the video of this incident[464]: of D2159 lying passively on his bed, when a shield is placed on top of him. He is so weak that he cannot stand, and so is relocated in arm-locks and hand-cuffs to E wing. Even then he can barely walk and falls to the floor at several points during the move. It makes for abject viewing. Both Dr Bingham John Collier share the view that the use of force here was completely inappropriate and this should have been managed as a medical move[465].

284. Dr Bingham criticises the complete failure of healthcare to raise clinical objections to the restraint of D2159 both prior to and during the intervention[466]. This was notwithstanding his prima facie indicators of clinical vulnerability. The total failure to protect against D2159 from the inimical use of force is illustrated by the evidence of Chrissie Williams, the RMN who had advised custodial staff that D2159 needed to be moved due to clinical concerns over his welfare. She subsequently inputted an entry in the medical records

[464] S1970002.MP4
[465] Dr Bingham first witness statement, §§139-141, BHM000033_0053-54; Jon Collier first report: §§125-133, INQ000111_0035-36; §665, INQ000111_0158
[466] Dr Bingham first witness statement, §§139-141, BHM000033_0053-54

earlier on 5 April 2017 confirming "*restraints may be used*"[467]. In her evidence to the Inquiry, Ms Williams stated she had simply meant "*holding his hand*"[468] if needed and had not anticipated that force would be used, which was inappropriate. Ms Williams accepted, albeit reluctantly, that what she had written had amounted to a de facto approval and sanctioning of the use of force against D2159, which was firmly outside of her clinical remit. Instead, as Ms Williams accepted, she ought to have clearly raised the obvious clinical contra-indications to force being used against D2159 at the outset[469].

285. The C&R removal of D2159 is illustrative of the complete breakdown in the protective function of healthcare, involving dual failures to discharge its UoF monitoring duties on both fronts. Both Ms Williams, who advised in advance of the removal, and the nurse in attendance at the C&R intervention (Mr Little) failed to intervene to raise clinical concerns against the restraint of an acutely vulnerable detained person. In fact, healthcare staff did the very opposite, by seeking to involve itself in the custodial decision as to use of force. In her careless reference to 'restraints' being used, Ms Williams inadvertently sanctioned the use of force against a highly vulnerable patient. This entirely outsteps the remit of healthcare in respect of their distinct and protective UoF monitoring role and directly implicates clinical staff in the use of coercive measures against their patient. This is, in the words of Dr Hard, "*100 per cent unacceptable*"[470].

286. The use of force against D1914 on 27 May 2017 is another stark illustration of this conflict of loyalties. The Inquiry has heard as to the memorandum issued by Dr Oozeerally that D1914 was fit to fly, fit for detention, and that he was "*happy for reasonable force to be used in order to facilitate the removal*"[471]. This was in turn relied on by the officers involved in the C&R intervention as a disclaimer for the force used in case D1914 died. Dr Bingham was clear in her view that Dr Oozeerally had seriously overreached his clinical remit in making this statement. His words amounted to an active endorsement of restraint which entirely overstepped his professional boundaries. She firmly rejected the evidence of Dr Oozeerally that his assessment that D1914 was fit for restraint (or detention or to fly) was one and the same as recording there were no clinical

[467] CJS007001_0001
[468] Chrissie Williams 10 March 2022 107/17-19
[469] Chrissie Williams 10 March 2022 109-110

[470] Dr Hard, 28 March 2022, 89/24
[471] CJS001160_0001

contra-indications[472]. Language matters: it is the fundamental way that healthcare demarcate their independence from these custodial decisions[473] The misuse of language can risk clinical staff being 'drawn' into custodial processes. This reflects the position of the British Medical Association and their published guidance on healthcare conflict of loyalties in the IRC setting, it being of fundamental importance that doctors do not say or do anything which could be seen to implicate them in issues of custodial management[474]. Because of this, Dr Bingham advised that healthcare needed to "*be constantly on their guard… and really watch their language so that it's not, as in this case, used in another context to justify a use of force*"[475]. It is of particular concern that Dr Oozeerally cannot, even now, see the material distinction between his role as a doctor raising contraindications to the use of such blunt and violent custodial measures, and agreeing to its use.

287. In respect of D1914, Dr Bingham was clear that, as well as over-reaching his clinical remit, Dr Oozeerally failed to discharge his protective monitoring role. Specifically, he failed entirely to identify or raise D1914's cardiac condition and self-harm history as contra-indications to the use of force[476]. This failure carried through to the UoF intervention itself, during which, even after D1914 suffered a clinical episode mid-restraint, healthcare failed to raise any clinical contra-indications to its continuation. Again, Dr Bingham observed, from the UoF records that the healthcare staff over-stepped their remit in confirming they were 'happy' for the restraint to continue[477]. It is to be noted that these are a but a few examples from the evidence of the extent to which healthcare failed to fulfil its safeguarding role in respect of the use of force: there are many other such incidents, including the extreme and prolonged restraint of D1234 and D2054, both highly vulnerable detained persons who were naked throughout. The abject failings of healthcare in these cases will be considered further below in Section VII on Misuse of Force.

288. This pattern of healthcare being drawn into custodial processes is also reflected in the recurrent use of segregation as a means to manage mentally unwell detained persons. The

[472] Dr Oozeerally 11 March 2022 131/1-12, 135/12-20
[473] Dr Bingham, 14 March 2022, 46/7-22
[474] Dr Bingham first witness statement, §129, BHM000033_0048
[475] Dr Bingham, 14 March 2022, 47/1-9
[476] Dr Bingham, 14 March 2022, 48/5-17
[477] Dr Bingham first witness statement, §137, BHM000033_0051-52; see also DCF2: CJS005651_0020, _0031

persistent misuse of segregation is indicative of the failure by healthcare to discharge its safeguarding function in respect of raising clinical contra-indications against segregation both at the outset and throughout. This resulted in seriously unwell detained persons being maintained on segregation as a crude containment strategy to reduce their risk, rather than to provide any form of enhanced safeguarding or clinical care for the detained person. As Dr Bingham made clear, this is not simply a neutral custodial mechanism but is in fact '*worse than nothing*'[478] as it is actively injurious to the mental health of those detained. This is why it is all the more concerning that healthcare appeared to have all but entirely abdicated their critical monitoring role in this context. It results in cases such as D2951, who suffered from serious mental health issues and was maintained on prolonged segregation whilst awaiting transfer to an MHU, despite officers raising their concerns over his deterioration[479].

289. As Dr Bingham made clear, in cases such as this, where a person's mental health is so unstable and high risk as to lead to a perceived need to segregate them, this should be taken as a fundamental– albeit significantly delayed – indication that they should not be in detention in the first place[480].

290. The effects of this conflict of loyalties within healthcare cannot be under-stated. In involving itself so closely in the custodial processes, healthcare failed wholesale to safeguard vulnerable detained persons from harm, sanctioning the routine misuse of segregation and force to manage seriously vulnerable detained persons. It is clear from the evidence received by the Inquiry that the healthcare professionals working at Brook House at the relevant time were unable to fulfil their primary duty of care to their patients well above the pressures of immigration removal priorities.

[478] Dr Rachel Bingham 14 March 2022 54/5
[479] Dr Rachel Bingham 14 March 2022, 52-54
[480] Dr Bingham first witness statement, §166, BHM000033_0066 ; Dr Rachel Bingham 14 March 2022, 54/9-14

## VII. Misuse of Force

291. The evidence before this Inquiry lays bare the multiple and extreme ways in which vulnerable detained persons were subject to the coercive misuse of force, and addressed below. In particular, the alarming pattern of force being wrongly used on mentally unwell detained persons, including those who are naked, visibly distressed and at risk of self-harm. This was exacerbated by the systemic failures in Control and Restraint ("C&R") training and incompetence identified by Mr. Collier, the Inquiry's Use of Force expert, which resulted in the prevalence of poorly executed, unsanctioned and often harmful practices being deployed and causing detained people significant distress, humiliation and re-traumatisation. The prison-based C&R model, in the most brutal way, exhibited the worst of the prisonisation of Brook House. It fed into the toxic staff culture which developed at Brook House; its use and misuse provided a direct means to perpetuate and act out punitive attitudes and actions held against vulnerable detained persons.

292. The coercive and routine use of force contributed to the climate of fear and intimidation at Brook House, in which detained persons existed in a state of constant anxiety and threat. The default use of force to effect removal, including no notice charter removals, generated an intense sense of insecurity and subjected detained persons to witnessing and hearing the distress of those being forcibly removed. Detained persons also witnessed the frequent use of force, including excessive and pain-inducing measures, on those who were mentally unwell, including detained persons who were self-harming or suicidal, which was inevitably highly distressing and alarming. Many formerly detained persons, including D1713[481], have spoken of how witnessing these incidents seriously affected them. This is important. The use of force not only had a profound psychological impact on those directly subjected to it, but on the many detained persons who witnessed its use. Professor Katona explains that witnessing restraint in this context would be *"traumatising in itself and risks re-traumatising any detainee with a past history of trauma"*[482]. Moreover, it heightened detained persons' sense of powerlessness and lack of trust in those who they expected protection from, adding further to their "*acute distress and anxiety"*[483] with an already low-trust, harsh environment.

[481] BHM000018_0010-0011 [37-39]
[482] Professor Katona, first witness statement, §77, BHM000030_0038
[483] Professor Katona, first witness statement, §78, BHM000030_0038

293. Mr Collier is commendable in the clarity and focus of his evidence to this Inquiry on his findings from the assessment of a selection of use of force ('UoF') incidents at Brook House. He was also however upfront about the limits of his expertise: that he was not a clinical expert, and had no medical or clinical experience of working with those suffering from mental illness or trauma[484]. Thus he was not provided with the underlying medical records or related material on vulnerabilities in respect of any of the individual cases he had considered[485]. His analysis therefore does not factor in clinical considerations, including relating to mental illness, into his individual findings as to whether force was reasonable, proportionate and justified. In the circumstances, whilst Mr Collier's evidence is clearly of significant assistance to this Inquiry in identifying thematic concerns with the implementation and oversight of the current UoF model, it only takes us so far. His evidence must be considered together with that of Dr Brodie Paterson, a lead practitioner on restraint reduction techniques with clinical expertise as a mental health nurse. Given the population of detained people who were routinely subjected to use of force at Brook House, Dr. Paterson's analysis, based on his cross-sectional expertise on the use of force and clinical issues, fills a significant lacuna in the evidence. He is the witness best, and indeed singularly, placed to consider the use and appropriateness of restrictive practices on mentally unwell detained persons. Mr Collier himself defers to the findings of Dr Paterson on these issues[486]. The Inquiry ought accordingly to adopt a similar approach.

294. In particular, and whilst we do address in this section our analysis of the inherent flaws in the model of C&R techniques used in IRCs, and the multiple and graphic ways in which force was misused time and time again at Brook House, it is important for the Inquiry to have in mind Dr. Paterson's ultimate conclusion on this issue when it comes to consider what remedial action is required. Dr. Paterson called for a "*fundamental rethink*" [487] of the model for the use of force to be adopted in the IRC environment. What he means is not just tinkering with the machinery, so as to put greater emphasis on de-escalation and the use of force only in extremis[488], or moving toward more therapeutic models that adopt comparable approaches to those used in mental health institutions.[489] Dr. Paterson is clear

[484] Jon Collier second report :§30.2, INQ000158_0065
[485] Ibid: §1.6, INQ000158_0007
[486] Ibid, §§30.2-30.3, INQ000158_0065
[487] Dr Paterson witness statement: §29, BHM000045_0005
[488] Jon Collier, 30 March 2022, 143/1-5; Dr Paterson witness statement, §19, BHM000045_0004
[489] Dr Brodie Paterson witness statement, §§40-43, BHM000045_0009-10; Jon Collier second report, §30.2, INQ000158_0065

that whilst these changes are necessary and *may* mitigate against current high risks of routine misuse of force as the default, not as a last resort, tinkering alone *will not* prevent the risk of mistreatment, abuse and the misuse of restraint. This is because changing the model is not and cannot be a stand-alone solution to preventing the extreme physical violence and abuse captured on BBC Panorama footage and body worn cameras that was inflicted on detained people. The need for the use of force to "manage" and respond to distress, self-harming and suicidal attempts, plainly shows that there are too many people in detention who are vulnerable and should not be in there in the first place. The high numbers of vulnerable people, the lack of skill and capability on the part of custodial staff to care for them, the systemic failures in detention policy and safeguards, and the dehumanising toxicity of the institutional culture at Brook House, mean that the serious and real risk of recourse to blunt custodial measures such as overt force or passive forms such as the use of segregation will be ever-present.[490] The increasing prevalence of use of force highlighted in the IMB 2020 report on Brook House, coincident with the very high levels of self-harm and suicidal ideation within the centre, is indicative of this[491]. So long as vulnerable detained persons continue to be detained, the risk of misuse of force will endure.

**(6) <u>Inappropriate model for use of force interventions</u>**

295. Mr. Collier and Dr. Paterson agree that the fact of force being routinely used as a default first resort at Brook House, and in excessive and harmful ways, cannot simply be explained by ascribing blame to a handful of officers' poor behaviour. The model used for control and restraint – even where it may become necessary – was fundamentally not fit to be deployed in the context of an IRC. The model adopted by the Home Office not only at Brook House but across the immigration detention estate – during the relevant period, and even now – is blindly imported from the prison context, with no real adjustments or modifications made whatsoever to reflect the distinct needs and vulnerabilities of the IRC detained demographic. That model was designed for a different purpose, as a system of physical intervention to respond to and manage refractory and violent prisoners. It proceeds on the basis that high-level restraint interventions, using

[490] Dr Brodie Paterson witness statement, §§146-149, BHM000045_0035-0036.
[491] IMB Annual Report on Brook House for reporting year 1 January -31 2020: IMB000202_0016

techniques including locks, pain compliance and prone restraint are a necessary response to contain challenging violent behaviour.

296. Mr. Collier, who designed this model for the prison estate, confirmed that the model was never intended for use to manage victims of torture and trauma, deterioration in mental ill-health, self-harm and extreme distress. Nor was it designed to be used as a physical means to facilitate the forced removal of people from the UK under immigration powers. It is therefore unsurprising that there was and is[492] no guidance in the applicable training manual concerning the use of force in the context of mental illness[493]. Nor is there anything in the criteria used to evaluate the appropriateness and safety of the C&R techniques deployed to include consideration of vulnerabilities relating to mental illness or a history of torture and trauma.[494]

297. However, it is clear that the current UoF model is fundamentally unsuitable for use in the IRC estate as it fails to account for and reflect the complex needs and vulnerabilities of the detained person demographic[495]. Dr Paterson criticises the prison-based C&R model for being a blunt model that focuses on reactive physical intervention (i.e. use of force and segregation) and the default recourse to techniques including pain-compliance and prone restraint [496] without making allowance for sufficient use of non-restrictive measures and de-escalation strategies first or in the alternative.[497] He considers it "*extremely problematic*" and inconsistent with good clinical care to deploy such a model for the use of force against mentally unwell detained persons when less intrusive or non-restrictive measures can and should be contemplated and used[498]. Moreover, the use of force can become inherently coercive when applied to vulnerable detained persons, given their impaired levels of response from their state of distress or underlying mental illness. Techniques such as pain-compliance presume that the subject has sufficient capacity to understand what is being done to them, and what they need to do to bring the pain to an end[499]. Individuals who suffer from mental illnesses, such as psychosis or PTSD, may

[492] The applicable HMPPS C&R model and training manual is the same now as it was as at 2017: see 2015 NOMS UoF Guidance (v.2.1). NOM000001; Jon Collier confirmed in his oral evidence that this hasn't been updated since the 2015 version: 30 March 2022, 141/14-18
[493] Jon Collier, 30 March 2022, 140/3-24
[494] Jon Collier, 30 March 2022, 141/3-18
[495] Dr Paterson witness statement, §26, BHM000045_0005.
[496] Ibidm §§45-46, BHM000045_0010-11
[497] Ibid, §§44-47, BHM000045_0010-11
[498] Ibid, §47, BHM000045_0011
[499] Ibid, §§36 and 47, BHM000045_0008, 0011

dissociate during the incident and struggle to understand what is happening. Consequently, the detained person may struggle for longer, resulting in the application of prolonged, or even more acute, restraint.[500]

298. Mr. Collier endorses Dr. Paterson's analysis as to the unsuitability of the current UoF model for the IRC estate,[501] adding that the needs of the IRC population are "*so specific… they couldn't just take a generic package*"[502].

299. Given this evidence, it is hardly surprising that such routine misuse of force has a grave and harmful impact on mentally unwell detained persons. That is evident from Medical Justice's case studies put before this Inquiry. Professor Katona is of the view that the use of physical restraint is likely to be an episode of re-traumatisation for detained persons with pre-existing clinical vulnerabilities or a past history of torture or trauma[503]. Dr Bingham agrees, additionally noting that it can also foster mistrust between detained persons and detention centre staff, including healthcare, and deter them from engaging in clinical care[504]. This reflects the findings of the Independent Inquiry into Child Sex Abuse which identified, in its phase concerning the abuse of children in custodial institutions, the use of pain inducing techniques as an inhibitor to reporting abuse and contributing to an overall climate of fear and suppression:

> *"The use of [pain compliance techniques], however challenging the behaviour of the child, normalises pain for staff and children. This in turn prevents staff from building trusting relationships and inhibits a child from reporting sexual abuse. The use of pain compliance, although authorised as a last resort, has attracted criticism from a number of informed commentators. Pain compliance contributes to a culture of fear and has the effect of silencing the child at a time when it is important that the child feels safe to speak out about aspects of their lives, including sexual abuse".*[505]

[500] Ibid, §§36 and 47, BHM000045_0008, 0011
[501] Jon Collier, 30 March 2022, 148/1-21
[502] Jon Collier, 30 March 2022, 152/5-10
[503] Professor Katona witness statement , §§77-78, BHM000030_0038
[504] Dr Rachel Bingham witness statement, , §133, BHM000033_0050
[505] IICSA : Sexual Abuse of Children in Custodial Institutions: 2009-2017, Investigation Report (Feb 2019) conclusion pg 99 [§10]: https://www.iicsa.org.uk/key-documents/9560/view/sexual-abuse-children-custodial-institutions-investigation-report-february-2019.pdf

300. There are obvious parallels between the position of child and that of a mentally unwell immigration detained person in the context of the use of force in the closed custodial context. Both are inherently vulnerable and have relevant characteristics which contra-indicate the use of force as a default tool for behaviour management. The Chair and Panel in IICSA concluded that the use of pain compliance techniques should be seen in itself as a form of child abuse, recommending that the Ministry of Justice prohibit the use of pain compliance technique by way of regulation." [506] These findings should apply with equal force to this Inquiry.

301. Concerns about the adoption of prison-based C&R techniques in IRCs are not new. They had been identified by Medical Justice as long ago as their 2008 Report, *Outsourcing Abuse*,[507] and subsequently by Baroness O'Loan in her 2010 report, commissioned by the Home Office in response to the Medical Justice report. Baroness O'Loan made a series of recommendations, including in particular on the need to review the C&R techniques in IRCs, including with reference to comparative measures used in mental health establishments[508].

302. The Inquiry has received no evidence from the Home Office to demonstrate that it has ever undertaken a review of the kind recommended by Baroness O'Loan in 2010, as to whether a prison-service UoF policy was and is an appropriate model for use in the IRC setting, particularly given the high levels of vulnerability and mental illness[509].

303. Similarly, there is no evidence that lessons were learnt and effective remedial action taken from the death of Jimmy Mubenga in 2010 and the reviews that followed including the Inquest findings and the Report of the Independent Advisory Panel on Non-compliance Management in 2014[510]. These investigations identified the now common themes of the entrenched failures by the Home Office to ensure adequate training and monitoring on the use of force, to ensure effective use of force governance and management and to inculcate a rights and respect based culture[511].

[506] IICSA : Sexual Abuse of Children in Custodial Institutions: 2009-2017, Investigation Report (Feb 2019) conclusion pg 102 [recommendation 5]: https://www.iicsa.org.uk/key-documents/9560/view/sexual-abuse-children-custodial-institutions-investigation-report-february-2019.pdf
[507] Emma Ginn witness statement, , §26, BHM000041_0009-10
[508] Emma Ginn witness statement , §§28-31, BHM000041_0011-12
[509] Dr Brodie Paterson witness statement,, §18, BHM000045_0004.
[510] Emma Ginn witness statement, §§105-110, BHM000041_0037-40
[511] Emma Ginn witness statement, §108, BHM000041_0038-40

304. Like Baroness O'Loan, Shaw emphasised in this report on Non-Compliance Management that "*certain groups are more vulnerable to risks when being restrained*", including those with "*serious mental illness, or learning disability and those from black and minority ethnic communities*".[512]

305. The Home Office's repeated disregard of recommendations by its own commissioned investigators in this context – as it did in the context of the Shaw Review – once again exposes its belief in the institutional impunity that it enjoys and perpetuates.

306. The Inquiry has also received no evidence of localised training on the use of force in the context of mental illness being provided by G4S, which has had a long-standing contractual relationship with the Home Office in the provision of services in immigration detention (not just at Brook House but across other detention centres)[513]. Nor is there any evidence before this Inquiry to indicate that has Serco put this in place since taking over the contract at Brook House in 2020[514].

**(7) Misapplication of the C&R Model**

307. The adverse impact of this inherently flawed C&R model on vulnerable detained persons was compounded by the misapplication of techniques and poor training of custodial staff. In his evidence to the Inquiry, Mr Collier raised concerns over various incidents where it appeared that force was used inappropriately on vulnerable detained persons[515]. Moreover, of the 43 incidents Mr Collier reviewed, he found that 25% raised significant concerns over staff competence[516].

308. These were, Mr Collier suggested, and as indicated above, likely only the tip of the iceberg: given the limits of his expertise and that he not reviewed the underlying clinical material, he accepted there was "*every likelihood*" of there being other incidents which could be classified as inappropriate restraints of clinically vulnerable detained persons beyond those he had identified[517]. Mr Collier is of course entirely accurate in his prediction. All three Medical Justice clinical witnesses, Dr Bingham, Professor Katona

[512]Emma Ginn witness statement, §108(c), BHM000041_0039
[513] Jon Collier second report, R2 Q7, INQ000158_0076
[514] Jon Collier, 30 March 2022, 141/22-23
[515] Jon Collier, 30 March 2022, 111/21-25, 112/1-21
[516] Jon Collier, 30 March 2022, 31/1-10
[517] Jon Collier, 30 March 2022, 138/14-24

and Dr Patterson, identify evidence of a pattern of restraint being used as an inappropriate tool to manage detained person's mental health problems and distress[518]. This of course is consistent with, and flows from, the clinical consensus on the evidence that mental illness cannot be effectively treated in detention.

**(a) Routine misuse of force**

309. Mr Collier and Dr. Bingham both identified multiple incidents where force against vulnerable detained persons was not used as a last resort, [519] and there was no evidence of sufficient de-escalation efforts[520].

310. In the case of D149, officers waited a mere 1 minute 40 seconds before resorting to force, despite the detained person's reasonable requests to understand what was happening to him and why.[521]

311. D687 was restrained after being found in the toilet with a slack ligature around his neck. Mr. Collier criticises the 'alarming' actions of DCM Haughton, who, on attending the ongoing incident, moved immediately to restrain D687, despite the obvious scope for engagement and negotiation[522]. In having such a rapid recourse to restraint, Mr Collier assessed that force was not used as a last resort. He considered the actions of DCM Haughton were indicative of 'crisis management' in which, rather than attempt to engage with and de-escalate the detained person's distress, he was "*intent on getting the incident done and dusted*"[523]. Another "*massive failing*" was the non-attendance of healthcare[524], who, if they had attended, could have assessed his mental health and avoided the use of force altogether[525]. This reflects the view of Dr Bingham that force was used as a first-line custodial response to manage self-harming, with little if any clinical input from healthcare.[526]

[518] Dr Bingham witness statement, §§133-143, §§147-149, BHM000033-0050-58 ;Dr Paterson witness statement, §21, BHM000045_0004 Professor Katona witness statement, §§51-52, 54(v)], BHM000030_0026-27
[519] Jon Collier first report: §636, INQ000111_0145-146
[520] Jon Collier first report: §28, INQ000111_0013 ; third report: §§82-83, INQ000177_0016
[521] Jon Collier, 30 March 2022, 34/4-25, 35/1-14
[522] Jon Collier first report, §666, INQ000111_0158-159 ; §§238-239, INQ000111_0060-61
[523] Jon Collier, 30 March 2022, 94/12-21
[524] Jon Collier, 30 March 2022, 96/15-20
[525] Jon Collier, 30 March 2022, 96/21-25, 97/1
[526] Dr Bingham witness statement, §§147-148, BHM000033_0056

312. Poor de-escalation compliance was also reflected in the "*cultural process of automatically resorting to staff in full PPE*"[527] for all planned removals, despite this only being required for high-risk removals. As Mr Collier noted in his first report, it was not conducive to a safe environment to have officers clad in riot gear regularly being seen "*lifting' detained persons and 'taking them away'*"[528]. It reflected and reinforced staff macho attitudes around C&R, as high-tariff, adrenaline-fuelled interventions against 'risky' detained persons. Mr Collier also criticised the failure to de-escalate an incident by the removal of PPE (i.e. helmets) once the incident was under control, despite this providing reassurance to the detained person that force was being reduced[529] . He considered that this only served to aggravate detained persons' fear and distrust of an already punitive environment.

**(b) <u>Unsafe use of techniques</u>**

313. Mr Collier also identified numerous incidents where DCOs showed a fundamental lack of technical ability or understanding, applying C&R techniques incorrectly and causing potential harm to the detained person[530].

314. In the case of D687, mentioned above, his suffering was further exacerbated by the application of an inverted wrist hold, a pain-inducing measure, after his initial restraint. Mr Collier finds that, on its face, the use of this pain-inducing measure was entirely unjustified, with D687 already in handcuffs by this point and posing no risk to others[531].

315. This mirrors Mr Collier's view that the use of a pain-inducing thumb lock against D1527, during his relocation to CSU on 4 May 2017, was unjustified in view of the further information provided to him as to D1527's serious mental illness and the absence of immediate risk[532]. These incidents must be considered in the context of Dr Paterson's evidence that pain-inducing measures are fundamentally inappropriate for use in the IRC setting against those experiencing mental illness[533].

[527] Jon Collier first report: §658, INQ000111_0156
[528] Ibid
[529] Jon Collier, 30 March 2022, 78/7-25, 79/1-20; first report: §650, INQ000111_0151-152
[530] Jon Collier, first report, §637, INQ000111_0146; §§661-662, _0157 ;§667_0159 ]; Jon Collier, 30 March 2022, 30/1-16
[531] Jon Collier, 30 March 2022, 135/10-25, 136/1-8
[532] Jon Collier, 30 March 2022, 99/6-12, 100/12-122
[533] Dr Paterson: §47, BHM000005_0011 [BHI website link doesn't work]

316. A further case illustrative of the poor and incompetent UoF practices deployed by custodial staff concerns the restraint of D149 on 31 May 2017. During removal to CSU, D149 was subjected to a series of poorly executed C&R measures: the incorrect placement of handcuffs, prolonged restraint in the prone position, the misapplication of a pain-inducing-technique, and of a four-figure leg hold in which staff forcibly pulled and twisted his legs[534]. D149 is heard crying out in pain at several points during the move. Throughout, the officers appeared *"lost and lacking in knowledge"* on how to carry out the techniques[535]. The unsafe application of these measures inhered the risk of significant injury and, in the case of the prone restraint whilst D149 was hand-cuffed and breathless, even fatality[536]. Mr. Collier concluded that the unsafe execution of these techniques caused undue pain and discomfort to D149 and constituted unjustified, disproportionate force[537].

317. The negligent use of force practices cannot however be explained by mere incompetence. It occurred within the wider staff culture of callous indifference and causal violence towards detained persons. We see this for instance in Dave Webb's bragging to other officers about hurting D149, the day after the above restraint: "*I fucking hurt [...] Big time. When I put him in a straight hold [....]... the officer downstairs heard screaming.....if you're going to be a fucking dick, its gonna hurt in it*"[538]. Mr. Collier considered these comments to indicate that the infliction of pain by DCO Web was deliberate, not simply the offshoot of inexperience[539]. This punitive attitude towards C&R, under the guise of mere misunderstanding, is similarly reflected in the advice given by DCO Webb to Mr Tulley on using a shield against D1914: to "*hit the edge anywhere between the knee and the throat... just keep fucking going*" "*hit him with the big gun*" "*don't stop until he's got nowhere else to go*"[540]. As Mr Collier pointed out, this advice was entirely wrong in suggesting that the bottom edge of the shield should be used to target parts of the body, which ran contrary to its purpose as a protective, rather than offensive, tool[541]. The use of

[534] Jon Collier, 30 March 2022, 33/3-10; Jon Collier, first report §§83-96, INQ000111_0026-0028
[535] Jon Collier, first report, §66, INQ000111_0023
[536] Jon Collier, 30 March 2022, 43/23-25, 44/8-18
[537] Jon Collier, first report, §94, INQ000111_0028
[538] TRN0000088_0020[629-636]
[539] Jon Collier, 30 March 2022, 47/1-19
[540] CJS005979_0008
[541] Jon Collier first report: §116, INQ000111_0033

the shield in this way as a weapon would inhere a high risk of injury and amount to a pre-meditated and excessive use of force[542].

318. In his evidence, DCO Webb sought to chalk up his comments on the use of the shield to poor training and lack of knowledge[543]. The Inquiry is asked to reject outright his explanation. The language used by DCO Webb is clearly not just misplaced guidance: it is overtly provocative and extreme. It reinforces what the Inquiry has heard of the aggressive and prison-like use of PPE, with Mr Tulley confirming officers were taught to use the shield to "*subdue the detainee*" rather than for personal protection[544]. Whilst it is clear that DCOs were not sufficiently trained or confident in the use of force, they were all too alive to the pain and suffering caused to detained persons by their lack of technical ability. That their actions were not rectified, but rather flaunted to their colleagues as feats of macho cruelty is indicative of the wide-ranging and punitive effects of the use of C&R within the IRC setting. This was compounded by the fact that the DCMs and healthcare staff present, monitoring such incidents, did nothing to intervene or correct obvious instances of poor and dangerous applications of force[545], their inaction serving to perpetuate the normalisation of misuse of force and indifference to pain and suffering it caused.

**(c) <u>No regard to vulnerabilities in the use of force</u>**

319. Mr Collier links together two cases of particular concern, where force was used inappropriately against clearly unwell detained persons[546]. These concern the planned C&R interventions against D1914 and D2159. Both detained persons were highly vulnerable. D1914 suffered from a serious cardiac condition and was at high risk of self-harm. D2159, who was on constant watch for prolonged food refusal, required a protective move to E wing on account of serious concerns over his physical weakness. Despite their acute vulnerability and lack of resistance, both detained persons were subject to high-level planned C&R removals, involving teams deployed in full PPE with shields. Both were placed in arm locks and handcuffs, before being escorted under restraint to E wing, during which both detained persons struggled to walk and dropped their weight. Whilst not apprised of their clinical background, Mr Collier found that, even

[542] Jon Collier first report: §117, INQ000111_0033 ; see also Jon Collier, 30 March 2022, 123-124
[543] Dave Webb, 3 March 2022, 134-145
[544] Calumn Tulley, 2 December 2021, 61/18-22
[545] Jon Collier, 30 March 2022, 57/11-25, 58/1-9; 50/17-25, 51/1-3
[546] Jon Collier first report, §665, INQ000111_00158

from his non-clinical perspective, force in both cases was *prima facie* excessive and disproportionate[547]. Both detained persons were clearly unwell, and presented no level of threat or risk to others as to require restraint, let alone to the extent used.

320. In the case of D2159, who was food refusing and so weak he could barely stand, Mr Collier said this was a classic situation where any attempt to transfer him to E Wing for observations should have proceeded as a medical move given the concerns over his condition[548]. There was no need whatsoever to use force – and absolutely no need for the full riot gear by the officers – in the circumstances. This would have been abundantly apparent had the DCMs and healthcare bothered to carry out any proper assessment prior to the decision to use force for the relocation[549]. The footage is stark in showing the utter failure to contemplate de-escalation given the "very short" time between DCM Dix looking through the hatch and thereafter ordering the PPE team to enter, pinning D2159 with the shield[550]. No opportunity was permitted to sit down and engage with D2159, which was especially important given his unresponsive and very unwell state.

321. Mr. Collier considers these failings are reflected, with equal force, in the inappropriate restraint of D1914, who similarly presented with no risk or threat to others. D1914 lay half-naked, pleading: "*please please….I'm sick…I die, I die*"[551]. Stepping back, Mr Collier was clear that the incident was "*only about him feeling unwell at that time*"[552]. Officers should have, but did not, simply assisted him to move[553]. The recourse to, and escalation of, C&R measures was, in Mr Collier's view, entirely unjustified. Mr Collier's evidence on these two incidents corroborates that of Dr Bingham's, who considered that force in both cases was, and ought to have been raised by healthcare, as directly contra-indicated by the detained persons' serious clinical issues[554].

**(d) <u>Misuse of force against naked detained persons</u>**

[547] Jon Collier first report, §§120-124, INQ000111_0033; §133, INQ00111_0036; second report, §5, INQ000177_0005; §§2-5, INQ000177_0004
[548] Jon Collier, 30 March 2022, 112/23-25, 113/1-23
[549] Jon Collier, 30 March 2022, 117/4-12
[550] Jon Collier, 30 March 2022, 121/11-20
[551] Jon Collier, 30 March 2022, 126/1-9
[552] Jon Collier, 30 March 2022, 127/11-12
[553] Jon Collier, 30 March 2022, 127/12-20; 128/8-12
[554] Dr Bingham, §135-141, BHM000033_0051-0054

322. Another disturbing pattern that emerged from the evidence was the routine use of force against naked detained persons. The Inquiry has heard of various instances of prolonged and heavy-handed restraints being deployed against detained persons who were entirely or near naked throughout. Mr Collier raised serious concern over this wholly inappropriate practice and the *"unusually high"* number of such incidents within so short a space of time[555]. He roundly rejected insinuations from the Home Office that detained persons' naked state was a deliberate attempt to disrupt these interventions, attributing it rather to the circumstances of no-notice removals, in which many of these restraints took place, with detained persons being woken up, in the early hours of morning, and having little time to adjust before force was used against them[556].

323. The use of substantial or prolonged force against a detained person, whilst naked, is inherently humiliating and degrading[557]. In this vein, Mr Collier considered the C&R intervention against D2416 on 11 April 2017. He was restrained whilst naked, handcuffed, and escorted for handover to Tascor staff for a Charter Flight removal. D2146 was then left, still naked, in the presence of at least seven officers, for about 10 minutes whilst staff purportedly tried to find a sheet to cover him. Mr Collier criticised such treatment – of leaving a detained person, naked and shackled, for a lengthy period of time – as obviously unacceptable and degrading[558]. The ill-treatment was, in Mr Collier's view, compounded by the fact that the underlying restraint was itself disproportionate and unjustified. The Inquiry will recall that Mr Collier's view on the proportionality of the use of force in D2416's case changed after receiving BWF which firmly discredited the officers' accounts that force was used only after 'ample' attempts to persuade D2416 to comply had been made[559]. The footage exposed the multiple ways in which force was misused including an utter failure to attempt any de-escalation, with a window of a mere 26 seconds between the DCM entering the cell to inform D2146 of the removal and force being initiated[560]. Mr Collier called this a woeful failure to attempt

[555] Jon Collier, 30 March 2022, 61/1-19; Jon Collier, first report, §660, INQ000111_00157; second report, §14.4, INQ000158_0052 & §2.1, INQ000158_0039
[556] Jon Collier, 30 March 2022, 61/22-25, 62/1-8
[557] Jon Collier, 30 March 2022, 70/1-7
[558] Jon Collier third report, §36, INQ000177_0009
[559] Jon Collier third report, §34, INQ000177_0009 ; *cf* findings in first report: INQ000111_00102-103
[560] Jon Collier third report, §34, INQ000177_0009 ; *cf* findings in first report: INQ000111_00102-103

any verbal engagement with D2416 and expressed no doubt that force was not used as a last resort[561].

324. Many of the detained persons against whom force was used, whilst naked, were seriously mentally unwell. Mr Collier considered that where the detained person who is subjected to restraint whilst naked was mentally unwell or otherwise vulnerable, this is an additional factor which aggravates the nature and effects of such degrading treatment[562]. The intensely humiliating and grossly demeaning treatment of D1234 is such a case in point. D1234 was subject to a full C&R intervention on 28 March 2018 in order to effect his removal for a Charter Flight. He was plainly highly vulnerable, being held on E wing at the time on constant watch[563]. The Inquiry viewed the distressing footage of his restraint at the end of the First Phase of the hearings[564]. On entry of the C&R team, D1234 stripped naked and started chanting phrases such as *'Jesus' 'fire' 'I am here, I am power'*. He presented with obvious indicators of distress and mental illness, which ought to have prompted urgent clinical assessment. At the very least, his disturbed presentation should have been identified as a firm contra-indication to the use of force. Instead, and appallingly, the officers present attributed his acute distress to simply being 'refractory'[565] and to resistant behaviour. Likewise, the member of healthcare present, Nurse Sihali, failed to intervene or raise any clinical concerns, in clear dereliction of her safeguarding role[566]. In turn, D1234 was subjected to a lengthy and high-tariff restraint: he was restrained supine on the ground, before being handcuffed in an impermissible sitting position and thereafter transferred in a carry lift for handover to Tascor officers, at which point he was placed in both waist a restraint belt and leg restraints.[567]

325. Even without expertise or consideration of his mental health issues, Mr Collier found the use of force against D1234 to be obviously excessive and unjustified. He criticised the officers' extensive misapplication of C&R measures, which were executed unsafely and entirely contrary to UoF training. This included the excessive pushing down of D1234's head whilst restrained supine, which posed a risk of serious injury to the neck[568] and the

[561] Jon Collier, 30 March 2022, 67/10-25
[562] Jon Collier, 30 March 2022, 70/1-7
[563] HOM002750_0007[§6.2.1]
[564] Disk 23 S1940003; played in Inquiry on 10 December 2021, 175/16-20
[565] S Dix Incident report, 28/3/17: HOM002497_0002
[566] HOM002750_0008 [§6.2.10]; 0028[§6.17.1]
[567] Jon Collier, first report, §§134-135, INQ000111_0037
[568] Jon Collier, 30 March 2022, 49/19-25, 50/1-25; see also Jon Collier first report, §143, INQ000111_0039

handcuffing of D1234 whilst seated. The latter was a non-approved and highly unsafe technique which had been removed from the UoF training manual in 2015 given its risk of positional asphyxia[569]. Of equal concern for Mr Collier was the wholly inadequate execution of the carry lift of D1234, which he considered to be "*doomed to failure*" from the outset, with staff showing no knowledge of how to set up for or carry out such a lift[570]. The misuse of this technique compounded D1234's pain and anguish, having the effect of "*straightening (him) out rather than bending (him) forward*"[571]. His suffering was exacerbated further yet by the incorrect re-application of handcuffs, on arrival at the discharge area, fixing his wrist in a flexed position, which resulted in "*every movement…causing pain and potentially causing damage*"[572].

326. The pain and grave indignity caused to D1234 by this prolonged restraint, whilst naked, was aggravated by his treatment by the escort staff. On handover, he was placed in a WRB and leg-restraints, as well as a rigid-bar handcuff which was used to apply pain-compliance when he resisted transfer[573]. He was, it appears, at least still partially naked. The application of such extreme and high-tariff restraint measures by escort staff, to a detained person who was evidently unwell and in serious distress, would have only served to intensify his severe physical and mental suffering.

327. The restraint of D2054 on 28 June 2017 bears stark similarities to that of D1234. He was another seriously unwell detained person, who was subjected to a prolonged restraint, whilst naked, to further an attempted Charter Flight removal. D2054 suffered from serious mental health issues at the time and was awaiting an urgent mental health assessment[574]. He had in fact self-harmed earlier that morning, making lacerations on his arm with a razor blade, resulting in his being moved to E wing and placed on constant watch[575]. Similar to D1234, his known mental health issues and self-harming risk ought to have been identified by healthcare as a *prima-facie* contra-indication to the use of force. However, Chrissie Williams, the nurse who attended the C&R briefing, confirmed there were no clinical

[569] Jon Collier, 30 March 2022, 52/2-17; see also Jon Collier first report, §151, §166, INQ000111_0042; _0044
[570] Jon Collier, 30 March 2022, 55/1-25, 56/1-10; see also Jon Collier first report, §142, §152 INQ000111_0039; _0042
[571] Jon Collier, 30 March 2022,56/7-9
[572] Jon Collier first report, §144, INQ000111_0039
[573] Jon Collier first report, §147, INQ000111_0040
[574] HOM002389_0014
[575] CJS005991_0009 [§§6.2.2-3]

objections to the restraint[576], notwithstanding her knowing full well that there were serious concerns about D2054's vulnerabilities, having herself initiated the mental health referral[577] several days earlier. In her oral evidence to the Inquiry, she accepted that she ought to have raised clinical objections to the use of restraint, and could not explain why she had not[578]. Her omission was critical, and directly sanctioned the use of coercive measures against her patient, causing him deep humiliation and distress as is apparent from the transcript of the incident.[579]

328. The restraint of D2054 was extreme and degrading in both its nature and effects. D2054 was restrained in the supine position, whilst naked, continually shouting 'Jesus': the same, disturbed refrain used by D1234[580]. As Mr Collier notes, D2054 was then subjected to the same non-approved and dangerous practice of being handcuffed whilst seated[581]. He was then escorted under restraint to the discharge area for handover to the Tascor staff. He was still naked with only a towel covering his groin, during which time there was, as Mr Collier notes, a "*lengthy pause*" in the movement[582]. On his handover to the Tascor officers, still in handcuffs and arms holds, he can be heard on the footage crying out "*this is the end of my life*".

329. Mr Collier finds that, even from a non-clinical perspective, the continued restraint of D2054 in these circumstances was excessive. He plainly posed no risk to others[583]. More generally, when D2054's mental health issues were put to him, Mr Collier accepted that this would be a significant aggravating factor which, together with his undressed state, would make this treatment degrading[584]. By comparison, it is of particular concern that Ms Williams, the healthcare staff present to monitor this use of force, failed to intervene or raise any clinical concerns throughout. Again, Ms Williams was unable to provide an answer as to why she had not raised her concerns, accepting that she ought to have done and that the restraint was degrading[585]. She appeared entirely unaware of the extent to

[576] CJS005991_0009 [§6.2.4]; HOM002416_0003 – 22:19:36
[577] HOM002389_0014
[578] Chrissie Williams, 10 March 2022, 113/3-12
[579] HOM002416_0001-0006
[580] Jon Collier first report, §300, INQ000111_00111
[581] Jon Collier first report, §300, INQ000111_00111
[582] Jon Collier first report, §302, INQ000111_00111
[583] Jon Collier first report, §301, §311, §318: INQ000111_0076; _0078; _0079; Jon Collier second report, §1.4, INQ000158_0009
[584] Jon Collier, 30 March 2022, 69/20-25, 70/1-7
[585] Chrissie Williams, 10 March 2022, 114/1-25,

which she had neglected her safeguarding duty towards D2034, both prior to and throughout this restraint.

330. It must be appreciated that the use of C&R, of the type Collier considers, sits within a wider continuum of the misuse of force within Brook House. The use of segregation in itself is a restrictive intervention, as is the incidental use of force to effect removal, which was used as a routine and inappropriate contain mechanism to manage mentally unwell detained persons. The evidence of Dr Bingham and Dr Patterson as to this pattern of misuse, and its adverse effects on vulnerable detained persons, has already been rehearsed and is to be afforded significant weight by the Inquiry[586].

331. Another form of restrictive practice however, which has been afforded less attention by this Inquiry, is the use of passive restraints equipment by escort staff, including Waist Restraint Belt ("WRB") and leg restraints. The evidence available bears out a concerning pattern of the routine misuse of the WRB to facilitate the discharge of vulnerable detained persons to Tascor officers. The above cases of D1234 and D2054 are stark examples: both placed in WRBs whilst naked and presenting with obvious signs of acute distress. The mistreatment of D1473, a highly vulnerable detained person on an ACDT who was placed in a WRB within the context of an unlawful removal, is similarly familiar. There are however many other such examples of this misuse of WRBs on vulnerable detained persons, which are summarised in the UoF table annexed to Dr Bingham's statement[587]. These include the use of WRBs on various other detained persons whilst naked (D2416[588]), threatening self-harm (D31[589]) and on constant watch (D1914[590]). The indiscriminate use of passive and humiliating restraints in these circumstances, with no prior consideration of the risk and vulnerabilities of the person, reflected the general normalisation of the use of force in the centre. Officers did not appear to think twice about handing over highly distressed detained persons to escort staff for restraint in WRBs: this was an inevitable extension of the day-to-day coercive treatment of vulnerable detained persons through to the end point of removal.

[586] Dr. Rachel Bingham witness statement, §§153-166, BHM000033_0060-0066; Dr Brodie Paterson, §§71-88, BHM000045_0016-0019
[587] Dr Bingham, Annex 3 to witness statement, BHM000033_0185-0187
[588] CJS005630_0014.
[589] CJS005601_0008.
[590] CJS001064_0016-0017.

332. Unsurprisingly, concerns over the misuse of WRBs are again not new. In the 2014 report by the Independent Advisory Panel on Non-Compliance Management, commissioned to review the use of restraints in escorted removals following the death of Jimmy Mubenga, Mr Shaw found that the WRB should only be reserved for the "*most disruptive detainee*", where other forms of continued physical restraint were practically impossible or too dangerous[591]. He advised that considerable caution must be taken with its use, as its prolonged application could be inimical to the person's dignity and subject them to inhuman or degrading treatment[592]. HMIP also raised concerns in its 2016 report that all the footage it reviewed of scheduled removals showed that WRBs were not being used as a last resort[593]. No action was taken by the Home Office or its contractors to address or mitigate this practice by the point of the relevant period. No evidence is given that would assist the Inquiry to begin to understand the rationale, if any, of such inaction. It must be clearly understood that the application of WRBs in these circumstances, against mentally unwell detained persons, in itself constituted inhuman and degrading treatment, especially when deployed for prolonged periods. The end-point use of punitive restraint in this manner however also exacerbated the cumulative effects of the coercive mistreatment and suffering that such detained persons had endured whilst at Brook House.

**(8) UoF supervision, governance and oversight**

333. The overall quality of UoF governance was "*very poor*" and enabled the development of abusive attitudes, behaviours and persistent misuse of force[594] by custody officers. There were failings in the UoF governance framework at every level.

334. In Mr Collier's view, this started with the '*wholly inadequate*' management of UoF incidents by the DCMs acting as supervisors, who demonstrated a lack of basic knowledge on incident management[595]. This included, for instance, failures to ensure that PPE was only used in planned removals where absolutely necessary (and not as a routine part of the process), that de-escalation measures were properly attempted, and incorrect and unsafe C&R practices identified and corrected. Mr. Collier also criticised the

[591] Para 4.38, pg.44 of report, linked to Annex 3 (42) of Emma Ginn's witness statement BHM000041_0079
[592] Para 4.44, pg. 45, ibid.
[593] HMIP000613_0028 [§1.54]
[594] Jon Collier, 30 March 2022, 183/24; 184/6-13
[595] Jon Collier, 30 March 2022, 57/11-25, 58/1-18

inadequacy of the post-incident de-briefs, run by DCMs, which were superficial and failed to consider areas of poor practice and lessons learned[596].

335. Inadequate DCM supervision was compounded by the lack of senior management oversight[597]. The attendance of a member of the SMT at use of force incidents was a requirement under the PSO 1600 and would have, in Mr Collier's view, provided for more incident robust management[598] and *"a greater level of assurance"* for those involved[599]. The lack of visual leadership from the SMT lent itself, in Mr Collier's view, to an environment in which unprofessional behaviours and poor practices persisted unchallenged [600]. This is evidenced by the influence which various 'core' DCMs exerted over officers, who perpetuated macho attitudes which glorified violence and the suffering of detained persons. This is how abusive attitudes exhibited by DCMs such as Nathan Ring, who acted frequently as a Supervising Officer, as well as figures of perceived authority on C&R such as John Connolly, were cascaded down to officers and normalised as accepted practice.

336. A fundamental failure in the mechanisms for UoF oversight was the inadequate use of body worn footage ('BWF'). The use of BWF and/or handheld cameras is required for all planned or anticipated use of force per the applicable prison-service policy[601]. The importance of such footage is obvious, providing key contemporaneous evidence which acts as a vital check against the misuse of force. Put simply, Mr Collier explains, such footage provides *"far better evidence and enhances the review process"*[602]. Mr Collier criticises the prevailing 'culture' in Brook House of staff not activating BWF cameras when responding to use of force incidents,[603] underlined by the paucity of available footage in the incidents he reviewed, despite the presence of staff with cameras[604]. Again, Mr Collier attributes this omission primarily to the DCMs.

337. The critical importance of video evidence is illustrated by the stark mismatch, in various use of force incidents, between officers' written accounts and what was shown in the

[596] Jon Collier third report, §87, §§14-17, INQ000177_0017; _0005
[597] Jon Collier first report, §668, INQ000111_00159-160
[598] Jon Collier first report, §26, INQ000111_0013
[599] Jon Collier, 30 March 2022, 155/23-25, 156/1-20
[600] Jon Collier first report, §668, INQ000111_00159-160
[601] NOM000002_0023
[602] Jon Collier, 30 March 2022, 157/3-21
[603] Jon Collier, 30 March 2022, 157/3-21
[604] Jon Collier first report, §669, INQ000111_0160

footage. Mr Collier was compelled to revise his opinion in respect of several incidents after receiving the accompanying footage, which had not been previously made available to him at the time of writing his first report. One such case was that of D52. Mr Collier's initial conclusion, on the basis of the use of force documentation alone, was that the force used was reasonable and proportionate to the claimed threat that D52 posed[605]. On review of the missing footage, Mr Collier's opinion changed completely, with a conclusion that the force had not been used as a last resort and was unnecessary[606]. The footage showed that there was no reason to initiate force when the officers did as, contrary to the officers' accounts, the footage showed D52 was sitting down at the time and posed no threat. The claimed risk of harm was "*impossible to justify*"[607] and entirely insufficient attempts had been made to engage and negotiate with D52 first. Mr Collier accepted as concerning that he had only identified this misuse of force so late in the day, on receipt of this footage, without which he would have remained under the impression that the officers' actions were appropriate[608]. This serves to illustrate the extent to which the concerted practice amongst staff of not activating BWF was itself a powerful mechanism for cover-up and suppression.

338. Allied to the inadequate use of BWF was the poor report writing on use of force. Mr Collier concluded that the overall standard of report writing was poor, lacking detail on what happened and why, and with sections left blank.[609] This resonated with the evidence of Callum Tulley that officers were taught to use specific terminology when completing such forms in order to cosmeticise certain uses of force[610]. Taking this further still, many of the incident reports failed to accurately reflect what in fact had happened. This was an issue which, in the absence of an effective review process, only came to light through the course of this inquiry. Mr Collier recommended for far greater scrutiny in this area, with managers reviewing the reports and challenging the writers on any omissions or inaccuracies in order to allay the suspicion of wrongdoing[611].

[605] Jon Collier first report, §§367-369, INQ000111_0091
[606] Jon Collier third report, §20, INQ000177_0006-0007
[607] Jon Collier, 30 March 2022, 164/7-24
[608] Jon Collier, 30 March 2022, 165/3-6
[609] Jon Collier first report, §651, §25, INQ000111_0152; 0013
[610] Calumn Tulley, 29 November 2021, 49/21-25, 50/1-19
[611] Jon Collier, 30 March 2022, 172/9-20

339. The most profound failure in use of force governance was the complete inadequacy of the post-incident review process. The Inquiry has heard as to how this was a paper-based process, consisting merely of the completion of a tick-box form with generic questions which did not permit detailed review of the restraint, underlying material, or wider issues. There was no accompanying scrutiny meeting or multidisciplinary review: the use of force pro-forma was the sole and entirely unsatisfactory mechanism for scrutiny. Moreover, the significant majority of these reviews were undertaken by the same individual, DCM Steve Webb, who ended up reviewing several incidents in which he had in fact been the Supervising Officer. As criticised by Mr Collier, this was a clear conflict of interest that amounted to Mr. Webb "*reviewing his own homework*", and creating a system which "*lacks any credibility*[612].

340. This lack of independence is borne out by Mr. Webb's review of the restraint of D191 on 27 April 2017. Mr Webb was the Supervising Officer in the incident and applied a wrist flexion pain-inducing technique to D191 during his removal to CSU[613]. Mr. Collier found the continued use of this pain-based measure was disproportionate, given D191's suspected vulnerability from spice,[614] whereas Mr. Webb's own review asserted that the restraint was appropriate, identifying no concerns or areas for learning[615]. The failings in this and so other many other incidents were patently clear on the footage: calling into question whether Mr. Webb had in fact reviewed this footage or, as Mr Collier suggests, his understanding of basic use of force[616].

341. This flawed review process failed entirely to root out the poor and harmful use of force practices which were so prevalent at the time. Unsurprisingly, of the numerous incidents that Mr Webb reviewed in this period, he concluded that nearly every use of force was justified and did not require further investigation. Nor did Mr Webb identify any additional training needs, or suggested improvements, in the reviews Mr Collier considered despite, as he observes, the myriad issues of training and competence which it didn't take an 'expert' eye to identify[617]. Mr Collier expressed shock that, for example, Mr. Webb could identify no concerns or training needs arising from the restraint of D149

[612] Jon Collier, 30 March 2022, 177/22-25, 178/1-4
[613] CJS005549_0009
[614] Jon Collier first report: §§187-190, INQ000111_0048
[615] Jon Collier first report: §§171-172, INQ000111_0046
[616] Jon Collier, 30 March 2022, 176/14-25, 177/1
[617] Jon Collier, 30 March 2022, 178/21-25, 179/1-2

(discussed above), despite the persistent misapplication of C&R measures, including prolonged prone restraint, and high levels of staff incompetence. The significant delay between use of force incidents and these reviews, often three months, further increased the risk of bad practices being repeated with increasingly severe consequences[618]. The serious systemic failure in this review process, which was intended to act as the ultimate check against abuse, compounded the effects of the subsidiary failings in supervision and scrutiny. Incompetent and harmful C&R practices, ineffective management, poor record-keeping, the absence of BWF: none of these were identified or addressed, facilitating the conditions in which misconduct could prevail and be perpetuated. The complete absence of input or scrutiny from the Home Office in respect of use of force oversight served to further aggravate these failings: the evidence provided to Verita confirmed that use of force committee meetings, which were due to happen on a weekly basis, had not taken place regularly since 2016[619]. The Home Office was recklessly indifferent to the fundamental absence of any framework for use of force governance within its centre and to the routine misuse of force which this perpetuated on the ground, pursuant to its own deeply flawed C&R model.

342. These chronic failings in use of force oversight centrally contributed to the climate of impunity at Brook House, which perpetuated and normalised the abusive misuse of force. In the absence of any working system of scrutiny, a culture of silence and complicity thrived, in which staff not only failed to report or challenge wrongdoing but actively encouraged it. As Mr Collier notes, the fact that such misconduct was only identified through covert camera footage is indicative of the extent to which this suppressive climate took root[620]. This climate was reinforced by acts of concerted cover-ups in use of force interventions. The extent of the collusion over the non-reporting of the assault on D1527 is stark and well-known. It is overwhelmingly clear that this was a collective and deliberate cover-up: Yan Pashcali's evidence to this Inquiry that his directive to the other staff - "*no use of force as it stands*" - meant simply that they were too busy complete the report at the time is frankly insulting[621]. So too was Paschali's claim that Mr Tulley had deliberately destroyed his use of force report for the purpose of making good tv.[622]

[618] Jon Collier, 30 March 2022, 180/10-24
[619] Draft Verita report (October 2018): CJS0073709_0207 [§§12.69-12.71]
[620] Jon Collier first report, §670, INQ000111_0160
[621] Ionanis Paschali, 24 February 2022, 148/8-23
[622] Ionanis Paschali, 24 February 2022, 153/1-25, 154/1-4

Even aside from any authoritarian hold Yan Pashcali had, it was the individual responsibility of each and every officer to submit a report. Their collusive failure to do so, reinforced by the complete absence of effective oversight mechanisms, allowed the serious mistreatment of D1527 to remain concealed up until the airing of Panorama.

343. The recently disclosed footage of the restraint of D52 is another stark example of the extent of such cover-ups. The lens of the BWF camera remained obscured throughout the initial restraint[623]. The Inquiry saw this for themselves, of a hand coming over the lens as soon as the restraint starts, and remaining there throughout, during which we hear the detained person screaming[624]. The lens was only uncovered when D52 was on the floor, under control, with hand-cuffs being applied. After excluding all other possible hypotheses, Mr Collier came to the only conclusion he could arrive at, that someone had deliberately covered the camera[625] to obstruct the processes of use of force transparency. This was, in his words, *'massively'* concerning.[626] This left a crucial gap in the evidence, with the footage concerning the application of the pain-inducing measure obscured and thereby not susceptible to scrutiny. The incident echoes the chilling exhortation of John Connolly to "scrub" the footage of the planned assault of D275: a highly vulnerable detained person in crisis on the suicide netting[627].

344. These actions concerning the restraint of D52 point to a cavalier confidence by those responsible that they will not be held to account – that the oversight mechanisms expressly designed to root out such misconduct would fail entirely, notwithstanding that the cover-up ought to have been obvious on any cursory review of the footage. This prediction of course was precisely correct. The serious systemic deficits in the use of force monitoring and governance framework enabled such abusive practices to persist entirely without sanction.

[623] Jon Collier third report: §85, INQ00177_0016
[624] Jon Collier, 30 March 2022, 165/7-25
[625] Jon Collier, 30 March 2022, 166/2-12
[626] Jon Collier, 30 March 2022, 166/14-19
[627] John Connolly, 2 March 2022, 193/1-11; 197/5-15 ; KENCOV1019: V2017051700016 - Clip 2 (TRN0000085_0054).

## VIII. Suppression of Dissent

345. The corrupted and toxic staff culture which developed at Brook House did not allow for dissent, whether it be interventions in attempted cover ups of excessive use of force or disciplinary action for verbal abuse or acts of derogatory and abusive language, behaviour or attitudes toward detained people and racism. It was suppressed through bullying, ostracism, marginalisation and intimidation. This along with complicity and acquiescence of so many other officers led to a culture of impunity.

### (1) Ineffective and unsympathetic G4S leadership

346. None of the G4S officers who gave evidence to this Inquiry professed to have any confidence or trust in the 'Speak Out' whistleblowing process. Mr Tulley confirmed in his oral evidence that staff were not made aware of the whistleblowing hotline in initial training, and he had in fact only came to know about it inadvertently, much later on in his time at the centre[628].

347. The Inquiry has heard, for instance, of the 'Speak Out' posters defaced with threats to those who used it such as *'snitches'* and *"don't be a rat"*[629]. Owen Syred spoke of his experience of facing a campaign of harassment and abuse from his colleagues after he reported the racist language used by DCO Gurney[630]. It had a chilling effect: officers who witnessed the way he was targeted were in turn unwilling to challenge inappropriate conduct directed at him, fearful of facing the same consequences. Therefore, when Mr Syred witnessed Derek Murphy, a *"dominant DCO"* [631] punch a detained person square in the face, he did nothing. Mr Syred explained to the Inquiry that *"if I'd have reported that... you know for a fact I'm going to get ostracised"*[632].

348. There was a similar reluctance to raise concerns directly with senior management staff, who were perceived as either colluding or at least indifferent and unwilling to address issues of staff misconduct. Many officers saw the managers as close to and protective of the 'core' cliques of officers against whom concerns were raised[633] and indifferent even

[628] Callum Tulley, 29 November 2021, 79/1-4; 80/5-7
[629] Callum Tulley, 29 November 2021, 79/16-19
[630] Owen Syred, 7 December 2021, 116/21-25, 117-118, 121/2-11; Owen Syred first witness statement, §§125-128, INN00007_0030-21
[631] Owen Syred, 7 December 2021, 126/10-14;
[632] Ibid
[633] Shayne Munroe first witness statement, §16, §§71-73, INN000013_0006; _0022-23; Nathan Ward first witness statement: §168, DL0000141_0059

when the concerns raised were of the most serious nature. In the case of Owen Syred, where concerns raised were of racism of the most extreme order, no action was taken at all against DCO Gurney nor support provided in respect of the subsequent abuse Mr Syred endured which he reported directly to Ben Saunders, the Centre Director[634].

349. Mr Syred's experiences were a snapshot of the absence of effective leadership from G4S' senior management team ("SMT") which permitted and reinforced this climate of impunity. The Inquiry has heard considerable evidence of the chaotic and fractious dynamics amongst the SMT. Lee Hanford likened the 'toxic' dynamics to a soap opera, plagued by grievances and infighting[635]. Both Steve Skitt[636] and Lee Hanford[637] said they had never seen such a high level of inter-staff grievances before in their respectively long-standing careers. The perception of the SMT as low-trust and disaffected was inevitably "*dispersed across the centre*"[638], contributing to a fundamental erosion of trust and confidence in the management team. This was compounded by the physical absence of SMT members from the wing floor, with many officers speaking of how managers remained sequestered in their officers, rarely getting involved in daily operational issues.[639] This style of distanced and dysfunctional management created a fundamental void in leadership which, as Professor Bosworth explains, enabled the "*aggressive, authoritarian*" attitudes of core DCMs/DCOs to take hold and permeate the staff culture[640].

350. It was not however through mere ineptitude of leadership alone that the SMT sanctioned abusive staff practices. The evidence before this Inquiry is clear that members of the SMT had known from at least 2014 onwards that there was a corrosive and bullying culture amongst the staff. The recurrent pattern of complaints raised by those such as Owen Syred, Nathan Ward, Stacie Dean and Michelle Brown made this clear, however no action was taken. The SMT was equally on notice, from these reports, of officers' abusive treatment of detained persons and yet did nothing. This included the entirely unheeded allegations raised by Stacie Dean, as early as 2015, that Luke Instone-Brewer

[634] Owen Syred, 7 December 2021, 116/5-8, 117/2-6, 120/22-25, 121/1-25
[635] Lee Hanford, 15 March 2022, 70/1-25, 71/1-20
[636] Steve Skitt first witness statement, §38, SER000455_011
[637] Lee Hanford, 15 March 2022, 71/13-16
[638] Lee Hanford, 15 March 2022, 73/1
[639] Shayne Munroe first witness statement, §15, INN000013_0005
[640] Professor Bosworth, first report: §6.5, INQ000064_0032

and Babatunde Fagbo were deliberately goading and targeting a detained person[641]. The persistent inaction of the management staff in the face of such complaints indicates that they were, at best, recklessly indifferent to the abuse playing out before them, and at worst actively complicit. That various SMT members such as Juls Williams were seen to adopt, and perpetuate, the same macho attitudes as officers, and to openly humiliate those who were not seen to 'man-up' to these values, strongly reinforces the notion of complicity[642]. So too does the evidence of the punitive approaches taken towards certain officers who sought to speak up over staff misconduct[643]. These attitudes, coupled with the complete deficit in leadership, gave further protection to the coercive practices that predominated.

**(2) Operational Failings in Home Office Oversight**

351. This closed rank G4S culture did not however develop in a silo. The Home Office, as the state body with executive authority over immigration removal centres and with non-delegable duties to ensure that the systems in place in IRCs protected detained persons from the known risk of misuse of power and abuse in custodial settings is ultimately responsible for the oversight, management and operation of Brook House. That duty was only intensified by the previous abuse scandals in IRCs, such as Yarl's Wood and Oakington[644], and in the context of immigration removals[645], where misuse of force was a recurring theme and strong recommendations had already been made about the need for robust oversight and governance of institutional practice and culture.

352. The Home Office staff on site had direct and daily exposure to the Brook House regime, with access to all areas of the centre. They had a critical role in the authorisations of the use of force and segregation, monitored the terms of contractual compliance including use of force and had involvement in all key custodial processes such as ACDT and rule 40/42 segregation reviews. It is simply not plausible that these Home Office staff members, such as Paul Gasson and Ian Castle, were not aware of any of the *prima facie*

[641] CJS0073677_0001-2; CJS0073633_0004
[642] Ed Fiddy, 7 March 2022, 154/3-25, 155/1-16, 157/4-13
[643] Calumn Tulley, 30 November 2021, 5-7: concerning a DCO who raised complaints to the SMT over DCM Purnell stealing detainees' money – in response she was taken off her DCO duties and re-assigned to menial tasks usually given to an ACO.
[644] See witness statement of Emma Ginn, §§95-100, §§120-122, BHM000041_0034-36; _0043-44;
[645] See witness statement of Emma Ginn, §§105-110, BHM000041_0037-40

indicators of abuse and the harmful staff culture, particularly given the commonplace and causal use of abusive language about and towards detained persons.

353. The punitive contractual focus of the Home Office, based on maximising enforcement of removals at the expense of detained person welfare, played out in its operational presence at the centre. The narrowed remit of their contract monitoring role which, as accepted in the evidence to Verita, paid no practical consideration to wider concerns of detained person welfare, informed a general disinterest and indifference as to how detained persons were viewed or treated by staff.[646]

354. The structure for contractual scrutiny, which was reliant on G4S self-reporting breaches, further compounded this lack of will to pro-actively supervise what was happening on the ground. This reflected the fact that it was of no institutional benefit to the Home Office to look too closely at the conditions within its centre, which was designed solely for the purpose of "*warehousing*" detained persons pending removal. Home Office operational staff, for example, did nothing to ensure scrutiny of use of force, which was within their contractual remit, and shockingly allowed UoF meetings to lapse from 2016 onwards.[647] Similarly, the Home Office operational staff failed entirely to interrogate the fact that no performance points were self-reported by G4S at all with respect to self-harm incidents which failed to follow G4S prescribed procedures, during the relevant period, despite the high level of self-harming throughout these months[648]. This stark anomaly failed to provoke any concern or inquiry on the part of the Home Office staff, with Mr Gasson admitting they would not go beyond the absence of non-reporting of contractual breaches to pro-actively check if there had in fact been a breach[649].

355. Home Office operational staff were not given any leadership or instructions from ministers or the senior civil servants responsible for the system in place and for overseeing IRC operations across the detention estate to look beyond these narrow contractual considerations. Accordingly, they adopted a crudely functional approach to their role in Brook House which placed little value on the care and protection of detained

[646] Verita report: CJS005923_0241-243
[647] Draft Verita report (October 2018): CJS0073709_0207 [§§12.69-12.71]
[648] Ian Castle, 15 March 2022, 22-24
[649] Paul Gasson, 15 March 2022, 1601-62

persons and directly exhorted G4S staff to do the same[650]. When information was self-reported to the Home Office operational staff at Brook House, no basic analysis was applied to consider the significance of the information or lack thereof. For instance, despite operational staff being on notice over low staffing levels which fell below the contractually-specified minimum level, nothing was done to address this or ascertain further information as to the cause for this[651]. This was notwithstanding that Mr Gasson accepted, blankly and unapologetically, in his oral evidence that staffing provision below contractual levels would have inevitably affected detained person welfare.[652]

356. It is plainly clear that the reckless indifference of Home Office staff to the practices and conduct of G4S officers directly permitted the conditions for a culture of impunity to predominate, even in light of the well-known and recurrent pattern of previous abuse scandals in immigration removal centres.

**(3) Failure of Detained person Complaints Processes**

357. Against this backdrop, there was also no effective recourse for detained people to be able to effectively complain about their treatment. As the Inquiry well knows, the complaints process is a critical safeguard against abuse, as well as an important means by which the state discharges its systemic and investigative obligations under Article 3 ECHR. However, the evidence before this Inquiry demonstrates the comprehensive failure of the complaints process, on all levels, to identify and root out abuse, and prevent its recurrence. Indeed, this process is similarly infected by the culture of disbelief and impunity that pervades and reinforces other aspects of the IRC system.

358. In 2016 HMIP found that, even where complaint forms and boxes were prominent, not all detained persons knew that forms were available in different languages[653] and 24% of detained persons said it was difficult or very difficult to get a complaint form.[654] Even after the relevant period, the situation was no better. The 2019 HMIP report found that 58% of detained persons still didn't know how to complain.[655]

[650] This is reflected for instance in Lee Hanford's evidence that Home Office staff directly criticised some G4S staff for "*showing too much empathy*" to detainees: VER000266_0022; Lee Hanford, 15 March 2022, 88/12-25, 89/1-10
[651] Ian Castle, 15 March 2022, 9-14; Paul Gasson, 15 March 2022, 165-172
[652] Paul Gasson, 15 March 2022, 169/1-6; Ian Castle, 15 March 2022, 9-14
[653] HMIP 2016 report CQC000022 [not adduced, but report also referred to by CTI as HMIP000613 at 137/10]Hindpal Singh-Bhui 24 March 2022 137/10]
[654] Ibid
[655] HMIP 2019 report C00000025_0083 [not adduced on BHI website]

359. An obvious initial barrier is that detained people are not properly informed about it. The experience of our formerly detained clients plainly demonstrates this. D1713, for instance, said that when he was subjected to abusive and dehumanising language by an officer, he "*did not know who to report the incident to or how to make a complaint*"[656]. When he asked his roommate how to complain, he was told "*there was no system of oversight at Brook House and no safe space in which to report a member of staff who had crossed the line*"[657]. D2158 similarly states: "*No one ever told me that a complaints system existed or how to access it*"[658]. The evidence of D801[659] and D1473[660] is to similar effect. Our clients also speak to their lack of any informed awareness of what the PSU was or its role.[661] Their experiences reflect that of the general detained population at Brook House at the time.[662]

360. Even where detained persons knew how to complain, the culture of fear and disempowerment was so pervasive, and its effects so chilling, that many detained persons did not complain. D1713 speaks of his fear of reprisal in making a complaint in the following terms: [663]

> "*I did not know who to complain to and I was scared that officers may target me if I did complain and that I may be taken to the block... We were all scared of the consequences of speaking out in that environment. We were living in fear. Brook House was like hell. I also did not think that anyone would listen to me if I reported these incidents or that anything would change because they happened so often and so many officers were involved.*"

361. Detained persons' fear and distrust in the complaints process is an issue endemic to the immigration detention estate. In their 2014 report 'Biased and Unjust: The Immigration Detention Complaints Process' Medical Justice provided numerous examples from their casework of complaints about staff not being made by detained persons for fear it would

[656] Witness statement of D1713, §34, BHM000018_0009
[657] Witness statement of D1713, §40, BHM000018_0012
[658] Witness statement of D2158, §38, BHM000029.
[659] Witness statement of D801, §60, BHM000034.
[660] Witness statement of D1473, §43, BHM000039.
[661] Witness statement of D1713, §45, BHM000018_0013 & D801, §60, BHM000034
[662] See for example, D2077 witness statement, §158: DL0000226_0039 & D313 §83, DL0000233_0018
[663] Witness statement of D1713, §40, BHM000018_0012; see also D2158, §38, BHM000029.

mark them out for mistreatment "*I feared making any complaints, or voicing anything against the guards and other detention staff because it was for my benefit to lie low and not seen as a trouble maker… I was made to feel like they can stamp on me or spit at me, and had no option than to submit to anything they subjected me to*".[664] For many detained persons, this fear is compounded by a sense of hopelessness, powerlessness and inertia: that complaining will make no difference, so why risk the consequences. The HMIP's 2018 report still found nearly half of detained persons said they didn't have confidence in the complaints system.[665]

362. An allied concern that prevented detained persons complaining was the perception that it would affect their immigration case. In speaking of the barriers that detained persons faced to complaining, Mr Hindpal Singh-Bhui, the HMIP lead for immigration detention, said that his "*major concern*" was that detained persons were "*worried that if they say anything, then it will affect their case in some way*".[666] This is a significant point specific to the context of immigration detention. A prisoner detained pursuant to a lawful court order or sentence faces little risk that the complaint will have any bearing over the length of the complainant's detention. But in the context of immigration detention, where the decision-making is concentrated in a state body whose powers are administrative and does not require external scrutiny or authorisation, this perceived risk of punishment arising from a complaint is real and enduring.

363. Added to this is their mistrust of the system of complaint, where ultimately the complaint is escalated to the Professional Standards Unit, which is an arm of the Home Office and is not institutionally independent nor even functionally so, since it operates from the same building. PSU witnesses of course have sought to persuade the Inquiry that the unit is independent of the decision-makers and custodial officers who are the subject of the complaints. Their evidence is blind to the reality of the underlying power dynamic between the Home Office and detained people, and how their association as an arm of the Home Office compromises the trust that detained people may have in the system and the perception that a PSU investigation may result in punitive action against the detained person. Moreover, in the absence of clear and sufficient assurance, it is hardly surprising that detained persons will be deterred from complaining for fear of reprisal.

[664] Emma Ginn witness statement, §117, BHM000041_0042-43
[665] CQC000025_0016-17 [not adduced on BHI website]
[666] Hindpal Singh-Bhui, 24 March 2022, 146/5-15

364. Even when detained people did make complaints, the evidence before the Inquiry shows that multiple systemic failings in the complaints system make it wholly ineffective as a safeguard against abuse and mistreatment across the detention centre.

365. The complaints policy limits the PSU to investigating individual serious misconduct complaints.[667] This means that the PSU cannot consider the extent to which a complaint may support wider trends or patterns of systemic concern. For instance, whilst the PSU is able to investigate an individual allegation of racism, it is precluded from considering how this sits within, or corroborates, evidence of institutional racism. This differs markedly to other systems of institutional scrutiny such as, for instance, the police, who can be investigated for institutional or systemic failings by the Independent Office for Police Conduct (IOPC) by way of the 'super-complaint' system which can be instigated by charities / NGOs. In evidence, Mr Mohammed Khan (the current Head of PSU Operations) stated that it would be helpful for the PSU to have a similar super-complaint function and that it would fit well with their role.[668] There is similarly no information-sharing process between the PSU and other oversight organisations. HMIP does not, for instance, ask for complaint information from the PSU to feed into the systemic analysis within its own investigations.[669] This means that, in the absence of there being any system for PSU to analyse systemic issues, the patterns and trends emerging from the complaints made is not picked up and analysed via an alternative means so that remedial action, if necessary, can be recommended and acted upon.

366. Even in respect of individual complaints, it is clear that PSU investigators are not looking at broader patterns of officer misconduct. There is no requirement for investigators to consider whether an officer has been complained about for similar issues in the past, even though Mr Khan accepted there was merit in doing so[670]. Even Phil Riley was surprised that PSU did not have access to that type of information, or analyse it. [671] No rationale was offered or attempted for why the PSU were not doing this. In similar vein, PSU investigators were often not equipped with highly relevant information about officers

[667] Mark Hartley-King first witness statement, §36, HOM0331946_0016
[668] Mohammed Khan 24 March 2022 13/6-11
[669] Mohammed Khan 24 March 2022 51/9
[670] Mohammed Khan 24 March 2022 8/5-11 ; Helen Wilkinson 24 March 2022 66/21
[671] Philip Riley 4 April 2022 157/3-23

when making their findings. For instance, Ms Wilkinson, a PSU investigator, was not aware that DCO Fagbo had been dismissed for verbal abuse towards a detained person when deciding D687's complaint of the same, notwithstanding that she accepted that that was important to know and would have impacted on her decision.[672]

367. Moreover, there is clear evidence that the PSU investigations were ineffective and operated with institutional bias towards the Home Office and G4S in its method of investigations. The Inquiry has heard evidence of the PSU inappropriately deferring to G4S or immigration officers during the course of investigations, including that:

    a. PSU investigators gave inappropriate levels of information to witnesses;[673]
    b. PSU investigators interviewed two people at once creating risk of contaminated evidence;[674]
    c. PSU investigators used G4S to take statements for their investigation;[675]
    d. PSU investigators showed G4S complaint reports prior to them being issued.[676]

    These were all serious procedural flaws undermining the integrity and fairness of PSU's investigatory processes.

368. The PSU's investigatory methods and practices prejudiced detained persons in more implicit ways as well. For example, when investigating allegations of racism, the Inquiry heard evidence of investigators asking for witness accounts from staff (who inevitably supported their colleagues), but did not ask for witness accounts from other detained people (who might have supported the allegation)[677]. The Inquiry also heard that investigators were applying too high an evidential bar to corroborate a detained person's account, wanting CCTV evidence to make out allegations of verbal abuse (despite the absence of audio) and requiring dates and times of incidents with officers before their account could be believed.[678] It was accepted by Ms Helen Wilkinson that she should

[672] Helen Wilkinson 24 March 2022 83-84
[673] Mohammed Khan 24 March 2022 31/20-21
[674] Mohammed Khan 24 March 2022 32/17-19
[675] Mohammed Khan 24 March 2022 43/22
[676] Mohammed Khan 24 March 2022 21/22
[677] Helen Wilkinson 24 March 2022 77/6-25
[678] Helen Wilkinson 24 March 2022 88/12-25

have taken a wider approach when investigating verbal or racist abuse, rather than applying these narrow methods and high evidential bars.[679]

369. The prejudicial treatment of detained person's complaints is clear for instance from the PSU investigation into the mistreatment of D1527 whose complaints which were not captured on Panorama were rejected as unsubstantiated, in the absence of independent corroboration. This is indicative of the general approach where the word of the detained person alone has little if any value or weight.

370. There was a reciprocal failure by the PSU to apply anxious scrutiny to officers' accounts. When it was put to Ms Wilkinson that it was plainly incredible that none of the officers she interviewed had heard or seen any verbal or racist abuse of thee type alleged by detained persons, she simply said she could only go off the 'information available'.[680] The complete absence of organisational curiosity or concern on the part of the PSU towards entrenched patterns of officer misconduct is deeply troubling. This is especially so given the clear evidence before the PSU that G4S was not acting transparently in their dealings with them: failing to refer complaints promptly [681] or sometimes at all, on the basis that G4S had already decided for itself that the allegation was unsubstantiated[682]. Whilst Mr Khan accepted this was wrong[683], it does not appear this provoked any concern that the complaints which made their way to the PSU were only the tip of the iceberg.

In these circumstances, it is unsurprising that detained persons nurture a perception that the PSU is not independent from the Home Office. These concerns are sustained on a structural level as well. Whilst Mr Khan insisted that there is no conflict of interest within the PSU, it remains the case that the PSU and Detention Services both report to the Home Secretary.[684] Even in investigations where Article 2 and 3 ECHR is engaged, requiring an independent investigation,[685] the position of the PSU appears to be that this is all about perception and that in reality there is no difference between an independent investigation and a PSU investigation.[686] Irrespective of the merits of this view, it is clear from the evidence that detained persons do not agree that PSU was capable of fairly and

[679] Helen Wilkinson 24 March 2022 80/24
[680] Helen Wilkinson 24 March 2022 83-84
[681] Mohammed Khan 24 March 2022 27/1-4
[682] Mohammed Khan 24 March 2022 26/13
[683] Ibid
[684] Mohammed Khan 24 March 2022 3/15
[685] VER000031
[686] Mohammed Khan 24 March 2022 5/3-5

independently considering their complaints. It is the fact and force of that perception alone which is important. Detained persons do not know the arrangements and policies in place which the PSU relies on to assert independence. They only know that the Home Office is investigating their own, or their contractors', misconduct. Or worse, if the PSU considers it 'minor' the contractors are investigating themselves. For example, in D1473's case, his allegation of prima facie assault, by prolonged and unlawful application of a WRB, was initially categorised by the PSU as 'minor misconduct' and referred back to its contractor for investigator. Even after the PSU finally agreed to investigate it, it failed to recognise or address his serious allegation through the prism of Article 3 ECHR mistreatment. This is notwithstanding the findings of Mr Shaw in the 2014 report prepared by the Independent Advisory Panel on Non-compliance Management that the prolonged use of the WRB may in and of itself constitute inhuman or degrading treatment[687].

371. This lack of a robust complaints system contributed to the overall failure of the Home Office and its contractors to identify mistreatment or poor practice or indeed to learn from mistakes. These problems with the PSU are not new. Concerns over the process were raised repeatedly by the Complaints Audit Committee until it was disbanded in 2008[688], by the detailed research of Medical Justice in 2014[689], and by both the IMB and the HMIP who have, over the years, raised particular concerns about the lack of quality and impartiality of investigations.[690] The failure by the Home Office to address these issues facilitated and perpetuated a wholly defective system which lacks robust scrutiny or transparency. The deterrents to access to this process, coupled with its structural inadequacy, results in system which fails to identify abuse and prevent its re-occurrence, directly facilitating the conditions in which the culture of impunity prevailed.

**(4) Limits to effective external oversight**

[687] Emma Ginn first witness statement, §108, BHM000041_0039 and link to report at Annex 3 (42) BHM000041_0079

[688] When it assessed 83% of complaints investigations as inadequate: see Emma Ginn witness statement, §114, BHM000041_0041

[689] *Biased and Unjust: The Immigration Detention Complaints Process;* at Exhibit EG9 of Emma Ginn's witness statement [BHM000043, not yet fully adduced], see also a summary of this report found at Annex 2 to Emma Ginn's witness statement, BHM000041_0074; see also first witness statement of Emma Ginn, §§111-119, BHM000041_0041-43

[690] The HMIP noted in their 2019 report that only 1 out of 95 complaints had been upheld that and that there were clear examples of complaints not being upheld "*which should have been*": CQC000025_0006

372. Robust systems of transparency, scrutiny and oversight are essential in closed institutions like Brook House. Independent bodies such as HMIP and IMB play an important role in shining a light into these closed institutions. The Inquiry has heard various examples of good practice from both organisations. However, the Inquiry is also asked to note that the culture of abuse and mistreatment at Brook House during the relevant period did remain hidden from the scrutiny and knowledge of both HMIP and IMB.

373. To that extent, both organisations failed at a primary level. It is of course necessary to place this in context of limitations that both oversight bodies face in their role as external monitoring mechanisms. IMB and HMIP are necessarily limited in their roles and resources. Their internal structures and practices were not, at the relevant time, sufficiently robust to identify the range of complex and intersecting problems at Brook House IRC. They also lacked any enforcement powers that could compel change. Despite these known limits that both external bodies work within, the Home Office has tried to shift their oversight and governance responsibilities on to these bodies, whilst at the same time persistently ignoring their recommendations.

**(a) <u>IMB</u>**

374. Ms Jackie Colbran, Chair of the IMB during the relevant period, accepted in evidence that the IMB had got it completely wrong in November 2016: the IMB's view at that time was that Brook House was a "*well run establishment*" with "*a remarkable attitude of care to the detained persons from the staff*".[691] The difference between the IMB's view of Brook House during November 2016 and as at the relevant period, and the actual reality of on the ground, is stark. It follows that there were obvious failures in the IMB's monitoring of Brook House during the relevant period.

375. The structural limitations of the IMB played a part in this. Firstly, the number of IMB visits at Brook House was capped during the relevant period by the National Council according to the funding available. Brook House was only afforded 193 visits in 2017. This cap had a very real impact: for example, despite IMB volunteers being required by the IMB handbook and Detention Centre Rules to visit a detained person held under Rule 40 within 24 hours, that simply was not possible as there were not enough allotted visits

[691] HMIP000148_0002; Jackie Colbran, 25 March 2022, 34/4

to do so.[692] In addition to the constraints of funding, there are also limitations associated with the IMB's structure as a volunteer-led organisation requiring daily on-site presence. On a practical basis it is not an easy task: volunteers go to Brook House in their own time, with the IMB only covering travel expenses. The time that volunteers can devote to the task is therefore inherently limited. Further, Mr Hindpal Singh Bhui noted in his evidence that it is a very difficult task for volunteers, often with no requisite experience and no training in issues specific to the IRC context, to be remain alert to and scrutinising of problems that arise, such that there is a real risk of "*not seeing what's in front of you sometimes*".[693] In this context, volunteers struggle to maintain a critical mind and appropriate distance from the organisation being monitored.

376. In addition to those structural limitations of the IMB, the Inquiry has heard evidence that that the Board's practices also contributed to the systemic failures in oversight. For instance, the IMB was not effectively reaching detained people in Brook House during the relevant period. Our clients' evidence, and that of other detained people, was that IMB wasn't sufficiently visible in Brook House. D1473 stated that at The Verne he saw IMB volunteers regularly, but never did at Brook House.[694] Ms Mary Molyneux accepted in evidence that the IMB must do more to make detained people aware of the IMB.[695] The lack of awareness was evident from the low numbers of applications to the IMB from detained people: in 2017 there were only 123 applications, which amounted to about one application every three days. That was plainly not representative of the level of issues that detained people had at the time, as accepted by Ms Molyneux in evidence.[696] Part of the problem was with the IMB's application forms which were, and are still, in English only[697] and require people to write in English, which the IMB accepts is itself a fundamental barrier.[698] Part of the problem was also with G4S, who persistently failed to put enough application forms on the wing, which the IMB said was a "*constant problem*".[699]

[692] Jackie Colbran, 25 March 2022, 68/3
[693] Hindpal Singh Bhui, 24 March 2022, 140/25
[694] Witness statement of D1473, §44, BHM000039_0009
[695] Mary Molyneux, 25 March 2022, 118/14-15
[696] Mary Molyneux 25 March 2022 117/12
[697] Mary Molyneux 25 March 2022 110/16
[698] Mary Molyneux, 25 March 2022, 111/21
[699] Mary Molyneux ,25 March 2022, 112/20

377. The Inquiry has also heard how the IMB were broadly alive some of the issues at Brook House during the relevant period, but did not get to the heart of the problems. The IMB's understanding of how Rule 35 was functioning at that time is an example of this. The Board noted in 2016 that Rule 35(1) and (2) reports were not being produced. Whilst the IMB requested a full breakdown of how many Rule 35(1), (2) and (3) reports were being prepared, they did not push for this when the information was not forthcoming from the Home Office, which Ms Colbran accepted she should have done. This meant that she was not aware that no Rule 35(2) reports ever had been completed. Similarly, whilst the IMB noted the low numbers of Rule 35(1) and (2) reports in their 2016 report, they failed to mention it again or follow this up in their 2017 report.[700] The IMB also noted that G4S were relying on Part C's, but it did not occur to Ms Molyneux for example that Part C's were being used instead of, not in addition to, Rule 35 reports. This demonstrates that whilst the IMB was aware that Rule 35 was not working properly, it didn't push hard enough or probe sufficiently to uncover the scope of the dysfunction.

378. One of the more concerning aspects of the evidence heard by the Inquiry is the extent to which the IMB participated and fed into the staff culture at Brook House during the relevant period. Professor Bosworth noted that on occasion the IMB used the same language as that adopted by G4S staff, casting detained people as miscreants[701] and to some extent contributing to the 'prisonisation' of Brook House by doing so. Professor Bosworth considered that this may have arisen due to IMB Chairs often having prison backgrounds. In this context, Mr Bhui considered that such a shared culture arises due to difficulties volunteers face in maintaining a sense of independence. It was his view that this placed the IMB at risk of over-empathising with the establishment[702]. These concerns were also raised in the Verita report, which noted the sense of collegiality between the IMB and G4S staff and a tendency on the part of the IMB members to over-empathise with the G4S management team and the Home Office, rather than to hold them to account and press them on their plans for action to address concerns and make improvements at Brook House. In this regard, Ms Molyneux accepted that the IMB was too affected by managers' criticism of GDWG[703]: in fact, it is evident that the Board actively engaged with some of the Home Office's and G4S's unfounded criticisms of GDWG, failing to

[700] Jackie Colbran, 25 March 2022, 58/9
[701] Professor Bosworth, 29 March 2022, 137/5-12
[702] Hindpal Singh Bhui, 24 March 2022, 141/2-17
[703] First witness statement of Mary Molyneux, §126, IMB000203_0044

maintain their organisational independence in that respect. The closeness between the IMB and Home Office and G4S is exemplified by the email that Ms Colbran sent to Mr Bhui, HMIP, in 2016[704] in which she disagreed with HMIP's rating of Brook House as 'reasonably good' and appeared to be asking HMIP to give the centre a higher score. Ms Molyneux accepted in evidence that that this had been inappropriate overreach of the IMB remit. Due to these factors, it is perhaps not surprising that Professor Bosworth's conclusion is the IMB were not sufficiently independent during the relevant period.[705]

379. The IMB has plainly reflected on the various aspects of poor practice demonstrated during the relevant period and sought to strengthen its oversight and monitoring mechanisms of the Home Office and its contractors. For example, the Board now monitors use of force more closely and analytically than during the relevant period (albeit Ms Molyneux noted that IMB still required more guidance on what the IMB can monitor in that regard[706]). Moreover, since Panorama, it is clear that the Board has become more emboldened and focussed in their remit, making clearer, stronger criticisms of the Home Office. The compelling findings of its 2020 report is indicative of this, which found that the circumstances in the centre amounted to inhumane treatment of the entire population.

**(b) HMIP**

380. The structure and arrangements of the HMIP also limits how effectively it can oversee and monitor Brook House. Unlike the IMB, HMIP reports are ultimately only a snapshot of a particular IRC at a given time. HMIP cannot systematically monitor how an IRC and the applicable safeguards generally operate over time.

381. The nature of HMIP inspections in itself poses problems. Once an IRC is on notice of a scheduled inspection, staff often undertake significant work to improve the centre. Mr Bhui said in evidence that he expected this, and takes into account the improvements which have plainly only recently been made, like wet paint on the walls. HMIP can only judge the centre on what it sees during that inspection and try their best to guard against being misled by an incomplete or cosmeticised picture of how things are. Ultimately, that is a challenging exercise: Mr Bhui accepted that it was therefore difficult to uncover behaviour that is being deliberately concealed within the short inspection windows

[704] HMIP000148
[705] Professor Bosworth, 29 March 2022, 138/10
[706] Mary Molyneux, 25 March 2022, 115/10-17

afforded to the Inspectorate.[707] Moreover, the demands on HMIP's role means that, between inspections, very little is done by way of monitoring. In fact, monitoring is minimal and if intelligence is received between inspections HMIP would only hold it on file, or in the case of more serious intelligence. decide to have an inspection earlier than planned.[708] This means that HMIP by its structural and operational nature cannot respond quickly or with agility to new issues that arise (like, for example, concerns raised by doctors about use of restraint during medical treatment[709]), nor are they able easily to plug the gaps in their knowledge and data-set between their inspections to draw out emerging patterns of concern or changes thereto. Instead, the HMIP is focused on their short, scheduled 'deep dives', a methodology which of course can only ever reveal a snapshot in time. It is for this reason that HMIP cannot comment in detail on the conditions in 2017: there was no scheduled inspection in this period, therefore critical information was simply not captured.

382. The structure of HMIP's inspections also means that they are reliant on detained people or other organisations to provide them with accurate information. However, despite their reliance on sources, HMIP does not have strong systems in place to seek out and gather such information. For example, the only information that is provided to the HMIP by the Home Office with regularity is the number of self-inflicted deaths or incidents of concerted disorder in an establishment. They might receive informal information from NGOs, but during the relevant period it was not structured or solicited. Further, even where the PSU made findings of serious misconduct, HMIP would not be, and are still not, informed, despite Mr Bhui accepting in evidence that that would be sensible and helpful.[710] In this context, HMIP was and is still not equipped with the necessary intelligence in advance of their inspections to roubstly scrutinise the situation on the ground.

383. The Inquiry has seen that the methodology employed by HMIP during inspections was problematic. By its nature and limitations, HMIP is focussed on the general, at times to the detriment of the specific. Ms Deborah Coles of INQUEST stated in her evidence that their concern about the HMIP has always been that their focus on generalised issues was

[707] Hindpal Singh Bhui, 24 March 2022, 119/18-23
[708] Hindpal Singh Bhui, 24 March 2022, 120/18
[709] HMIP000658_0001; see also Hindpal Singh Bhui, 24 March 2022, 127/6-23
[710] Hindpal Singh Bhui, 24 March 2022, 124/20-25

at the expense of identifying patterns or trends arising from individual cases and therefore *"it is not clear how they would ever identify a potential breach of the ECHR"* , such that if they encountered "*evidence of an immediate or recent breach of Article 3 ECHR, there is nothing that I am aware of in their methodology that would ensure that this was reported to an independent body, in line with international standards*".[711] The difficulties of focusing on the general was demonstrated in HMIP's approach to detained person's comments on healthcare. HMIP's 'triangulation' method meant that feedback from detained people was often treated as 'individual comments', as it couldn't be evidenced by three sources to support a finding. This meant that those comments were not fed into in HMIP reports. Mr Bhui was taken to two examples where detained people told HMIP that the quality of healthcare was poor, healthcare staff in Brook House were rude and abrupt, and that healthcare staff said they were faking it when they attempted suicide: those comments were not included in HMIP's report, despite the fact that, when taken together, they suggest seriously concerning patterns of staff misconduct[712]. Mr Bhui acknowledged that HMIP had not been adequately reporting detained people's feedback in the healthcare context, which prevented HMIP putting together a fuller picture of what was happening at Brook House, and that they now intend to include detained persons' feedback more fully in their reports.

384. In fact, HMIP was compelled to overhaul its methodology post-*Panorama* given that the methodologies it was employing at the time were not robust enough to uncover the abuses taking place at Brook House during its inspections. HMIP's 'enhanced methodology' now provides for various improvements to its information-gathering processes, including offering a confidential interview to every detained person and the introduction of staff interviews, to gain a more in depth understanding of staff culture and practices.

385. The evidence heard by this Inquiry has highlighted HMIP's blind spots in a number of thematic areas, most concerningly in respect of Rule 35. In HMIP's 2016[713] inspection of Brook House there was no critique at all of healthcare's failure to issue Rule 35(1) or (2) reports. HMIP did not notice that this was happening, and only became aware of the complete lack of Rule 35(2) reports in their 2019 report when they started to hone in on

[711] INQ000037_0063-0064
[712] Hindpal Singh Bhui, 24 March 2022, 159-160
[713] CQC000022 but also referred to by CTI as HMIP000613, as explained above.

the discrepancy between the large numbers of detained people on constant watch and the corresponding absence of any Rule 35(2) reports.[714] Even in their 2019 report, however, HMIP did not pick up on the lack of Rule 35(1) reports. This was an omission and oversight by HMIP. However, it was not isolated. HMIP also failed to identify the pattern of excessive and inappropriate use of force at Brook House: their 2016 report found that in "*most cases force was used proportionately and as a last resort*"[715]. This stands in stark contrast to the findings of Mr Collier, whose key thematic concerns included the failure to use force as a last resort, the lack of de-escalation attempts, and the application of poor and excessive restraint practices including against vulnerable detained persons.[716] In a similar vein, HMIP found that reviews of use of force were effective, whilst Mr Collier found that they were entirely inadequate, constituting a mere tick box exercise. The only justification Mr Bhui could offer for this serious discrepancy was that practice may have deteriorated since HMIP left in 2016,[717] which, given the evidence before this Inquiry as to the entrenched issues at the centre, is simply not likely. The stronger and more likely hypothesis is that, like with Rule 35, HMIP simply missed this red flag. In fact, HMIP only came to learn of certain key information concerning the systemic practices at Brook House in the Second Phase of these Inquiry hearings, including the lack of any provision for independent advocates for detained people lacking mental capacity[718].

386. Even when the IMB and HMIP are at their most effective and perceptive, they are fundamentally hampered by their lack of enforcement powers. We have seen time and time again that the Home Office simply ignores the recommendations made by these bodies. The Home Office has failed entirely to responded to the IMB's improved scrutiny and critical focus by being more proactive in turn: instead, it continues to obfuscate and ignore the IMB's urgent concerns and recommendations. Similarly, with HMIP, we have seen it raise serious concerns with the Home Office over the impact of the IRC conditions and regime on the welfare of detained persons, including keeping detained persons locked in their cell overnight. Yet the Home Office did nothing about it: in fact their

[714] Hindpal Singh Bhui 24 March 2022 165/23-25
[715] CQC000022_0025
[716] IN0000111
[717] Hindpal Singh Bhui 24 March 2022 135/22-25
[718] Hindpal Singh Bhui 24 March 2022 190/8

response was, in the view of the HMIP, "*deeply unimpressive*".[719] Similar to the IMB, HMIP has no power to compel the Home Office to change.

387. In light of the clear limitations of these oversight bodies, it is plainly incumbent on the Home Office to apply and practice proper oversight and scrutiny of its own detention estate and contractors. Yet, perversely, we have seen that rather than IMB and HMIP reports prompting the Home Office to investigate further and take action to address concerns, reports have instead been relied on by the Home Office to justify their own inaction, in an indirect attempt to outsource its monitoring functions to these external bodies. Various Home Office witnesses suggested that HMIP's 2016 report essentially provided a 'clean bill of health' to Brook House[720]. In response Mr Bhui said that the Home Office had "*seriously misconstrued what's in the reports*".[721] Ms Molyneux also expressed her surprise at the extent to which the Home Office seemed to rely on IMB to monitor their own contract, explaining "*They have compliance teams. That is what compliance should be doing. We don't even see the contract.*"[722] She was emphatic that the Home Office "*should not be putting -- that much reliance on what IMB or HMIP does.. that is not our role, to do that*".[723]

388. None of the oversight organisations – PSU, IMB or HMIP – joined up the dots, or established effective, collaborative investigatory processes that operated to uncover the culture of abuse at Brook House in the relevant period. Each organisation failed in its own way, and also collectively. However, given the inherent limitations in monitoring organisations, it is both absurd and insulting that the Home Office seek to rely on their reports to justify their own inaction and to persistently refuse to act on recommendations made by these bodies. It was the Home Office that was apprised of the relevant information, practices, and conditions which fostered the culture of abuse at Brook House, and the Home Office who allowed this to continue unchallenged.

[719] Hindpal Singh Bhui 24 March 2022 175/4
[720] Hindpal Singh Bhui 24 March 2022 207/20-25
[721] Hindpal Singh Bhui 24 March 2022 208/10.
[722] Mary Molyneux 25 March 2022 1172/2-6.
[723] Mary Molyneux 25 March 2022 1172/16-18.

## IX. Alternative theories and Responsibility for Abuse and Mistreatment

389. On the evidence received from the Inquiry, it is simply impossible not to find that the whole centre was subject to a system that exposed the detained population to high risks of inhuman and degrading treatment during the relevant period.

390. Five years on, it is surprising – and indeed shocking – that senior officials in both the Home Office and G4S continue to attempt damage limitation by reducing the abhorrent behaviour captured on Panorama to *"isolated"* incidents as the fault of a few who chose to conduct themselves as they did, and not a product of the fundamental flaws in the system at Brook House and in Home Office policy. [724] That narrative is unsustainable and the Inquiry should categorically reject it. Whilst the Terms of Reference define the "relevant period" as between April and August 2017, the evidence is not constrained by these artificially drawn parameters. As Mr. Tulley himself said, in his oral evidence on 30 November 2021:[725]

> *A. I suppose the reason why the inquiry are interested in the relevant period, April to August -- ... is because of my filming, but to me it's the years and months before that were just as relevant if not more relevant, because at least I was able to capture some of the abuse during – between March and – between April and August. You know, to be honest, it's not the things I saw whilst secretly filming under cover which trouble me most, because at least I filmed it so the world can see it. But it's the stuff that I witnessed before I started waring secret cameras ... those officers have gotten away with it and it seems G4Sand the Home Office are only being held accountable for the months of April to August, and I hope that's not going to be the case because the abuse was not exclusive to those months.*

391. The fact that Callum Tulley was able to record in some detail incidents of excessive use of force or the casual and normalised use of derogatory, violent and racist language and attitudes amongst custodial staff does not in fact support the narrative of blame on a few bad apples or even a rotten barrel sub-culture. As Mr. Collier pointed out, the footage that Mr. Tulley was able to capture is itself evidence of a wider culture of suppression of

[724] Gordon Brockington 31 March 2022, 25/13; Jerry Petherick 21 March 2022, 8/24-25; Ben Saunders 22 March 2022, 133/22; Peter Neden 22 March 2022, 67/16-18; Home Office closing submissions, 6 April 2022, 64/11-14; G4S closing submissions, 6 April 2022, 74/12-19.
[725] Callum Tulley 30 November 2021, 50/20-25 to 51/1-13.

the true extent of the way in which mistreatment and abuse was inflicted upon detained people in a routine and normalised way. For example, but for the undercover footage, it would have been impossible to uncover the true scale and nature of the assault and abuse of D1527. The silent complicity of officers and nursing staff who did not raise concerns about his strangulation or threats to kill by Yan Paschali, captured on film, provide concrete evidence of the pervasiveness of this toxic and corrupted culture was at Brook House and how it is allowed to happen again and again.

392. The number of occasions that Mr. Collier reversed his view about the justification of force between his first report and his oral evidence from reasonable to excessive and unjustified, once body worn camera footage was made available, rather demonstrates that so much of the truth of what happen to detained people was hidden in the dark until and unless an Inquiry of this scale, and the teams of lawyers representing the Inquiry and individual Core Participants actively pursued disclosure of the footage and testimony; documentary evidence alone, certainly, could not begin to provide an accurate and truthful picture of the recurrence of incidents of mistreatment and abuse of detained people. The suppression of the truth continued even after the Inquiry started hearing evidence in November 2020, more than three years after the BBC Panorama Programme broadcasted. Body worn camera footage was being disclosed even in the very last week of the evidence phase at the end of March 2022, with no real explanation for the delay. Mr. Collier considered it very likely that what has been made available remains the tip of the iceberg.[726]

393. Dr Hard's views on the arrangement and operation of statutory safeguards in immigration detention also fundamentally shifted over time from his first report to his oral evidence, having heard the evidence from the range of healthcare witnesses. Whereas in his first report, Dr. Hard considered, on a documentary review of Rule 35 reports and some video footage that policies and procedures were being adhered to by healthcare staff[727], after listening to the oral evidence of the healthcare witnesses, including the GPs, Dr Hard gave his damning indictment that not only were the policies and procedures not properly followed (e.g. the failure to raise Rules 35(1) and (2) reports and the failure to asses impact of detention in Rule 35(3) reports) but the entire system was dysfunctional[728] This

[726] Jon Collier, 30 March 2022, 138/14-24.
[727] Dr Hard 1st Report, dated November 2021, §6.1.1, INQ000075_0152-0154.
[728] Dr Jake Hard 28 March 2022, 72/17-19.

was because in every way, the statutory safeguards intended to identify vulnerable people so that they can be removed from detention failed to function properly or at all: (a) rule 34 compliant examination cannot be done at the outset because the arrangements did not make this possible; (b) there were significant delays to access to a Rule 35 assessment; (c) Rule 35 reports were not being used effectively or at all; (d) Part Cs were wrongly substituting out the statutory safeguard; (e) ACDT measures were completely disconnected from and did not prompt Rule 35 reports; (and (f) food and fluid refusal did not lead to recognition of a need for safeguarding of the detained person and consideration of a Rule 35 report.[729] Dr. Hard agreed that the evidence he heard and read exposed an approach of "satisfactory management" of mentally ill detained people contrary to good psychiatric care because it appeared to give "permission to continue detention indeterminately"[730]. As Dr. Hard put it, the safeguards *"went off down their own cul-de-sac"* and *"weren't connected back to those underlying safeguarding principles embodied within r34 / 35 and there needs to be a connection between all of those things."*[731]

394. The evidence from the PSU, HMIP and IMB only confirmed that to date and until the evidence phase of this Inquiry commenced in November 2021, no one was connecting the dots between incidents, complaints, reports, and concerns (expressed by detained people, their lawyers and NGOs) to see that there was an ever pervasive pattern of recurring overreach of power, callous difference toward the welfare of detained people, and a system deprived of functional safeguards, both by design and in its operation. Certainly, despite reports by HMIP and IMB of aspects of defects in the operation of Rule 35 safeguards and the management of vulnerable detained persons, neither oversight body had investigated or identified the fundamental underlying reasons for those problems and many more that were repeatedly recorded by Medical Justice, the Royal College of Psychiatrists and others over more than a decade but never properly investigated and scrutinised by either oversight body. The need for HMIP to revise its methodology of inspection evidences the inadequacy of the framework it adopted to fulfil its statutory remit before 2017. IMB's revised approach to oversight led to the uncovering in 2020 of similar patterns of failures of policy and safeguards across the spectrum from

[729] Dr Jake Hard 28 March 2022, 69/3-19.
[730] Dr Jake Hard 28 March 2022, 44/21-25 to 45/1-8.
[731] Dr Jake Hard 28 March 2022, 69/ 23-25 to 70/1-2.

statutory Rules 34 / 35 mechanisms failing to identify and prompt the removal of vulnerable people from detention to the use of ACDT, segregation and force to manage distress, self-harm and suicidal ideation and attempts.

395. There is a suggestion made by the HMIP in closing submissions[732] that staffing levels during the relevant period as compared to when it inspected Brook House in November 2016 may explain why abuse and mistreatment occurred in Brook House. We assume that HMIP does not consider this to be the only factor contributing to mistreatment as that would oversimplify matters, and also ignore the clear evidence from other witnesses that mistreatment and abuse were not confined to the relevant period. This is clear from Callum Tulley's evidence; the overwhelming body of evidence that has been heard and seen by the Inquiry about a pervasive culture of desensitisation and dehumanisation that permitted and encouraged the use of physical force on detained people as a first resort and the routine use segregation to contain distressing mental health behaviours reveal long-standing issues which both G4S and the Home Office knew and ought to have known about. For HMIP to take this position speaks more to the oversight body's failure, still, to reflect on the adequacy of its methodology for inspection and the true causes of the mistreatment. Contrast that with the closing submissions of the IMB, which acknowledged that understaffing was a contributory factor[733], but described the causes of the mistreatment and abuse as stemming from systemic institutional and cultural problems.[734]

396. Understaffing cannot be the only explanation for the mistreatment in the face of the evidence before the Inquiry pointing to other more fundamental causal factors. None of the officers who had been dismissed for their role in the abuse and mistreatment of detained people sought to explain their conduct by reference only to understaffing. DCM Nathan Ring, DCO Yan Paschali and DCO Derek Murphy all told the Inquiry that understaffing and under resourcing was a constant feature of Brook House throughout the entire period of their employment, which commenced several years before the relevant period.[735] Mr. Tulley told the Inquiry that understaffing was even worse outside

[732] HMIP closing submissions, 6 April 2022, 18/21/25.
[733] Jackie Colbran 25 March 2022 50/5-12.
[734] IMB closing submissions, 6 April 2022, 37/6-10.
[735] Nathan Ring 25 February 2022, 9/6-12; Yan Paschali 24 February 2022, 33/4-8; Derek Murphy 2 March 2022, 12/13-22.

the relevant period.[736] Gordon Brockington declined to comment on the causes of mistreatment captured on BBC Panorama but went on to say that abusive behaviour had nothing to do with staffing levels.[737] Moreover, the HMIP's explanation does not address how three years after the Panorama programme aired, and after changes to the contract brought up staffing levels at Brook House, the IMB could still have found that the whole detained person population was subject to inhumane treatment in the latter months of 2020. The IMB drew the link between the inhumane treatment and the circumstances in Brook House relating to the Dublin Charter flight programme, and how the numbers of highly vulnerable detained people who were entered into the IRC for removal and were exposed to the harmful effects of detention, made the centre unsafe.[738] Whilst Stephen Hewer of Serco put emphasis on improving staffing levels as a means of ensuring improvements in detained person welfare, he went on to say that Home Office policy was also a key factor outside of Serco's control.[739] Thus, the connection between Home Office responsibility and the safety of the arrangements and operation of the centre is one which simply cannot be ignored. The correlation between systemic failures in detention policy and safeguards to prevent prolonged detention and the detention of vulnerable people is at the core of the causes for the mistreatment and abuse during the relevant period. The answer does not lie in more detention staff including welfare officers but in ensuring, as Mr. Shaw identified in 2016, large scale reduction in the numbers of people, particular those who are vulnerable to harm in detention, and in the length of detention.

397. Similarly, whilst it is clear that training of healthcare and custodial staff was woefully inadequate and that significantly impaired the staff's ability to understand and distinguish between distressed behaviour arising from the exacerbation of mental illness in detention and refractory behaviour, the totality of the evidence before the Inquiry shows that the culture of disbelief, desensitisation and dehumanisation was so ingrained that training alone cannot fix it.[740] Dr. Paterson stressed[741], and Mr, Collier agreed[742], that a fundamental change in C&R techniques – not just better training - is long overdue given it is not appropriate or safe to be deployed in an immigration detention environment

[736] Callum Tulley 9 March 2022, 150/8-14.
[737] Gordon Brockington 31 March 2022, 22/5-8.
[738] IMB report 2020, IMB000202_0005-0006.
[739] Steve Hewer 1 April 2022, 120/8-12.
[740] Professor Mary Bosworth 29 March 2022, 25/24-25.
[741] BHM000045_0033-34 [138].
[742] INQ000158 §§30.2-30.3; Jon Collier, 30 March 2022, 148/1-21.

against a population of detained people who present with high prevalence of mental illness, vulnerabilities and histories of torture and trauma. Moreover, better trained officers and health care staff will not render detention a suitable environment for vulnerable detained persons, or equip them with the means to address their needs because that is simply impossible within the detained environment. This is because the detention environment is inherently harmful to detained persons who have pre-existing mental disorders, past histories of torture and trauma, self-harm and suicidal ideation, as is clear from the evidence set out above from Professor Bosworth (in Mr. Shaw 1st Report), Dr. Bingham and Professor Katona. Better training must be focused on identification of vulnerability so that referral and reports can be made be made to secure prompt review and release from detention, but if the safeguards are not arranged structurally in a way that makes identification possible, better training is not going to be bridge the gap. The Inquiry is therefore urged to make plain that improved staff levels and training are not for the purpose of better management of people whilst detained but to strengthen the safeguards that prevent detention of those who are unsuitable for it and at risk of harm, if detention continues.

398. In any event both G4S and PPG told the Inquiry that it was and continues to be challenging to obtain the necessary materials and deliver training on the detention safeguards. G4S told the inquiry that the problems were not new, are long-standing and are widespread across the detention estate.[743] PPG pointed to factors which are *"out of its control"* including the physical capacity of the centre, and the policies and procedures developed and owned by the Home Office.[744] Sandra Calver, still the Head of Healthcare at Brook House, told the Inquiry that the Home Office needs to explain to its contractors what it is that they want from the statutory safeguards intended to protect vulnerable people from harm in detention.[745]

399. Even Mr. Cheeseman, who was the senior civil servant responsible for the Home Office's AAR policy accepted that training or redesigning Rule 35 forms and documentation would not, on its own, remedy the deficiencies in the Rule 35 safeguard.[746] After all, Mr. Cheeseman accepted in oral evidence that there were fundamental structural problems

[743] G4S closing submissions, 6 April 2022, 85/14-19.
[744] PPG closing submissions, 6 April 2022, 59/7-13.
[745] Sandra Calver 1 March 2022 211-19-25 to 212/2.
[746] Ian Cheeseman 16 March 2022, 164/6-11.

with the way the AAR policy was designed, including the significant dilution of the strong protections against the detention of vulnerable people by downgrading categories of harm to indicators of risk that would not, if present, be sufficient to mandate a person's release save in very exceptional circumstances, imposing on detained people the burden of evidential proof of likely harm, the retention of an approach of satisfactory management of the mentally ill, and recalibrating the exercise of the discretionary power to detain to focus not on safeguarding but on the priority of immigration enforcement and removal.

400. The Inquiry should also reject the suggestion that abuse and mistreatment happened because of the high numbers of Time-Served Foreign National Offenders ("TSFNOs") being held at Brook House during the relevant period, which created and aggravated the spice pandemic in the centre. This alternative theory attempts (wrongly) to somehow apportion blame for the mistreatment of detained people on their past history of criminal offending or the offending history of others, when it is abundantly clear from the video footage of assaults against detained people such as D687, D1527, and D1914, the fact of their being TSFNOs simply cannot explain the unlawful use of force including pain-inducing techniques, abusive language, threats to kill or callous indifference to the mental health crises they were suffering, In D1275's case, his vulnerabilities, especially to be exploited as a guinea pig for spice, were known to officers but no action was taken to stop the exploitation; his past offending – most likely arising from his undiagnosed severe mental ill-health – had nothing to do with this and could not possibly be said to be a precipitating factor for the derogatory and racist language used against him by Derek Murphy or Nathan Ring. The proponents of this theory – Lee Hanford, Jerry Petherick, Peter Neden, Steve Skitt, and Sarah Newland – are the same senior management staff at G4S who were rarely present at Brook House, perpetuated chaotic and fractious dynamics of in-fighting within the SMT, suppressed and disregarded incidents of racism and physical aggression toward detained persons, and failed to put in place any training or processes capable of providing some direction to custody staff on the safe management of self-harm, suicidal ideation and mental illnesses amongst detained people.

401. As Professor Katona pointed out, clinical research show that ex-prisoners are a particularly vulnerable group with higher levels of mental illnesses and unmet needs than

other detained persons. [747] Clinical research showed that rates of self-harm and suicidality amongst TSFNOs is a serious cause for concern; clinical literature shows that they account for 20% of self-inflicted deaths in prisons in England and Wales in 2015 / 2016 despite representing only 12% of the prison population. [748] They therefore require enhanced and specialist service provision within detention which was simply not available to them at Brook House (or across the detention estate).[749] Ms. Calver confirmed that it is not always the case that the use of spice created mental health crises; rather, in the absence of appropriate mental health treatment in detention, spice was used in the form of self-medication, in ways that created acute medical emergencies and worsened the detained people's health.[750]

402. In Mr. Shaw's second review, which was carried out in 2016 and 2017 and published in 2018, he identified concerns with the treatment of TSFNOs under the AAR policy as it applied to Brook House and across the detention estate. Despite their being "very vulnerable with complex needs", Mr. Shaw noted that their vulnerabilities were not being given sufficient weight owing to Home Office case workers being "risk averse. [751] Of the seven cases in which the Courts have found the treatment during detention constituted inhuman and degrading treatment in breach of Article 3 ECHR, four were TSFNOs with convictions for serious criminal offences, and who suffered inhuman and degrading treatment, by reason of their prolonged detention, the absence of treatment options in detention and the default use of force and segregation to manage them.

403. Try as the Home Office may, but their corporate knowledge of widespread and persistent dysfunction and failings in the system is undeniable.

    a. The Home Office has known for many years the critical importance of pre-detention screening and of the Rule 34 / 35 safeguard and the systemic failure in this process. This was apparent from the court cases dating back to 2006 and coronial jury findings on these failures. Mr. Shaw also told them so in his first report. So did the HMIP and the IMB. This was also apparent from the Home Office's own statistics

[747] Professor Katona witness statement, §115, BHM000030_0050.
[748] Professor Katona witness statement, §116, BHM000030_0050.
[749] Professor Katona witness statement, §115, BHM000030_0050.
[750] Sandra Calver 1 March 2022, 183/8-13.
[751] Professor Katona witness statement, §116, BHM000030_0050.

on Rule 35 reports and release rates. Yet both Sandra Calver and Dr. Oozeerally told the Inquiry that the HO had never raised any concerns with them about the rarity of a R35(1) report or the absence of any R35(2) reports. These failures of safeguards – which have persisted for many years - cannot be solved by the sending of a lame letter – presumably to all detention centres – on 1 April 2022 – to highlight the importance of rules whose purpose and application are not properly understood by healthcare and in any event not properly resourced or prioritised to be efficacious. That letter – purely an information only directive – does nothing to address the fundamental gaps in the system identified by Medical Justice, Dr. Hard and Sandra Calver.

b. The HO had been told no less than 7 times that indeterminate detention of a mentally ill person, the infliction of segregation and use of force, and the failure to provide adequate psychiatric treatment, amounted to inhuman and degrading treatment in breach of Article 3 ECHR. The Inquiry knows all too well what Mr. Shaw told them - that "satisfactory management" of mental illness was contrary to good medical practice and an "affront to civilised values", Yet Mr. Cheeseman had to accept that although the phrase was itself removed from the AAR policy, it was retained in the policy structure and its operation in substance. What does it tell you about a state authority who is told a policy is an affront to civilised values but carries on with the policy anyway, and in fact makes it more far-reaching in application?

c. Mr. Shaw in his January 2016 report also warned that the levels of self-harm was a *"critical indicator of the health of an institution and the welfare of detained population."* The 2016 HMIP report on Brook House recorded high numbers of detained persons feeling suicidal and staff failing to identify trigger points for self-harm and failing to have any effective arrangements to monitor vulnerability over time. Yet nothing was done to stop the use of blunt risk management tools on the most vulnerable of immigration detained persons, and no steps were taken to interrogate the efficacy of statutory safeguards such as the Rule 35(1) and Rule 35(2). It was again a critical feature of the inhumane environment at Brook House documented by the IMB in its 2020 Report[752]

[752] IMB000202_10-11.

d. Baroness O'Loan, commissioned by the Home Office to investigate abuse by its contractors highlighted in the 2008 Medical Justice report, *Outsourcing Abuse*, reported to the Home Office in 2010 that there was "*inadequate management of the use of force by the private sector companies*", which resulted in "*failures properly to account for the use of force by recording fully the circumstances and justification for the use of force*". In response, Lin Homer, the Chief Executive of the UKBA at the time, pledged her commitment on behalf of the Home Office, "*to ensure we maintain robust systems of accountability to ensure that we root out any individual whose behaviour falls below the high standards we should rightly demand in this sensitive area. The public deserve nothing less.*" Yet a year later, in his Independent Advisory Panel report into death of Jimmy Mubenga,[753] Mr. Shaw identified that not only were DCOs not being trained in safer techniques of restraint, there was also a culture among DCOs where detained persons were not treated as individuals and their rights and dignities were not being respected (§3.4, p1111). He recommended a values-based practice: "*It is necessary for such a culture to exist amongst DCOs as a prerequisite for ensuring that the decisions they take in respect of individual detainees are informed both by the facts of the situation and by the correct values*" (§3.5, p1111). None of the Home Office witnesses could provide any assistance to the Inquiry on what had been done if at all.

e. Mr Collier's evidence was that the very techniques involving handcuffing in a seated position identified as dangerous in the Mubenga case were still being used on D1234 in 2017 as seen in the footage and overseen by Steve Dix who is now one of a number of officers still in post and like him even promoted.

f. The HO had been warned of the inherent risks in the use of coercive power of detention and removal breeding racism and a toxic culture. Mr. Shaw found in 2005 a "a subculture of abusive comments, casual racism and contempt for decent values". The Coronial report on Jimmy Mubenga's death found that the material found on private mobile phones of two DCOs was racist (§39) and that there was evidence of "more pervasive racism within G4S" (§§43-44). In 2015, Channel 4

[753] Emma Ginn statement BHM000041 (§§108(d)-(e); Exhibit to EG, BHM000043_1085.

undercover reporting captured detained women being called "animals" "beasties" and "bitches" by custody officers. Each scandal ends with a review of sorts which identifies urgent and necessary changes to institutional culture but the reoccurrence of racism – this time at Brook House – exposes the pervasiveness of institutional racism, not confined to specific IRCs, specific contractors, specific officers.

404. It is these systemic failures – the complete deprivation of safeguards, the use of blunt prison measures in the context of administrative detention, and the absence of effective oversight, accountability and transparency – that meant a significant number of highly vulnerable people being detained and exposed to a toxic, corrupted macho-aggressive culture that flourished and was marked by recurring incidents of physical violence, verbal abuse and neglect of the vulnerable.

405. When the events of 2017, shown on BBC Panorama, are considered in this proper context, the inescapable conclusion here is that the HO does not learn any lessons from past scandals, reviews, inspectorate reports, court cases or coronial jury findings, and is callously indifferent to doing so: It does not want to, and does not care.

406. This conclusion is fortified by evidence heard by the Inquiry that there is no process within the Home Office for feeding back to managers of detention centres, HO decision makers, contractors, healthcare criticisms made of them, not even filter down through training / basic update, audits. Shockingly, there is no process for learning from even the most serious court findings of breaches of Article 3; or from coronial jury findings, where the harm caused by systems defects had resulted in actual death of a detained person. Mr. Schoenberg looked perplexed that he was the subject of criticism by the High Court in both *BA and HA*. None of the healthcare witnesses were aware that the way in which detention safeguards had been operated – and especially the failures of the Rules 34 and 35 safeguard and the breaches of Article 3 arising from the management of mentally ill people in a wholly unsuitable detained context – had been heavily criticised by the Courts either.

407. Lip service is paid to recommendations by oversight bodies such as the HMIP and IMB, neither of which have any enforcement powers to require the HO to comply. Nor do they have the resources or capacity to monitor and follow up in between inspections. Even where the HO has commissioned an independent review, at its own expense, purportedly

to reflect a commitment to make changes for the better, it doesn't do so. This is clear from Mr. Cheeseman's shocking admissions that the AAR policy does not reflect Mr. Shaw's recommendations, and was not intended to do so. This despite the Shaw Review being commissioned specifically in response the Article 3 findings by the Courts, the APPG on refugees and migrants, the Tavistock Review, and widespread concern about the need to remedy the systemic failures identified.

408. Systems failures identified in those reviews pre-dating the relevant period have been repeated with little impact in subsequent reports post-Panorama, published by Mr. Shaw, HMIP, IMB and the Independent Chief Inspector of Borders and Immigration:

a. Rule 35 continues to operate in a dysfunctional way in which Rule 35(2) is not used at all in the face of high levels of self-harm in detention, Rule 35(1) continues to be a rarity and Rule 35(3) reports do not result in release despite its effect being the identification of a vulnerable adult at risk who, on objective clinical evidence, is likely to be harmed by being detained.[754]
b. There has been continued increase in self-harm, overreliance on ACDT and constant watch without any functional statutory safeguard to prompt urgent consideration of the removal of the detained person from the IRC.[755]
c. Segregation continues to be used, especially where it concerns containment of mental ill-health in detained people, with the length of time spent increasing disturbingly.[756]

[754] Shaw 2nd report 2018, CJS0073862_0049-0054: §§ 2.139-2.149, 3.36; HASC 2019, INQ000061_0055: §§150-151; ICIBI Report: Annual inspection of 'Adults at risk in immigration detention' 2018 -2019 §§ 8.174, 8.177, 8.178; ICIBI 2021, INQ000156_0065-0081 §§ 9.4, 9.20-9.21; IMB 2018, IMB000156_0008 and 0018 §§ 4.4, 8.10; HMIP 2019, CQC000025_0020 and 0025, §§ S43, 1.18-1.24; IMB 2020: IMB000202_ §§ 4.5-4.7.

[755] Shaw 2nd report (2018): increase in self-inflicted death CJS0073862 (§§ 5.2, 5.28-5.33), very high numbers of ACDTs at BH and over reliance on staff intensive constant watch (§§ 5.13-5.19); HMIP 2019: CQC000025 S44, §§ 1.19-1.24 – 40% detainees suicidal. Significant increase in self-harm but no R35(2). Inadequate assessments of ACDT; IMB 2020: INQ000008_7-0008 Section 4.3 – ACDT observations can be short on detail, fail to indicate meaningful engagement with detainees; IMB 2021: IMB000202 para 3.1 – dramatic increase, 30% self-harm; ACDT over 40%; § 4.2 – disturbing number of detainees on constant watch. IMB and IMB Charter Flight Monitoring Team wrote jointly to HO minister for immigration compliance on 2 October 2020 raising concerns over 'severe and continuing' impact of charter programme on detainees facing removal and population in general which amounted to inhumane treatment.

[756] IMB 2019 report: IMB000156 significant increase in average length of time spent on R40 (§6.3); IMB 2020 report: INQ000008 concerned over pre-emptive use of R40 (§5.4); IMB 2021 report: IMB000202 disturbing number of detainees on constant watch (§4.2).

d. Part C continues to be shown patently not to be a substitute for the statutory safeguards Rules 34 / 35 with the ICIBI directing significant criticisms at this continued practice.[757]

e. The absence of effective pre-detention screening through a gatekeeper mechanism continues to result in highly vulnerable people being detained in circumstances where the detention safeguards do not operate effectively to remove them from detention under the AAR policy.[758]

f. Case progression panels do not provide a safeguard against defective detention reviews for the removal of vulnerable people. As with Rule 35, there is distinct Home Office disrespect of the panel's recommendations where it concerns the need to release a detained person.[759]

g. The institutional culture is still desensitised, and culture of disbelief and hostile attitudes toward detained people still thrives, according to the IMB in its report about the reporting period from January to December 2020.[760]

409. The systems failures documented in these reports are further shown by Medical Justice in their report, *Harmed not Heard*[761], recently published in April 2022. In this report, Medical Justice examined the cases of 45 detained persons for whom medico-legal reports were completed by the organisation in the period July to December 2021 across the immigration detention estate. Despite the clinical risk of harm from detention present for all of these individuals identified by an independent clinical assessment, none of them had a Rule 35(1) report. 87% of the cohort were identified by a Medical Justice as

[757] ICIBI 2021: Second annual inspection of 'Adults at risk in immigration detention' July 2020 - March 2021, INQ000156 §§ 3.9, 8.16-8.19 ,8.22.

[758] *Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons:* A follow-up report to the Home Office by Stephen Shaw (July 2018): CJS0073862 §§1.20, 2.20, 4.8, 4.14-4.15, 4.20-4.23; HASC Immigration Detention report 2019 (fourteenth report of session 2017-19): INQ000061 §79; ICIBI 2020: ICIBI Report: Annual inspection of 'Adults at risk in immigration detention' 2018 §§ 3.7-3.8, 6.4, 6.72; IMB 2020: IMB000202 §4.4; ICIBI Report: Second annual inspection of 'Adults at risk in immigration detention' July 2020 - March 2021: INQ000156 §7.10.

[759] *Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons:* A follow-up report to the Home Office by Stephen Shaw (July 2018): CJS0073862 §§1.20, 2.20, 4.75-4.88; HASC Immigration Detention report 2019 (fourteenth report of session 2017-19): INQ000061 §§174, 178-181; ICIBI 2020: ICIBI Report: Annual inspection of 'Adults at risk in immigration detention' 2018 -2019: §8.136; ICIBI Report: Second annual inspection of 'Adults at risk in immigration detention' July 2020 - March 2021: INQ000156, §§3.12, 11.26-11.28.

[760] IMB 2020 report, section 5.4, IMB000202_0020-0023.

[761] Accessible at: https://medicaljustice.org.uk/wp-content/uploads/2022/04/2022_HarmedNotHeard_Final.pdf April 2022.

presenting with suicidal risks, but again, none of them had a Rule 35(2) report raised either. 34 of the 45 detained people received a Rule 35(3) report, but less a quarter of those reports (24%) contained a clinical opinion as to the impact of detention on the individual. Medical Justice only saw Home Office responses to the Rule 35 in 27 cases; only 1 of those people was released further to a Rule 35 report.

410. The Inquiry has heard evidence from both Medical Justice and Freedom from Torture that the Home Office has taken no concrete positive steps to effect change in the light of the recurring identified systems failures in the detention safeguards. Instead, as both organisations gave clear (and uncontradicted) evidence of regressive reforms. For example the Home Office introduced a set of criteria for acceptance or exclusion of independent medical evidence adduced by detained people to evidence their vulnerabilities and risk of (and actual suffering of) harm in detention, which seeks to justify rejecting medical evidence on the basis of technical breaches of the criteria, such as the medical expert not immediately contacting the IRC healthcare raising urgent clinical concerns. As well the criteria allow the Home Office to put no or little weight of the medical evidence if it does not contemplate the availability of healthcare and management of the medical condition in detention, thereby blatantly entrenching "satisfactory management" of mental illness into the AAR policy as amended.

411. Refusing to learn lessons has consequences – serious ones – for people liable to be detained, who are powerless to resist this draconian power in the absence of a humane and safe detention system. That is tragically demonstrated by the recurrence of large scale mistreatment at Brook House in 2020, just three years after the Panorama documentary aired. A different contractor (Serco) was in post then. Tweaks were made to the contract for increased staffing. There were significantly fewer detained persons because of the Pandemic. Furthermore, the detained population was a different profile, not TSFNOs but almost exclusively asylum seekers who were newly arrived in the UK from small boats that crossed the channel (with no history of criminal convictions), and whose experiences made them especially vulnerable, including trauma experienced in their countries of origin, during their journeys, limited English-language skills and limited awareness of

the systems in the UK and how to access their rights and entitlement.[762] Yet, even under those circumstances, the IMB found, in its report on the year from January to December 2020, that:

a. Due to the circumstances related to the compressed nature of charter flight removals under the Dublin Convention, in the latter months of 2020, Brook Houes was *"not a safe place for vulnerable detainees who had crossed the Channel in small boats."*[763]
b. On occasion, nearly half of the detained persons in the centre had a claim under Rule 35. The increase in the number of such claims meant lengthy waiting times.[764] The IMB did not know at the time, of course, that this was also because Rule 34 medical examinations were incapable of leading to a Rule 35 report and there was an existing in-built delay to Rule 35 assessments in the structural arrangements for healthcare. Delays meant that some detained people did not see a GP before they were removed.[765]
c. Whilst Brook House was accustomed to distress among detained persons, the substantial number of cases of self-harm and threats of suicide by detained persons was a major concern for the IMB and everyone in the centre.[766]
d. ACDT was used to monitor the welfare of detained persons where there is a concern that they were at risk of suicide or self-harm or from a medical condition. 205 ACDTs were opened for a 5-month period from August to December 2020, which was a significant proportion of the detained population, which was averaging 80 to 122 people a day. At least a third of the detained population was on constant supervision in a given month.[767] The numbers on constant watch were so high that one member of the mental health team told the IMB that he spent almost all his time carrying out these reviews and struggled to have any time to provide other care.
e. On IMB's visits to the centre and from conversations with detained persons and staff during that time, they also felt that there was usually an atmosphere of tension, fear and despair pervasive among detained persons, and great stress on staff caring

[762] See "Background to report" in the Annual Report of the Independent Monitoring Board at Brook House IRC, Reporting year 1 January – 31 December 2020, §3.1, IMB000202_0005.
[763] IMB 2020 Report, §3.2, IMB000202_0006.
[764] IMB 2020 Report, §4.2, IMB000202_0013.
[765] IMB 2020 Report, §4.2, IMB000202_0013.
[766] IMB 2020 Report, §4.2, IMB000202_0010.
[767] IMB 2020 Report, §4.2, IMB000202_0010-0011.

for them. On frequent occasions, Board members heard detained persons in ACDT reviews say plainly that they would kill themselves if served removal directions. In conversations, they also heard detained persons talk of being subject to racism, homelessness and hunger in the countries to which they were to be removed.[768]

f. The IMB was particularly concerned about detained persons being removed while in a state of distress or injury following self-harm, which was felt to be inhumane and put detained persons at further risk. This included a detained person being taken to a plane directly after having received hospitalisation for injuries, another being removed after being stuck on the suicide netting and a further detained person being presented for a charter flight bleeding from self-harm wounds in a state of partial undress.[769]

g. At least 26 detained persons were removed on charter flights whilst on ACDTs, yet there appeared no formal arrangements in place for briefings to the receiving authorities about those most vulnerable of detained persons.[770]

h. The IMB found "puzzling" that given this scale of self-harm and suicide threats, there were only 2 reports made under Rule 35(1) and none under Rule 35(2) for the five-month period from August to December 2020. The IMB found the frequency of suicidal ideation irreconcilable with there being *"absolutely no Rule 35(2) reports."*[771]

i. The number of incidents involving the use of force continued to fall. However, the prevalence of use of force in 2020 is double what it was in 2019 and 2018 when looked at by reference to the average proportion of detained persons having force used on them each month. An average of about 17% of detained persons had force used on them in each month in 2020, compared with between 7% and 8% in 2019 and 2018.[772] The high prevalence was not just in the latter five months; it was similarly higher in the first half of 2020.

j. There was a noticeable increase in prevention of self-harm being given as the reason for force being used, compared to past years. It correlated with the higher levels of self-harm and suicidal ideation seen among the small-boat population brought to the centre for charter flight removals.

[768] IMB 2020 Report, §4.2, IMB000202_0011.
[769] IMB 2020 Report, §4.2, IMB000202_0011-12.
[770] IMB 2020 Report, §4.2, IMB000202_0012.
[771] IMB 2020 Report, §4.2, IMB000202_0014-0015.
[772] IMB 2020 Report, §4.2, IMB000202_0012.

k. Large numbers of detained persons who were detained for removal were later released, having been exposed to the harmful effects of detention in the interim: 53% of those detained in 2020 were released, with the level rising to 72% between August and December, when the charter programme was being run.[773]

412. On the basis of these findings, the IMB considered that the circumstances in Brook House in the latter five months of 2020, "amounted to inhumane treatment of the whole detained person population by the Home Office".[774] Large numbers of detained persons who were detained for removal were later released, having been exposed to the harmful effects of detention in the interim: 53% of those detained in 2020 were released, with the level rising to 72% between August and December, when the charter programme was being run.[775]

413. The fact that the ill-treatment still happened, as recently as 2020 – with the same features of systemic failures (leading to high numbers of vulnerable detained persons) provoking the same patterns of mistreatment (with the use of segregation, force and damaging management of mental illness in detention) supports our submission that the root causes are far deeper and engrained in the system which the Home Office bears ultimate responsibility for. The fact that Steven Hewer, Director of Gatwick IRCs, could not give any assurance to the Inquiry that a repeat of the situation in 2020 would not reoccur and is outside his control as the contractor – and in the control of the Home Office – also speaks to the challenges to bring about change if the state authority responsible for the polices, practices, measures and arrangements for immigration detention centre is unable and unwilling to take these matters seriously and address them. The evidence of Ms Molyneux of the IMB on the Home Office's wholly inadequate response to the Rule 61 Notice and the 2020 Report whilst predictable, is shocking and revealing about the Home Office's true attitude toward the welfare of detained people. She said:

*"There was nothing. Not even an acknowledgment. I mean I knew they had it because we copied in our people. And then I think nearly six weeks later this*

[773] IMB 2020 Report, IMB000202_0032.
[774] IMB 2020 Report, IMB000202_0006.
[775] IMB 2020 Report, IMB000202_0032.

*response comes in. I don't think it was coincidental that it was received on the day we were giving evidence before the Home Affairs Select Committee.* [776]

*Our letter was about the impact. It's headed "The Impact". It is all about what is happening to the people. We were not challenging particular processes or saying, "You cannot remove people under the Dublin Convention". It was, "This is what's happening". You know, it was a concern about safety, that there is going to be more of this if you persist. The reply is all about process. "We have the right, we have the process", so there is just a total disconnect and not, in my view, acknowledgement of the problem and the issues we had raised.*[777]

414. This is critical evidence for the Inquiry when it comes to determining culpability, what lessons have been learnt by the Home Office and what remedial action is required in the face of Home Office recalcitrant indifference to recurring grave harm.

[776] Mary Molyneux 25 March 2022, 163/1-13
[777] Mary Molyneux 25 March 2022, 162/11-21.

## X. Submissions on behalf of Individual Formerly Detained Core Participants

### (1) D801

### (a) Introduction

415. D801 is a Sri Lanka national of Tamil ethnicity and now a recognised refugee. He was detained at Brook House from 1 March to 3 April 2017 for 35 days. But this was not the first time he was detained there. Although his earlier detention in 2015 is strictly outside the Inquiry's time parameters, it is an essential background context to understand and assess how his mistreatment during the subsequent detention occurred.

416. His is a case which powerfully evidences how the Home Office has continued to operate the damaging detention policy of "satisfactory management" of mentally ill detained persons and how none of the statutory safeguards operated within that framework to protect D801 from detention in inhumane conditions and suffering inhuman and degrading treatment in breach of Article 3 ECHR.

### (b) First Detention and Impact

417. D801 is a victim of horrific torture by Sri Lanka authorities, which included beatings, rape and sexual assaults and suffocation.[778] He came to the UK on a student visa ran out. When the visa ran out, D801 applied for asylum in 2012 but he was unsuccessful.

418. D801's first detention from 9 April to 21 May 2015 was a "shocking experience". The sounds of doors banging, key chains jangling, the smells and noises of people screaming all brought back the worst of his memories of torture in Sri Lanka. He secured release after the immigration tribunal granted him bail in late May 2015.

419. On release, his mental state rapidly deteriorated. He continued to experience intrusive flashbacks and epileptic fits. He also took overdoses on at least two occasions that resulted in hospital admissions. On one further occasion, he was found in London, some distance from where he lived, hanging on to some railings on the side of the road, not knowing where he was or how he came to be there. The mental health crisis team assessed him to have PTSD. An independent consultant psychiatrist, Dr. Lawrence found him to

[778] Witness statement of D801, §§12-13, BHM000034_0003-0005.

also suffer from psychotic depression. [779] This was all notified to the Home Office, who in fact referred D801 to the adult safeguarding team in his local area in January 2016. The safeguarding team told the HO that D801 was at serious and immediate evidence-based risk of suicide or serious self-harm.

**(c) D801 was unlawfully detained in 2017**

420. Everything that the Home Office knew about D801 should have, but did not prevent him from being detained from 1 March to 3 April 2017: D801 would not have been exposed to any of the mistreatment he later experienced had a competent and lawful decision been made about his detention.

421. Prior to D801's re-detention, he was preparing a fresh claim for leave to remain based on Article 3 suicide risks. He was due to submit these in person at the Home Office's Further Submissions Unit in Liverpool on 8 February 2017 (later rescheduled for 30 March 2017). Immigration Rule 353A operates as a barrier against removal of a person whilst their fresh claim is under consideration; until that fresh claim is considered, the Home Office cannot and should not be actively pursuing removal action; at a minimum they need to see what the person has to say. But in D801's case, the Home Office decided to pursue his removal anyway before seeing the fresh claim. That decision paid no consideration of his overdoses, high suicidal risks and diagnosis of psychotic depression. The Home Office also had no regard to the gist of the fresh claim provided by D801's immigration solicitors, that it would be based on suicide risks and Article 3, hence information that had not previously been considered. The only reference to D801's health in the removal decision was a reference to his being on anti-depressants, a gross understatement of what his true mental state was at the time.

422. When the Detention Gatekeeper authorised D801's detention for removal purposes, he was assessed him to be an Adult at Risk Level 2[780], even though the Home Office had Dr. Lawrence's reports and knew that he suffered from psychotic depression and PTSD and had attempted to overdose twice in the community. Had this evidence been properly considered – as it should have been under the AAR policy - it patently showed him to be

[779] Witness statement of D801, §§26, 31-33, quoting an extract from Dr. Lawrence's report, BHM000034_0006-0010.
[780] Witness statement of D801, §§34-36, BHM000034_0010-0011

an Adult at Risk Level 3 – the highest level – and that he would be harmed if re-detained. Adults at Risk Level 3 cannot be detained unless there was a fixed date for removal in cases without public protection concerns.

423. The Home Office's recognition of him as a Level 2 Adult at Risk ought in any event to have resulted in a strong presumption being applied in his favour and against detention, particularly given there being no fixed removal date yet, and his having complied with conditions of immigration bail in between his first and second detention and his being vulnerable. Being monitored on immigration bail in the community was patently a clear and reasonable alternative to re-detention in his circumstances. This is what would have happened under EIG 55.10, the policy which preceded the AAR policy. The strong presumption against detention would have been applied in D801's favour given his past history of torture, the medical evidence supporting this and the evidence of significant likely (and actual) harm by being detained. There were, on his facts, no "very exceptional circumstances" that could have justified detention. But, as discussed above, that was not the outcome under the Adults at Risk policy because the Home Office had recalibrated the strength of the presumption afforded to vulnerable detained persons by demoting evidence of vulnerabilities to indicators of risk which are weighted against immigration factors, on which great emphasis is placed.

**(d) <u>Deprivation of Safeguards at Brook House</u>**

424. Not only was the AAR policy not capable of protecting D801 from being detained in the first place, the statutory safeguards were wholly dysfunctional and failed to ensure his swift removal from detention.

425. Dr. Hard's critique of the treatment of D801 in detention speaks for itself. He said in oral evidence that:

> *Although not physically assaulted by staff or verbally abused, leaving him in detention during this period for a total of 34 days caused him to suffer ill-treatment because none of the safeguards that were meant to function to remove him from detention worked.*[781]

[781] Dr Jake Hard 28 March 2022, 74/21-25 to 75/1-2.

*[D801 was a] really good example of a complete inattention of the understanding of the purpose of the rules and that there was an imperative to relay that information to the HO at the earliest opportunity with the mechanism that would have meant that a review of detention was undertaken at that point in time."*[782]

**(e) Failure of Health screening to prompt the statutory Rule 35 safeguard**

426. Although he disclosed a history of torture, past overdoses and self-harming, on admission[783], no Rule 35 assessment was done, and no report was raised under any of the three limbs of the rule. Instead, D801 was put on ACDT.

427. Throughout his entire detention, detention policy and safeguards failed to ensure D801 was identified as a victim of torture under R35(3), to have his suicidal risks alerted to the HO under R35(2) or to have concerns raised about detention being likely to be injurious to his health under Rule 35(1), at least until the very last day of his detention, 3 April 2017. None of the healthcare witnesses – including Dr. Chaudhary and Karen Churcher who had been directly involved in his "care" at Brook House - could provide an explanation for why the statutory safeguards failed entirely in his case.

428. It was in the context of D801's case that Ms. Churcher told the Inquiry that ACDT was not a measure that did anything prevent deterioration in a detained person[784]; it was just management, and just what they did at Brook House, although she could not explain, as an experienced mental health nurse, she thought that would be an appropriate approach to adopt in D801's case, or indeed routinely.

**(f) Rule 35 safeguard not triggered at all to fulfil its purpose**

429. D801 was eventually one[785] of only five Rule 35(1)s that were produced within the relevant period at Brook House, but that report came too late, on the last day of his detention and only after the Home Office had already decided to release, and only after irreparable harm to his mental integrity and his human dignity was already done[786].

[782] Dr Jake Hard 28 March 2022, 75/11-17.
[783] Entry of 1 March 2017, HOM032191_0001-0002.
[784] Karen Churcher 10 March 2022, 57/14-19.
[785] HOM0828619_0001.
[786] D801's statement at BHM000034_0012-0017 for a summary of his medical treatment at Brook House.

430. Dr Chaudhary, who very belatedly prepared a Rule 35(1) report only at the end of the period of detention accepted that the Rule 35 system was did not operate in D801's case given that the report he completed was done about a month after his detention,[787] after D801 had been deprived of any appropriate medical care or psychiatric treatment and had in fact attempted suicide by ligature. Dr. Chaudhary had several opportunities prior to 3 April 2017 to consider and assessment D801 for a Rule 35(1) report. He saw D801 on the first day of his detention, and despite D801's disclosure of past suicide attempts, noted that he was not suicidal,[788] a conclusion that is difficult to understand given his history. When Dr. Chaudhary saw D801 again on 9 March 2017, a week later, D801 was on ACDT and in the E Wing; Dr. Chaudhary carried out no assessment of D801 and only reviewed his medication.[789] We now know that Dr. Chaudhary proceeded on the basis that Rule 35(1) reports would not be raised if it appears the person was "managed" on ACDT[790], and at least was (in Dr. Oozeerally's words) prevented from dying[791].

431. Sandra Calver at first suggested that D801 had improved over the course of his detention.[792] But when it was pointed out that he tried to kill himself, and Dr. Belda, the IRC psychiatrist, had observed on several occasions that he was not fit to be detained in Brook House, she accepted the point made by Dr. Hard in his supplementary report, that it was unacceptable that the Rule 35 safeguard failed to function at all in D801's case, and that a Rule 35(1) should have been triggered, at the latest after his hospital transfer under the Mental Health Act 1983 had been declined on 9 March 2017. The month-long delay thereafter was wholly unacceptable.[793]

432. Karen Churcher, who had seen D801 with Dr. Belda on the second day of his detention[794], clearly knew that D801 was so unwell because an IRC psychiatrist recommended an urgent hospital transfer. Yet she took no steps to make arrangements for a Rule 35(1) report. This was so even after Dr. Belda said on 17 March 2017 that

[787] Dr Saeed Chaudhary 11 March 2022, 218/1-4
[788] HOM032191_0003.
[789] HOM032191_0005.
[790] Dr. Saeed Chaudhary, 11 March 2022, 193/18-23, 199/1-12.
[791] Dr. Husein Oozeerally 11 March 2022 53/2-5.
[792] Sandra Calver 1 March 2022, 203/1-14.
[793] Sandra Calver 1 March 2022, 205/19-25 to 206/1-5.
[794] HOM032191_0002-0003.

detention was *"less than ideal placement for him as he needs intensive trauma therapy"* which was not available in Brook House or across the detention estate.[795] We now know that is because she did not know what Rule 35(1) safeguards did during the relevant period (despite being the lead mental health nurse).[796] She also wrongly believed that because a referral for hospital transfer was in process, that substituted out any obligation to apply the Rule 35(3) safeguard,[797] and that the Rule 35(3) threshold did not need "severe" torture, just concerns that a person may have been tortured.[798]

433. Despite D801 giving a history of past suicide and being on ACDT for the whole period of his detention as a result, none of the many nurses or Dr. Chaudhary or Dr Belda contemplated the use of the Rule 35(2) safeguard to notify their concerns to the Home Office of his suicidality.

**(g) Use of de facto segregation**

434. Pending assessments for a s. 48 transfer, D801 was moved to E-Wing at Brook House in a situation of de facto removal from association. This was on day 2 of his detention. He was never served any paperwork under Rule 40 or given any explanation of why he had to be on E Wing. E Wing came with certain specified restrictions such as lock-ins, but D801 could not challenge any of this because he was given no information about his rights and entitlements.

435. From day two onwards, and until he was eventually released on 3 April 2017, the only course of treatment he received was containment on the E-Wing and anti-depressants under ACDT – which amounted to no appropriate or adequate treatment at all.

**(h) Lack of treatment and management on ACDT**

436. The use of ACDT to manage D801's illness was patently inappropriate, inadequate and failed to provide any treatment for his condition. The frequency of observations under ACDT fluctuated over the course of his detention. No assessments have been disclosed

[795] HOM032191_0007.
[796] Karen Churcher 10 March 2022, 47/6-25 to 48/1-4, and 49/16-25.
[797] Karen Churcher 10 March 2022, 42/1-6.
[798] Karen Churcher 10 March 2022, 44/1-10.

as to *how* the level of ACDT observations was determined, *by whom*, and based on *what evidence.*

437. When D801 was assessed to be ineligible for a hospital transfer under s. 48, there was no consideration of the suitability of Brook House in circumstances where he still was someone who required treatment for his complex mental illness. Instead, the rejection of a hospital transfer was wrongly taken as sanction to keep him detained at Brook House when one simply does not follow the other.

438. Dr Belda noted on 17 March 2017 that D801 needed intensive trauma therapy and should be released to receive this in the community as it was not available in Brook House on 17 March 2017[799] and later stated *"was also not fit to be at Brook House because he cannot receive appropriate treatment"*[800]. But his recommendation for D801's release on health grounds was ignored.

439. The inadequacy of ACDT was graphically demonstrated when D801 attempted suicide by hanging himself using a shoelace as a ligature on 19 March 2017. This was entirely predictable given what the Home Office and healthcare already knew of his history of mental illness, PTSD, failed suicide attempts and the re-traumatisation triggered by re-detention at Brook House. The fact that D801 was observed to be withdrawn and disengaged was wrongly taken as improvement (Sandra Calver) rather than as avoidance, a core symptom of PTSD.

440. The only response by healthcare after his attempted suicide was to move D801 to ACDT constant supervision for three days[801]. Then he was downgraded to every 2 hours during the day, and half hourly at night, and a few days after, 3 hourly during the day and 2 hourly at night. None of this was based on any clinical or risk assessment of its appropriateness or effectiveness as a strategy. No Rule 35(1) or (2) report was promulgated at this time.

[799] HOM032191_0007.
[800] HOM032191_0010.
[801] HOM032191_0008.

441. The only other "treatment" suggested to D801 was Karen Churcher advising him on the *"use of rubber bands for the relief of stress"*[802] which she accepted in evidence was only about risk management, not a therapeutic intervention[803]. She also accepted that this did not prevent deterioration in his mental state [804]

**(i) Failure to grapple with clinical issues in Detention Reviews**

442. The detention reviews were silent as to D801's medical conditions.

a. Other than repeatedly noting the fact of he was an adult at risk Level 2, there was no engagement at all with what that meant or just how serious his mental illness was.
b. In fact, and on the contrary, the reviews repeatedly stated that there were no exceptional circumstances or risk indicators rendering D801 unsuitable for detention. The HO maintained this position even after his suicide attempt.
c. The HO said in responses to requests for temporary admission that D801's health could be and was managed by IRC healthcare.
d. None of this was true. The IRC psychiatrist as noted above told the HO repeatedly that D801 should not remain detained.

**(j) Use of IS91 RA Part C**

443. A number of Part Cs were produced during D801's detention which clearly failed to result in a review of detention. D801's suicide attempt on 19 March 2017 generated an IS91 RA Part C – not R35(2). The problem with Part Cs is that it is merely a form for notification of concerns[805]; there is no corresponding obligation on the HO to look at the information on the form, think about what is said, and take any steps. Indeed, in D801's case, nothing was done in the light of the Part Cs. When detention was reviewed 10 days later, it was maintained on the asserted basis of an absence of risk and the fact of his being on ACDT.

**(k) <u>Conclusion</u>**

[802] HOM032191_0008.
[803] Karen Churcher 10 March 2022, 55/8-15.
[804] Karen Churcher 10 March 2022, 57/14-19.
[805] Philip Schoenenberger 23 March 2022, 80/14-81/8.

444. At every opportunity, detention policy and safeguards designed to protect D801 failed:

a. No R35(1), (2) or (3) was raised throughout the whole of his detention, until the very last day, when a R35(1) was completed by Dr. Chaudhary, and only because Dr. Belda, the IRC psychiatrist, said unequivocally that D801 was not suitable to be detained. All the signs of this were apparent long before Dr. Belda made that assessment on 31 March 2017.
b. He was someone that the HO, G4S and healthcare knew required medical treatment that was unavailable in detention. Dr. Belda had made an urgent request for hospital transfer on Day 2.
c. This did not alert the HO to the fact that this was seriously unwell man who, on a proper application of the AAR policy, should not remain in detention. There was then no contemplation of other alternatives to detention – namely release into the community – when a hospital transfer was declined a week later.
d. Instead, D801 was *"managed"* unlawfully contrary to good psychiatric care, in de facto segregation on E Wing, subject to ACDT the whole time, at the beginning on constant watch. This was not appropriate or adequate medical treatment, and did nothing to prevent his deterioration. In fact, he tried to kill himself using a shoelace as a ligature and using razors whilst on ACDT. But even that did not trigger statutory report mechanisms under R35. A total of 4 Part Cs were sent to the Home Office, instead, each *"uploaded"* on to the system, each ignored.
e. The only "treatment" following his suicide attempt was advice on how to snap an elastic band around his wrist to help him cope with stress. He was left to languish in the isolated environment of E wing

445. Dr. Bingham gave evidence that detention has the effect of forcing victims of torture to relive their past torture as if it was happening to them again[806]. There is no doubt from D801's narrative to an independent expert, Dr. Sen, that this was D801's experience of Brook House in 2017:

> *He could not eat and was throwing up all the time. He just stayed inside his room and did not want to socialise with anybody. The food tasted to him as if he was 'eating a pair of glasses, like it was burning.' He did not wish to explain anything*

[806] Dr Rachel Bingham 14 March 2022 8/10-22.

*to the authorities and just stayed away from food. The whole experience felt to him 'like walking on fire.' Every single day felt as if it was biting on his skin and he physically felt the pain.* [807]

446. The treatment of D801 accordingly should be accepted by the Inquiry as breaching article 3 ECHR as he was clearly subjected to inhuman and degrading treatment. The Inquiry should assess whether the threshold for such a breach is made out against the background that D801 should clearly not have been detained at all during 2017 as the Home Office were on notice of his acute mental health problems. D801 did bring proceedings for his unlawful detention during this period which was settled by the Home Office with a payment of substantial compensation but no apology.

447. D801's pre-existing mental illness seriously deteriorated and was exacerbated by detention and the inhumane conditions of detention. He was not provided with appropriate or adequate medical treatment, which in any event was not available in detention. He was subjected to de facto segregation and continued to further deteriorate during the period of detention in an inhumane environment. He made a further suicide attempt before being released. He clearly suffered acute distress, anguish and serious harm during this period.

448. The investigative duty under article 3 has also been breached. The Home Office did not accept liability for his unlawful detention despite settling his claim. There has been no accountability for his treatment or any proper examination of it until this Inquiry.

[807] BHM000034_0021 quoted in D801's statement.

## (2) D1275

### (a) Introduction

449. D1275 is an Iranian national who suffers from PTSD as well as a bipolar schizoaffective disorder.[808] He currently has discretionary leave to remain, granted as part of the settlement of a judicial review claim by the Home Office for unlawfully detaining him under immigration powers (including at Brook House), and subsequently unlawfully subjecting him to immigration bail conditions with which he was unable to comply because he lacked mental capacity to understand the bail conditions and make decisions as to compliance.

450. The fragility of his mental state is a product of the inhuman and degrading treatment he suffered in breach of Article 3 ECHR in immigration detention for two exceptionally lengthy periods of time, from 1 December 2015 to 11 July 2016 (for 223 days) and from 19 October 2016 to 25 June 2018 (for 616 days). He was held at Brook House for 422 days of the latter period of detention – from 1 May 2017 until 26 June 2018.

451. The extent of the ill-treatment he suffered whilst detained at Brook House, has only come to light because of the disclosure obtained through this Inquiry's Article 3 investigation. More than 1,000 pages of documentation has been provided by G4S and the Home Office to this Inquiry, in circumstances where this information had repeatedly been withheld from D1275 and his lawyers over the course of judicial review proceedings which commenced in early 2018 and concluded at the end of 2019.

452. D1275's case is a paradigm example of a detained person who the system of safeguards was incapable of protecting: his mental ill-health manifested in an inability to make decisions about engaging with mental health services; he received no treatment whilst at Brook House, and in any event there was no appropriate treatment available in the centre; he was exploited by other detained persons for his vulnerabilities to be a guinea pig for spice with the full knowledge and acquiescence of detention custody officers; and he was subjected to repeated derogatory and demeaning mockery and verbal abuse. In the absence of independent advocacy for people like him who were so severely unwell they lacked mental capacity, he had no voice, could not access legal advice and assistance and

[808] Witness statement of Hamish Arnott, §58, BHM000042_0016.

could not challenge repeated removals from association, the repeated discharge from healthcare and his indeterminate and unlawful detention. All this caused an intensity of mental and physical anguish, humiliation, neglect and deterioration in his mental health for a prolonged period of time that was both inhuman and degrading in breach of Article 3 ECHR. That breach was only ended further to a judicial review application led to his release from immigration detention.

453. The severity of his deterioration is reflected in the fact that within a month of release from Brook House, D1275 was detained under the Mental Health Act 1983, at first under s. 2 and then under s. 3 for treatment whist detained at hospital, because his mental health had deteriorated so significantly at Brook House. He was discharged from hospital on 7 December 2018 under a Community Treatment Order. The CTO has been discharged but his mental state remains extremely fragile.

**(b) <u>Incident on 14 June 2017</u>**

454. The Inquiry has seen and heard evidence concerning a specific incident of abuse on 14 June 2017 perpetrated by Derek Murphy and Nathan Ring, at a time when D1275 was suffering a spice attack. The footage[809] that has been shown to the Inquiry shows D1275 in a state of extreme physical distress on the ground in a courtyard with officers seeming unprepared in the response to what may well have been a life-threatening situation. Officers and other detained persons look on whilst D1275 is on the floor experiencing what appears to be a severe physical reaction to spice. D1275 needed to be moved from the courtyard to the wing, the Inquiry will recall footage of Callum Tulley running around the centre looking for an evacuation chair and not finding one.

455. When D1275 was moved to a bed in E Wing, he was repeatedly subject to cruel and casual mockery by DCM Nathan Ring and DCO Derek Murphy.

456. DCM Nathan Ring first mocked D1275 in front of a nurse, whilst he was groaning from the acute effects of spice, saying *"Does your face taste nice? 'Cause you appear to be*

[809] KENCOV1035 V2017061400015 and V2017061400016.

*chewing it off."*[810] The nurse did not challenge this and instead joined in, responding "Homie's after your coke."[811]

457. Whilst D1275 was tachycardic, and a nurse was heard saying that his heart rate was *"life threatening"* [812], DCM Nathan Ring responded saying *"I'll get him cold water, that will sort his heart out, that will do it the world of good."*[813] Nathan Ring also made a slew of disparaging remarks including "*stay still,* you *div"*[814] and *"scrotum"*[815]

458. DCO Derek Murphy was separately recorded in a conversation with Callum Tulley saying, chillingly, *"I've no sympathy for them. absolutely no sympathy... if he dies he dies"* [816].

459. All of this contempt for D1275 went unchallenged by others present including healthcare staff responsible for his care and despite his serious medical condition and his extreme vulnerability. The incident in and of itself self-evidently intruded on D1275's human dignity and starkly illustrates the callous indifference shown by staff towards the welfare of vulnerable detained persons and the extent to which this was normalised within such a desensitising environment.[817]

460. What makes this worse is the evidence before the Inquiry that shows that custody staff were fully aware that D1275 was not some recreational spice user who was making bad choices; rather they were aware that he was being exploited by other detained people as a 'guinea pig' for drugs and bullied into doing this on account of his vulnerability. Staff however failed to report this and in effect allowed it to continue with their knowledge and acquiescence.[818] This persisted within a climate of general fear and insecurity, where the high levels of intoxication and prevalence of drugs would have inevitably affected D1275's welfare. The high levels of mental distress, humiliation and anguish which these

[810] TRN0000015_019, lines 11-12.
[811] TRN0000015_019, line 23.
[812] TRN0000016_0002 lines 40 and 58.
[813] TRN0000016_0003 lines 33-35; KENCOV1035 – V2017061400016.
[814] TRN0000016_0002 line 15.
[815] TRN0000016_0002 line 35.
[816] TRN0000015_0021 lines 45-46.
[817] DCO Murphy said in his oral evidence on this incident "*we were a product of our environment, unfortunately":* Derek Murphy 2 March 2022 79/1.
[818] CJS001127 (G4S support plan); CJS005347 (Security Information Report).

circumstances must have provoked, turning on the above incident, are clearly sufficient as to amount to inhuman and degrading treatment.

461. A G4S' own investigation into the incident[819] in September 2017 found the allegation substantiated, noted that DCO Murphy displayed little remorse in relation to the comments he admitted to making about D1275. Nathan Ring's actions were also found to be unprofessional and negligent towards the management and care of detained persons[820].

462. The oral evidence of these officers in this Inquiry shows that they continue to minimise the seriousness of their actions and show no remorse for the verbal abuse committed against a detained person at his most helpless. Nathan Ring has claimed that his comments were made out of frustration, and Derek Murphy has even sought to claim that the BBC edited the footage relating to his "if he dies, he dies" comment[821]. The Inquiry should categorically reject these attempts to justifying their actions; their unwillingness to express remorse for their unacceptable behaviour only go to aggravating the gravity of the ill-treatment.

**(c) <u>D1275 should not have been detained at all at Brook House</u>**

463. As chilling and disdainful as the degrading incident captured on camera was, if the Inquiry's investigation into D1275's mistreatment were to stop there, it will not have achieved what it set out to do, and to go where the evidence takes it. It would not address the full extent of the Article 3 mistreatment to which D1275 was subjected at Brook House.

464. The evidence in this Inquiry demonstrates that D1275 should not have been detained at all during the relevant period at Brook House or beyond. But for the Home Office's unlawful decision to detain him and keep him in detention for 616 days, 442, D1275 would never have been exposed to the inhuman and degrading treatment he suffered whilst at Brook House. The Home Office, being the detaining authority with full knowledge of D1275's circumstances, must ultimately be held responsible for putting

[819] CJS005928.
[820] CJS000814.
[821] Derek Murphy 2 March 2022 80/1-3.

D1275 directly in the line of harm that was inevitable given his vulnerability and the prolonged length of his detention.

465. During D1275's previous immigration detention in 2015, the Home Office had already known that the Iranian Consulate declined to issue an Emergency Travel Document to him on the basis that there was insufficient information to issue him such a travel document[822]. Without a travel document, D1275 could not be removed from the UK to Iran because the Iranian authorities did not accept enforced returns. By 26 May 2016, the Home Office accepted, in a detention review, that *"detention cannot be maintained with no prospect of removal."*[823] This was the basis upon which he was released on 15 July 2016.

466. After a further short 4 months sentence from which he was released on 20 October 2016 he was however re-detained under immigration powers. No pre-detention screening was undertaken so this critical legal barrier to D1275's removal was not grappled with. Within a month of his re-detention, the Home Office recognised, in a detention review dated 16 November 2016, that a release referral needed to be drafted in view of the absence of an emergency travel document and *"there is no realistic prospect of removal within a reasonable timescale"* unless D1275 wishes to help facilitate his own return[824]. Yet so far as we can see from all of the disclosure now in our possession, there was no release referral drafted, and D1275 would remain in detention for an unbelievably lengthy period of 616 days before he is finally released, and as the Inquiry heard in evidence, only after judicial review proceedings were brought.

467. By the time judicial review proceedings were brought in May 2018, D1275 had entirely lost mental capacity, could not communicate with any coherence or sense with staff, healthcare, charitable detained person welfare groups or his lawyers. He therefore had no way of understanding the legal position as to his detention, questioning his continued detention or challenging the conditions under which he was detained.

[822] HOM007838.
[823] HOM007236_0003.
[824] HOM011328_0004.

468. Instead, he was left by the Home Office to languish in detention, first at Morton Hall, Harmondsworth, Colnbrook and then Brook House, By the time he arrived at Brook House, he had been detained for 193 days. He was repeatedly removed from association and segregated under Rule 40, at Morton Hall, and then at the Heathrow IRCs. Medical records indicate that D1275 was put in Rule 40 segregation at Heathrow for the entirety of the time he was held there until his transfer to Brook House on 1 May 2017.[825] This was notwithstanding the Home Office being fully aware that *"36 days in R40 at Colnbrook will be having a detrimental psychological effect on him"*[826].

469. Judicial review proceedings settled in 2019 with a bare admission by the HO that D1275's detention had become unlawful by the end of his time at Brook House, when he had entirely lost his mental capacity, and but for a referral for legal representation by Gatwick Detainee Welfare Group, D1275 may well have languished further in Brook House. That muted admission by the Home Office of unlawful detention was an entire mismatch with the settlement agreement to pay out a significant sum of damages and to grant D1275 a period of discretionary leave to remain. It was also made in circumstances where the Home Office had withheld significant documentation concerning D1275's treatment in detention in breach of their duty of candour and in an attempt to keep his ill-treatment cloaked in secrecy.

**(d) Failures of detention policy and safeguarding at Brook House**

470. The disclosure now available and the evidence heard from various witnesses show how the systems that were supposed to protect vulnerable detained persons, both from detention itself and from its effects, failed utterly in his case and led to his suffering inhuman and degrading treatment in breach of Article 3.

**(i) Failures of Healthcare**

471. The medical records showed that when he had transferred to Brook House on 1 May 2017 he was referred to see a mental health nurse on admission as the medical records state "*Claims mental health issues. States he hears voices... Vague and misleading with*

[825] See D1275's medical records CJS001121_0062-66.
[826] Entry of 28 April 2017 in the Detainee Detention Review: HOM007752_0064.

*answers to questions on admission*"[827]. The nurse also recorded on a mental health referral form that he said "*they will find me*" but "*would not elaborate on who he was*"[828].

472. In the 422 days that he was at Brook House, his severe mental health issues were not identified, managed or treated at all. This was despite recurring healthcare logs citing his bizarre and at times aggressive behaviour and incoherent answers to questions. Even the Iranian Consulate told the HO so.[829] Instead, and frequently, D1275's behaviour was seen as refractory and was managed by segregation.

473. He was repeatedly discharged from the mental health team case load. No one bothered to do the most basic checks to find out why he missed so many appointments – 13 in total. Karen Churcher Sandra Calver were both clear in their oral evidence that attendance at medical appointments was a matter of patients' choice irrespective of vulnerabilities.[830] D1275's non-attendance was described by Karen Churcher in medical records in terms of wasted hours and resources of the mental health team, rather than symptomatic of a seriously unwell man: *"This equates to 130 hours offered"*[831].

474. It was only after D1275's solicitors provided to healthcare an independent medico-legal report from Dr. Ragunathan[832] that D1275 was finally seen by an IRC psychiatrist, Dr. Belda, for the first time in Brook House on 29 March 2018.[833] He observed that D1275 presented as confused and giving irrelevant information in answers to questions. On 10 April 2018 an ongoing observations log noted that he seemed very depressed and low.[834]

475. The significance of Dr. Ragunathan's report is his point that the medical records for D1275 was littered with indicators of his serious mental disorder and that should have prompted action from healthcare. He expressed a strong view that immigration detention was *"perpetuating his mental disorder"* and that he *"is not able to receive the*

[827] CJS 001121_0065-66.
[828] CJS001121_0106
[829] References in the Home Office detention reviews refer to an interview with the consulate on 4 October 2017 – see HOM011253_0002. See Statement of Hamish Arnott, §52, BHM000042_0015 regarding a further interview in February 2018.
[830] Karen Churcher 10 March 2022, 64/8-14; Sandra Calver 1 March 2022, 181/1-25.
[831] Entry of 25 January 2018, CJS001121_0070.
[832] Witness statement of Hamish Arnott, §§58-68, 79, BHM000042_0016-0022, and 0025.
[833] Witness statement of Hamish Arnott, §69, BHM000042_0022.
[834] CJS001052.

*appropriate care and support for his mental disorder whilst he remains at the immigration detention.centre."* Whilst Dr. Ragunathan did not consider D1275's mental disorder to be severe enough at the time to require a hospital transfer for urgent treatment under the MHA 1983, he was of the view that D1275 did require *"a comprehensive psychiatric assessment with the support of a Farsi speaking interpreter to gain a better understanding of the nature and the severity of the mental disorder."*[835]

476. Despite Dr. Ragunathan identifying existing medical information in the healthcare records that was at all material times in the possession of healthcare professionals at Brook House, no Rule 35(1) report was ever contemplated during the whole time that D1275 was detained there. He was allowed to slip under the radar of all professionals and the Home Office and he suffered serious deterioration in his pre-existing mental illness and medical neglect as a result. He received no appropriate medical care or adequate medical treatment.

**(ii) <u>Discriminated on grounds of disability</u>**

477. Neither Ms. Calver nor Ms. Churcher contemplated that D1275 could have lacked mental capacity to make decisions about accessing medical treatment. There was no practice to do so; they did not know how to do it.

478. It was only in oral evidence, under extensive questioning by Ms. Simcock that Karen Churcher grudgingly accepted that some people who might most need help from healthcare do not seek it themselves,[836] and that at the very least, healthcare had a duty of care to patients to make inquiries into why a person had not attended an appointment, by speaking to the wing staff and by going to try and find the patient on the wing.[837] This of course was never done for D1275.

479. It was only after Ms. Simcock pressed Ms. Churcher that she accepted that, with hindsight, D1275 should not have been discharged from the mental health caseload[838]. Sandra Calver also accepted that healthcare should have checked on him, assessed whether he had mental capacity and should not have discharged him from the mental

[835] Witness statement of Hamish Arnott, §59, BHM000042_0017.
[836] Karen Churcher 10 March 2022, 63/12-16.
[837] Karen Churcher 10 March 2022, 64/8-25 to 65/1-6.
[838] Karen Churcher 10 March 2022, 67/9-13.

health caseload[839]. Ms. Calver accepted that the systems designed to safeguard detained persons failed in his case[840].

480. Suspicions that D1275 may lack mental capacity to make decisions about accessing healthcare or accessing legal advice and assistance were not only evident from his non-engagement with healthcare, it was also apparent from the information that the detention custody officers had. In an initial meeting for an anti-bullying Support Plan[841], opened on 22 June 2017, the record noted:[842]

> "*a lot of D1275's answers made no sense to what I was asking him. I don't believe he grasped what I'm saying. D2553 is also concerned because he tries to sort out appointments for him with solicitors and doctors but it appears D1275 doesn't have mental capacity to know when his appointments are and to attend them. Have informed him that we are opening an anti-bullying log which means we will be keeping an eye on him if he needs to talk to any of us just come to see us about any concerns*".

481. It is evident from the repeated discharge from the mental health team that no assistance was given to him to access doctors' appointments. There is no evidence before the Inquiry to confirm that assistance was actually given to D1275 to enable him to access a lawyer. Stewart Povey-Meier, the supposed safeguarding lead, admitted in his evidence that he had had no training on mental capacity at the time[843].

482. As the Inquiry has heard, the Court of Appeal has been critical of the absence of any provision of independent advocacy to facilitate mentally ill people like D1275 who may lack mental capacity to access legal advice and assistance, particularly as this many involve advice and assistance on a challenge to their detention and conditions of detention which, by the very nature of their incapacity, they cannot do themselves. Like *VC, ASK* and *MDA*, D1275 suffered recurring discrimination on grounds of his disability in breach of the Equality Act 2010 because there was no mechanism or provision made

[839] Sandra Calver 1 March 2022, 181/19-25 to 182/1-4.
[840] Sandra Calver 1 March 2022, 182/15-22.
[841] CJS001127.
[842] CJS001127_0003.
[843] Stewart Povey-Meier 17 March 2022 20/13.

at Brook House, or indeed across the detention estate, to assist people like him. But for the tenacity of Naomi Blackwell, a caseworker at GDWG, he could have remained in detention indefinitely in an environment that failed to meet a fundamental need arising from his mental illness, because the HO had systemically failed to comply with its legal duties in refusing to make provision for independent advocacy for people who may lack mental capacity. By the time GDWG found him, he had been in immigration detention for nearly 400 days. Her evidence is that it was obvious that he was mentally unwell but nothing was being done by the IRC to assist him in accessing legal help to end his detention[844].

483. Dr. Hard described it as *"quite serious concern"* that they appeared to be no consideration at all of mental capacity when he had missed so many appointments;[845] and that there ought to be more proactive investigations, even if to be reassured that clinically there were no concerns, rather than assuming there were not any.[846] Dr. Hard was of the view that this significant absence in provision of independent advocacy contributed to harm to D1275 because he continued to deteriorate in detention whilst he lacked capacity to deal both with his treatment and attendance at medical appointments and immigration case.[847] It also prevented him from challenging his patently unlawful detention.

**(iii) Exposure to exploitation and bullying as a result of failure of safeguards**

484. The Inquiry has also seen evidence that there were a number of other systems failures in D1275's case as information was repeatedly available to show that he was vulnerable. A Security Information Report (SIR) raised on 20 June 2017 noted "*mental health issues, erratic and strange behaviour, wing staff reported concerns yesterday regarding his associations and believe he may be easily led and vulnerable. RMN requested to add him back on their list*"[848].

485. A further SIR raised on 22 June 2017[849] resulted in an anti-bullying plan being put in place. This raised concerns that D1275 was being used as a guinea pig to try out drugs

[844] Naomi Blackwell witness statement, §7, BHM000040_0002.
[845] Dr Jake Hard 28 March 2022, 153/3-14.
[846] Dr Jake Hard 28 March 2022, 153/15-23.
[847] Dr Jake Hard 28 March 2022, 157/1-13, 19-24.
[848] CJS004642_0005.
[849] CJS005347.

trafficked into Brook House. This was some 8 days after the incident on 14 June 2017. The SIR raised other concerns of bullying and stated "*The officer does not feel he is aware of some of his decisions and has been taken advantage of*"[850]. The anti bullying plan noted that D1275 attended the initial meeting with another detained person D2553 and stated "*I don't believe he grasped what I'm saying. … Have informed him that we are opening an anti-bullying log which means we will be keeping an eye on him if he needs to talk to any of us just come to see us about any concerns*"[851].

486. The Inquiry has heard that this anti-bullying plan, despite raising concerns that D1275 was "*possibly not fit for detention*"[852], was closed before it should have been (as Steve Dix accepted that it should have been open for at least 14 days) and there was no evidence as to what steps had been taken to protect D1275[853]. It is clearly appalling that D1275 remained in detention for a further year after the closure of this document.

487. Similarly in September 2017 a Supported Living Plan (SLP) was opened by Stewart Povey-Meier, the safeguarding lead, as D1275 featured in the Panorama documentary[854]. This reasons given for opening the SLP were "*Learning Disabilities*" and "*Safeguarding*" but unaccountably Mr Povey Meier claimed that D1275 was not an "adult at risk"[855]. This was despite the fact that throughout his detention D1275 was identified as a level 2 adult at risk (see for example detention review[856]).

488. As with the anti-bullying plan in June the SLP was closed with no evident steps being taken to ensure he was properly assessed. Referrals to healthcare resulted in discharge from mental health for failure to attend appointments without proper examination of why.

489. The Panorama documentary also resulted in G4S referring D1275's case to the local social services department for a safeguarding review. However the referral form completed by Michelle Brown did not mention that D2175 had been subject to verbal abuse, had been repeatedly referred to mental health or that there had been concerns about

[850] CJS005347_0002.
[851] CJS001127_0003.
[852] CJS001127_0004.
Steve Dix 9 March 2022, 20/10-24/19 and 49/14-51/4.
[854] CJS001036_001.
[855] CJS001036_005.
[856] HOM007742_0004.

his mental capacity. Further it did not refer to the length of D1275's detention. He had by that time been detained for about 11 months including 4 months at Brook House. It solely referred to the fact that he had taken spice[857]. Social services did nothing to properly investigate D1275's well-being or safety, did not visit him in person and relied on a report from G4S that D1275 had "no social care needs"[858]. Clearly it was inadequate safeguarding by social services to allow G4S to self report in this way when its own staff had been guilty of abuse of D1275, and there was a failure to properly monitor his deteriorating mental health, and a wholesale failure to consider the need to properly assess his mental capacity. "[859]. There was no proper investigation of the extent to which D1275 might be *"experiencing, or is at risk of, abuse or neglect"* as required by section 42 of the Care Act 2014

490. Shockingly D1275 was detained for a further 9 months after the closing of the SLP in September 2017 during which his mental health continued to further deteriorate.

**(e) <u>Conclusion</u>**

491. D1275's case is a paradigm example of how the different parts of the immigration detention system – and the individuals responsible for operating those parts – collectively and individually mistreated him by reckless indifference for his safety, neglect of his health, and acquiescence to his bullying, exploitation and abuse. The root cause is not just poor training, poor application of policies or the bad behaviour of a few. It is the inadequate and failing systems in detention policy and safeguarding, and the institutional culture of dehumanising indifference, disbelief and impunity that allowed this abuse to go on for so long in D1257's case – 616 days, 422 at Brook House.

492. Dr Bingham notes that the healthcare failures in his case "*led to someone with multiple indicators of vulnerability, who appears to have learning difficulties, being left in detention without his needs being addressed for an extended period of time. The chronology of events in Brook House, and the approach of the mental health team suggests that had he not been referred to solicitors and supported to challenge the conditions of his detention, he would have remained in detention for even longer and*

[857] WSC0000008_0002.
[858] WSC000010_0002.
[859] WSC000010_0002.

*suffered further deterioration, because there is no indication prior to this of the healthcare staff recognising the need to raise concerns about his health in detention. The fact that he was detained under section 2 and then 3 of the Mental Health Act 1983 soon after his release from immigration detention indicates how seriously unwell he had become, to the extent that he required a prolonged compulsory psychiatric admission*"[860].

493. Beyond the appalling verbal abuse he suffered at a time of acute vulnerability in a potentially life-threatening situation his case has the following key features which reflect systemic failures:

a. D1275 had serious and untreated mental health issues which were not identified or managed at all at Brook House. This was despite recurring healthcare logs citing his bizarre and at times aggressive behaviour and incoherent answers to questions. No Rule 35 report was produced during his detention which was unlawful and prolonged,

b. Allied with this was the failure to undertake any assessment of D1275's mental capacity in circumstances where it was noted that he appeared not to understand questions asked of him or appointments with doctors, their purpose, their relevance or their importance. Until November 2017, when Gatwick Detainee Welfare Group encountered D1275 and referred him for legal advice and assistance, he could not take any steps to seek advice about his immigration detention for more than a year because he had no mental capacity to do so.

c. This failure to deal effectively with mentally incapacitated detained persons and to ensure they have an ability to effective access legal remedies for their detention and treatment in detention was not new to Brook House in 2017. The Inquiry has our submissions on the significance *VC* case[861], and the continued failure of the Home Office to put in measures to address the specific vulnerable position of mentally incapacitated detained persons by provision of advocacy support.

[860] Dr Rachel Bingham witness statement, §92, BHM000033.
[861] Witness statement of Hamish Arnott BHM000042_0040-0041.

d. All of this happened with the knowledge and acquiescence of detention centre staff, despite it being their statutory duty under R45(2) of the Detention Centre Rules 2001 to promptly report any abuse or impropriety which comes to his knowledge.

e. Worse, this was set against HO decision-making, which was characterised by a disregard of the clear and credible clinical indicators of D1275's vulnerabilities and a single-tracked focus on deportation action where there was just no prospect of achieving that. The HO refused to grapple with that reality and continued to make attempts for D1275 to be interviewed by Iranian Consulate officials on 5 occasions even after the Consulate officials raised concerns about D1275's bizarre behaviour and incoherent speech[862].

494. Accordingly this is a clear case where the Inquiry should make findings that D1275's treatment breached article 3 ECHR in relation to the state's systems duty which directly caused or contributed to the operational failures in his individual case. There is also a breach of Article 3 investigative duties. When considering the threshold for article 3 the Inquiry should take into account that D1275 was not being lawfully detained during his detention at Brook House.

495. In relation to the operational duty the serious mistreatment of D1275 and abuse he suffered from detention centre officers clearly constituted inhuman and degrading treatment given the serious and prolonged humiliating abuse and the vulnerability of D1275 given his condition and his mental health.

496. The admitted systemic failures of healthcare resulting in D1275's deterioration to the point of losing mental capacity and developing a serious mental illness that required compulsory hospital treatment shortly after his release also breach article 3 given the duty to provide adequate healthcare to detained persons[863]. These failings include the complete failure to provide any or any appropriate medical care or adequate medical treatment. Instead D1275 was repeatedly discharged from the mental health caseload with inadequate investigation and the failure to assess mental capacity. There was in addition the failure by the Home Office to comply with the *VC* judgment to remedy the

[862] HOM011253_0002.
[863] *Rooman v Belgium* 18052/11 21 January 2019 para 147.

discrimination against those that lack capacity or are seriously mentally unwell in detention. D1275's pre-existing mental illness was clearly exacerbated by the fact of and conditions of detention.

497. In relation to the investigative duty the Home Office failed to disclose in judicial review proceedings the circumstances of D1275's mistreatment on 14 June 2017 or the documents relating to the anti-bullying plan opened in June 2017 or the SLP from September 2017 that showed that there were serious concerns about his suitability for detention and his mental capacity. To date there has been no real accountability within the Home Office for these unlawful actions whether at a system or individual level. The challenge to the lawfulness of D1275's detention was settled for a very substantial sum of money but with the most minimal concession on when the detention became unlawful and why. No apology was offered. The concessions appeared to be tactical to avoid the full proceedings and scrutiny of the court. Only this Inquiry is uncovering the full extent of the failure of detention and safeguarding policies, as well as the true gravity of the consequences for D1275's fundamental rights, physical and mental health, and moral integrity and human dignity.

## (3) D1713

### (a) Introduction

498. D1713 is a Nigerian national who was granted refugee status in the UK in 2019. He is a victim of torture, sexual and physical abuse. He was violently attacked in Nigeria as a result of his sexuality. As a result of these horrific experiences, he already suffered from PTSD before entering Brook House on 31 March to 17 April 2017 and then 20 - 22 April 2017.

499. In Brook House there was a complete failure of detention policy and, safeguards. D1713's case is a classic illustration of the lasting mental harm caused by such deprivation of safeguards. D1713 was dehumanised in Brook House: he frequently said he felt like a dog, and, shockingly, a DCO also described him in those terms. The complete dysfunction of clinical safeguards in D1713's case precipitated a direct and acute deterioration in his PTSD symptoms for which he received no appropriate and adequate medical care. This exposed him to intense mental suffering, anguish, humiliation and feelings of complete helplessness of such a degree it amounted to inhuman and degrading treatment under Article 3 ECHR.

### (b) Initial failures in Rule 34 and 35

500. D1713 arrived at Brook House IRC in the early hours of 31 March 2017 and was "*tired and confused*".[864] At this time he had a health screening appointment, but this process entirely failed. He was not asked questions about his mental health, nor if he was a victim of torture. He wasn't offered to see a doctor for a Rule 34 appointment; however, in his medical records the nurse wrongly recorded that he had refused to see a doctor.

501. After this he was locked in a cell and was immediately "*desperate and petrified*".[865] Within only a few hours of being locked in the cell his mental health started to deteriorate: "*I started having hot flashes and flashbacks to events in my childhood and mistreatment I had suffered, including being attacked and physically abused. I felt really low and started to have thoughts about hurting myself, which scared me. I felt claustrophobic*

[864] Witness statement of D1713, §18, BHM000018_0004-0005.
[865] Witness statement of D1713, §22, BHM000018_0005.

*being locked in the cell. It also felt humiliating that we would be locked up all night until someone came to release us in the morning, like animals*".[866]

502. Upon D1713's request, he was seen by Dr Chaudhary on 1 April 2017 and disclosed self-harm ideation, flashbacks, and a history of torture with scarring. D1713's presentation was distressing: he told Dr Chaudhary that he was "*scared to look in the mirror was going to harm himself*", was "*scared of himself*" and he "*didn't want to lose it*". Dr. Chaudhary plainly considered D1713's mental ill health serious, recording that "*Pt tearful +++ (appears Genuine)*".[867] However, despite this no Rule report was prepared under any of the three limbs.

503. Dr Chaudhary was asked in oral evidence about seeing D1713 on 1 April 2017 and why – in the face of D1713 expressly stating he had scars on his body and suffered from traumatic flashbacks – he failed to refer him for a Rule 35(3) report. Dr Chaudhary's response was woefully confused. He sought to suggest first that he didn't consider a Rule 35(3) report was necessary as torture was a 'historic' rather than 'ongoing' issue, before then suggesting he had understood a report would have booked in at the reception screening. This had of course not been done, which would have been obvious on any cursory review of D1713's medical records. He accepted in his oral evidence that he was concerned about the impact of detention on D1713's mental state and suspected suicidal ideation;[868] however when pressed on why he had not prepared a report under Rule 35(1) or (2) he betrayed a serious misunderstanding in the relevant threshold, believing that positive evidence of mental deterioration was first required.[869] Whilst this threshold was plainly wrong, the fact that D1713 had immediately started experiencing flashbacks was positive evidence that he had already started deteriorating and experiencing harm in detention.

**(c) Ongoing safeguarding failures, lack of treatment & management on ACDT**

504. Dr Chaudhary prescribed anti-depressants and referred D1713 to the mental health team for an urgent review: D1713 again disclosed his history of torture and showed the nurse

[866] Witness statement of D1713, §22, BHM000018_0005.
867 BHM000005_0004-5.
868 Dr Saeed Chaudhary 11 March 2022 189 /17-25 & 190 /1-4.
869 Dr Saeed Chaudhary 11 March 2022194-200: in practice, he was clear that R35(1) was construed as whether the detainee's mental health could be managed in detention and that R35(2)s simply were not done.

his scars. He said that "*Brook House makes him feel like he is a dog*".[870] He said that he hadn't eaten since arrival at Brook House. He had further appointments with mental health nurses and during these sessions he repeatedly said that he was too stressed to eat, disclosed trauma symptoms including continued flashbacks and a past history of torture. He said again that the Home Office "*looked at him like an animal*"[871] and he "*felt like a dog*".[872] D1713 suffered recurring intrusive flashbacks, as if he was re-experiencing his torture again, almost every day[873] but received no medical treatment. Not once during these mental health reviews did nurses consider Rule 35 referrals or an assessment of his PTSD symptoms. He was not referred to a psychiatrist. There was no consideration of the clinical implications of his inability to eat due to stress, nor were any food refusal forms produced throughout his detention. Instead of treatment, he was managed by healthcare by way of anti-depressants and non-clinical suggestions (he was told to "*be as active as possible, gym and football*"[874] and "*not to dwell on the past*"[875]). These sessions stopped on 10 April 2017 and D1713 was discharged from the mental health team, despite the fact that he had received no substantive mental health assessment and his mental health symptoms persisted.

505. Dr Chaudhary reviewed D1713 again on 8 April 2017; however, despite the repeated disclosures he had made to mental health nurses, Dr Chaudhary failed to refer D1713 for an assessment. He said both in his written and oral evidence that he still wasn't sure if D1713 had been referred for a Rule 35 appointment by this stage. When asked whether he should have checked this – he said that was "*very difficult'* to answer and that '*you have to trust the system'*. [876] In fact, a Rule 35(3) report was only prepared on 6 May 2017 after D1713 had been transferred out of Brook House to Harmondsworth IRC. When it was put to Dr Chaudhary that D1713 only had a Rule 35(3) 36 days into his detention, Dr Chaudhary just blankly accepted this: with no explanation or apology offered.[877]

870 BHM000005_0005.
871 BHM000005_0006.
872 BHM000005_0006.
873 Witness statement of D1713, §§22-24, 29, 31, BHM000018.
874 BHM000005_0006.
875 BHM000005_0005.
876 Dr Saeed Chaudhary 11 March 2022 206/12-20.
877 Dr Saeed Chaudhary 11 March 2022 24 /21-25 & 248 / 1-2.

506. On 1 April 2017 D1713 was placed on an ACDT: he was initially on 2 hourly observations, then hourly observations, then 2 hourly observations at night with two quality conversations a day before the ACDT was closed on 11 April 2017.[878] Despite the necessity for regular observations this did not prompt any consideration of a Rule 35(1) or (2) report. Further, D1713 said the checks were cursory and less regular than they should have been: he said he tried to talk to the G4S officers who came to see him but did not feel listened to when he did.[879] The ACDT is not a therapeutic intervention and it certainly was nothing of the kind for D1713: during his ACDT review on 4 April 2017 D1713 disclosed that he was emotional, suffering from migraines, that detention was "*killing him*" and that he was "*doesn't want to hurt himself but is struggling*". In response, he was told by a nurse that "*humans have ups and down*".[880] Despite the seriousness of the concerns about D1713's symptoms (his ongoing flashbacks, that he was "suffering from migraines and crying a lot" [881]) the ACDT was closed on 11 April 2017 (without D1713 being notified of the same) because he "*was looking better… trimmed his beard and had his hair cut*", was "*taking his medication*", and that whilst he had "*thoughts that disturb him… he is dealing with them*".[882] Plainly, healthcare were not dealing with them.

507. D1713 was transferred to Harmondsworth IRC for an asylum screening interview on 17 April 2017 without notice: he had been washing his clothes and was giving no time to dress, so had to wear a wet t-shirt. He was cold and humiliated. He was returned to Brook House IRC on 20 April 2017. Again, the screening process entirely failed: it was recorded that D1713 had "*no medical or mental health issues*" and "*had not received medication for mental health problems*",[883] which was plainly incorrect.

**(d) <u>Detention Environment and Culture</u>**

508. The environment of fear and callous indifference at Brook House intensified the extent of D1713's mental suffering. D1713 was directly exposed to the demeaning attitudes of staff, including when one DCO compared locking him up to locking up a dog: "*I would*

[878] CJS001308_0002, CJS001318_0004, CJS001274_0003.
[879] Witness statement of D1713, §26, BHM000018_0007.
[880] CJS0074066_0001.
[881] Witness statement of D1713, §29, BHM000018_0008.
[882] CJS0074067_0001.
[883] BHM000005_0010-11.

*never lock up my dog but I would lock you up*". This left him feeling "*humiliated and scared… like I was not being seen or treated as a human being*".[884]

509. D1713 was also scared of the secondary effect of spice on him, as his roommate was addicted to it and smoked it regularly. Such was the chilling atmosphere at Brook House that D1713 never complained or reported this because he was "*scared of what could happen to me or him if I reported it…. we did not know what would happen and people thought they would not provide medical help but would instead punish the detainee*". He also felt physically at risk of sexual assault in Brook House, as other detained persons made advances towards him which felt like both mockery and threat. He reported this to healthcare on 8 April 2017, but didn't raise it again because he was "*scared that some members of staff may be homophobic and I would not be safe*".[885]

510. He also witnessed numerous instances of vulnerable detained persons in crisis, including those who were actively self-harming, being subject to the excessive use of force. In all he felt reduced to less than human in an environment where, as he describes, "*we were all scared of the consequences of speaking out……we were living in fear. Brook House was like hell*".[886]

**(e) <u>Failure of AAR policy framework</u>**

511. The comprehensive failure of the Rule 35 safeguards in D1713's case was compounded by the broader misapplication of the AAR policy framework. D1713 was not suitable to be detained due to his history of torture and mental ill health. He was also not removable as he had claimed asylum on 1 April 2017: his claim was clearly complex and credible, as he was subsequently granted refugee status. However, detention reviews throughout his time at Brook House consistently disregarded the ample evidence of his deteriorating mental state, at times stating that the Adults at Risk policy was not engaged at all, and at others assessing him as an Adult at Risk Level 1 with no risk indicators.

512. Despite the lack of Rule 35 report, the Home Office was on direct notice of D1713's mental ill health from the outset of his detention on 1 April 2017, as he had written to the

[884] Witness statement of D1713, §34, BHM000018_0009-0010.
[885] Witness statement of D1713, §44, BHM000018_0013.
[886] Witness statement of D1713, §40, BHM000018_0012.

Home Office directly stating that he felt depressed and suicidal and that he had lost his appetite and was suffering from flashbacks.[887] The Home Office was aware that he was on an ACDT. Yet in their 7-day review the Home Office stated that "*there are no known or claimed medical conditions*" and "*no risk indicators under the Adults at Risk (AAR) Policy*".[888] The complete dysfunction of these processes meant that D1713's detention was procedurally unlawful from the outset of his detention at Brook House and throughout.

**(f) <u>Impact of Detention at Brook House</u>**

513. Detention and in this inhumane environment exacerbated D173's pre-existing mental illness for which he received no appropriate and adequate medical care during detention. After leaving Brook House, D1713 he was diagnosed with a severe episode of depression and PTSD with a poor prognosis. He says: "*Detention has had a long-lasting effect on me and my mental health. I have struggled with symptoms of PTSD and depression since being released. I have frequent nightmares related to my time at Brook House and often feel very low. I easily feel scared if for example I hear a door banging as it brings my mind back to the time I was in detention. I also suffer from flashbacks which are both about my traumatic experiences in Nigeria and my time at Brook House*".[889]

[887] HOM032998.
[888] HOM032970_0001-2.
[889] Witness statement of D1713, §65, BHM000018_0018.

## (4) D2158

### (a) Introduction

514. D2158 is a refugee from Iran who was detained at Brook House from 10 April to 15 May 2017. He is a victim of torture in state detention, and a victim of child sexual abuse, whose vulnerabilities were not identified by the Home Office prior to detention. His is a case of serious mistreatment by persistent failures to identify and act upon the fact that a) his detention was unlawful and he should never have been detained; and b) he was acutely vulnerable and at risk of harm in detention. The cumulative dysfunction of detention policy and safeguards in his case exposed him to intense suffering, fear, and humiliation in breach of Article 3 ECHR.

### (b) D2158 should not have been detained

515. The 35 days that D2158 was detained at Brook House were, unequivocally, unlawful. The Home Office was, or ought to have been, aware that his detention was unlawful from the outset as, whilst he was liable to be returned to Germany under the Dublin III Regulations, the regulations only provided for a power to detain *if and only if* the person posed significant risks of absconding. D2158 posed no such risk. In fact, the Home Office even noted in GCID records prior to detention that D2158 had "*no history of absconding*", and therefore was low risk of harm and low risk of absconding.[890]

516. Despite having correctly assessed that D2158 was a low risk of absconding (and therefore could not be lawfully detained), the Home Office decided on 30 March 2017 that he needed to be detained pending removal. Rather than grapple with the truth of its own risk assessment, the Home Office instead inexplicably raised his risk level from low to high in successive detention reviews.[891] As there was no change of circumstance, there can be no explanation for this, other than the Home Office artificially increased his risk level in an attempt to justify detention – a classic example of the Home Office engineering assessments to serve their immigration enforcement agenda, irrespective of legality.

### (c) Initial failures in Rule 34 and AAR

[890] GCID 07.04.17 [this has not been disclosed, or adduced – see Tab B(33) p.85 in bundle of documents provided by Bhatt Murphy].
[891] Detention Review 13.04.17/ Detention Review 24.04.17 / Detention Review 28.04.17 [These have not been disclosed, or adduced - see Tab A (8) p.23, Tab B (31) p.64 in bundle of documents provided by Bhatt Murphy].

517. At the point of his detention the Home Office designated D2158 as an Adult at Risk Level 1 on the basis that he reported having heart palpitations.[892] No attempt however was made to elicit his account of torture at the time. In any event being an Adult at Risk Level 1 was a meaningless status and afforded him no protection against harm in detention. This is because the Adults at Risk policy devalues information about likely harm coming directly from the detained person on the purported basis that it was self-declared, and therefore self-interested.

518. D2158 was detained on reporting. He had very limited English, so understood that he wasn't allowed to leave but did not understand why. He was confused, scared, overwhelmed, and did not understand what he was being told.[893] He only knew that "*something bad was happening*" and he was "*really frightened*".[894] He was handcuffed and taken to Brook House. Detention paperwork was not translated to him, so even upon arrival he did not understand what was happening to him.

519. D2158 managed to communicate that he had been tortured in Iran, had anxiety, and pains in his stomach, despite not having an interpreter available at the healthcare screening appointment.[895] Without an interpreter, however, he wasn't able to communicate any detail, including the fact that his stomach pain was a result of having been stabbed in Iran and that he wanted medical attention.

520. Despite his disclosure of torture, and related symptoms, D2158 was not referred for a Rule 35(3) assessment following his reception screening. Nor did he receive a Rule 34 assessment within 24 hours of being detained or at all throughout his detention. If this safeguard had functioned properly, then a Rule 35 assessment as to whether he was a victim of torture or indeed had other vulnerabilities would have formed part of this assessment. This ought to have enabled prompt identification of D2158 as an Adult at Risk and the consequential decision that he was unfit for detention. As it was, however, this initial and important safeguard failed D2158 entirely.

[892] HOM014772_0001 & GCID 10.04.17 [see Tab B(33) p.85 in bundle of documents provided by Bhatt Murphy].
[893] Witness statement of 2158, §7, BHM000029_0003.
[894] Witness statement of 2158, §9, BHM000029_0003.
[895] IRC medical records 11.04.17 [these have not been disclosed, or adduced – see Tab C p.119-120 in bundle of documents provided by Bhatt Murphy].

521. This deprivation of the Rule 34 safeguard led to a serious delay before D2158 was able to receive professional evidence capable of supporting his self-declaration of risk. He was not referred for a Rule 35(3) assessment until several weeks into his detention, by which point irreversible harm had already been done. This was compounded by the entirely incorrect assessment by the Home Office, in several subsequent detention reviews, that D2158 did not engage any of the Adults at Risk evidence levels.[896] This was notwithstanding that he had been previously assessed by the Detention Gatekeeper as an Adult at Risk Level 1 and nothing had changed since his detention to nullify this. His self-reporting of torture in his screening of course only reinforced this.

**(d) <u>Continued failures in safeguards and deterioration in his health</u>**

522. D2158 struggled in the inhumane environment at Brook House. He felt claustrophobic in the cell and found being locked in "*really hard to cope with*" but didn't have the means to communicate to anyone his distress and fear. He heard officers taking other detained persons out of their cells and it sounded like "*they were in distress*",[897] so he was both scared to be in the cell, and scared to leave it. He started having daily headaches, heart palpitations and nightmares that were so vivid they felt real, often feeling like *"someone was putting their hands around my throat and I struggled to breathe"*.[898] Healthcare knew this: D2158 reported his escalating symptoms to a nurse on 17 April 2017 (using another detained person to interpret), yet nothing whatsoever was done.[899]

523. Whilst a mental health referral was later made on 26 April 2017, this was not in fact actioned until several weeks two later. Further still, the first and only mental health review D2158 thereafter received was not a full mental state examination and failed entirely to identify or address his serious trauma-related symptoms. Despite D2158 repeating his details of torture, and being woken up by the slightest of noises, the RMN erroneously recorded that "*there was no issue regarding his mental health reported or noted*". D2158 was just told he was in a safe place which, of course, was patently untrue.

[896] See Detention Review 13.04.17 [this has not been disclosed, or adduced – see Tab A p.23-24 in bundle of documents provided by Bhatt Murphy].
[897] Witness statement of D2158, §17, BHM000029_0005.
[898] Witness statement of D2158, §21, BHM000029_0006.
[899] IRC medical records 17.04.17 [these have not been disclosed, or adduced – see Tab C p.120 in bundle of documents provided by Bhatt Murphy].

524. D2185 also suffered from severe dental pain as a result his experiences of torture. His dental pain was noted by healthcare and his broken teeth were "*visible on visual inspection*".[900] Predictably, this did not raise the alarm bells it should have, instead he was sent away with ibuprofen and put on the waiting list to see a dentist. His persistent reports of heart palpitations similarly failed to provoke any concern or clinical investigation. This informed the central failure to identify the root causes of D2158's composite clinical presentation, including the extent to which his physical health issues were symptomatic of his history of torture. In fact, D2158 did not see a doctor at all for the first 16 days of the 35 days of his detention. When he did finally see a doctor, no clinical investigation was carried out into the multiple physiological and psychological symptoms of a history of past torture, symptoms that had been brought to the forefront by being locked in once again by the state from which he had thought he would be able to seek protection.

525. The intense physical and mental suffering that D2158 endured, concomitant to the complete absence of clinical input or safeguards, was exacerbated by the inhumane environment at Brook House. The conditions were so humiliating for D2158 that he still finds it difficult to think about: the lack of privacy when using the toilet, the dirty showers and overflowing drain water, the smells.[901] He also witnessed acts of self-harm by other detained persons: he tried to help one detained person who had cut his wrists very badly and was bleeding, but was pushed away by an officer.[902] He saw another detained person cut his wrists in a common area and saw blood everywhere,[903] and he saw a detained person who had wrapped an electric shaver around his neck to strangle or hang himself, with detained persons shouting for help as it looked like the man was suffocating.[904] The very high levels of distress and self-harm at Brook House, together with the cruel indifference of officers to such pain, created a brutalising and traumatising environment for all detained persons. This was especially acute for a detained person such as D2158, who did not know or understand why he was being detained and felt entirely powerless and subjugated in his attempts to communicate his serious issues to healthcare.

[900] IRC medical records 14.04.17 [these have not been disclosed, or adduced – see Tab C p.120 in bundle of documents provided by Bhatt Murphy].
[901] Witness statement of D2158, §§19-20, BHM000029_0006.
[902] Witness statement of D2158, §42, BHM000029_0012.
[903] Witness statement of D2158, §43, BHM000029_0012.
[904] Witness statement of D2158, §44, BHM000029_0013.

526. A Rule 35(3) report was eventually prepared by Dr Ooozeerally on 26 April 2017, more than 2 weeks after D2158 was detained.[905] D2158 found it difficult to communicate through a telephone interpreter and the Farsi speaker wasn't fluent so the interpreter struggled to understand. He was therefore unable to convey the intensity of his mental anguish and physical suffering. The report produced failed to address the causal link between D2158's history of torture and the palpitations, broken teeth, and trauma symptoms he suffered. D2158 did not understand the purpose of the appointment and felt like the doctor wasn't really listening, and that "he didn't really *see* me".[906] There was no clinical analysis of his mental health and risk of deterioration, nor was any consideration given to preparing a parallel report under Rule 35(1).

527. In response, the Home Office accepted that D2158 was an Adult at Risk Level 2, but concluded that, presumably in the absence of any such indication from Dr Oozeerally, there was no evidence that detention would harm him. His detention was therefore unjustifiably maintained, in keeping with the Home Office's single-track focus of removing D2158 to Germany.[907]

528. In the absence of having any voice, and because he "*couldn't take it anymore*",[908] D2158 resorted to a short period of food refusal.[909] With the same cavalier disregard shown by healthcare across all aspects of his care, this was dismissed as a dietary issue, with no clinical investigation into the nexus with his escalating trauma symptoms and deteriorating mental health. The single clinical solution to all of his medical problems – even after the Rule 35 assessment – was apparently ibuprofen and a little mouthwash.

529. The Rule 34 and 35 processes failed entirely to safeguard D2158 from the risk of harm in detention. This was due to the systemic failure of both, and the reckless incompetence of both Home Office and healthcare staff, who failed at every level of decision-making

[905] This Rule 35(3) report has never been disclosed by the Home Office or G4S. We were told in an email from STI on 22.03.22 that "*G4S and the Home Office have confirmed that they have reviewed their records and were not able to locate this report*". See entry in IRC medical records which extracts the content [see Tab C p.121-122 in bundle of documents provided by Bhatt Murphy].
[906] Witness statement of D2158, §25, BHM000029_0007.
[907] HOM014757_0001.
[908] Witness statement of D2158, §46, BHM000029_0014.
[909] IRC medical records 11.05.17 [these have not been disclosed, or adduced – see Tab C p.123 in bundle of documents provided by Bhatt Murphy].

to identify D2185 as a highly vulnerable victim of torture who should never have been detained in the first place.

530. These serious failures were compounded by the fact that D2158 was entirely powerless to identify or challenge them and to obtain the appropriate medical care or adequate treatment for his mental ill-health, because he didn't know his rights and couldn't speak English. He didn't even know that such detention safeguards existed to protect victims of torture such as himself, let alone how to ask for them or raise concerns that they weren't being applied properly. The total dysfunction of these safeguards directly exposed D2158 to mental suffering, anguish, and feelings of inferiority of such an intensity as to constitute inhuman and degrading treatment under Article 3 ECHR.

**(e) <u>Physical assaults</u>**

531. Like countless other detained persons, D2158 was subjected to bullying and demeaning treatment whilst at Brook House. He describes how officers at Brook House "*did not treat us like humans*".[910] They were treated "*more like animals*".[911] He was also kicked by a DCO on two occasions. On the first occasion, an officer approached him from behind and "*kicked the bottom of one of my feet pushing me further into the cell*"[912]. The officer was wearing boots, and D2158 was wearing flip flops, so this hurt a great deal. D2158 was too scared to react, or complain, in case officers punished or hurt him. On the second occasion a different officer kicked the back of his knees – again, this caused him pain and D2158 stumbled forward. These unprovoked, senseless assaults were unlawful and degrading: D2158 said "*it was just humiliating*".[913] This casual violence was an overt demonstration of the overbearing power which officers wielded over vulnerable detained persons such as D2158. Within the context of the dehumanising environment that the Inquiry has heard prevailed at Brook House, there is no doubt that such violence was perpetrated with the express intention to intimidate and humiliate.

532. These episodes of physical mistreatment intensified the fear that D2158 felt at being detained. This fear manifested in his physical symptoms: the sounds of doors being opened, banging and the sounds of keys would make his whole body shake and he would

[910] Witness statement of D2158, §34, BHM000029_0009.
[911] Witness statement of D2158, §34, BHM000029_0009.
[912] Witness statement of D2158, §37, BHM000029_0010.
[913] Witness statement of D2158, §39, BHM000029_0011.

feel an electric shock in his body.[914] Such humiliating and demeaning treatment served also to aggravate the acute mental suffering and anguish caused to D2158 by the fact and conditions of his ongoing unlawful detention.

533. D2158 had no knowledge of the complaints system, nor anyone to talk to about the assaults. He was left both voiceless and powerless. Even if he had known about the complaints process, and been provided with an interpreter to enable him to communicate, the atmosphere at Brook House was so oppressive and coercive that D2158 was too scared to speak up for fear of reprisal. His experience is a stark example of the chilling effect perpetuated by the climate of fear and intimidation at Brook House.

**(f) Impact of Detention**

534. D2158 was released on 15 May 2017 without any explanation, similarly to the way that he had been detained. After his release the Home Office accepted responsibility for his asylum claim and granted him refugee status. In the community D2158 felt able to eat again and was able to get medical help – he was diagnosed with depression in December 2017. In 2021 a psychiatrist found that D2158 suffers from PTSD and that detention at Brook House had exacerbated his condition. D2158 still struggles to sleep properly and has flashbacks and nightmares about his treatment in Iran and his time in Brook House IRC.

[914] The report of Dr Paula Murphy 05.08.21 was submitted to the Inquiry on a confidential basis on 09.08.21.

## (5) D1473

### (a) Introduction

535. D1473 is a Nigerian national who is a victim of torture and sexual violence. He was detained at Brook House from 19 August to 29 September 2017. The extent of his mistreatment at Brook House is graphically illustrated by the prolonged and excessive restraint he suffered for some 5 and a half hours during an attempted unlawful removal in breach of Article 3 ECHR.

### (b) Initial periods of detention

536. D1473 was initially detained at The Verne IRC in 2014 – 2015 and thereafter re-detained there on 13 July 2017 prior to being transferred to Brook House IRC. These initial periods of detention are relevant to this Inquiry to the extent that:

a. He suffered from flashbacks, nightmares, and ongoing thoughts of self-harm and suicide throughout these periods of detention.[915]
b. In July 2017 an ACDT was opened as D1473 had self-harm ideation and was prescribed 50mg of anti-depressant. He was told that he would see a psychiatrist, but never did.[916]
c. In August 2017, D1473 tied a belt from his dressing gown around his neck and was subsequently placed in CSU.[917]
d. A month after his detention in 2017, D1473 received a Rule 35(3) report which detailed his account of torture in Nigeria, his symptoms, his scarring consistent with his account of torture, and stated that his "*psychological symptoms which have worsened and may continue to worsen due to detention*".[918] D1473 disclosed suffering flashbacks which had worsened in detention due to provoking factors e.g. hearing keys in doors.
e. The Home Office accepted that D1473 was an Adult at Risk Level 3 but unjustifiably maintained his detention nonetheless[919] on the basis of his purported risk of re-offending, despite him plainly not presenting as a significant public protection concern so as to justify the exceptionality of his ongoing detention.

[915] HOM029928_12.
[916] Witness statement of 1473, §17, BHM000039_0003.
[917] Witness statement of 1473, §19, BHM000039_0004; HOM029928_0012.
[918] HOM029580_0002-004.
[919] HOM025028_001-003.

f. On 16 August 2017 his immigration solicitors submitted a fresh claim arising from his family life, which meant that he was not removable during his subsequent period of detention at Brook House. This barrier to removal, in combination with his status as an Adult at Risk Level 3, rendered his detention unlawful and in breach of policy.

**(c) <u>Failures in safeguards & healthcare at Brook House</u>**

537. In light of the above, D1473 arrived at Brook House as an already intensely vulnerable individual, on an open ACDT (which he remained on throughout his detention). Shortly after his arrival, he was placed on constant watch and transferred to E wing after expressing suicidal thoughts linked to being behind locked doors. Despite D1473's obvious and acknowledged risk of suicide, there was no consideration of a Rule 35(2) or Rule 35(1) report. Instead, healthcare informed the Home Office that he was on an ACDT using a IS91RA Part C form.[920]

538. The inhumane environment at Brook House was a "*real shock*"[921] to D1473 and he found E wing in particular to be "*really difficult*" as he felt that "*no one actually cared about me*".[922] He found being locked in a room highly stressful and claustrophobic, intensifying traumatic flashbacks of his mistreatment in Nigeria. He says of this: *" I started to feel less like myself and less like a human at all."*[923] He felt increasingly depressed and anxious and was afraid to be behind locked doors.[924] However, he felt lucky that he could speak English as he witnessed other people in Brook House struggling to understand their situation; in fact, he considers that if he couldn't speak English, or read and write, he would have been unlawfully removed from the UK as he wouldn't have been able to find help.[925] D1473 found the overall atmosphere at Brook House wholly dehumanising and derogatory, feeling that "*staff at Brook House wanted to deliberately put you down, or kill your spirit, because then you feel less of yourself, less human, and you're less likely to speak up or resist*".[926]

[920] HOM025617_0008.
[921] Witness statement of 1473, §30, BHM000039_006.
[922] Witness statement of 1473, §33, BHM000039_006-007.
[923] Witness statement of 1473, §34, BHM000039_007.
[924] HOM029928_18.
[925] Witness statement of 1473, §40, BHM000039_008.
[926] Witness statement of 1473, §42, BHM000039_008.

539. D1473's experience at Brook House is characterized by a comprehensive failure in detention policy and clinical safeguards which ought to have protected him from further harm in detention. His clinical needs were seriously and persistently mis-managed whilst at Brook House in the following ways:

a. D1473 was identified as having a depressive disorder during his Brook House screening and being on anti-depressant medication. However, despite this, and his placement on constant watch, he did not receive a Rule 34 compliant assessment on arrival or throughout his time at Brook House. His first appointment with a GP was not until some five days into his detention and failed entirely to assess his deteriorating mental state.

b. He did not receive any form of substantive assessment or medical treatment for his serious trauma-related symptoms throughout his time at Brook House. This was even after he reported feeling that the index restraint had 'traumatised' him, precipitating his traumatic memories, and that he was hearing voices.[927]

c. His AAR risk level was inappropriately downgraded to AAR L2 on 7 September 2017[928] on the basis of wholly misleading information communicated by healthcare to the Home Office that further detention was not injurious to his health and that his "*mental health appears to be well managed*". There had been no positive change to the clinical picture of risk captured in the original R35(3) report to warrant this re-assessment. D1473's mental state had in fact deteriorated further during his time at Brook House, accelerated by his wrongful restraint and attempted removal, in respect of which he still had yet to receive any psychiatric input. His detention was therefore unlawfully maintained on the basis of a further egregious misapplication of the Adults at Risk policy.

540. The collective failure of these clinical safeguards operated to expose D1473 to serious mental suffering, precipitating a serious deterioration in his PTSD symptoms and increasing his risk of self-harm and suicidality.

**(d) <u>Unlawful removal and restraint</u>**

[927] Witness statement of 1473, §67, BHM000039_0013.
[928] HOM025617_0001-0005.

541. On 23 – 24 August 2017 the Home Office attempted to remove D1473. This was despite the fact that he had outstanding Article 8 ECHR representations which the Home Office had yet to consider and was assessed as an AAR L3. Both of these facts, which the Home Office was well are of, operated as absolute barriers to his removal. D1473's removal in this context was entirely unlawful. D1473 was well aware he could not be removed, but his attempts to explain this to G4S officers and escort staff were entirely ignored. The shock and intense anguish of this experience was significantly aggravated by his treatment throughout. D1473 was subjected to a prolonged restraint by way of a Waist Restraint Belt for 5 and a half hours during the attempted unlawful removal. Whilst the restraint was applied by Tascor officers, it was initiated on Brook House premises, with the knowledge and apparent supervision of G4S and/or Home Office staff.

542. There was simply no justification for this restraint:

a. This was clearly an unplanned restraint. There was no prior authority and risk assessment carried out for a planned restraint as required by DSO 07/2016.[929] Nor would this have been authorised on the basis of his vulnerability and absence of relevant risk indicators.
b. D1473 was compliant throughout the removal process and presented with no actual risk to others as would justify the use of spontaneous force. The DSO advises that only in a "reactive" situation, such as one of medical emergency, or urgent situations following sudden disruptive behaviour, can a DCO authorise their own restraint premised on a dynamic risk assessment. D1473 was not resisting or showing any signs of aggression, nor did he have any positive risk indicators of violent or disruptive behaviour which, together with a refractory presentation, may be taken to justify recourse to restraint. As the CCTV footage from the escort van clearly illustrates, D1473 was compliant throughout.
c. There was a complete and cavalier failure to consider D1473's serious vulnerabilities. None of the documents relating to the decision to use of force on D1473 indicated any consideration at all of his known mental vulnerabilities: that he was an Adult at Risk level 3, or on an open ADCT for suicidal ideation, or how use of force would impact of his mental health.

[929] HOM005928.

d. Most significantly of all, the restraint simply should never have happened because D1473 was not removable at the time. The fact of his outstanding representations, and designation as an Adult at Risk with Level 3 risk evidence, rendered him manifestly unsuitable for detention.

543. The application of extreme and prolonged force during an already unlawful removal compounded the horror and trauma of the incident for D1473. The impact of this incident on him has been profound and long-lasting:

> *"I found the experience of that night terrifying and humiliating from start to finish. I was treated like an animal you were transporting. I had not had any experience like this before. I couldn't believe this was happening to me. The whole experience from being put into the waist restraint belt to getting back to Brook House the next morning lasted about 10 ½ hours. The terror of facing removal to Nigeria, of being ignored when I tried to explain I had an application preventing this, and being placed in prolonged restraint throughout, was indescribable. I still find it difficult to think about the experience and it makes me feel very uneasy remembering it. I often have nightmares about it, and wake up sweating so much that my bed sheets are wet".*[930]

544. After this incident D1473 felt "*more and more desperate*".[931] His flashbacks and nightmares increased in frequency, and he had sharp abdominal pain from the prolonged use of restraint.

545. D1473's case is but one of the many cases concerning the routine misuse of waist restraint belts to facilitate the discharge of vulnerable detained persons to Tascor officers. This highly concerning pattern of restraint has already been addressed above. Similarly, the finding of Stephen Shaw in his 2014 report prepared by the Advisory Panel on Non-Compliance Management[932] that the use of waist restraint belts in itself, when applied for a prolonged period of time, is inimical to the person's dignity and may subject them

[930] Witness statement of 1473, §63, BHM000039_0013.
[931] Witness statement of 1473, §68, BHM000039_0013-0014.
[932] BHM000043_1085-1158

to inhuman and degrading treatment in breach of Article 3 ECHR. In the case of D1473, the nature and impact of this prolonged unjustified restraint was further intensified by his acute mental vulnerability. The duration and effects of this use of force against D1473 subjected him to intense mental and physical suffering, anguish, and feelings of powerlessness. His treatment cannot be characterized as anything other than reckless, inhuman and degrading.

546. Even after this traumatising experience, D1473 did not receive any mental health assessment nor any appropriate medical care or treatment. He was given paracetamol for his pain and nothing more.[933] Further, and despite his deteriorating mental health, he was placed in segregation under Rule 40 on 28 September 2017 for refusing to share a cell with someone he didn't know: plainly this wasn't on grounds of 'security or safety' and was instead punishment – it made D1473 "*feel vulnerable and scared again*".[934]

**(e) <u>Failures in complaint process</u>**

547. After D1473's release on 29 September 2017, D1473 pursued a complaint against his unlawful removal and the use of force. Despite the fact that an unlawful application of a Waist Restraint Belt is capable of breaching Article 3 ECHR, the Home Office considered that Tascor could internally investigate it as it was only 'minor misconduct'.[935] It was only after his legal representations intervened that the PSU agreed to investigate it. However, their response displayed a complete lack of understanding of the issues.

548. PSU dismissed[936] D1473's complaint on the basis of a claimed history of disruptive behaviour and self-harm risk, notwithstanding that it was accepted by the PSU that D1473 had, in fact, been compliant during the escort as was shown on the CCTV. The PSU failed entirely to grapple with the primary question of the actual and contemporaneous rationale for the prolonged restraint or indeed its appropriateness in relation to an acutely vulnerable individual. There was a wholesale failure to consider this extreme use of force through the prism of Article 3 ECHR mistreatment, instead

[933] HOM029928_19-20.
[934] Witness statement of 1473, §73, BHM000039_0014.
[935] CAP000539_0001-0004.
[936] Witness statement of 1473, §85, BHM000039_0015-0016 & CAP000534_0001-0006.

approaching the use of a waist restraint belt in such circumstances as an entirely acceptable default restraint method. Moreover, despite requesting it multiple times, the PSU never disclosed the CCTV footage of the attempted removal (it was only recently disclosed by the Inquiry), further exacerbating D1473's sense of powerlessness and dismissal.

549. Similarly, a complaint made to the Detention Services Unit concerning D1473's unlawful removal was not upheld on equally unsatisfactory grounds: the DSU stated that he wouldn't have actually been removed prior to his claim being considered, which is entirely illogical given D1473 was actually taken to the airport.

550. D1473 settled civil claims against the Home Office and Tascor for his detention and also his attempted removal and the use of force. However, neither organisation apologised or sought to make any changes to their practice in respect of unlawful practices.

551. The lack of accountability for Home Office illegality is still something that D1473 struggles with: "*I don't see how things will change if nobody is held to account for their decisions and actions. They just seem to get away with it. I am also frustrated that my complaints were just dismissed and I was made to feel again like they did not listen and did not care about what had happened to me. Feeling worthless is one of the worst feelings you can have. It still really affects me*".[937]

[937] Witness statement of D1473, §85, BHM000039_0016-0017.

## XI. Proposals for change, suggestions and lessons learned

552. The Inquiry's overarching task asks the Chair to *"investigate into and report on the decisions, actions and circumstances surrounding the mistreatment of detainees broadcast in the BBC Panorama programme 'Undercover: Britain's Immigration Secrets' on 4 September 2017."* The Inquiry cannot start to answer this question effectively in compliance with its Article 3 investigative duty in ignorance of the nature of the underlying power to detain that led to so many people being held at Brook House and exposed to abuse and mistreatment there. The administrative power to detain is the most draconian power available to a government department, and closed environments are inherently difficult to monitor. It requires robust and rigorous polices, methods and arrangements and an institutional culture that is vigilant to ensure a humane and safe system of immigration detention.

553. The evidence that the Inquiry has heard and seen establishes that the Home Office is incapable of diligent and robust oversight and has failed to instil a strong institutional human rights-compliant culture of prevention, protection, and accountability. When this is absent and executive powers are used in a hostile political climate, abuse is predictable, even inevitable. That is why it is a recurrent problem in the immigration detention context, confirmed by court cases finding Article 3 ill-treatment, jury findings in inquests and repeated exposés of abuse, racism and ill-treatment by undercover reporting and subsequent investigations.

554. It has, at times, been suggested that the exercise of the detention power is outside the scope of the Terms of Reference. However, the wording of the overarching task of the Inquiry clearly states to the contrary, and must encompass all decisions, policies and practices that affected the detention of vulnerable people at Brook House during the relevant period. These plainly fall within the *"method, policy, practice or management arrangement, that causes or contributes to any identified mistreatment."* The fact that the policies and practices have been in existence for some years, and systemic failures in their structure, management and operation have been known for a long time, cannot make them outside the scope of the Inquiry's Terms of Reference.

555. To exclude consideration of this would be to ignore the volume of evidence that the Inquiry has received, not least from formerly detained Core Participants, who tell of how

their experiences at Brook House were marred and made worse by the indeterminate nature of immigration detention.

556. The formerly detained people are not alone in giving this evidence. This is the view of the full spectrum of witnesses to the Inquiry, from specialist NGOs, such as Medical Justice[938], Gatwick Detainee Welfare Group[939], Freedom from Torture[940], Detention Action[941], Bail for Immigration Detainees[942], Inquest[943], to G4S senior manager[944] and former managers[945], to professional bodies[946], to oversight bodies such as the HMIP and the IMB,[947] Mr. Shaw[948] (a reviewer commissioned by the Home Office to scrutinise the welfare of vulnerable detained people in detention) and Parliamentary committees[949].

557. It is of course, also the view of the Inquiry's own expert, Professor Mary Bosworth who considers that ending detention and canvassing alternatives to detention, or at a minimum introducing a time limit, would go significantly to reducing the type of distress, abuse and mistreatment captured on film on BBC Panorama.[950] But she is also not the only expert to the Inquiry to express such a view. Dr. Hard, the Inquiry's clinical expert, also gave clear evidence, based on his review of documentary evidence and footage that the

[938] Emma Ginn witness statement, §§153-159, BHM000041_0056-58
[939] Anna Pincus first witness statement, §228, DPG000002_0079-80
[940] "Freedom from Torture is opposed to immigration detention because we believe that the safeguards in place are incapable of preventing harm to vulnerable people, including torture survivors" – FFT000012_0001
[941] "It is important to recognise the particular impact that indefinite detention has on people… this would be ameliorated by a strict 28-day time limit on detention, with people held for a maximum of 96 hours before their detention is reviewed by tribunal, with detention only then extended if the person's removal or deportation from the UK in the following 14 days is certain" – DPG000020_0030
[942] BID is opposed to immigration detention and we believe it should be ended" – DPG000038_0029
[943] There have been repeated, myriad recommendations over many years made by INQUEST and other NGOs campaigning to end the dehumanising experience that we believe is inherent in immigration detention, that by its nature makes all detained people very vulnerable" – INQ000037_0027
[944] Lee Hanford, 15 March 2022, 96/17-19; Peter Neden, 22 March 2022, 68/3-7; Steve Skitt, 17 March 2022, 48/8-17; Jerry Petherick, 21 March 2022, 98/17-25.
[945] Rev. Nathan Ward first witness statement, §353, DL0000141_0125.
[946] British Medical Association (2017): Locked Up, Locked Out: Health and Human Rights in Immigration Detention, Recommendation (p73): https://www.bma.org.uk/media/1862/bma-locked-up-locked-out-immigration-detention-report-2017.pdf
[947] The HMIP has raised concerns about the indeterminate nature of detention since 2015, the IMB has raised this since 2018. See Annex 1 to Emma Ginn's witness statement on list of relevant bodies and individuals who have recommended an immigration time limit, BHM000041_0070-73; see also IMB's inspection of Brook House in 2020, recommendation 3.3 to the Minister : IMB000202_0006
[948] Shaw first report, Recommendations 62-63, INQ000060_0200;
[949] This includes the Home Affairs Select Committee, Joint Committee on Human Rights and the All Party Parliamentary Groups on Refugees and Migration. See the list of Parliamentary committee reports listed in Annex 1 to Emma Ginn's witness statement BHM000041_0070-732
[950] Professor Bosworth second report, §§1.6-1.9, INQ000123_0002-3; Professor Bosworth, 29 March 2022, 24/3-798/23-25, 99/1-4, 121/1-11

lack of time limits and the fact of prolonged detention would inevitably cause someone harm, even if they have no underlying pre-existing mental health issues or past histories of torture and trauma.[951]

558. The consistency of evidence all saying the same thing across these different kinds of witnesses tells us something: despite the differing interests, experiences and expertise of all of these witnesses, they all point to the indeterminate nature of detention as a culprit and reason for the mistreatment and abuse of detained people at Brook House during the relevant period.

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

560. The following proposals for change serve to reflect and reinforce the long-standing recommendations which have been made by Medical Justice, for many years now and well before 2017, in respect of the recurrent systemic concerns over immigration detention policy, safeguards and healthcare provision. The detailed research and reports underpinning these recommendations are summarised in the statement of Emma Ginn and annexed thereto[952], as is Medical Justice's key contribution to successive inquiries and reviews into the detention of vulnerable persons[953]. That these recommendations remain of utmost relevance and importance to this Inquiry illustrates not only the resolute focus of the work done by Medical Justice, but the engrained failure of the Home Office to listen to and accept such failings and to effect real and enduring change.

**(1) <u>Phase out the use of immigration detention</u>**

561. The absence of a time limit on immigration detention means detention can be for an indeterminate period, and is experienced by those detained as indefinite. The significant

[951] Dr. Jake Hard, 28 March 2022, 143/14-20, 178/20-25.
[952] Emma Ginn witness statement, §§21-41, BHM000041_0008-0015; see also Annex 2 which provides a summary of 2 of these reports: BHM000041_0075-76;
[953] Emma Ginn witness statement, §§42-48, BHM000041_0015-0017;

and lasting damage to people of not knowing how long they will be detained, and of prolonged detention, is clearly borne out from the case studies from Medical Justice clients both in 2017 and in the more recent years, as well as from documents we have reviewed from the Inquiry's own disclosure. The effect of detention does not end when people are released. It is imprinted into their memory as a traumatic event, and that is clear from the accounts given by former detained people who are Core Participants and witnesses to the Inquiry.

562. On behalf of the Bhatt Murphy Core Participants, we submit that change can only begin with the introduction of strict measures to circumscribe the exercise of the power to detain, and the use of immigration detention should be phased out and replaced with a more humane and indeed effective means of monitoring and managing people facing removal from the UK. In any event, detention policy must effective constrain the exercise of that power and prevent its exercise where the detained person is vulnerable in particular by reason of a past history of torture, trauma or mental illness. Nothing less will begin to address the deficits in the system, in the institutional culture and practices of both the Home Office and its contactors, which have proved impervious to any significant or durable change over near two decades. Although on each occasion when an exposé from undercover reporting is aired on television, it shocks the public, it does not jolt the Home Office to bring about real and lasting actual change to the system, institutional culture, policies and practices that have allow repeated abuse scandals to occur. Those failures to learn lessons remain hidden from public view and accountability, unless brought into the light by journalists, or a horrific death and inquest.

563. The Inquiry should take into account that even before, but certainly since, the Brook House scandal, there is widespread recognition that the only realistic solution capable of achieving any real change is, to curtail this power and to end its indefinite nature. The list of these reports and their recommendations for a limit to the detention power and length of detention is set out at Annex 1 to Emma Ginn's witness statement.

564. Detention under current policy is meant to be the last resort; it is not meant to be used if more humane and effective means of monitoring and managing people facing removal from the UK are available and fully utilised. There has long been a call, including by Mr. Shaw in his 1st report in 2016, on the Home Office to undertake a proper evidence-based

investigation into the need for immigration detention. Such an investigation must not lose sight of the fact that reporting to immigration officers is 95% effective;[954] and compliance could be further improved by implementing the recommendations of the ICIBI, so it is plainly a viable alternative to detention. There is already evidence of this, from a report recently published on a pilot scheme overseen by UNHCR, which showed no increase in absconding when alternatives to detention are used for women.[955]

565. For a period of time during the Covid-19 Pandemic, the detained population significantly reduced. That presented a unique opportunity for the Home Office to consider whether the significantly reduced numbers of people being detained actually had a detrimental effect on immigration control. Instead, the Home Office embarked on a politically driven project to detain and remove large numbers of asylum seekers with reckless indifference to the consequences for both the staff and people detained at Brook House IRC creating an environment that subjected the whole detained population to risks of inhumane treatment in breach of Article 3 ECHR. The Home Office has also inexplicably opened a new IRC for women, IRC Derwentside in county Durham, despite the very low number in detention and before evaluation of the UNHCR polite scheme. At the same time, the Home Office sought to and has now succeeded in passing the Nationality and Borders Act 2022, which includes a statutory power to reintroduce the discredited, unfair and unjust detained fast track system for asylum seekers. The Inquiry has to bear in mind that the whole detained fast track system was suspended in 2015 because of the inability of the detention statutory safeguards of Rules 34 and 35 of the Detention Centre Rules 2001 screening out all those whose vulnerabilities make them unsuitable to be detained and subjected to an accelerated decision-making process, and because the accelerated process also made it impossible to secure a fair opportunity to obtain all relevant evidence in support of appeals against adverse immigration decisions.

**(2) <u>Limit on the power to detain</u>**

566. Where immigration detention continues to be used as a key immigration control approach to facilitate removal, the policy should make clear that the circumstances in which the

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

power can be exercised should be strictly limited. It should be targeted so that it is closely aligned with the removal power limited to facilitating arrest and transfer to the airport.

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

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

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

568. These were specific *policy* choices made in response to repeated criticisms by the court and by independent oversight bodies of exposing parents, children and pregnant women to the harms of immigration detention. In Medical Justice's experience, these time limits have been a more effective and more humane way of managing removals for vulnerable groups. They should be extended to all categories of vulnerable people.

569. This approach should be no different for foreign national offenders facing deportation. This group is likely to face prolonged detention and often include some of the most vulnerable and with the most complex needs.

**(3) <u>Strong Presumption against detention</u>**

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

571. The failures of the AAR policy to safeguard against vulnerable people being detained and suffering harm are clear from the facts and experiences of individual formerly detained Core Participants, Medical Justice's casework experience, supported by the case studies produced for the Inquiry, and from by statutory, Parliamentary, and other reviews.

572. There is an urgent need to return to a category-based approach to the identification of vulnerabilities as recommended by Mr. Shaw in his first report, where vulnerable people are treated as unsuitable save in *"very exceptional circumstances"*. A return to the previous category-based approach, albeit encompassing a more holistic approach to vulnerability recommended by Mr. Shaw by way of a broader additional exemption, would significantly reinforce the protections for vulnerable persons against arbitrary and harmful detention.

573. There should be no requirement for additional or specific evidence of risk of harm, given the clinical literature and research identified by Professor Bosworth, Professor Katona and Dr. Bingham on the inherent harm that is likely to be suffered by those with pre-existing mental disorders and past histories of torture and other forms of ill-treatment. That was the premise of previous detention policies; the evidential basis for that premise remains the same, and therefore this premise should underpin the finding of vulnerability as it did under previous policy. A detention policy that addresses vulnerability – whether it be called the AAR policy or some other name in future – must be operated on these preventive principles in recognition of the clinical evidence that detention is harmful for those with existing vulnerability.

**(4) <u>Effective Screening of Vulnerabilities, Disabilities, Trauma and Mental Health Problems</u>**

574. There must be effective screening before a person is detained. This is a vital frontline safeguard against the detention of vulnerable persons at risk of harm. It is clear that, despite some reforms in recent years, the current system is still unable to reliably recognise indicators of vulnerability and to act to prevent detention from occurring at all. The Detention Gatekeeper is an internal process and is not adequate because it is reliant on Home Office caseworker information which remains piecemeal, selective and inaccurate. The Home Office already knows this, and has done for several years now,

having been told so by Mr. Shaw in his 2018 report, by the ICIBI, and by NGOs including Medical Justice. Dr. Oozeerally also told the Inquiry of such a need in his oral evidence.

575. It has shown to be effective in the context of the Family Returns Process, and thus is not a radical recommendation.

576. There is no reason why this cannot be implemented now and urgently.

577. A clear system for independent and robust oversight must be introduced, similar to the Family Review Panel with a procedure for proactive inquiry so that the Panel is satisfied that there are no legal or practical barriers to removal and all relevant up to date evidence has been obtained and considered by the Home Office about the person's health and any other vulnerability.

**(5) Effective safeguards for identify vulnerable people**

578. Pre-detention screening must be coupled with an effective clinical screening process upon a person's detention. This must be more than a mere tick-box exercise. It must include a targeted mental and physical health assessment by properly trained medical staff aimed at identifying any vulnerability indicators which contraindicate detention. There needs to be clear instructions to medical staff on the purpose of this initial clinical screening with safeguarding being the urgent priority, as recommended by Dr. Hard, because that is the first opportunity for vulnerabilities to be identified. The fact that some detained people may not feel able to engage at the outset is not a reason not to do it; the important point is that the system must itself make it possible to achieve this.

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

580. As Mr. Shaw identified in his report in 2016,[956] further and better monitoring and training are not going to get at the root problems. Allowing other healthcare professionals to also complete Rule 35 report will not address the problem; it will compound it. It will not result in improvement in the quality of responses to Rule 35 reports. The simple answer is for the Home Office to end the fundamental "*disconnect*" and accept the advice of the

[956] Shaw 1, §4.118. INQ000060_0108

IRC doctor identifying the detained person as vulnerable. In the absence of very exceptional circumstances, the Home Office should release them.

581. It is important for the Inquiry to note that this proposal for change does not depend on the safeguards being contained in Detention Centre Rules; indeed Mr. Shaw contemplated reform would entail an alternative measure away from the existing regime of Rules 34 / 35. Whatever the reformed system may look like or be called, the fundamentally important point is its purpose and object as a core and mandatory safeguard for ensuring that detained people who are vulnerable and at risk of harm in detention are identified at the earliest opportunity so that they can be removed promptly from the detention environment, known to pose risks of and cause actual harm to them.

582. The Rule 35 process also needs to actually be capable of and reflect all indicators of risk identified in the Adults at Risk policy and be clear, whether by amendment to the rule or by policy instruction, that the aim is to address risk of harm from detention *before* it eventuates.

583. Decision urgent steps are needed to address some of the immediately obvious resourcing issues necessary to make it possible for Rules 34 and 35 to function effectively as safeguards. The Inquiry Chair had already identified, rightly, the concern that in the absence of urgent remedial action, the current system of safeguards – descripted as completely deprived by Dr. Hard – is currently putting vulnerable individuals at risk of or actual harm. The steps that can and should now be taken as a matter of urgency are as follows:

a. Additional resources need to be urgently made available so that initial GP appointments within the first 24 hours of a person entering detention can be of a sufficient length to be capable of completing a medical examination that can result in a Rule 35 report;

b. R35 appointments should be automatic and delays must be eliminated or reduced. This will require additional and sufficient resources to be made available urgently so that the number of Rule 35 appointments are not capped at 1 or 2 a day. Rather resources need to be made available so that appointments are made available immediately where there is a need;

c. Instructions need to be given to GPs and healthcare staff that the threshold trigger for a Rule 35(1) or Rule 35(2) does not require evidence that a person cannot be satisfactorily managed in detention through other means, contrary to the misdirection set out in the templates for those two limbs of Rule 35. This is a necessary urgent first step to ending the application of a satisfactory management threshold to responding to mentally ill detained people, which has already been found by Mr. Shaw to be contrary to good psychiatric care and an affront to civilised values.

d. Opening an ACDT because of risk of self-harm or suicide should result in a R35(2) report, or at least sufficient assessment and consideration of one, and further a consideration of a R35(1) report, with a view to a speedy detention review for consideration of release;

e. GPs and healthcare professionals should be given clear instructions that they should be able to review a person's circumstances and not impose limits to the number of Rule 35 reports they need to do. The fact that the Home Office refuses to release further to a Rule 35 report should not act as a deterrent or barrier to raising a further Rule 35 report. So far as the healthcare professionals are concerned, a Rule 35 report should be raised whenever and however often the need arises but has not resulted in release.

f. Segregation due to self-harm and suicide risk should likewise trigger Rule 35 report and release.

584. This cannot wait until the publication of the Inquiry's report. It needs to happen urgently. The Chair should consider interim findings and recommendation on Rule 34 and Rule 35 and the AAR policy.

**(6) <u>Healthcare</u>**

585. There are recurrent failures by IRC mental health staff to diagnose and treat mental health problems, and by the primary healthcare staff to identify obvious clinical concerns, despite being within a setting in which it is or ought to be known that there is a high incidence of mental illness, trauma, and overall vulnerability. As Dr Bingham notes at

§62 of her statement[957], there may be a number of contributing factors, including the level of training, support and supervision, alongside inadequate reflective practice and ongoing professional development activities, as well as the impact of staff working in an environment in which there is a high risk of becoming "*desensitised*" to the needs and suffering of detained people.

586. The failure to identify PTSD and other incidences of mental illness leads to a failure to identify the need for the statutory Rule 35 safeguard to be triggered and consideration to be paid to the suitability of continued detention of an individual. Therefore this is not just an issue about diagnosis or treatment, but rather one of safeguarding, and in that way, a priority.

587. There must be robust training delivered by independent trainers, for all healthcare staff, in the delivery of trauma-informed clinical care. IRC healthcare staff should fulfil a primary protective role in identifying and escalating indicators of mental or physical vulnerability. Particular attention must be given to the identification of individuals suffering from PTSD, the symptoms of which are often missed or mis-identified in an environment which remains wilfully resistant to the recognition of the psychological consequences of trauma.

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

589. On both, Sandra Calver, still Head of Health at Brook House, confirmed the significant deficit in knowledge not only during the relevant period but also now.

590. The use of the criteria of "fit for detention" should be ended and should be immediately brought in line with the AAR policy of particular risk of harm. This reflects the need for IRC healthcare staff to adopt a precautionary model of care, rather than a reactive response to evidence of harm already caused by detention. Where there may appear to be a conflict of interests as between healthcare's duty of care to the patient and its

[957] Dr. Rachel Bingham witness statement, §62, BHM000033_0021

contractual relationship with the Home Office, it is vital that all instructions make clear the primacy of healthcare professionals' duty to the patient. Abandoning the use of and acquiescence to requests to assess "fitness for detention", and "fitness for removal" should occur forthwith, as it has the immediate benefit of better safeguarding the important independence of healthcare professionals both functionally and in the eyes of the detained person.

591. The practice of participating in the authorisation of "fitness" to use restraint or segregation should also end as being inimical to the purpose of the AAR policy, which is that fewer vulnerable people should remain in detention, and should not be managed in detention. This again is a criticial realignment to focus on priorities of safeguarding which Dr. Hard found to be lost in the evidence he read and heard about the healthcare's arrangements and operations.

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

593. We endorse the Royal College of Psychiatrists' position on the limitations of being able to provide effective mental health treatment within the context of immigration detention. This is clear from Medical Justice's casework experience and illustrated by the experiences of several of the Bhatt Murphy formerly detained Core Participants.

Treatment of mental illness requires a holistic approach and continuity of care. Psychotropic medication is very unlikely to achieve good outcomes unless given as part of a broader multi-model therapeutic approach. The recovery model cannot be implemented effectively in a detention centre setting, and in these circumstances, healthcare has a responsibility to raise concerns about the suitability of the person for continued detention as soon as mental illness is identified.

## (7) Mental Capacity

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

595. Acquisition of knowledge and understanding the nature of mental capacity and what to do is important. But it will be futile if there is no provision of assistance that can be afforded to detained people to practically assist them to access not only medical treatment but more crucially, legal advice and assistance concerning their detention and conditions of detention. The Court of Appeal in *VC* and then in *ASK / MDA* has already found the absence of independent advocacy to discriminate against mentally ill detained people. It simply cannot be let to continue, and no reason has been given to the Inquiry by Home Office witnesses as to why such a provision has been delayed for this long.

596. From a clinical perspective, unsurprising, Dr. Hard agreed with Medical Justice that it is crucial to establish a role for *independent* advocacy services for detained people with serious mental illness where it *appears necessary,* the person has *substantial difficulties*

and there is an absence of an appropriate individual to support them.[958] Importantly he agreed that that role cannot be done by healthcare because the issues requiring independent advocacy do not all concern medical treatment matters; to expect healthcare to step into this role would be to create and build in conflicts of interests that would jeopardise the healthcare – detained person relationship and undermine the efficacy of any such safeguard.

**(8) Management of self-harm and suicide risks**

597. The current use of the prison-based ACDT mechanism for managing self-harm risk is inadequate and effective in the immigration detention context because it is not therapeutic and does not prevention deterioration. If a person is self-harming, it necessitates an urgent review of their mental state and suitability for detention. This needs to be done through a Rule 35(1) or (2) report. ACDT is currently disconnected with the AAR policy, such that an open ACDT is not treated as professional evidence that a person is an adult at risk who is particularly vulnerable to harm in detention. This situation needs to be corrected urgently so that if a person self-harms this triggers an urgent assessment under Rule 35(2) or an alternative mechanism, leading to a review of detention.

598. As a suicide prevention tool, ACDT is inadequate; is not clinically led and does not trigger clinically informed risk assessments of immediate physical harm or underlying mental deterioration. The Rule 35(2) template must be amended to remove the misdirection that an open ACDT can constitute satisfactory management of the mentally ill person in detention and to encompass all circumstances where there are *suspicions* of suicidal ideation, including risk factors concerning impulsive self-harming and suicidal acts.

**(9) Use of Force / Segregation of vulnerable people**

599. As both Mr. Collier and Dr. Paterson pointed out, there needs to be a fundamental rethink of the use of the prison-based Control and Restraint (C&R) model within the IRC context. It is simply not fit for purpose in that environment and is not designed to and cannot operate to adequately address the position of vulnerable detained persons, such as alternative de-escalation strategies, attempting to identify underlying vulnerabilities

[958] Care Act 2014 s. 9.

potentially associated with a person's distressed behaviour, and the distinct psychological damage that may be caused by restraint for those who are particularly clinically vulnerable due to a history of torture or other experiences of trauma.

600. The fundamental rethink should not stop at the development of a therapeutic model of intervention, but be taken further, as suggested by Dr. Paterson to involve a model where force is only used as a very exceptional circumstance, so that there is a more focused approach to de-escalation and the clinical assessments, and with a view to considering the suitability of the person's detention (rather than the need for escalation). If a person's mental ill health is such that force is required to contain it, that is a clear demonstration a person who is unlikely to be suitable for continued detention. The current arrangements do not require healthcare to address this, as opposed to the question of force being used, and in that sense, the clinical consideration, if they occur, are again unfortunately disconnected from the AAR policy in a way that undermines its protective and precautionary objectives.

601. Healthcare staff need to be clearly instructed on the limits of their clinical role, such that they are clear on their duty of care to advise on the likely impact of a planned use of force on a detained person, including on their pre-existing mental disorders and vulnerabilities. They should be clearly instructed never to approve or authorise the use of force, or give a view as to its positive suitability (as opposed to its unsuitability).

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

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

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

## (10) End the Prison-like Design and Conditions of Brook House

605. The evidence before this Inquiry is unanimous that the prison-like environment, conditions and regime at Brook House were entirely unsuitable for administrative detained persons, especially those who were mentally unwell or otherwise vulnerable, and inimical to the ethos and requirements of immigration detention under Rule 3 of the Detention Centre Rules 2001. Nearly every institutional witness before this Inquiry apart, tellingly, from Mr Riley, accepted that the secure physical design and punitive regime at Brook House adversely affected the welfare of detained persons[959].This was compounded by the indefinite and lengthy periods for which many detained persons were held there, intensifying the impact of such a restrictive and desolate environment.

606. Professor Bosworth was clear that the *"very very harsh"* physical conditions at Brook House fed into the 'prisonisation' of the centre[960], in which detained persons were dehumanised as criminals, other and unworthy of even basic respect or decency. This was of course a critical facet to the extreme mistreatment and abuse which detained persons suffered whilst at Brook House.

607. To the extent that Brook House is maintained (which, for the avoidance of doubt, runs contrary to the fundamental position taken by all five Bhatt Murphy Core Participants) it must clearly undergo a complete structural overhaul. The Home Office must make significant and material changes to ensure that, consistent with the requirements under Rule 3 of the Detention Centre Rules, the accommodation provided at the IRC is humane, the regime relaxed and conducive to the dignity and welfare of those detained. This of course is not asking for much – it is a directive for the Home Office to do what they ought to have already been doing, as a bare minimum, in keeping with their statutory

[959] See for instance Phil Schoenberger, 23 March 2022, 16/14-25, 17/1-4; Jerry Petherick, 21 March 2022, 55-56 ; Lee Hanford, 15 March 2022, 96/23-25, 97/1-23; Hindpal Singh Bhui, 24 March 2022, 155/19-23
[960] Professor Bosworth, 29 March 2022, 33/11-16; Professor Bosworth, 29 March 2022, 13/23-25, 14/1-2

obligations. The mere fact that the Home Office must be pressed commit to the provision of humane accommodation consistent, with the purpose of an administrative detention centre, is indicative of the abject extent of its failings before this Inquiry.

**(11) Monitoring and oversight**

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

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

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

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

a. Deaths in detention, including publication of all investigations concerning the circumstances of the death;
b. Incidents of self harm leading to medical treatment;
c. People taken to hospital for treatment of mental illness: both under the MHA and as informal patients;

d. Numbers of detained persons with a history of mental illness prior to detention, broken down by reference to ICD-11 diagnosis and people diagnosed with a mental illness in detention, again referencing ICD-11;
e. Numbers of people subject to ACDT procedures, and the length of time held in detention whilst on such a process, with information about the proportion with a diagnosed mental illness broken down by reference to ICD-11 diagnosis and supported by local ACDT policies being publicly available;
f. Review of the audit requirements and consultation with stakeholders on an annual basis.

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

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

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

d. Concerns were raised in the Verita report about the sense of collegiality between the IMB and G4S and a tendency on the part of the IMB members to over-empathise with the G4S management team and the Home Office, rather than to hold them to account and press them on their plans for action to address concerns and make improvements at Brook House. The Rule 6 Notice and evidence in the IMB's annual 2020 report on Brook House appears to be an important improvement further to

these criticisms, but the impact of its reports still depend on the Home Office not only accepting the findings and recommendations but also taking concrete action to respond where there is no requirement that it do so. We are not aware of any response to the Rule 6 Notice nor the 2020 Report.

e. To our knowledge, the CQC has not yet inspected Brook House. Medical Justice has made recommendations to the CQC regarding the Inspection Criteria for IRCs in 2015. Appropriate expertise is required and should include experts in the clinical care of asylum seekers, and those with a lived experience of immigration detention, in addition to secure environments expertise. It is essential that people who are detained are spoken to confidentially in the course of the inspection. It is essential that as part of assessing the safety of the service, the ability of healthcare staff to function as safeguards in the Adults at Risk Policy is considered and the treatment of the vulnerable is prioritised

**(12) <u>Accountability</u>**

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

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

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

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

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

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

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

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

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

**(13) <u>Institutional culture, openness and restoration of confidence</u>**

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

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

622. The Home Office must take primary responsibility for ensuring that the detention system is arranged and operated by its contractors in a manner that is safe, humane and protects

the fundamental rights of people in detention. A "humane" and "safe" approach will not be realised if the agenda of the Home Office is to continue to promote a hostile environment policy and rhetoric. Its role in fostering division, an "*us and them*" mentality and prejudice institutionalising racism, and dehumanisation must also be acknowledged and addressed.

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

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

b. to implement, monitor and assess:

i. the sufficiency and efficacy of strategies for the prevention, recording, investigation and prosecution of racist and other discriminatory incidents directed at people in detention;
ii. measures to encourage reporting of racist and other discriminatory incidents;
iii. the nature, extent and achievement of racism and anti-discrimination awareness training for its staff and contractors;
iv. the efficacy of direct and indirect performance indicators in contractual arrangements to ensure staffing levels, working practices, hours and demands do not breed discontent, frustrations and desensitisation, all of which have been identified to be factors triggering and perpetuating discriminatory "us and them" attitudes and actions;

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

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

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

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

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

**(14) Complaints process**

624. Complaints involving serious misconduct should be released to enable completion of all complaints processes, including police investigations and appeals to the Ombudsman.[961]

625. The IMB should visit all detained persons who allege they have been assaulted and they should monitor such complaints and publish a report annually. The IMB should also have random and unannounced monitoring of escorts. [962]

626. Information from complaints should be separate from the immigration determination process. Until this happens contractors should ensure that detained persons making a complaint know that any information may be passed to the immigration caseworker.[963]

627. The complaints procedures should be strengthened to include[964]:

a. Simple leaflet on how to make a complaint should be available in all IRCs in main languages.
b. Plan for the investigation communicated to the complainant.
c. Standards for investigation and interviewing of witnesses including other detained persons.

[961] Outsourcing Abuse: state sanctioned violence during the detention and removal of asylum seekers (2008) pg5: see exhibit to Emma Ginn statement, BHM000041
[962] Outsourcing Abuse: state sanctioned violence during the detention and removal of asylum seekers (2008) pg5, see exhibit to Emma Ginn statement, BHM000041.
[963] Biased and Unjust: the immigration detention complaints process (2014) Pg 20, see exhibit to Emma Ginn statement, BHM000041
[964] Biased and Unjust: the immigration detention complaints process (2014) Pg 20, see exhibit to Emma Ginn statement, BHM000041.

d. Timescales for investigation should be shortened.

e. Replies should be sent in the language they are submitted.

f. An action plan shared with complainants for lessons and improvements following complaints.

**Dated 3 May 2022**

**STEPHANIE HARRISON Q.C.**
**SHU SHIN LUH**
**LAURA PROFUMO**

**Instructed by Bhatt Murphy Solicitors**

**On behalf of the following Core Participants**

**Medical Justice**
**D801**
**D1275**
**D1713**
**D2158**
**D1473**

**ANNEX 1**

## NOTE ON ARTICLE 3 CASES

References in brackets [ ] are to paragraphs in the relevant judgment

| Case name | Period of detention that breached Article 3 | Location of detention | Deterioration in health | Loss of capacity | Use of segregation | Delay in treatment | Self-neglect / symptomatic behaviour | Application of relevant policy |
|---|---|---|---|---|---|---|---|---|
| *S* [2011] EWHC 2120 **Tab 22** | April 2010-September 2010 (5 months) | HMP Bullingdon, Harmondsworth and Colnbrook | Prior history of mental health problems; within days of detention mental illness symptoms returned [73] | No capacity assessment | | Delay in obtaining psychiatric assessment and 2 month delay in transferring S to hospital [209] | Command hallucinations [16, 17]<br>Self-harm [16, 28, 81, 83]<br>Found naked being pulled along a corridor by other detainees [100] | Failure to properly understand or apply Chapter 55 or to make enquiries/efforts to obtain S's psychiatric reports [69,182];<br>Failure to consider psychiatric reports expressing concern [85];<br>Failure to consider appropriate treatment or to appreciate that detention would cause deterioration in S's health [85, 179]<br>Failure to understand 'exceptional circumstances' test [181] |

**ANNEX 1**

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| *BA* [2011] EWHC 2748 | July – August 2011 (1 month) | Harmondsworth | Prior transfers to hospital under s47 MHA during prison sentence [29-33]<br>Relapse after transfer to detention [56]<br>Unfit for 'prolonged detention' from 29 June 2011 [70]<br>Refusal to transfer to hospital [81]<br>Improvement in condition after eventual transfer to hospital [234] | No capacity assessment | | Failure to monitor condition in the IRC [56]<br>Antipsychotic medication ran out [57]<br>Not seen by psychiatrist until 7 weeks after symptoms appeared [60] | BA reported to be disoriented and lethargic during interview [27]<br>Lying on the floor, reporting visual hallucinations [60]<br>Prolonged food refusal leading to preparation of end of life plan [61, 82]<br>Auditory and visual hallucinations [63, 67] | Initial decision to detain did not refer to the Ch 55.10 test [205], failure to consider what condition required or risk of deterioration [205]. Reviews referred to detention for 'continued treatment in the interest of the subject [229]. Breach of policy material to detention from 17/21 June 2011. |
| *HA (Nigeria)* [2012] EWHC 979 **Tab 7** | February – July 2010 and November-December 2010 (7 months total) | Brook House<br>Harmondsworth<br>Colnbrook | Prior psychiatric symptoms during prison sentence [17];<br>Deterioration requiring transfer to hospital on 5 July 2010 [64]<br>Re-detention after stabilised and discharged | No capacity assessment in detention | Prolonged segregation and transfer to Colnbrook in segregation [30-33, 45, 61] | Prolonged failure to transfer to hospital following psychiatric recommendation; transfer did not take place for over 5 months (January – July 2010) | Sleeping on floor<br>Drinking and washing from toilet<br>Not eating [72]<br>Not washing or changing clothes for prolonged periods [47]<br>Bizarre behaviour [33, 36, 40]<br>[179-181] | Public law failure to consider available information including Rule 35 notice; breach material to detention from 1 February 2010 [154] |

**ANNEX 1**

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| | | | from hospital [73] | | | | | |
| *D* [2012] EWHC 2501 **Tab 23** | February – November 2011 (9 months) | Brook House<br>Harmondsworth<br>Colnbrook | Reported auditory hallucinations and displayed disturbed behaviour within a few months of detention during a previous period, previous diagnosis of schizophrenia [7, 26]<br>Condition deteriorated to florid psychosis and thought disorder [7]<br>Deterioration to the point that he no longer had capacity and transfer to hospital proposed by February 2012 (against views of IRC doctor) [225] | No capacity assessment until referred to solicitors. Loss of litigation capacity by 11 January 2011 [83]. Continued loss of capacity through to July 2012 [94, 118] | Segregation under Rule 42 following dirty protest [37, 58] and assaults on staff [59-60, 83] | Failure for 5 ½ months in providing anti-psychotic medication or access to psychiatrist [21] | Auditory hallucinations, command hallucinations [19, 39, 41, 88]<br>Talking to spirits [41]<br>'Dirty protests' [26, 37, 58, 84, 88] | Failure/irrationality in applying policy from February 2011 onwards [151]; breach material from June 2011 onwards.<br>Failure to consider treatment required and lack of procedures in IRCs to address non-compliance with medication [151] |
| *MD* [2014] EWHC 2249 (Admin) | October 2011 – September 2012 (11 months) | Yarl's Wood | No presentation suggestive of mental illness on detention; self-harming began | Loss of capacity resulting from mental illness by 12 | Removed from association to prevent self-harm; use of restraint | Psychiatric assessment cancelled [115]; failure to provide | Self-harming by cutting, ligature, banging head against wall [21]<br>Persistent suicidal thoughts [25, 96] | Chapter 55 policy and medical report not considered in detention reviews [24]; |

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| | | | after 4 months' detention [21]<br>Unfit for detention by February 2012 [26]<br>Diagnosed with severe depressive episode [25, 32] with episodes of acutely severe mental distress [96]. Illness caused by detention [139]<br>IRC doctor view that condition could be treated in the IRC with antidepressant drugs and counselling [30] | August 2012 [31] | including by male officers [21, 141] | antidepressant treatment [116];<br>Long delay in arranging psychiatric assessment [116] | | An informed judgment about whether the policy applied was not made [117]<br>Breach of policy material from 16 February 2012 to 13 September 2012 [121] |
| *ARF v Home Office* [2017] EWHC 10 (QB) **Tab 25** | mid-May 2012 to 11 October 2012 (5 months) | HMP Peterborough and<br>Yarl's Wood | Delayed onset PTSD exacerbated in severity, no psychosis symptoms prior to detention [45, 49, 120-121];<br>Self-harm and suicidal ideation not effectively managed [121] | No capacity assessment in detention until point of transfer to hospital. ARF's lack of capacity to give instructions on immigration case was a reflection of | Forced removal to segregation [25]<br>"Conduct" in detention consequent on mental illness was treated as deliberate disruptive | Not adequately assessed. Delay in transfer to hospital [121]<br>Delay in assessment by a psychiatrist [133] | Incidents of self-harm [22, 23]<br>Reported suicidal ideation and visual and auditory hallucinations and disturbed behaviour [22, 23, 25] | No proper application of Chapter 55. No consideration of Chapter 55 until August 2012 [139].<br>Reviews stated 'no known mental health issues' [32]<br>Continued detention after IS91 Part C reports assessing as unfit for detention in May 2012 |

**ANNEX 1**

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| | | | Deterioration to psychosis and transfer to hospital during detention [121] | the extent of her mental illness at time of transfer to hospital [147] | behaviour [131]<br>Segregation and monitoring by officers was not a medical decision and breached Article 3 [148] | | | was a material error [141] |
| *R(VC) v SSHD* [2018] EWCA Civ 57 and order of Supreme Court 11/1/21 | 30 June 2014 to 27 April 2015 (10 months) – the Supreme Court Order states "It is declared that during the period of immigration detention in issue when the Appellant suffered from a serious psychiatric illness, his rights under Article 3 | Brook House | A Rule 35 report was prepared on 30 June 2014 at Brook House which noted that he had been diagnosed with bipolar effective disorder with psychotic features, had been subject to multiple sections and a compulsory treatment order. It concluded that "*[He] is very unstable currently and the stress of detention is impacting negatively on his mental illness. I* | IRC records noted loss of mental capacity by March 2015 | VC was placed in segregation on six occasions [25]. The use of segregation was accompanied on several occasions by the use of force. When removing him to segregation it was claimed that he was '*aggressively*' refusing to go to segregation and so the detention offices entered his | VC was non compliant with treatment in the IRC and so did not receive treatment until transferred under section 48. | He was "unkempt and delusional" was drinking dirty water and unable to meet his daily needs [27(7)] | The Secretary of State misapplied her own policy on the basis that the presumption against the detention of the seriously mentally ill only applied if there was deterioration to the point of requiring hospitalisation [40] |

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| | ECHR not to suffer inhuman and degrading treatment were infringed" | | *have significant concerns that should he continue to deteriorate he will be unfit for detention and will pose a risk to himself or others*" ([25], High Court). By March 2015 he had seriously deteriorated and it was noted that VC appeared to have lost capacity ([29], High Court). He was subsequently transferred from Brook House to a psychiatric hospital under section 48 MHA 1983. | | room "*in arrow formation and [struck] him with a shield*", handcuffed him and 'took control' of his hands and legs, despite being aware he had apparent mental health problems [27(8)(a)]. | | | |