THE BROOK HOUSE INQUIRY

CLOSING STATEMENT ON BEHALF OF

D1527

REVEREND WARD.

D1851

D1914

D2077

D1538

D643

3 MAY 2022

Contents

Introduction

1. As Stephen Shaw said in report on Racism and Mistreatment exposed by undercover reporting in Oakington IRC over 15 years ago:

> "*The strength of a liberal democracy is measured not by how it treats the majority but by how it cares for minorities and those at the margins of society. The best tests for humanity and decency are conducted in its dark places: in prisons, psychiatric hospitals, and in institutions for failed asylum-seekers and other migrants*".[1]

2. The Inquiry is presented with an historic challenge and opportunity to once and for all expose and understand the reality of the dysfunction within the system of immigration detention which for over a decade and a half has been repeatedly found to subject those within it to mistreatment and abuse. Dehumanisation and racism are not one-off actions of abhorrent individuals, bad apples (2004)[2] or a subculture (2005)[3] – they are manifestations of systemic and institutional toxicity and corruption in the treatment of those subject to immigration control. These investigations, along with those into the death of Jimmy Mubenga (2010)[4] and the Windrush Scandal, document and highlight the recurring failure at both a systems and operational level to protect the fundamental rights, the welfare and human dignity of the most vulnerable and marginalised.

3. The significance of the conclusions the Inquiry may draw, or fail to draw, cannot be understated, not just for those subject to immigration detention, but for the rights of everyone and for the nature and values of the society in which we live. The Inquiry is tasked with assisting the state to understand what has gone wrong and to prescribe a means of preventing repeated torture, inhuman and degrading treatment from ever again casting a shadow over our open and democratic society. The Inquiry must play its part in promoting a society in which the rule of law and human decency prevails over political imperatives and outs front and centre the rights of all persons to enjoy equal recognition as human beings; and which eliminates violations of essential human dignity through the imposition of dehumanisation, stereotyping, prejudice and the violence and oppression that the Inquiry has seen to flow from those cancers.

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[1] PPO Investigation into allegations of Racism and Mistreatment of detainees at Oakington Immigration Reception Centre and while under escort (2005 pg 3) - https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2015/11/special-oakington-irc-051.pdf .

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

[3] Inquiry into allegations of racism and mistreatment of detainees at Oakington immigration reception centre and while under escort. (Exhibit EG [15] to statement of Emma Ginn, BHM000043_727)

[4] Report by the assistant deputy coroner relating to the inquest into the death of Jimmy Mubenga (2013) (Exhibit EG19 to Witness Statement of Emma Ginn – BHM000043_1052, and Report of the independent advisory panel on non-compliance management (2014) (Exhibit EG20 to Witness Statement of Emma Ginn – BHM000043_1045

4. The terms of reference ask the Chair to act in something like the role of a physician: the first term of reference requires the identification of the mistreatment and responsibility for mistreatment; the second and fourth Terms of Reference ask the Chair to diagnose and distinguish between the causes of mistreatment and contributory factors to that mistreatment in policies, practices, management arrangements and in clinical care; and the third, fifth and sixth Terms of Reference ask the Chair to prescribe cures for the failings in policies, practices, management, clinical care, and systems for complaints and monitoring mechanisms. The Duncan Lewis (DL) CPs structure their submissions around that framework established by the Terms of Reference.

Identification of the Mistreatment and Responsibility for the Mistreatment (ToR 1)

5. In light of the analysis of the causes and contributory factors above, the DL CPs submit that Brook House was not a "*secure but humane accommodation with a relaxed regime with as much freedom of movement and association as possible*" as mandated by rule 3 of the Detention Centre Rules 2001 (DCR 2001). It follows that the environment was liable to impose suffering which went "*beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment*" in almost any case and was thus liable to impose conditions which risked a violation of Article 3 ECHR for almost anybody detained there[5] for any prolonged period. Pre-existing vulnerability would inevitably exacerbate that risk.

6. Reverend Ward with his first-hand extensive knowledge and lived experience of Brook House from the inside has given cogent and compelling evidence upon which the Inquiry should conclude that the environment as a whole at Brook House was inhumane and degrading for those detained there[6].

7. D1851's case illustrates the nature of the risks of harm that are inherent within the inhumane environment that operated at Brook House: he went into detention as a care worker, lawfully exercising his free movement rights as a spouse of an EU citizen, was falsely imprisoned for twelve weeks, and emerged with enduring PTSD, traumatised by violent, chaotic and alarming incidents, a climate of fear, disrespect and threat as well as the general debased environment, in which his powerlessness to correct the wrong done to him broke his moral and physical integrity, his human dignity and self-worth. As he so

[5] *Kudla v Poland* (2000) 35 EHRR 198
[6] First Witness Statement of Reverend Nathan Ward dated 10 November 2021 and in his live evidence- Nathan Ward 7 December 2021

eloquently described – his experience at Brook House was "crushing" subjecting him to inhuman and/or degrading treatment in breach of Article 3 ECHR.[7]

8. Against that background, each of the other DL individual Core Participants all of whom had additional pre-existing vulnerability submit that they too suffered inhuman and/or degrading treatment in breach of Article 3 ECHR while they were detained and the evidence of their individual experiences is set out in individual closing submissions on behalf of each CP.

9. In D1527's case he submits that both the individual incidents on 25 April and 4th May and *a fortiori* the combination of repeated specific incidents of mistreatment and harm he suffered and/or the cumulative effect of detention was that he suffered torture as well as inhuman and degrading treatment.

Causes and Contributory Factors (ToRs 2 and 4)

10. The Closing Submissions for the DL CPs address the causes of and the contributory factors to the mistreatment suffered by detainees in Brook House first. There are six principal causes of mistreatment:
    i. The arbitrary, indeterminate nature of the detention and the lack of clarity of purpose of detention in policy and/or practice. A practice of short, time limited detentions focused around the immediate days before an organised removal might rarely lead to the scale of harm and the incidence of inhuman and degrading treatment documented. By contrast, the absence of any time limit on the detentions and the pointless nature of the detentions (over half of all detainees being released) has been identified by witnesses across the board as a principal cause of article 3 mistreatment.
    ii. The systemic failure to comply with legal requirements including what might be called the 'systems duty' or "anticipatory duty' under Article 3 ECHR[8]. That is a duty not to establish a system that is liable to result in inhuman or degrading treatment, and/or to act prospectively to avoid any breach of article 3. That implies a duty (if an immigration detention system is to operate) to adequately screen, make the necessary inquiries as to individual circumstances; to apply

[7] D1851 3 December 2021, 60/5-6

[8] For further explanation, see paragraph 4 of D1527's closing submission and *R (Bagdanavicius) v Secretary of State for the Home Department* [2005] 2 AC 66, Lord Brown at [19]; *(Limbuela) v Secretary of State for Home Department* [2006] 1 AC 396, *R (W) v Secretary of State for the Home Department (Project 17 intervening)* [2020] 1 WLR 4420; [2020] EWHC 1299 (Admin) at [42] the Divisional Court (Bean LJ and Chamberlain J) "… the law imposes a duty to act prospectively to avoid the breach"

policies and practices to ensure that detention is used for the lawful purpose of facilitating imminent removal and to identify the vulnerable and take decisions on detention accordingly order to prevent the known risks of harm in detention occurring. In each of the DL individual CP's cases, in breach of that duty, there were clear vulnerabilities which should have been (but were not) identified and which should have been factored into a decision not to detain, or to release prior to any prolonged detention.

iii. The "prisonisation" of the Detention Estate reflected in the design, regime and conditions of the building, the prison based methods of use of force, ACDT and segregation as primary management tools including on the vulnerable.

iv. Toxic and corrupted institutional culture of dehumanisation, xenophobia and racism.

v. The contractual arrangements and institutional relationship between the Home Office and G4S based on enforcement over fundamental rights, cost cutting over welfare and profit over protection and welfare.

vi. The overriding and institutional practice and culture of the Home Office which prioritises enforcement imperatives over welfare and culture of hostility, disbelief indifference and impunity.

11. Absent a cure for these fundamental causes, no number of changes to the physical environment or the numbers of staff or the training or even the culture and practices within Brook House (or elsewhere in the detention estate) will prevent recurring mistreatment which is inhuman and degrading. There are however, at Brook House a number of factors in the environment, staff, practices and culture which are related to the causes and contributed to the extent of the mistreatment and abuse. The following contributory factors are addressed in the submissions below.

    i. Staffing Levels;
    ii. G4S Staff and Management Dysfunction and Culture;
    iii. Home Office failure of contract management and oversight;
    iv. Monitoring and Complaints.

Prescribing the Cures (ToRs 3, 5 and 6)

12. In short, the DL CPs submit that the Inquiry should not adopt the practice that has pertained through countless reports of the IMB, the PSU, Stephen Shaw, the PPO, HMIP, Kate Lampard etc. of making recommendations for numerous changes in policy, practice, management and oversight yet which retains the basic structural problems that cause and will continue to cause the mistreatment and abuse to reoccur. The point of this Inquiry is

not to conspire in the pretence that these problems can be resolved in that way. Its starting point must be that those remedial methods and recommendation have categorically failed to prevent the recurrence of prohibited harm. Stephen Shaw himself acknowledged that and May J took that into account in the judgment that lead to the establishment of this Inquiry. The point and purpose of this Statutory Inquiry is and must be to identify measures that can one and for all eliminate the factors leading to mistreatment for good. To that end it must be recognised there are only limited realistic and reliable options that will make a genuine and effective difference:

i. Strict limits clearly stated in law and policy on the ability of the Home Office to detain so that it is only used for the specified purpose of immediate removal i.e. within 72 hours of detention. Otherwise, thereafter requiring Ministerial authorisation and judicial oversight with a maximum 28 day period (as per the recommendations of Mr Ward).
ii. Strict limits in law and policy to prohibit the detention of those with identified vulnerability and if detained to secure their prompt release;
iii. End the use of IRC's designed like Brook House to specifications of a category B prison and regime.
iv. To recommend the phasing out of immigration detention facilities altogether and the use of effective alternatives.

Preliminary Points

Law – Relating to Art 3- the prohibition on torture, inhuman or degrading treatment

13. Article 3 of the ECHR reflects a key constitutional principle and common law protection and prohibition on torture and inhuman or degrading treatment[9]. English Jurists and Judges from John Fortescue in the 15th Century through Edward Coke, Blackstone, to Lord Bingham[10] have all stated in the clearest terms that torture and other forms of cruel and inhuman treatment are "*totally repugnant to the fundamental principles of English law*" and "*repugnant to reason, justice, and humanity.*" Such cruelty, as we have graphically seen from the *Panorama* and other footage, serves to destroy the moral and physical integrity of the victim, subjecting them to pain and/or severe mental anguish and strips them of their human dignity. It also serves to degrade those who engaged in the practice as well as those who instigated it, encouraged it, colluded in or acquiesced in it. Once mistreatment, abuse and disrespect has become acclimatized, as surely it was in Brook

[9] *A v Secretary of State for the Home Department* [2006] 1 AC 221 at [11], [12], [64], [83], [129], [152]; *R v Secretary of State for Social Security ex parte Joint Council for the Welfare of Immigrants* [1997] 1 WLR 275, 292F-G; *Reg. v. Inhabitants of Eastbourne (1803) 4 East 103, 107.*

[10] *A(No2) v SSHD* [2006] 2 AC 221 at [11-12]

House, it further hardens and brutalizes all those who have become accustomed to it and corrupts the whole.[11]

14. Legally sanctioned ill-treatment in England came to an end with the Bill of Rights of 1689 that prohibited cruel and unusual punishments. What came to be understood by Parliament in the 17th century was that the existence of extraordinary powers then exercised by the Crown was incompatible with the liberty of the subject. It is no coincidence that the central subject of this Inquiry - the mistreatment and abuse of detainees held under immigration powers - is precisely in the context of one of the few remaining extraordinary draconian powers still exercised by the Executive, normally only used in times of war or public emergency, of administrative detention - being held for indeterminate periods without charge or trial[12]. It is not the task of this Inquiry to look at immigration detention more widely, but 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 broader context of immigration detention policy and practice: it is relevant to understanding the profound weaknesses in the legal protections and safeguards for detainees' rights, and the attitude to those rights (or lack of them) both within the Home Office and on the ground in the detention centre. It is obviously also relevant to the detainees' own experience. As Professors Bosworth's study for the first Shaw Review into the Welfare of detainee in Immigration Detention published in 2016 confirmed, immigration detention has a negative impact upon a detainee's mental health and that impact increases the longer that person is in detention.[13] 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. In this context the Inquiry should expect to see rigorous and robust enforcement of the safeguards in policy and practice, as well as the highest standards of governance, oversight, management and vigilance in ensuring compliance. The extensive evidence now available from many sources, however, points to exactly the opposite at all levels within both the Home Office and G4S.

15. It is also why the key safeguards in the Rule 34 and 35 of the DCR 2001 and the Adults At Risk policy are so critical. They should provide a procedure for the mental and physical examination of a detainee within 24 hours of their entry to an IRC so that prompt identification and report of key indicators of vulnerability - risk of injury to health through

[11] See for example Witness Statement of Dr Brodie Paterson dated 21 January 2022, paras 89-141, BHM000045_0020-0034

[12] Sedley LJ has commented that the introduction of administrative detention here represented a "dramatic constitutional innovation", "unprecedented in peacetime" (per Sedley L.J. in ***SSHD v Pankina*** [2011] QB 376).

[13] 'Review into the Welfare in Detention of Vulnerable Persons, A report to the Home Office by Stephen Shaw' (2016), Appendix 5 INQ000060_0305-0334

continued detention, suicidal ideation and a history of torture - are made. The purpose of these safeguards is intended to be (but is not in practice) to secure prompt release of those whose vulnerability means they should not be detained. It is now clear beyond any argument from the evidence of Dr Hard[14] and Medical Justice[15], that this process even now continues to systemically fail both in terms of the efficacy of the Rule 34 and 35 procedure in ensuring a report is promptly and competently made - but also, and crucially, that it results in release. In 65% of rule 35(3) cases, it did not. That is not just an operational failure - it is a reflection of the fact that despite the promise to meet the recommendations of Shaw 1 (2016)[16] to improve protection for vulnerable detainees and reduce the numbers of vulnerable people in detention, as you heard from Medical Justice and others, the Home Office instead took the opportunity to in fact re-balance the policy away from release and in favour of immigration factors, resulting in very many fewer people benefiting from the very strong presumption against detention than the previous policy. The Home Office witness Mr Cheeseman responsible for the Adults at Risk policy not only did not dispute this he positively asserted it[17]. The healthcare witnesses, Drs Oozeerally and Chaudhary, Sandra Calver and the current health care providers PPG laid bare the full extent and gravity of the wholesale failure of key detention policy and safeguards designed to prevent harm including harm in breach of Article 3 ECHR. Dr Hard described it as a "*deprivation of safeguards*"[18]. He was correct to do so.

16. This represents a systemic failure in the protections in Article 3 ECHR which are intended to be stringent because they are absolute and non-derogable[19].

17. Article 3 impose both negative and 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* at [113-114, 118], and (ii) an operational duty to prevent a breach in the individual case.

18. 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, detained

[14] Dr Jake Hard 28 March 2022
[15] Dr Bingham and Theresa Schleicher of Medical Justice 14 March 2022
[16] E.g. 11.8, INQ000060_0194
[17] Ian Cheeseman 16 March 2022, e.g.181/18-25, 182/1-23, 184/14-25, 185/11-22, 188/2-25, 189/1-25, 190/8-25, 191/1-25, 192/1-17
[18] Dr Jake Hard 28 March 2022, 179/8-9
[19] 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.

persons are in a vulnerable position and the authorities are under a duty to protect them: *Edwards v United Kingdom* (2002) 35 EHRR 19 at [56]. This includes persons in administrative detention for immigration purposes: *Slimani v France* (2006) 43 EHRR 49.

19. States are therefore 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 steps to *prevent* and *forestall* actual breaches and potential breaches of the prohibition against torture and inhuman and degrading treatment. The evidence before this Inquiry demonstrates that these primary obligations have not been met in terms of the basic legal framework in detention policy and practice at a systems level with the inevitable consequence being breaches at an operational and individual level. Without recognition of that fact lessons learning will be incomplete and any remedial recommendations in effective to prevent recurrent harm.

What forms of ill-treatment does Article 3 cover?

20. The distinctions between the different forms of prohibited ill-treatment are relevant to the Inquiry's task. "Torture" is "deliberate inhuman treatment causing very serious and cruel suffering." Torture must also be inflicted for a purpose, such as, *inter alia*, inflicted to intimidate.

21. Torture can be psychological as well as physical. A single incident can amount to torture if serious/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[20].

22. By contrast, inhuman treatment does not need to be deliberate or intended to cause suffering, *Ireland v United Kingdom* supra, and there is no requirement that the suffering be inflicted for a purpose.

[20]In *Pretty v. UK* (2002) 35 EHRR 1the ECtHR held at [52] that "The suffering which flows from naturally occurring illness, physical or mental, may be covered by Article 3, where it is, or risks being, exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible."

23. The Court defined "inhuman treatment" and "degrading treatment" in *Kudla v Poland* (2000) 35 EHRR 198 to include treatment that "*caused either actual bodily injury or intense physical or mental suffering*". The touchstone threshold for a breach of article 3 in a detention case is whether the suffering and humiliation experienced by the detainee is "*beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment*". That minimum threshold incorporates consideration of the individual's circumstances, including his particular vulnerability by reason of his mental illness and his individual needs for medication and treatment. The most authoritative statement of principle is to be found in the 2019 Grand Chamber judgment of *Rooman v Belgium* [2019] ECHR 105 at [141-147]. The Grand Chamber held that "ill-treatment" for the purposes of Article 3 does not require physical ill-treatment:

> *1…In particular, the Court has held that 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 (see, in particular, Hüseyin Yıldırım v. Turkey, no. 2778/02, § 73, 3 May 2007, and Gülay Çetin v. Turkey, no. 44084/10, § 101, 5 March 2013). 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 (see Kudła v. Poland [GC], no. 30210/96, § 94, ECHR 2000-XI; Rivière v. France, no. 33834/03, § 74, 11 July 2006; and Claes, cited above, §§ 94-97).*
>
> *2. 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 (see Selmouni v. France [GC], no. 25803/94, § 99, ECHR 1999-V… it has recognised that detainees with mental disorders are more vulnerable than ordinary detainees, 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. 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…*
>
> *3. The Court also takes 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 detainees 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…

4. In this connection, the "adequacy" of medical assistance remains the most difficult element to determine. The Court reiterates that the mere fact that a detainee 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 detainee'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 detainee'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.

24. 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 with physical assault – 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)[21] also 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. 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; vii) self-neglect and compromised inter-personal relations causing humiliation in the eyes of the individual or third parties.

25. We emphasise this because the Core Participants whom Duncan Lewis represent were not all subject to overt physical ill-treatment or ill-treatment of the severity to which D1527

[21] 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).

was subject. Nevertheless, they have credible claims of ill-treatment in breach of Article 3 ECHR. We remind the Inquiry that in granting judicial review May J recognised at para 63 that the allegation made by D1527 go much wider than specific incident of physical ill-treatment shown in the Panorama programme notwithstanding the apparent difficulty of the Home Office to appreciate that as suggested by the "corporate" statement of Mr Riley.

Task of the Inquiry

26. It must first be recognised that this Inquiry is taking place in part because of a failure to date to meet the state's essential obligations to ensure that treatment contrary to Article 3 perpetrated by state agents does not go unpunished through criminal prosecution even in D1527's case. This is a matter that the Inquiry should address.

27. The first task of the Inquiry is to find the full facts, but the second crucial function is to understand how and why mistreatment and abuse took place, and understanding the systems, including the regime, policy and arrangements, which sanctioned or allowed them to occur. This is integral to the Article 3 duty asset out above relates not just to operational failures in individual cases but to ensuring at the system level policy and arrangements are in place to prevent such operational breaches occurring in the first place.

28. It is now clear that a toxic and corrupt environment operated at BH where fundamental disrespect and abuse were ingrained, thrived and came to dominate. Whilst it is accepted that what can be described as "cliques" existed, and indeed on the evidence of Nathan Ward and confirmed by other sources it coalesced around more senior officers[22], misconduct was widespread and repeated, widely known and not challenged despite the duties on each officer under rule 45 of the DCR 2001. As May J said it "*is the egregious nature of the breaches, the multiplicity and regularity of abusive events and the openness of the activity within units that is so stark and shocking*"[23] They were repeated events in front of others perpetrated by mangers and trainers as well as ordinary officers. It infected health care staff. It was known to seniors' mangers in G4S. It must have been known to Home Officials on the grounds in the IRC. This degree of abusive word and deed could only operate in a climate of impunity based on collusion and acquiescence within the SMT at G4S and Home Office officials on the ground and in the hierarchy, as well as its political leadership.

Lessons Learned and the Repetition of History

[22] E.g. see Witness Statement of David Waldock dated 19 March 2022, BDP00007_0006 regarding Steve Skitt and his shaping of culture at Brook House with his circle of favoured officers who were protected
[23] *MA & BB v SSHD* [2019] EWHC 1523, paragraph 62(1) (DL0000150)

29. The footage, documentary, written and oral evidence shows, that the laws, rules and processes designed to protect ordinary and vulnerable people from mistreatment in detention are not fit for purpose and are in any event flagrantly and openly breached. This state of affairs has been persistent over many years in spite of repeated recommendations by multiple bodies. The job of the Inquiry is to bring this to an end. That is integral to its role. It faces a daunting task, as the evidence of Stephen Shaw, (who has devoted a large part of his life to the patient work of trying to reform Home Office practice) to the HASC on the 11 September 2018 expresses:

> *As I say, I am tired of this in a way. I think it is now 15 years ago that I did the first review for the Government of abusiveness that had not been identified by the formal oversight mechanisms, had not been seen by management and had been revealed by an undercover reporter. The means by what was revealed at Brook House—leaving aside the appalling nature of it—came to public view was exactly the same as at Yarl's Wood two or three years ago and exactly the same as at Yarl's Wood and Oakington in the early 2000s. Therefore, we have not solved the problem."*[24]

30. The Inquiry is offered an easy way of avoiding the challenge and opportunity presented to it by the Home Office's deponent Mr Riley. Of all the evidence that has been provided to the Inquiry, his evidence was in some ways the most alarming and concerning in its recklessly complacency.

31. Mr Riley's opinions on behalf of the Home Office were openly based upon very limited acquaintance with the evidence. Even giving oral evidence he admitted to having been too busy negotiating new contracts for detention centres to attend to the evidence of the failures in the old contracts. His position on behalf of his employer was painfully predictable:

- He considered (based on no experience and directly contrary to evidence) that the events at Brook House are "*in no way indicative of the broader treatment of people detained under immigration powers at that time*".[25]
- Nonetheless, they have acted "*as a spur for the ambitious programme of reform that we have undertaken over recent years*".[26]
- He was unable to offer explanations for the behaviour of G4S "in *Panorama*" (implying the behaviour is strictly limited to that which *Panorama* filmed) but he

[24] DL0000150_0021
[25] Witness Statement of Phil Riley, paragraph 5, HOM0332005_0002
[26] Ibid

remains "*clear in my opinion that the misconduct in question was perpetrated by a small minority of staff who, according to the testimony of current and former G4S staff were not reflective of the whole workforce or the culture at the company*".[27]

- Mr Riley says at paragraph 53 that "*viewing the Panorama broadcast again, I do not find any evidence that the operation of Rule 35 of the Detention Centre Rules was systemically ineffective during the relevant period at Brook House*[28]". His opinion appears to be based entirely on *Panorama*, rather than the copious evidence of the systemic failures of the rule 35 system known to and provided to the Home Office since at least 2006 in litigation, in reports by the HMI, Stephen Shaw and many others. The extent of Mr Riley's detachment from the evidence heard by the inquiry was evinced by the fact that the day before giving evidence he took what to him clearly seemed to be a significant step of writing a letter to the medical contractors reminding them of rules 34 and 35 of the Detention Centre Rules 2001, as though that might remediate more than a decade of failure.[29]
- In his view the culpability of the Home Office lies largely in something called "performance management and assurance[30]" (para 8) and "On reflection… a number of issues in the Home Office's contract with G4S[31]" (para 17). At paragraph 24 he clarifies "*I would submit that a principal failing of the contract was its inflexibility in not allowing the Home Office to categorise the abuse perpetrated by G4S staff in Panorama as a contract failure*[32]".
- Mr Riley, still without irony, commends G4S for taking swift action against those individuals and considers the Home Office also "acted swiftly to take what action it could[33]" (paragraph 9).
- Mr Riley does not even acknowledge the possibility of systems and institutional failures, which Dr Hard and Mr Collier, the HMIP, IMB and Medical Justice address nor the evidence of the toxic and corrupted institutional culture, the racism and xenophobia to which Professor Bosworth, Dr Paterson and Reverend Ward referred (see further below). He gave no consideration to some of the oversight and management failings identified in the Lampard report.

32. Mr Riley's evidence does however serve one useful purpose: it shows us where the Home Office believes the problems and solutions lie. It shows that in its view the Home Office's systems, policies, oversight, management and decisions on detention of the vulnerable bear

[27] Paragraph 6, HOM03320005_0003
[28] HOM0332005_0017
[29] HOM0332160
[30] HOM0332005_0003
[31] HOM0332005_0006
[32] HOM0332005_0008
[33] HOM0332005_0004

almost none of the weight of responsibility; that G4S's corporate responsibility was largely limited to employing the individuals who were exposed by Panorama; and that such problems as there were in 2017 have now been eliminated. As to solutions, Mr Riley informs the Inquiry that the Home Office has now embarked on what it believes are "ambitious reforms and an "action plan", although it is described without particulars of any action. Nothing further was forthcoming in his oral evidence.

33. Its further value is this – it is highly revealing and incontrovertible evidence that the Home Office has not even begun to understand the nature and gravity of its failure and its responsibility for it and has not begun to be seriously engaged in any form of reflection change, reform and lessons learned. The work of this Inquiry remains as important and as urgent as it was on the 4th of September 2017 after the airing of the *Panorama* documentary.

34. That the Home Office is prepared to treat G4S as a company that can be permitted to manage custodial settings with vulnerable people beggars' belief. Mr Riley ignores repeated abuse scandals and its role in Yarl's Wood, Oakington, Medway, Rainsbrook as well as Brook House. This explains why G4S were able to see out and even have their contract extended by two years until 2020 rather than promptly ended. It continued to provide healthcare even to August 2021. It is why nobody within the G4S senior management and leadership has been held to account and disciplined. Even Mr Saunders was allowed to resign and take up employment with another private contractor[34]. It is also why no single person within the Home Office has been held to account to date for the mistreatment abuse and systemic failings that *Panorama* exposed. It is why no fundamental change has taken place to date and indeed, as the IMB's most recent reports for 2020 show[35], Brook House continues to be a place in which detainees as a whole continue to be subject to inhumane treatment and where fundamental rights, protections and welfare are overridden by the Home Office imperative of enforcement and removal.

35. On this evidence there are two central key issues:

    - Is it really the case, as claimed by Mr Riley for the Home Office, that the snapshot of Article 3 mistreatment emerging from the evidence to this Inquiry is attributable entirely to aberrant abusive conduct of a small group of individuals employed by G4S and poor contractual performance management assurance by the Home Office?

[34] Ben Saunders 22 March 2022, 192/7-10
[35] DL0000140_0113

Or, on the other hand, as for example Reverend Nathan Ward and Medical Justice explained and Professor Bosworth, Dr Hard and Jon Collier and other experts confirm, there are fundamental, deep rooted problems with the operation of Brook House rooted in the systems and system failures, toxic and corrupted cultures of prisonization, dehumanization, racism, xenophobia and sexism. Indeed, in some respects the staff at the sharp end were victims of the system failure that others instigated.; themselves brutalised and degraded by the system and its culture within which they operated, and which all converged to dehumanise, objectify and denigrate detainees.

- Consequently, are the remedies limited to the production of new paperwork, (new guidance, new DSOs, new contracts, new policies etc), training, more staff and to monitor operational changes that the Home Office asserts have already been implemented through its "action plan"?
- Or, on the other hand, when those who have power to take the political decisions that might ensure there is no repeat, will they be assisted by this Inquiry, and by what Professor Bosworth refers to as this unique "*opportunity to take stock of the system as a whole and to consider alternatives, for the only way to avoid the kind of events filmed in Brook House would be to stop detaining people and manage everyone's immigration case in the community*".[36]

36. If the inquiry chooses to adopt the Home Office fantasy to attribute wrongdoing to the actions of a few 'bad apple' staff, and to make a series of recommendations about incremental and instrumental operational changes, it will miss a once-in-this-century opportunity to end the shameful merry-go-round. And the opportunity will have been missed just at the moment it is most needed as recent reports from the IMB show and as the Home Office plans to put into effect and utilise new powers to expand detention to reintroduce a detained fast track procedure which sanctions the use of detention for administrative convenience whilst processing the claims of asylum seekers. As Emma Ginn of Medical Justice explains:

> *"At the same time, the Home Office is seeking a statutory power to reintroduce the discredited, unfair and unjust detained fast track system for asylum seekers without addressing and remedying the ongoing defects in screening and Rule 34/35 before seeking to implementing in IRCs".* [37]

Building Upon Existing Investigations

[36] Dr Mary Bosworth, INQ000064_0011 Paras 2.27-2.28
[37] Witness Statement of Emma Ginn dated 8 February 2022 at [161], BHM000041_0058

37. The following investigations of the specific events in Brook House in the first half of 2017 have already concluded and it is upon these findings that the Inquiry says it seeks to build. Looking at these findings the DL CP's emphasise:

- In November 2017, the Lampard Investigation found not just a number of renegade individual staff as the Home Office asserts, but rather "*A culture of menace towards some detainees and a conspiracy of silence and/or misrepresentation concerning incidents of violence or neglect,*"[38] and staff including managers and medical staff "*turning a blind eye*" to abuse. The report is also notable for its comments on the institutional failing of the IMB.
- There was also a key finding and recommendation at 1.57 that nobody should be detained at Brook House for longer than few weeks.[39]
- The 21 March 2019, House of Commons Home Affairs Committee ("HASC") report[40] emphasised that serious systemic failures, and problems of organisational culture, leadership and management, appeared to have contributed to the ill-treatment of detainees at Brook House Again in marked contrast to the Home Office's evidence to this Inquiry. The Committee identified "*serious problems with almost every element*" of the immigration detention process and indicated that "*substantial reforms*" were needed (para 20). Of the failings identified by the Committee, particularly in the area of the treatment of Adults at Risk, were policy failings, as opposed to merely operational failings or failings of implementation (para 118). It also drew attention to failures in oversight mechanisms, in whistleblowing procedures and in poor organisational culture. Unlike the Home Office, the HASC properly identified the duty to secure the humane treatment of detainees as lying on its shoulders, not in the terms of its contracts with G4S. It concluded that the Home Office had "utterly failed" in those responsibilities. It recommended a time limit of 28 days on the general detention power.
- The Joint Committee on Human Rights also recommend a time limit of 28 days on the general detention power (paragraphs 8-9 of recommendation section)[41].
- In 2020 the IMB issued a notice under rules 61 (3) and (5) DCR 2001, by the Brook House IMB and IMB Charter Flight Monitoring Team (CFMT) bringing a concern to the attention of the Minister on 2 October 2020 and identifying

[38] CJS005923_0281
[39] CJS005923_0015
[40] https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/913/91302.htm
[41] https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/1484/148402.htm

practices in detention that could amount to inhuman or degrading treatment[42]. The notice states that the IMB have evidence that the concentred programme of Charter flights in Oct 2020 "*indicates a series of issues ... 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*". It documents an increase in the number of vulnerable detainees in detention, high incidence of self-harm requiring use of ACDT and causing high levels of stress and anxiety. It also documents the breakdown in the Rule 35 process and people being removed when on ACDT and at risk of self-harm/suicide.

- Its subsequent report (its annual report for 1st January -31 December 2020, issued in May 2021) found that Brook House was operating at reduced capacity to 209 (47%) for most of 2020 which further documents these concerns. The report records disturbing numbers of detainees in segregation on constant supervision, and distressing statics on self-harm with a correlation with the increased use of segregation and force. The report pressed again for a review of AAR and identified systemic failure in the Rule 35 procedure. Most concerning for this Inquiry.

> "*…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 detainees having force used on them each month. An average of about 17% of detainees had force used on them in each month in 2020, compared with between 7% and 8% in 2019 and 2018. The Board is concerned by the increased prevalence of use of force this year, and our analysis of underlying data shows that it was higher in both the first half of 2020 and the latter part of the year, after the shift to a more vulnerable population*"[43].

Causes and Contributory Factors (ToR 2 and 4)

Causal Factor 1: Prolonged, unlimited and purposelessness detention

38. In principle our common law places the utmost importance on the right to liberty. In *R (Egal) v SSHD* [2010] EWCA 584 Sedley L.J. expressed it this way:

[42] DL0000140_0013
[43] DL0000140_0132

> "*The power of administrative detention is a striking exception to the rule that imprisonment is lawful only in the execution of the sentence of a court of law. The principle of habeas corpus requires it to be exercised with scrupulous attention to the proper ambit and due exercise of the power, so that nobody is detained for a day longer than is lawful.*"

39. That nobody should be detained *a day longer* than is necessary means that what is required is that where a person is wrongly detained- as all the DL detained CPs were – there should be mechanisms in place to secure that they are not detained a day longer than they should be. Indeed that is why rule 34 requires physical and mental examination within 24 hours: to ensure that those who should not be detained are released. Yet there is no evidence that anybody was released on day 2 as a result of the Rule 34 and 35 process. On the contrary, the evidence is that that safeguard did not, and still does not, operate.

40. None of the detainee DL individual CPs should ever have been detained. The fact they were all subsequently released is indicative of the systemic failure of detention policy and the purposelessness of detention, especially considering the detrimental impact it had on all the CPs. All of them suffered from prolonged detention, ranging from 3 weeks to almost 2 years and, of course, none of them knew, during the course of detention, how long they would be held for:

    i. D1851's detention was unlawful from the outset. He always had a right to remain in the UK as the spouse of an EU citizen.[44] The Home Office conceded he was unlawfully detained, and that they had acted in breach of EU law, in 2018.[45] The Home Office further conceded that he was entitled to substantial damages as a result in June 2020.[46] It took years of litigation to procure these admissions from the Home Office. D1851 was released after 12 weeks in detention which achieved nothing beyond the profound and ongoing destruction of the mental health of a man who went into detention healthy. He continues to live in the UK as someone with leave to remain.

    ii. D1914's detention was unlawful from the outset. He had previously succeeded in an extradition appeal on the basis of his Article 8 rights.[47] Despite this, the Home Office sought to re-litigate his case by pursuing a Deportation Order, without consideration of the extradition court's findings, and without providing

[44] DL0000143_0001.
[45] DL0000143_0030.
[46] DL0000143_0030.
[47] DL0000229_0012.

any reasons to counter the findings on D1914's Article 8 rights.[48] D1914 was released after four months in detention which achieved nothing beyond causing a severe deterioration in his mental and physical health, the impact of which he continues to feel to this day. He continues to live in the UK and is currently seeking to regularise his status as an EU citizen.

iii. D2077's detention at Brook House in the Relevant Period was unlawful from the outset. Despite previously having been released due to his severe vulnerabilities and as a victim of torture, the Home Office chose to re-detained him after re-grading his Adults at Risk level from level 3 to level 2.[49] The Home Office settled his subsequent unlawful detention claim.[50] D2077 was released after 3 weeks in detention which achieved nothing beyond the destruction of his already fragile mental health.[51] D2077 has since been recognised as a refugee.

iv. D1527's detention was unlawful from the outset for reasons explored further in Cause 2. Despite D1527's representatives wrote to the Home Office at the start of his detention at Brook House drawing their attention to his medical vulnerabilities and suicidality, they maintained detention. In the end he was forced to issue urgent judicial review proceedings, which the Home Office wastefully contested and lost.[52] D1527 was released after 2 months in detention – months in which nothing was achieved and he suffered torture and inhuman and degrading treatment and has left him permanently traumatised.[53] He described the upsetting and stressful impact of prolonged, indefinite detention where you do not know how long you will be detained for, and the detrimental impact this has on mental health.[54] He has now been waiting for over two years for the Home Office to make a decision on his application for discretionary leave.[55]

v. D643 was detained for 23 months.[56] Despite being granted bail in principle on 13 December 2017[57] and 9 February 2018[58] on the basis of his severe mental ill health, the length of his detention and the deterioration in his health, the Home

[48] DL0000229_0072.
[49] DL0000226_0012-15.
[50] DL0000226_0003.
[51] DL0000226_0040.
[52] DL0000209_0002.
[53] DL0000144_0059.
[54] DL0000144_0059.
[55] DL0000144_0056.
[56] DL0000228_0003.
[57] DL0000228_0055.
[58] DL0000228_0056.

Office did not release him due to their failure to arrange accommodation.[59] The Home Office further failed to act on a third grant of bail in March 2018,[60] and D643 only secured his release through a judicial review for unlawful detention. The Home Office settled his unlawful detention claim in 2019.[61] D643's prolonged detention achieved nothing beyond instigating an acute worsening of his pre-existing mental health conditions.[62] He continues to live in the UK and is currently seeking to regularise his immigration status.

vi. D1538 was detained for a total of over 12 months between 2014 and 2017.[63] He was repeatedly detained, despite the Home Office being aware that he did not have an ETD for Morocco and that his removability was therefore low,[64] and its own guidance stating that timescales for procuring such documents are inconsistent, but take a minimum of three months.[65] The Home Office continued to maintain detention of D1538 even after he submitted an asylum claim.[66] D1538 was released on 3 October 2017,[67] over 4 months after his detention, which had achieved nothing beyond traumatising D1538, leaving him with lasting mental health issues.[68] He spoke of the terrible impact of prolonged, indefinite detention, describing it as a "forgotten prison".[69] He continues to live in the UK and continues to seek to regularise his immigration status.

41. These examples demonstrate this is not a system where detention is used as policy requires for the shortest period possible, as a last resort, or where removal is possible in a reasonable timescale. The experiences of the CPs and so many others in detention illuminates the falsity of claims by the Home Office, including claims made to this Inquiry,[70] that the Home Office operates immigration detention in accordance with the law and policy. Even Philip Riley, the Home Office corporate witness , acknowledged that detention is "*prolonged*" in some cases, comparing it unfavourably to a time-bound prison sentence.[71] Steve Hewer admitted in his live evidence that the average length of detention today at Brook House is 35 days but with one man currently in detention for over a year.[72]

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[59] DL0000228_0055.
[60] DL0000228_0056.
[61] DL0000228_0077.
[62] DL0000228_0079-80.
[63] HOM032504.
[64] E.g. HOM0322211.
[65] Country_Returns_Guide_March_2022.ods (live.com)
[66] HOM0322211.
[67] HOM032503
[68] DL0000231_0041-42.
[69] DL0000231_0044.
[70] E.g. Phil Riley, 4 April 2022, 61/23 – 62/20.
[71] Phil Riley, 4 April 2022, 63/1-5.
[72] Steve Hewer, 1 April 2022, 52/19-24.

42. Numerous witnesses, including detention officers, managers, experts, men detained at Brook House, and medical professionals criticised the devastating impact of the unlimited extent of immigration detention powers. A table is attached at **Annex 1**, but for example:

i. Callum Tulley: "*You were constantly bearing witness to the conditions in which the detainees were held. So even if you went through phases in which you weren't seeing abuse, you know, the indefinite nature of the detention still remained and that was the most destructive element of detention. I mean, it was – it destroyed detainees, it completely stripped them of any sort of hope.*"[73]

ii. Dr Oozeerally: "*sometimes it was the uncertainty of detention rather than detention itself. If a patient knew they were only going to be there a week, then that would be better. If the patient knew that they weren't going to -- there would be no notice removals, which I think have changed now, that would be better that they didn't -- that they could prepare themselves. It was the immigration -- my experience is that it's the immigration uncertainty rather than detention itself…*"[74]

iii. Sandra Calver: "*Mental health for detainees has always been very high for the simple fact that in a prison they have got an end of sentence and in an immigration removal centre there often isn't an end of time so that's what can often play on their mental health*"[75]

iv. Michelle Brown: "*From the day Brook House opened in March 2009, it became clear that detainees would exceed the expected 72 hour stay and would soon tire of the same facilities, food and regime. From speaking to detainees in 2009 right through till 2020, there was a clear theme of uncertainty — they would not know how long they was going to be incarcerated and at the end, if they were to be bailed, released or deported. Over a period of time, I could see the physical and mental impact prolonged detention had on individuals.... Merely from reviewing the departure figures, there was a consistent trend that 33% of Detainees would be released / bailed, a further 33% transferred*"[76]

v. Jerry Petherick: A. *I think the real issue -- and, you're right, I'm not a clinician at all, but my experience would say that the real issue that impacted on*

[73] Callum Tulley, 30 November 2021, 54/22 – 55/5.
[74] Dr Husein Oozeerally, 11 March 2022, 107/11-22.
[75] Sandra Calver, 1 March 2022, 186/25 – 187/5.
[76] INQ000164_0054.

detainees' well-being and mental health was their sense of not knowing what was happening with them and the frustrations of their progress towards their release either into the UK or the repatriation, and so the major impact on the well-being was the uncertainty of the situation they found themselves in. Yes, the fact that the conditions were harsher than we would all want, the physical conditions, would have, I think, a further impact. But I don't move away from my very firm belief that it was -- the main issue is that of the uncertainty. And I think the research into detention centres would reinforce that view."[77]

vi. Professor Mary Bosworth: *"A time limit would significantly reduce the kinds of distress shown in the video footage"*[78]

Causal Factor 2: Systemic Failure of Detention Policy and Safeguards

43. Following the recommendation of Stephen Shaw the introduction of the Adults at Risk policy was supposed to work alongside an "enhanced gatekeeper" role to ensure that fewer vulnerable entered detention. This followed on from Stephen Shaw's 2016 report recommendation that the Home Office should introduce a single gatekeeper for detention to ensure consistent application of the criteria under EIG 55.10, to carry out risk assessments prior to detention and to maintain strategic oversight of the detained population so as to ensure, more systematically and consistently, that those who should not be in detention are not detained, and that individuals' shifting circumstances and suitability for detention are acted upon swiftly and appropriately.[79] However it was clear that these policies and safeguards in respect of the Detention Gatekeeper were entirely inadequate during the Relevant Period.

44. The failings of the Detention Gatekeeper system were set out by Theresa Schleicher of Medical Justice in her witness statement of 3 February 2022:

"The Detention Gatekeeper Team was created to meet a recommendation in Shaw 1 for pre- detention screening of vulnerabilities. But the gatekeeper relies solely on internal information for the decision to detain. The problem is that the information held by the Home Office may be out of date, incomplete or there may not be any significant information available, such is the case with people who are detained on arrival to the UK. Even where there is current medical evidence available, for example because

[77] Jerry Petherick, 21 March 2022, 98/17-25.
[78] [2.28]- INQ000064_0011
[79] 4.90-4.91, INQ000060_0101

reports had been adduced in immigration appeals, these do not appear to be considered (or accessed) by the gatekeeper team and therefore the often-valuable information about vulnerabilities in the reports are ignored. Even where relevant medical evidence is considered by the gatekeeper team, our experience was that the Home Office would proceed to make a decision to detain anyway, but seek to justify this notwithstanding acceptance that the person is an AAR level 2"[80]

"The gatekeeping function did not function well because it did not involve representations from detainees or legal representatives and was without clinical input."[81]

She summarised concerns by the ICIBI in their 2020 report on the Adults at Risk policy[82]: *"The detention gatekeeper is a weak screening tool, as decision-makers have no direct contact with the persons referred and are reliant on referral forms of variable quality with inconsistent understanding of vulnerability. (§§3.7, 6.34) Decision-makers and referrers also have no professional medical knowledge which risks hidden disabilities going undiscovered (§3.8)... Where vulnerabilities are identified by the gatekeeper, insufficient information is passed onto the IRCs (§6.72);"*[83]

45. This was supported by the witness statement of her colleague Emma Ginn dated 8 February 2022 who recommended: *"167. There must be effective screening before a person is detained. The Detention Gatekeeper is an internal process and is not adequate. A system for independent and robust oversight must be introduced, such as Detention Review Panel with a procedure for proactive inquiry so that the Panel is satisfied that there are no legal or practical barriers to removal and all relevant up to date evidence has been obtained and considered by the Home Office about the person's health and any other vulnerability."*[84]

46. D2077 is a prime example of the Detention Gatekeeping failures. Despite previously having been released due to his severe vulnerabilities and as a victim of torture as a Level 3 Adult at Risk, the Home Office chose to re-detained him after re-grading his Adults at Risk level from level 3 to level 2. The Gatekeeper initially rejected his re-detention on 12 February 2017. Yet despite no evidence of change or improvement to his health, the following month

[80] Para 157(a), BHM000032_0054-0055
[81] Para 166, BHM000032_0057
[82] ICIBI (2020) Annual inspection of 'Adults at Risk in Immigration Detention' November 2018 — May 2019
[83] Para 172(c)-(d), BHM000032_0059
[84] BHM000041_0059

on 28 March 2017, the Gatekeeper sought authorisation for his detention and seeking for his AAR level to be downgraded to Level 2 so he could be detained for a charter flight: *"Can this case be reviewed and authorised for Level 2? Vulnerability: on the referral from the ICE team it states that the subject is level 3AAR- suffers from depression and anxiety previous release on rule 35 grounds. Under special conditions is also states that the GP is arranging counselling for applicants mental health condition…. Recommendation: TCU case and subject removal on the German charter flight. Notes on CID confirm RD's to be set for 31/03/17. Due to subjects health and previous release on rule 35 grounds, can we accept this case?"* Following internal discussions in which the Home Office decided to re-evaluate a Rule 35 report they had already accepted was level 3 evidence, the Gatekeeper went on to confirm: *"AAR2 detention approved. RDs is for 11th April (not for disclosure). Sub would be detained for 12 days before RDs take place. There is no evidence to show that detention would be harmful to his health."*[85] D2077 went on to suffer considerably and to successfully challenge the lawfulness of his detention, in respect of which the Home Office agreed to settle and pay damages.[86] All the Gatekeeper achieved was the further deterioration of D2077's fragile mental health. The case illustrates the lack of independence of the Gatekeeper in wilfully- and it can be inferred- unlawfully changing the AAR rating in the pursuit of an unjustified detention (and removal).

47. The Inquiry heard evidence from the healthcare team at Brook House, independent healthcare professionals, and experts, about the systemic failings in Rules 34 and 35. **Rather than repeat the detailed and comprehensive analysis of Medical Justice, the DL CPs endorse and adopt their submissions on healthcare, rules 34 and 35.**

Rule 34

48. The DL CPs highlight the following:

Sandra Calver

i. She revealed early in her live evidence that she did not understand Rule 34 and appeared not to have read it. She believed it required an initial screening by a nurse within 2 hours, and then by a GP within 24 hours.[87] It only requires the latter.

[85] DL0000226_0012-15.
[86] DL0000226_0040.
[8787] Sandra Calver, 1 March 2022, 160/2-4.

ii. She admitted that the Rule 34 appointments were "very brief" – in 2017, only five minutes, so that detainees with any conditions had to make a further, longer appointment to discuss any conditions in detail.[88] It was not possible to adequately examine someone's mental and physical health in a five minute appointment. The short appointments were due to resource constraints.[89]

iii. Ms Calver acknowledged the Rule is an important safeguard for detained persons, so that if the assessment is not done quickly and adequately, people could be detained when they should not be and thereby be harmed.[90] The purpose of Rule 34 is to identify vulnerable detainees at the point of their detention, so they can be routed out of detention if necessary. This misapplication of the Rule meant that it did not function as intended, because the appointments were not long enough to undertake a proper screening.

Dr Oozeerally

iv. He revealed that he viewed Rule 34 appointments as a form of "triage", rather than a full mental health examination (which would not be possible in five or ten minutes).[91] He resisted the suggestion that the rule required a physical and mental state examination,[92] or that its purpose was to trigger a Rule 35 appointment if necessary.[93]

Dr Chaudhary

v. Dr Chaudhary stated that during his Rule 34 assessment, it was a case of "*literally just asking the patient, 'How are you, how are you feeling*?'"[94]

Theresa Schleicher

vi. On behalf of Medical Justice, Theresa Schleicher explained that the examinations undertaken at Brook House did and do not meet the purpose of Rule 34 as it is not a targeted mental and physical examination designed at eliciting information about whether a person is at risk in detention and in need of a Rule 35 assessment. Instead it is treated as a really brief assessment looking at immediate health needs.[95] Mental health is not assessed properly in the

[88] Sandra Calver, 1 March 2022, 208/19-21.
[89] Sandra Calver, 1 March 2022, 209/1-6.
[90] Sandra Calver, 1 March 2022, 213/8-16.
[91] Dr Oozeerally, 11 March 2022, 9/11-20.
[92] Dr Oozeerally, 11 March 2022, 10/11 – 20.
[93] Dr Oozeerally, 11 March 2022, 12/25 – 13/17.
[94] Dr Chaudhary, 11 March 2022, 202/6-12.
[95] Theresa Schleicher, 14 March 2022, 63/20-64/9.

appointments, which is often the key information which needs to go before the Home Office for a decision to release.[96]

Dr Hard

vii. Dr Hard stressed the importance of Rule 34 to identify people who may be at risk in detention, particularly given the lack of pre-detention screening.[97] He confirmed he did not think it possible to evaluate someone's risks as required by Rule 34 in a ten minute examination.[98]

viii. He agreed that the safeguard was systemically failing – a Rule 34 compliant examination cannot be done at the outset and so the Rule 35 process is delayed.[99]

Luke Wells

ix. Luke Wells explained that Brook House does not have enough resource to provide longer appointments for Rule 34. Staff do what they can with their resources, meaning ten minute appointments to identify immediate risks, with follow-up appointments.[100] He acknowledged there was a lack of understanding around the purpose of Rule 34.[101]

Anna Pincus

x. On behalf of GDWG, Anna Pincus explained that initial screening was done by a nurse, often late at night after the patient has undergone a long journey. Delays whereby patients were not assessed by a GP in the first 24 hours are common, and when those appointments did occur they are brief, with medical notes mostly only containing information on prescriptions without any indication of consideration of vulnerability.[102]

Professor Katona

xi. Professor Katona stressed that the Home Office was aware well before the start of the Relevant Period that Rule 34 was not identifying and securing the release of vulnerable detainees, in particular those with pre-existing mental health conditions or victims of torture.[103]

Emma Ginn

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[96] Theresa Schleicher, 14 March 2022, 66/6-13.
[97] Dr Hard, 28 March 2022, 12/8-16.
[98] Dr Hard, 28 March 2022, 18/12-19.
[99] Dr Hard, 28 March 2022, 69/8-19.
[100] Luke Wells, 31 March 2022, 173/3-13.
[101] Luke Wells, 31 March 2022, 171/18-172/2.
[102] DPG000002_0037.
[103] BHM000030_0027.

xii. Emma Ginn, for Medical Justice set out how the Home Office has known for decades about the failures in Rule 34, pointing to numerous reports to as far back as 2007[104] that raised concerns about failures in the system to identify vulnerable detainees.

xiii. She was highly critical of the failure of the Home Office to act on these reports to meaningfully reform the system, or to hold any official to account for such serious and sustained failures.[105]

xiv. She also criticised the Home Office for attempting to avoid blame for these failures by subcontracting services in relation to this crucial safeguard.[106]

Dr Bingham

xv. Dr Bingham explained that the absence of a proper Rule 34 examination leads to the belated identification of physical health issues and consequential delays to treatment. It also means an important piece of evidence relevant to the exercise of detention power is missing.[107]

49. This evidence pointed to consistent themes regarding Rule 34, namely:

i. A dangerous misunderstanding in the connection between Rule 34 and 35, as the Rule 34 assessment is meant to lead to a Rule 35 report where relevant;

ii. A dangerous misunderstanding regarding the purpose of Rule 34, which is meant to be a full mental and physical examination in order to identify vulnerability, not a triage process;

iii. A chronically under-resourced system which meant appointments were not adequately long;

iv. Failure to adequately assess mental health needs during the appointment, which is often a key vulnerability of relevance to decisions to maintain detention or release;

v. Home Office awareness of these issues for decades – but no meaningful reform in the face of consistent and repeated criticisms of the system.

50. The evidence was clear that Rule 34 was not functioning, as it should, either now, in 2017, or at any time. It should have been a key safeguard to identify vulnerable individuals who may not be suitable for detention. Instead, it was and is being used as a brief assessment to identify immediate health needs, in particular prescriptions.

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[104] BHM000041_0009.
[105] BHM000041_0026.
[106] BHM000041_0029.
[107] BHM000033_0028.

51. The Inquiry heard evidence about how these failures led to the unlawful and harmful detention of vulnerable individuals:

i. **D1527** arrived at Brook House on an open ACDT/ACCT and whose medical records contained multiple indications of his suicidality.[108] If the Home Office had operated Rule 34 in a lawful manner, he would have been identified upon his entrance into detention as too vulnerable, due to his severe mental ill health including a history of suicide attempts and history of torture, for detention. The opening remarks[109] and D1527's closing set out these failures in greater detail.

ii. **D643** had been diagnosed with PTSD as a result of his service for the British Army prior to his detention at Brook House[110], and a history of suicide attempts.[111] When he did receive Rule 34 assessments during his periods of detention at Brook House, they failed to identify his PTSD as a factor which made him potentially unsuitable for detention. Dr Hard agreed that there was a systemic failure in the screening and application of the rule 34 process in his case – his final screening in December 2016 failed to mention his history of PTSD or suicidal ideation.[112]

iii. **D1914** is a man which a serious heart condition. At the time of his detention, he had been deemed so ill that he was considered unfit to work.[113] If the Home Office had operated Rule 34 in a lawful manner, he would have been identified upon his arrival into detention as too vulnerable, due to his physical ill health, for detention. Although his medical records at his screening and Rule 34 appointment note his chronic heart condition, there was no detailed exploration of his medical condition, the heart procedure he was still waiting for in August 2017, or the interaction between his heart condition and the impact that the detention environment may have on him.[114]

iv. **D2077** is a victim of torture who suffers from PTSD, major depressive disorder, and has a history of serious self-harm.[115] Despite having previously received a Rule 35 report which identified him as a victim of torture and the Home Office

[108] Theresa Schleicher, 14 March 2022, 10/15-24.
[109] DL0000159_002-5
[110] DL0000228_0004.
[111] DL0000228_0002.
[112] Dr Hard, 28 March 2022, 141/2-25.
[113] DL000229_0009.
[114] CJS000990_0001-3.
[115] DL0000226_0001.

authorising release as a result,[116] and having been assessed after a suicide attempt in the community as an Adult at Risk level 3 which was deliberately downgraded by the Home Office[117] his initial medical assessment simply recorded that he was on medication and depressed, but fit for detention.[118]

v. **D1538**'s screening by a nurse contained numerous errors, including that his scars were from fighting rather than torture.[119] During his Rule 34 appointment, Dr Chaudhary records nothing about his history of torture, and decided that D1538's other complaints were to be discussed in a separate appointment.[120]

Rule 35

52. The Inquiry also heard extensive evidence about the systemic and dangerous failures by the Home Office and detention healthcare staff to operate Rule 35 at all or properly.

53. In particular, the Inquiry heard about the almost total failure in the rule 35(1) process for identifying these where continued detention is likely to be injurious to health and the total failure of the Rule 35(2) process, which is meant to identify detainees who are at risk of suicide.

Sandra Calver

i. Ms Calver explained that the failure to complete **Rule 35(2) reports** was not unique to Brook House. All the other IRC forums also suffered from the near total lack of Rule 35(2)s.[121]

ii. She also acknowledged that the **Rule 35(2) pathway**[122] she drafted was in fact not compliant with Rule 35(2), because it built in a delay of several days which was not present in the Rule itself.[123]

iii. She stated that **Part C**s were regularly used to alert the Home Office to medical conditions which meant the patient was not suitable for detention, despite also admitting that this was not be appropriate as Rule 35(2) was the designated pathway for raising such concerns.[124] She explained that healthcare staff used

[116] DL0000226_0008-9.
[117] DL0000226_0013
[118] DL0000226_0017.
[119] CJS007239_0002.
[120] CJS007239_0002.
[121] Sandra Calver, 1 March 2022, 174/11-175/2.
[122] CJS0073839
[123] Sandra Calver, 1 March 2022, 233/17-234/17-18.
[124] Sandra Calver, 1 March 2022, 195/10 – 24.

Part Cs over Rule 35 reports because they led to a quicker response by the Home Office.[125]

iv. She explained she understood that the Home Office had "glossed" Rule 35(1), such that it requires the diagnosis of a medical condition of a high level of severity for a Rule 35(1) report – she acknowledged her approach required that someone becomes so unstable that detention has actually harmed them before the consideration of release, which would be risky and dangerous.[126] She acknowledged that her understanding of the way the rules operated– as head of healthcare - was inaccurate, setting a **higher threshold**.[127] She stressed that this approach to Rule 35 was shared across the IRC forum, which was also attended by **Home Office officials** who were aware of and content with and approved of the thresholds she was applying.[128]

v. She stressed that the **Home Office is responsible** for compliance with the Rule.[129]

vi. She also explained that the greatest challenge regarding Rule 35 was timing and **resource constraints**, as it was not possible to complete the report within the required 48 hours where lots of patients requested one.[130]

vii. Ms Calver stated there had been problems with Rule 35 across the IRC estate since its introduction, and she had raised her concerns about its adequate functioning with the Home Office, but **it remains an ongoing issue**.[131]

viii. Ms Calver also accepted that there was a failure to recognise the link between **Rule 35 and ACDT** safeguards – one would expect, given the high numbers of ACDTs in the relevant period, for corresponding numbers of Rule 35(1) and (2) reports, but these were not completed.[132] The opening of an ACDT does not prompt a Rule 35 report.[133] She acknowledged this suggested that vulnerable detainees were not being protected, and this was a failure both of Healthcare and the Home Office.

Karen Churcher

ix. Ms Churcher acknowledged that staff did not have a good understanding of **Rule 35(2)** even after the training they received.[134]

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[125] Sandra Calver, 1 March 2022, 174/11- 175/1.
[126] Sandra Calver, 1 March 2022, 217/15 – 218/16.
[127] Sandra Calver, 1 March 2022, 219/3-22.
[128] Sandra Calver, 1 March 2022, 220/6-19; 222-20-21.
[129] DWF000009_0020.
[130] DWF000009_0020.
[131] DWF000009_0021.
[132] Sandra Calver, 1 March 2022, 225/5-16.
[133] Sandra Calver, 1 March 2022, 238/1-5.
[134] Karen Churcher, 10 March 2022, 24/4-8.

x. She admitted she was not aware of the provisions of **Rule 35(1)** at any time before the Inquiry proceedings.[135]

xi. She accepted there were instances were vulnerable patients, whose presentation should have triggered a Rule 35(1) or (2) report, were instead managed on **ACDT.**[136]

Chrissie Williams

xii. Ms Williams acknowledged that the low numbers of **Rule 35(1) and complete absence of Rule 35(2) reports** indicated that safeguards were failing, given the high numbers of ACDTs.[137]

xiii. Like Ms Churcher and Ms Calver, she accepted that staff did not have sufficient **understanding of Rule 35(1) and (2)** in 2017, which was a significant gap in knowledge.[138]

Dr Oozeerally

xiv. He revealed an alarming **attitude of cynicism and disbelief** where he stated that that there is "inevitable misuse" of the Rule 35 system, blaming "advocacy groups" for their use of Rule 35 as a "tool".[139]

xv. He explained that **resource constraints** meant patients were sometimes left waiting weeks for a Rule 35 appointment.[140]

xvi. He also stated that the reason for the low numbers of Rule 35(2) appointments was that GPs were using **Part Cs** instead,[141] despite Part Cs not triggering a review of detention as Rule 35 reports do.

xvii. Crucially, he explained that the rules were "**not practically implementable**".[142] He stated that he had been telling the Home Office that the Rule 35 system was not working.[143]

xviii. He explained, for example, that although "by the book" a **Rule 35(2) report** should be produced for example when someone fashions a ligature, this was and continues not to be the practice.[144]

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[135] Karen Churcher, 10 March 2022, 48/2-10.
[136] Karen Churcher, 10 March 2022, 56-59.
[137] Chrissie Williams, 10 March 2022, 10/15-23.
[138] Chrissie Williams, 10 March 2022, 103/11-104/14.
[139] DRO000001_0010.
[140] 18/19 – 21.
[141] Dr Oozeerally, 11 March 2022, 48/3-19.
[142] Dr Oozeerally, 11 March 2022, 48/14-16.
[143] Dr Oozeerally, 11 March 2022, 60/20-22.
[144] Dr Oozeerally, 11 March 2022, 81/14-24.

xix. He revealed that he understood he was required to send Rule 35 reports to **Sandra Calver** as head of healthcare.[145] This means there was, in fact, no communication with the Home Office about the vulnerability of patients.

xx. He stressed that the **Home Office is responsible** for ensuring compliance with Rule 35.[146]

Dr Chaudhary

xxi. He explained in his statement that **Rule 35 was viewed as static**[147] – whereas it is meant as a process, in part, to identify deterioration.

xxii. He sought to justify identified failures to complete Rule 35 reports for vulnerable patients by reference to **resource constraints**.[148]

Theresa Schleicher

xxiii. Ms Schleicher, on behalf of Medical Justice, called for complete reform of Rule 35. Reports should not be **routinely rejected**, and they needed to connect with the **Adults at Risk policy** meaningfully.[149]

xxiv. She criticised the failure of Rule 35 Reports to appropriately focus on mental health and vulnerabilities,[150] and the **quality of Rule 35 reports** more broadly.[151]

xxv. She noted the Rule has been the **same since 2001**, and that it is not a misuse of the process for those in detention to seek such a report.[152]

xxvi. She stated that Rule 35 has never worked effectively - this is not because of deficiencies in the rule itself, but because of it **not being prioritised by the Home Office, and the culture of disbelief and lack of will** there.[153]

xxvii. She explained that Medical Justice have been raising their concerns about failures in the Rule 35 process for decades, but that these concerns have been ignored.[154] **Lessons are evidently not being learned** – for example, Rule 35(2)

[145] Dr Oozeerally, 11 March 2022, 68/14-69/4.
[146] DRO000001_009.
[147] Dr Chuadhary, 11 March 2022, 229/14-19.
[148] Dr Chaudhary, 241/5-18.
[149] Theresa Schleicher, 14 March 2022, 95/5-17.
[150] Theresa Schleicher, 14 March 2022, 65/6-7.
[151] Theresa Schleicher, 14 March 2022, 65/14-25.
[152] Theresa Schleicher, 14 March 2022, 66/14-67/4.
[153] Theresa Schleicher, 14 March 2022, 76/2-23.
[154] Theresa Schleicher, 14 March 2022, 68/23 – 70/2.

failures was a feature in several reported inquests, but information was not identified or fed back to improve the system.[155]

xxviii. She set out the **failure of healthcare and the Home Office to operation Rule 35 proactively,** instead waiting for patients to ask for an assessment, the defective quality of Rule 35 reports (in particular in their assessment of the impact of detention), **failures to issue Rule 35(1) and (2) reports**,[156] the failure of **disclosure of torture to trigger a Rule 35 report**,[157] **delays** in completing the Reports, and **refusals by doctors** to complete Rule 35 Reports.[158]

xxix. She explained that **Rule 35(2)** is so dysfunctional so as to be stripped of any safeguarding process.[159]

xxx. Crucially, she noted that in almost all cases reviewed**, a Rule 35(3) report failed to result in release of the patient.** The Home Office response is usually to maintain detention on the basis of immigration factors.[160]

xxxi. She stressed that the failures in Rule 35 have been raised by oversight bodies and the Shaw review. **The issues were not new – but no action was taken**.[161] For example, the Home Office did not act on IMB recommendations to review Rule 35 so as to reduce the number of victims of torture who are detained.[162] She criticised the Home Office's routine flouting of its own policies, cavalier attitude to the deprivation of liberty, and lack of reflection on or response to criticism of its operation of the Rule.[163] She stated the failure to address the longstanding and serious issues in Rule 35 was a **stark illustration of Home Office resistance to change**.[164] Her evidence set out in detail attempts by NGOs to engage with the Home Office on the failures on Rule 35, and the litigation which has focused on Rule 35 failures – and their resistance to meaningful change or oversight to this engagement and litigation.[165]

Emma Ginn

xxxii. On behalf of Medical Justice, Ms Ginn stressed that the statistics demonstrate **the low numbers of people released from detention** despite a Rule 35 report.[166]

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[155] Theresa Schleicher, 14 March 2022, 77/8-16.
[156] BHM000031_0014.
[157] BHM000031_0018.
[158] BHM000031_0020.
[159] BHM000031_0025.
[160] BHM000031_0033.
[161] BHM000031_0049.
[162] BHM000031_0050.
[163] BHM000031_0050.
[164] BHM000031_0054.
[165] BHM000032_0016.
[166] BHM000041_0021.

Mary Molyneux

xxxiii. On behalf of the IMB, Ms Molyneux explained that the IMB had raised concerns about failures in the Rule 35 process in their reports, but **the Home Office has failed to act on these**.[167]

Anna Pincus

xxxiv. On behalf of GDWG, Anna Pincus set out her concerns that even where healthcare did identify vulnerabilities, this **was often not shared with the Home Office** via the Rule 35 system.[168]

xxxv. She criticised the templates used for Rule 35 reports, which did not contain a **prompt on the impact of detention**, and it does not appear the Home Office ever proactively sought this information where missing.[169]

xxxvi. She criticised the **delays**, which sometimes exceeded two weeks, for appointments.[170]

Deborah Coles

xxxvii. Deborah Coles, on behalf of INQUEST, warned that the failures in the Rule 35 process and other safeguards were **alarmingly similar to the types of systemic failures seen in Inquests at other IRCs** – but the Home Office has not acted on, for example, recommendations from HMIP to improve these safeguards.[171]

Professor Katona

xxxviii. Professor Katona was highly critical of the failure of Rule 35 reports to **secure release**, except in very exceptional circumstances.[172]

xxxix. He also criticised the failure of the **Rule 35(2) and ACDT** processes to ensure reports of self harm were sent to the Home Office and the suitability of detention reviewed.[173]

xl. He notes the **issues with Rule 35 are longstanding**, in particular the failures to produce Rule 35(1) reports or to identify deterioration in mental health.[174]

Hindpal Singh Bhui

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[167] IMB0000203_0021.
[168] DPG000002_0039.
[169] DPG000002_0039.
[170] DPG000002_0041.
[171] INQ000037_0026
[172] BHM000030_001.
[173] BHM000030_0027.
[174] BHM000030_0033.

xli. On behalf of HMIP, Hindpal Singh Bhui stressed that HMIP had raised concerns about the failure of Rule 35 Reports to lead to release in their reports.[175]

Home Office Response

Ian Cheeseman

xlii. Ian Cheeseman acknowledged that the Rule 35(1) template encourages a **higher threshold** than the rule because it encourages medics to say it is not necessary if the condition can be managed in detention.[176]

xliii. He also admitted the Home Office was aware that **Part Cs** were being used in the place of Rule 35 reports, and he was satisfied with this.[177]

xliv. His live evidence also made clear that the **Home Office was well aware of the failures in the Rule 35 process**, noting that Rule 35 works with the Adults at Risk policy to a "degree",[178] that the ACDT process had in some ways replaced Rule 35(2),[179] and that the low numbers of Rule 35(1)s gave "pause for thought".[180]

Michelle Smith

xlv. In her live evidence Michelle Smith acknowledged she had not, at the time, understood **the correlation between people on ACDT and expected numbers of Rule 35(2) and (1) reports**. There had been a failure to consider how the procedures interlinked.[181]

Philip Dove

xlvi. Mr Dove attempted, unconvincingly, to argue that Rule 35 is open to **interpretation** and that the approach taken to in 2017 was a matter of interpretation.[182]

xlvii. He also asserted, without any evidential support and contrary to the high numbers of ACDTs in the Relevant Period, that most self-harm incidents did not meet the **threshold for suicidal intent in Rule 35(2).**[183] Alarmingly, he asserted that some men self-harmed to avoid deportation rather than due to mental illness as the explanation for the lack of Rule 35(2) reports,[184] revealing an institutional **culture of disbelief and cynicism.**

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[175] HMIP000685_0046.
[176] Ian Cheeseman, 16 March 2022, 202/18-205/12.
[177] Ian Cheeseman, 16 March 2022, 202/18 – 205/12.
[178] Ian Cheeseman, 16 March 2022, 181/11-17
[179] Ian Cheeseman, 16 March 2022, 200/25 – 201/27.
[180] Ian Cheeseman, 16 March 2022, 201/24-25.
[181] Michelle Smith, 23 March 2022, 148/16 – 149/14.
[182] Philip Dove, 31 March 2022, 111/13 – 20.
[183] CJS0074040_0033.
[184] CJS0074040_0010,0037.

xlviii. He sought to **refuse to take responsibility**, or even some responsibility for the failure of management in the evident and widespread non compliance with Rule 35.[185]

Phil Riley

xlix. Despite acknowledging the Rule 35 system was widely flawed, he denied that the failures **were systemic**.[186] He refused to accept that the low numbers of Rule 35(2) reports meant that safeguards were failing.[187]

l. He cynically co-authored **a letter during the course of the Inquiry stressing the need for compliance with Rule 35** – despite Home Office officials being aware of these failures for years. He did however accept that it was a systemic failing that **Part Cs** continued to be used in the place of Rule 35 reports, particularly in light of the case *Medical Justice v the SSHD* [2017] EWHC 2461 which made clear that Part C was not a substitute for a Rule 35 report.[188]

Philip Schoenenberger

li. He astonishingly revealed that he had no **memory of litigation**, in which he was named and the Home Office found to be in breach of its Article 3 duties – litigation which included failures in the Rule 35 process.[189]

54. This evidence points consistently to wide-ranging and systemic failures in Rule 35, including:

i. Failures by the Home Office to release vulnerable people in detention despite receipt of a Rule 35 report, because of the over-reliance on immigration factors and cultural attitude which favours detention over release, in contradiction of common law principles, and approaches reports of detainee ill health cynically and with disbelief;

ii. Disconnect between the Rule 35 process and the Adults at Risk policy, leading to the continued detention of vulnerable individuals;

iii. Imposition of overly high thresholds in Rule 35(1) and (2), leading to fewer individuals being assessed under these rules than should be;

iv. A culture of cynicism and disbelief from healthcare and Home Office staff towards individuals who ask for Rule 35 reports;

[185] Philip Dove, 31 March 2022, 124/11-125/5.
[186] Phil Riley, 4 April 2022, 113/16-21; HOM0332005_0017.
[187] Phil Riley, 4 April 2022, 116/19-21.
[188] Phil Riley, 4 April 2-22, 140/8-141/4.
[189] Philip Schoenenberger 23 March 2022, 65/9-15.-

v. Chronic resource constraints on healthcare staff which set the system up to fail in that staff could not offer enough, or long enough, Rule 35 appointments;

vi. Lack of understanding of the content of Rule 35, despite its simplicity and breadth;

vii. Complete failure to understand the link and interaction between someone being placed on ACDT and the need to do a Rule 35(1) or (2) report;

viii. Complete failure to produce Rule 35(2) reports, and near complete failure to complete Rule 35(1) reports;

ix. Widespread misunderstanding of the purpose of Rule 35(2) reports, none of which were completed in the Relevant Period;

x. Use of Part Cs instead of Rule 35 reports – and Home Office awareness of this;

xi. Inadequate Rule 35 reports, which make a poor quality and cursory assessment of the patient's health and which do not properly assess the impact of detention on the patient;

xii. That the serious issues with Rule 35 have been present for decades;

xiii. Unwillingness from the Home Office to respond to long-standing criticisms of the system, or to set up adequate systems whereby they can learn from past mistakes, including those highlighted in litigation;

xiv. That the Home Office has known about these issues with Rule 35 for decades, but has chosen not to make meaningful reforms.

55. The profound impact of these systemic and acute failures in the Rule 35 system on vulnerable people in detention is evidenced in the experiences of the CPs and they harm they consequently suffered from continued detention:

i. **D1527** is a prime example of a patient who should have been identified at the outset of his detention via Rule 35 as too vulnerable for detention. Instead, the Rule 35 Report which was eventually completed was inadequate, no Rule 35(2) report was completed in response to clear evidence of suicidal intention, nor were Rule 35 reports completed in response to clear deterioration in health. Further, the Home Office maintained detention despite receipt of a Rule 35 report.

He is a man with PTSD, depression,[190] a victim of torture, and a history of severe self harm and several suicide attempts.[191] He met all three categories under Rule 35, as someone whose health was likely to be injuriously affected by detention, someone suspected of having suicidal ideations, and a victim of

[190] DL0000144_0001.
[191] DL0000144_0002.

torture.[192] After repeated chasing by his representatives upon his detention, Dr Oozeerally completed a Rule 35 report almost two weeks into his detention at Brook House which set out he may be a victim of torture and have mental health issues - but with no examination as to whether detention was deleterious.[193] The Home Office decided to maintain detention despite this Report.[194]

Despite expressing suicidal intention and refusing food and fluid, no Rule 35 was completed to record the deterioration in his mental health.[195] Despite making near daily attempts at suicide, no Rule 35(2) report was completed.[196] If the system had functioned properly, D1527 would have been spared months of abuse, suicide attempts, and deterioration in his mental health.

ii. **D1914** received a Rule 35(1) report four months into his detention which advised that detention was deleterious to his health.[197] No explanation has been provided for the delay in providing this report, given that the details of D1914's cardiac condition was available to staff at the outset of detention. In any case, that Rule 35 report was itself defective as it contained no details as to D1914's mental health problems. Also, staff initially relied on Part Cs over Rule 35 to report a deterioration in his health.[198]

Further, no Rule 35(2) report was completed despite D1914 making a very severe suicide attempt whilst in detention.[199] If the Rule 35 system had functioned properly, D1914 would have been released at the outset of detention, sparing him months of abuse, a mental health deterioration which led him to try to kill himself, and a severe deterioration in his physical health.

iii. **D1538** explained that he asked for a Rule 35 report whilst at Brook House, but the doctor did not give him an appointment for one.[200] At Harmondsworth, he received a Rule 35(3) report finding he may be a victim of torture, but the Home Office decided to maintain detention.[201] Further, no Rule 35 report was completed at Brook House despite D1538 stating clearly to healthcare staff that he was traumatised and distressed after witnessing the aftermath of his cellmate's attempted suicide.[202]

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[192] DL0000144_0004.
[193] DL0000144_0012.
[194] DL0000144_0013.
[195] DL0000144_0023.
[196] DL0000144_0046.
[197] CJS001024.
[198] DL0000229_0062.
[199] DL0000229_0060.
[200] DL0000231_0037.
[201] CJS003632; HOM00322007.
[202] DL0000231_0023.

iv. **D643** is a highly vulnerable individual with PTSD. Despite stating clearly and repeatedly to staff in 2016 that he had mental health problems which were deteriorating, no Rule 35 report was completed.[203]

When he asked specifically for a Rule 35 report as he had PTSD and was suicidal, this request was refused on the grounds they were only for torture survivors.[204] A further request in 2017 was rejected on the grounds that he had already received two Rule 35 reports.[205]

A GP did write a report for him on a second request in December 2016, which found his health was likely to be injuriously affected by detention.[206] The Home Office nevertheless maintained detention[207] In January 2017, a second Rule 35(1) report also recommended release.[208] Once again, the Home Office maintained detention, relying on immigration factors.[209] No Rule 35(2) report was completed during his detention despite repeated comments which evidenced suicidal intent.[210]

v. **D2077** previously had a Rule 35(3) Report at Tinsley House which had led to his release due to his trauma related psychological symptoms, history of torture and a suicide attempt in the community, leading to him being classified then as a Level 3 AAR.[211] Although identified as a victim of torture at Brook House, no Rule 35(3) report was completed. Staff stated he would not receive another report because he had previously had one.[212]

He repeatedly asked to see a doctor for a Rule 35 assessment, but the GP did not complete a Report when they finally did see him, instead using the Part C process.[213] Further, no Rule 35(2) Report was completed after he sewed his lips together.[214]

vi. **D1851** never received a Rule 35 report, despite detention causing his mental health to rapidly and severely deteriorate.[215]

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[203] DL0000228_0009.
[204] DL0000228_0010.
[205] DL0000028_0045.
[206] DL0000228_0026.
[207] DL0000228_0027-28.
[208] DL0000228_0035.
[209] DL0000228_0037.
[210] DL0000228_0062.
[211] DL0000226_0002, 0010-0011.
[212] DL0000226_0018.
[213] See the Medical Justice analysis of this case at BHM000031_0023.
[214] See the Medical Justice analysis of this case at BHM000031_0027.
[215] DL0000143.

56. The case studies prepared by Medical Justice make clear that these issues suffered by the CPs were endemic and systemic. It represents the failure to comply with the duties under Article 3 ECHR to have in place an effective system, in policies and practices to ensure necessary safeguards exist and operate in practice to prevent detention and the known risks of harm in detention occurring particularly to those with vulnerability.

57. In each of the CPs cases any functioning system capable of meeting the purported purpose of the policy framework of limiting lawful detention to measure of last resort and protected from harm those in detention would have meant they either should not have been detained at all or expeditiously released once their vulnerability to particular harm was identified, but in none of their cases did that happen.

Causal Factor 3: Prisonisation

Context

58. Reverend Ward sets out at paragraphs 62-66 of his statement:

> *"62. Gatwick IRCs cover Tinsley House IRC and Brook House IRC, albeit they are separate contracts for the running of each.*
>
> *63. Opening in 1996, Tinsley House was the first purpose-built IRC, replacing the use of the 'Beehive' in Gatwick for the accommodation of detainees in the airport terminal of Gatwick Airport. It was built to provide 150 additional detention places which allowed the Government to reduce the use of more expensive, less suitable, alternative accommodation including prisons. It was built to a high specification providing accommodation for male and female detainees and five families within zoned and separate residential accommodation.*
>
> *64. The design of Tinsley House had not changed by the time I arrived from its inception, with the building being a hollow square on two levels with an open space in the middle for recreation and also to the rear a sports hall and hard surfaced recreation ground. Accommodation was in dormitory style rooms. The corridors were separated but allowed detainees to associate on each side of the square and have access to toilets and bathrooms which were separate to the bedrooms. Detainees were not locked in their rooms and there were only two rooms in the entire centre which had cell doors on, all the rest being standard wooden doors.*

65. Following a significant expansion of the immigration detention estate from 250 places in 1993 to 2,644 in 2005; Brook House IRC opened in 2009 adding another 426 spaces to the estate bringing the total to 3,070. Brook House was a new style IRC based on prison designs developed in the 1980's and 90's built to category security specifications. The wings were connected by corridors and were set over three floors with balcony-style landings overlooking suicide netting. The cells had internal, seat-less toilets and thick prison doors which did not have handles on the inside so, once shut (even during association hours), they could not be opened from the inside. Detainees would be locked in their cells for 11 hours overnight with poor ventilation attributable largely to sealed and barred windows which only added to the prison-like feel.

66. The 1990 Woolf Inquiry, which followed a series of prison riots, made clear the importance of the nature and fabric of prison facilities. The Report that followed found that "[t]he physical state of a prison can significantly affect the atmosphere for both prisoners and staff" His set of principles for improving the physical buildings and prison estate included: (a) only holding prisoners in units of 50-70 with the prison itself holding no more than 400 prisoners; (b) the need to balance security with the 'avoidance of an over-oppressive atmosphere'; (c) a prisoner being entitled, if they wished, to a single cell; (d) adequate provisions for the requirements of staff; and (e) access to sanitation with standards of hygiene matching those in the community..."[216]

59. The design of Brook House itself, and its 'prison-like feel', ignored the 1990 Woolf Inquiry, which found that "*[t]he physical state of a prison can significantly affect the atmosphere for both prisoners and staff*"[217]

60. At paragraph 81, Reverend Ward set out how from his direct experience: "*The effect of this was twofold. Firstly, people were detained under conditions designed for a higher security than required for the majority of people. Secondly, it creates a heightened perception of 'risk' or threat. This drives the behaviour of: (a) detainees, who are frustrated and distressed by the 'security' environment in which they find themselves and (b) staff, perceiving detainees to be a higher threat than they are. Both the detainees and the staff tended to experience this as denigrating and dehumanising.*"[218] SMT member Michelle Brown confirmed that the design of the building (see further below) and length of stay contributed to "frustration" and "desperation" of detainees.[219]

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[216] First Witness Statement of Reverend Ward dated 10 November 2021, DL0000141_0021-0022
[217] http://www.prisonreformtrust.org.uk/portals/0/documents/woolf%20report.pdf – pg.17
[218] DL0000141_0027
[219] First Witness Statement of Michelle Brown, paragraph 64, INQ000164_0039

61. The distress caused to D643 and D1851 in being detained in prison-like conditions was highlighted in their witness evidence:

    i. D643 described how: *"The heavy prison doors at Brook House made sudden loud banging noises that could be heard throughout the corridors. The number of people going in and out of cells meant that there was a constant banging of doors and the noise echoed across the building. I remember that there was a detainee just around the corner from my cell who was very mentally unstable. He used to bang the door to his cell and shout at all hours of day and night. To me, the banging sounded like explosions and that triggered my PTSD. I told the officers on E wing at the time that the banging of doors triggering my PTSD but they did nothing to address this."*[220]

    ii. D1851 describes his shock about his arrival at Brook House: "*I saw the barbed wire and tall fences. It resembled a prison and was very imposing. Inside was no different. It reminded me of a prison you would expect to see in Zimbabwe or somewhere similar. It is not what I expected a detention centre in the UK to be like."*[221]

62. The relevance of a system designed for refractory detainees with a history of criminal conviction and experience of prison is that the same system was subject to the non-refractor, complaint and indeed terrified and vulnerable and for those without a criminal history. However it would be wrong to treat these as two district and separate groups. Criminal histories vary – many had sentence for immigration offences and many FNOs; are in fact also victim of torture and trauma and are amongst the most highly vulnerable. The Inquiry should consider the Article 3 cases - 4 of whom had criminal convictions: *S, HA BA* and *VC*. D1527 has minor criminal convictions as do others. Professor Katona addresses the positon of foreign national offenders and refers to research showing that this group may have particularly complex needs and include some of the most vulnerable.[222]

63. At paragraph 67 of his statement Reverend Ward, gave his view on the design of Brook House and on the contractual relationship as follows[223]: *"It is my view that part of the foundation that made Brook House such a toxic and dysfunctional centre, and which ultimately allowed the human rights abuses exposed by the Panorama documentary to*

[220] Witness Statement of D643 dated 14 February 2022, paragraph 33, DL0000228_0007
[221] Witness Statement of D1851 dated 19 November 2021, paragraph 16, DL0000143_0004
[222] See from paragraph 115, BHM000030_0050
[223] DL0000141_0023

occur, can be found in its physical design and the terms of the contract agreed for how the regime was to be run. I will focus on three main flaws that are traced to Brook House's conception: (1) a centre designed to hold detainees for 72 hours; (2) a centre designed as a category B prison; and; (3) a contract driven by profit and cost-savings over detainee and staff welfare."

64. These elements identified by Reverend Ward have formed an important part of the evidence that the Inquiry has received, with the first two elements being prime examples of the 'prisonisation' of Brook House. Here we highlight five different elements of the this and their impact on the treatment of detained persons:

    i. Intent as a 72 hour centre;
    ii. Category B prison design;
    iii. Regime and Conditions;
    iv. Control and Restraint/ Use of Force
    v. Misuse of Rule 40 and 42

(i) 72 Hour Centre

65. At paragraphs 68 to 76, Reverend Ward sets out the background and how Brook House was designed as a centre to hold detainees for no longer than 72 hours[224]:

> *68. When the Brook House IRC contract came out to tender, Tinsley House IRC, along with Dungavel IRC in Scotland, was already run by GSL, formerly part of G4S. G4S was sold in 2004, but was re-acquired in May 2008 after GSL successfully submitted a bid to run Brook House in 2007. Therefore, whilst GSL won the bid for Brook House, G4S ran the centre when it opened.*
>
> *69. The bid submitted to run Brook House by GSL, and the proposals for how it would be operated, was prepared on the basis that it would only hold detainees for 72 hours.*[225]
>
> *70. The contract also reflects the intention to use Brook House as a short term detention facility at 3.1 of Schedule D, which states that the throughput would be at least 2,500 detainees per month. The operating capacity for the centre at the beginning*

[224] DL0000141_0023-0026
[225] The HMCIP report of Brook House IRC, dated 15-19 March 2010, states on page 7, *"Brook House opened in March 2009 and is a purpose built immigration removal centre with a prison design. The centre was designed to hold detainees for no more than 72 hours".* (DL0000167_0007)

was 426 bed spaces. It is simply impossible to be able to accept and process 2,500 detainees a month with 426 bed spaces without only holding each detainee for a few days.

71. A '360 Degree Contract Review' produced by Ben Saunders in 24 June 2014 (CJS000768), as an internal G4S review of the contract, acknowledged when assessing the risks of the contract that there was a contractual requirement of a 2,500 detainee throughput but that "this has never been required and would be particularly onerous." He then noted that "The current throughput is typically 1200-1400 per month and been at this rate for over a year, before which time it was lower". As such he was able to confidently say: "There is no particular residual risk from the bid. There is no material risk due to onerous contact clauses".

72. This low throughput was far cheaper for G4S than having a high turnover of detainees. The cost for providing clothing, bedding, phones etc. was lower because there were fewer detainees in total, and less staff resources were needed to process people arriving at and leaving the centre. There was little incentive from G4S's perspective to hold them to the intended 72 hours turn around.

73. The IRC was, therefore, clearly not designed for those facing longer periods of detention as it developed into in practice. In my view, this played a significant role in the regime, activities and welfare provision proposed by G4S which would inevitably be stricter and more basic when an individual was expected to only by there for 72 hours before departing the UK. It clearly also played a role in the specification and design of the building which in my experience is conducive to humanely detaining individuals for any significant period. From my perspective, it was the failure of the Home Office to deliver their end of the deal, i.e. by only using Brook House as a 72-hour centre (for which they designed it) – or by at least updating the procurement proposals when it became clear the centre would be used beyond 72 hours, that contributed to the issues that developed.

74. Lee Hanford – who was interim Director between February 2016 and July 2016 (whilst Ben Saunders was seconded back to Medway) and then again after Ben left post-Panorama in September 2017 – confirmed to Kate Lampard and Ed Marsden in his interview for the Verita report into Brook House [VER000266] the 72 hour intention behind the design of the centre and the impact that it ultimately had upon the regime and the experience for detainees at Brook House: "[Lee Hanford – 44] I've raised this myself with the Home Office, they will get a better regime in a prison, because a prisoner will have the activity, the workshops, much fuller education

facilities, a much better curriculum, really, because this is aimed at short detention. The design of the building was all about short detention. [Ed Marsden – 45] Yes, three days. [Lee Hanford – 46] Yes... The design doesn't allow for the length of stay that people are staying here for, I think that's the summary – if they were short term, it wouldn't create an issue. [Ed Marsden -47] Which is what its original purpose was. [Lee Hanford]. What the original design was for, yes."

75. A key question for the Home Office, is: 'What was the plan for getting a 72 hour turnaround for removals on point of entry at Brook House, when history tells us that it often takes far longer than 72 hours to enforce removal from detention?' One can only assume that the plan was to develop Brook House IRC as the final part of an immigration removal journey, where people would only be detained when all obstacles had been resolved and removal was already arranged to take place and/or for detainees to spend longer periods in other centres, and only be transferred to Brook House for the final few days before the arranged removal would take place. If either had been operated effectively, there would have been a steady flow through of people. Instead, the flaws in the system led to people being detained or transferred when they could not be removed within 72 hours and people spending much longer periods of time in accommodation that was unsuitable. I believe the responsibility for this therefore lies squarely with the Home Office.

76. On a basic level, the failure to meet the policy objective of only detaining as a last resort, at the end of the process and to ensure that removal actions was taken appropriately and efficiently, led to many people being detained in Brook House for prolonged periods of time in unsuitable accommodation, with mental health suffering as a result. I was aware of many being detained when they are 'non-removable' for legal or practical reasons, many for weeks, some for many months and even for over two years. Throughout my time working in IRC's, I witnessed patterns of desperation and frustration from detainees held for these longer periods which led to pressure being placed on the IRC and tensions arising among staff. The desperation was visible in the deterioration of mental health among detainees and incidents of self-harm, staff assaults, fights between detainees and attempted suicides that I witnessed."

66. The fact that Brook House was intended to be a very short-term facility, holding detainees for 72 hours before removal, and was never intended to provide long term detention[226] had a consequential adverse impact on the contractual arrangements, the regime, conditions and

[226] Paragraph 65, DL0000141_0022

the culture of the institution[227]. In giving his live evidence, Phil Schoenenberger accepted that to a certain extent the bidders' proposals on regime, activities, staffing was based on the fact Brook House would be run as a 72 hour centre.[228]

67. Almost all witnesses including within G4S Managing Senior Management understood and agreed that Brook House was either intended to run as a 72 hour centre or at least on a short-term basis:

    i. Jerry Petherick, who was the Managing Director of G4S Custodial and Detention Services from 2008 to 2019 (so when Brook House opened and through past the Relevant Period) confirmed in his live evidence G4S' understanding that the centre was designed for 72 hours' detention: *"So the Home Office, understandably, wanted to increase the security of the fabric, and this was designed as a short-term holding centre. As it developed, detainees were held there for longer, and that's really when the frailties of the design became apparent, with the lack of outdoor space, with sporting space, with sports halls, education... as the length of detention increased, and as other factors came into play... The fact that Brook House was adjacent to Gatwick meant that it was used for accumulations of detainees for charter flights, and so forth, and all of those factors interplayed on it. Q. So something that was designed, for the reasons you state, around the prison idea, because of the security issues, but without all of the benefits that went along with what would have been a category B prison, was all fine and well if it was used as a short-term holding facility, 72 hours, but once that went out the window and people were held there for far longer and the accumulations you mention for the reasons you give, it had become a problem place, hadn't it? A. It had become more challenging. Q. Here you were talking about it being quite a challenge from the start? A. Yes."*[229]

    ii. Lee Hanford (the Acting Director) explained to Kate Lampard in his Verita interview: "*the design doesn't allow for the length of stay that people are staying here for, I think that's the summary – if they were short term, it wouldn't create an issue. [Ed Marsden -47] Which is what its original purpose was. [Lee Hanford]. What the original design was for, yes."*[230] Mr Hanford added in his witness statement of 17 February 2022: *"85. The design of Brook House was aimed at short-term detention. This aim was most certainly not fulfilled. In my*

[227] Paragraphs 70-71, DL0000141_0023
[228] Philip Schoenenberger 23 March 2022, 12/1-25/ 13/1-6
[229] Jerry Petherick 21 March 2022, 55/4-25, 56/1-20
[230] Lee Hanford Verita Interview dated 27 November 2017, VER000266_0005

personal opinion, the delay in resolving their cases, particularly for those who were detained for considerable periods, meant that many became frustrated."[231]

iii. Peter Neden of G4S gave his view in live evidence that he thought detainees should not have been held at Brook House for more than a week: *"A. Well, I think the two big changes, from when Brook House opened to 2017, were the increasing length of stay. The facility was designed for people to remain there for a week. Far too many people were staying there for upwards of a year."*[232]

iv. Hindpal Singh Bhui on behalf of the HMIP when asked in live evidence about their statement in their 2010 inspection report that Brook House was designed for 72 hour stays: *"A. I assume that we would have been told by the Home Office and/or G4S, or the contractor at the time. Q. Do you have any recollection of when that intention changed? A. I think it probably changed extremely quickly. It seems very unrealistic that you could have a centre designed only -- next to an airport, designed to hold people only for 72 hours when we have a system of indefinite detention. So I don't think, even at that 2010 inspection, the 72 hours was being achieved"*[233]

v. Former SMT member Michelle Brown in her witness statement: *""106. When I was initially interviewed for the role as a DCM in 2008, I was left with the perception that Brook House would be like a community centre — with accommodation, a gym, a library etc, that housed detainees with outstanding immigration issues for a short time... It wasn't until February 2009, that I visited Brook House and saw the design did I fully realise that it was not like Tinsley House at all. Although a larger site, it held more Detainees and the living and activities spaces were cramped and stuffy. From the day Brook House opened in March 2009, it became clear that detainees would exceed the expected 72 hour stay and would soon tire of the same facilities, food and regime From speaking to detainees in 2009 right through till 2020, there was a clear theme of uncertainty — they would not know how long they was going to be incarcerated and at the end, if they were to be bailed, released or deported. Over a period of time, I could see the physical and mental impact prolonged detention had on individuals."*[234]

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[231] CJS0074048_0022
[232] Peter Neden 22 March 2022, 68/3-7
[233] Hindpal Singh Bhui 24 March 2022, 176/23-25, 177/1-7
[234] Witness Statement of Michelle Brown dated 24 February 2022, INQ000164_0054

vi. Steve Skitt: *"**(81)** The building was designed and built on the specification, I would assume, set out by the Home Office. It is my understanding that Brook House was designed as a short term holding centre and so the initial purpose of the building was to take people in and very quickly move them on for flights rather than housing people for long periods of time."*[235] Mr Skitt emphasised in his live evidence that the building was "*originally designed as a very short-term removal centre."*[236]

vii. Callum Tulley discussing seeing the job role advertised to be an officer at Brook House: *"a holding facility for 72 hours, is what I recall it being advertised as"*[237]

viii. Owen Syred: *"151.Even though the situation improved, there weren't enough activities, and Brook House was never designed for this purpose - it wasn't designed as the long-term holding facility that it became"*[238]

68. It was only the Home Office's Corporate Witness, Philip Riley, an individual only in his post as the Director of Detention and Escorting Services (DES) since September 2018,[239] post the Relevant Period who appeared to dissent from this, claiming confidently that it was an "urban myth"[240] despite having no evidence to point to back up his claim or having any personal experience having not been in post at the time. The only contemporary Home Office evidence available was that contained within the procurement documents and the contract itself. Both the procurement assessment led by Phil Schoenenberger[241] and the contract in Schedule D[242] confirmed a throughput of admitting 2500 detainees a month. As Reverend Ward confirms at paragraph 70, the operating capacity on opening was 426 bed spaces meaning detainees could only be held for a few days to meet the throughput requirements.[243] In his live evidence on 23 March 2022, Mr Schoenenberger agreed that that monthly through put suggested Brook House was a short-stay centre of less than a week before stating: *"Yes, I do remember that, in general terms, yes. I think, and that's reflected, in some ways, by the design of the buildings."*[244]

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[235] SER000455_0028
[236] Steve Skitt 17 March 2022, 130/16
[237] Callum Tulley 29 November 2021, 7/17-25
[238] First Witness Statement of Owen Syred dated 16 November 2021, INN000007_0036
[239] First Witness Statement of Philip Riley dated 12 November 2021 , paragraph 1 – HOM0332005_0001
[240] Philip Riley 4 April 2022, 46/1
[241] DL0000140_0063
[242] The relevant section of Schedule D does not appear to have been adduced but is confirmed in the 360 Degree Contract Review at CJS000768_0014
[243] DL0000141_0023
[244] Philip Schoenenberger 23 March 2022, 11/4-25

69. It seems very unlikely that the HMIP in 2010 would have been misinformed about the intended use of Brook House as a 72 hour short term facility.

70. The Inquiry should not accept the evidence of Mr Riley in such circumstances where (a) he can give no first-hand evidence to it; (b) where the HMIP, senior G4S officials and Mr Schoenenberger all believed the centre was designed for 72 hours or similar; (c) where the Home Office have had a significant period of opportunity to provide contrary evidence and have failed to do so; and (d) where the Home Office's available contemporary sources of evidence (the procurement assessment and the contract) confirm a throughput that would require detention of no more than a few days.

71. Either way, whether intended for only 72 hours or not, its design and limited facilities makes it inherently unsuitable for immigration detainees and the Inquiry should adopt the long standing position of the HMIP that it is inappropriate and it use should end.

72. Kate Lampard concluded at 1.1.54 that people should only be held for a few weeks[245] but even that is too long. It is not a fit and proper place to hold detainees for any longer and certainly not for those with mental health problems or other vulnerability – as confirmed by Ian Castle who said: *"if you spent more than 24 hours in Brook House, you're going to develop mental health issues. It's not a nice place to be."*[246]

(ii) Category B Prison Design

73. As referred to above and at paragraphs 77 to 82, Reverend Ward sets out how Brook House was designed as a category B prison[247]:

> *77. "Brook House IRC was designed to the specification of a category B prison*[248]*.*
>
> *78. The Ministry of Justice's Security Categorisation Policy Framework for prisons, states at paragraph 1.2, that security categorisation is "a risk management process,*

[245] Verita, 'Independent investigation into concerns about Brook House immigration removal centre', dated November 2018 - CJS005923_0033
[246] Ian Castle 15 March 2022, 38/16-18
[247] DL000141_0026-0027
[248] Page 5 of the HMCIP report of Brook House IRC, dated 15-19 March 2010 confirms, "Brook House had been built to typical category B prison standards and was noisy and austere". Page 23, at paragraph 2.2 also states that, "there were four residential wings A, B, C and D, each consisting of three landings designed to category B prison specifications". DL0000167_0005, 0023

the purpose of which is to ensure that those sentenced to custody are assigned the ***lowest security category*** *appropriate to managing their risk" [emphasis added].*[249]

79. The policy goes onto state that Category B includes, 'offenders whose assessed risks require that they are held in the closed estate and who need security measures additional to those in a standard closed prison."

80. In my opinion, the development of Brook House to the specification of a category B prison, led in practice to an experience for detainees and staff that is inconsistent with Rule 3 and Rule 39 of the Detention Centre Rules 2001 and the need for a relaxed and humane regime. It was nothing like that in reality. Whilst the policy was clearly that you should have the least security to meet the risk, I witnessed many individuals being detained who were not offenders or a 'risk' at all, and many of those who were, had in fact come from lower category prisons.

81. The effect of this was twofold. Firstly, people were detained under conditions designed for a higher security than required for the majority of people. Secondly, it creates a heightened perception of 'risk' or threat. This drives the behaviour of: (a) detainees, who are frustrated and distressed by the 'security' environment in which they find themselves and (b) staff, perceiving detainees to be a higher threat than they are. Both the detainees and the staff tended to experience this as denigrating and dehumanising.

82. My experience reflects the consistent concerns of Her Majesty Chief Inspector of Prisons (HMCIP) about the prison-like environment and regime with its disproportionate restrictions on freedom and association. I also agree with Stephen Shaw's assessment in his 2018 review of the immigration detention estate of the more secure prison-like IRCs of Brook House, Colnbrook and Harmondsworth that "overcrowded, cell-like rooms with prison doors had the unacceptable feature of in-room toilets separated only by a curtain" which he found "troubling that such an arrangement was deemed acceptable when these institutions were designed and commissioned just a decade or so ago." Stephen Shaw found overcrowded cell at Brook House with the introduction of three-man cell noting "I did not find conditions in those rooms remotely acceptable or decent" something I agree with and raised concerns about, as discussed below."

[249] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1011502/security-categorisation-pf.pdf

74. Almost all witnesses asked about the design and layout of Brook House, agree it is built like a Category B prison:

i. Jerry Petherick who confirmed in his live evidence that "*Brook House was built to category B standards.*"[250]

ii. Centre Director Ben Saunders in his witness statement on 17 February 2022: *""56... Brook House was a much harsher environment, it was designed more like a prison and it felt like a prison. There were four main wings and a much smaller one designed for more vulnerable and challenging individuals. It was a far more oppressive building which we tried to soften but there is only so much you can do with the existing infrastructure.*"[251]

iii. Callum Tulley when discussing the harsh reality of the prison-conditions at Brook House: *"A. The realities, exactly. It's hard to -- it's kind of hard to – you can't really teach in a training room what it's like, what it smells like, what it sounds like, the atmosphere... Brook House is built to the standard of a category B prison. In my eyes, it is a prison. But I suppose it -- G4S were anxious to perhaps have us think that it wasn't. But, I mean, it was obvious to us that it was.. Well, we -- most of us referred to them as cells. Some of us would refer to them as rooms at times. They were small rooms. There was no handle on the inside of the cell door, there was no openable window, there was a toilet in the cell. I mean, they were so obviously cells that people referred to them as cells.*"[252]

iv. Professor Mary Bosworth in her first expert report dated 17 November 2021 describes its prison like features and rejects any justification for the design by reference to the numbers of FNO's:

"9.8 The design of Brook House Immigration Removal Centre is inappropriate for its purpose. The half doors of showers are undignified, while the toilets in the bedrooms and the inability to open the windows create unpleasant living spaces. Men on the footage and report that their living spaces became uncomfortably hot in the summer months. These claims are reinforced by details in the IMB minutes. There is limited access to natural light and outdoor space

[250] Jerry Petherick 21 March 2022, 55/4
[251] Witness Statement of Ben Saunders dated 17 February 2022, KEN000001_0011-0012
[252] Callum Tulley 29 November 2021, 37/6-13, 39/6-17

as well as only a small area for activities. The daily schedule is punctuated by roll calls during which men are locked back in their rooms.
9.9 The restrictions of a Category B prison make no sense for those held under Immigration Act powers. They make the delivery of a humane and supportive regime very difficult.
9.10 While the proportion of ex-offenders in Brook House has often been used to justify the secure design, FNO Statistics from 03 January 2017 to 09 January 2018 suggest that their numbers varied considerably from 29% in September 2017 to 53% in January 2018, with a median rate hovering around 36/38.247 In any case, given the administrative nature of their detention in Brook House, their prior criminal sentence is not, in itself, a prima facie explanation for the prison design."[253]

v. Owen Syred: *"A. It was because, the way the building was structured, it was never -- it was never designed for the structure -- for the purpose it was. It was a generic sort of design of a cat B prison. But it was never designed to have so many people."*[254]

vi. Dr Hindpal Singh Bhui on behalf of HMIP when asked in live evidence about the position of the HMIP that Brook House was mis-designed he said : *"The suggestion around "misdesign of Brook House" and it being a design failure, is that just what we have been talking about, that it was designed for 72 hours? A. Well, I mean, I think that's partly it, but, as I said earlier on, I think having a centre which is designed on a cat B prison design for immigration detainees I think is inappropriate... Q. Do you remember, what did you tell the Home Office? A. Well, I think it would have been something along the lines of, "We don't think you should be putting detainees in prison environments". Q. Is HMIP's view -- or, I suppose, your view, that detainees shouldn't be staying at Brook House? A. Well, we don't think they should be staying in prison-like environments. We think that's not an appropriate environment for detainees. Now, it's not our role to say whether or not the government can detain people or not detain them, and, you know, we can't tell them where to hold them. What we can do is to talk about the impact on the individual detainee of being held in that kind of environment."*[255]

[253] First Expert Report of Professor Mary Bosworth dated 17 November 2021 – INQ000064_0043
[254] Owen Syred 7 December 2021, 57/23-58/2
[255] Hindpal Singh Bhui 24 March 2022, 177/18-25, 178/3-16

vii. Sarah Newland (Head of Tinsley in 2017, now Deputy Director of Gatwick IRCs) in her interview with Verita on 3 May 2018: *"Brook House is ostensibly a prison. It is built like a prison - it is prison wings. I think the whole environment that that brings, the acoustics, the noise, the numbers can be really overwhelming for people who haven't experienced it before."*[256]

viii. Former Deputy Director Steve Skitt in his witness statement: *"82) In my opinion, Brook House IRC was built to a Category B security standard... 83) ... Brook House is restricted to the confines of the building. It would always be nice to have more open space or a bigger gym, greater activity areas and more recreational areas, but this is not possible in terms of the space available."*[257]

ix. Duty Director Dan Haughton in his witness statement of 2 March 2022: *"38. The building looks and feels in keeping with a more modern prison. This is likely to have an effect on the residents within it. It is a compressed site and the regime space is limited, which again can have a negative effect on longer term residents."*[258]

75. Again the only really dissenting voice was Phil Riley, and who appeared to intentionally choose when to rely on the fact he was not in post to answer difficult questions, stating that the centre was *"built to category B/C standard, but I don't believe it is a category B prison environment"*.[259] He sought to try justify the Category B prison-built standard on the basis of the Yarl's Wood fire in 2002 which was not built to such standard suggesting it a more secure site was needed for Brook House[260]. However, such Category B standards are plainly not suitable for those detained under immigration powers. As Professor Bosworth sets out above such a design *"makes no sense"* for those held under immigration powers and makes *"delivery of a humane and supportive regime very difficult."* Again as set out above, Professor Bosworth makes clear that the presence of TSFNOs, the proportion of which constantly fluctuated, would also not provide justification. The answer to any such claims that the presence of TSFNOs made a Category B design necessary is dealt with emphatically by Kate Lampard in her 2018 report for G4S. When quoting concerns by the Brook House head of security (likely Michelle Brown but not named) that an increase in TSFNOs in November 2017 had led to an increase in security problems in the centre, she went on to note:

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[256] VER000223_0004-0005
[257] Witness Statement of Steve Skitt dated 4 March 2022, SER000455_0028-0029
[258] Witness Statement of Dan Haughton dated 2 March 2022, SER000453_0011
[259] Philip Riley 4 April 2022, 61/5-7
[260] Ibid, 65/23-25, 66/1-15

"The head of security told us however that TSFNOs held in the more attractive and less restricted environment of Tinsley House did not present the same degree of problematic behaviour as those at Brook House. She acknowledged that it was likely that the environment of Brook House affected the behaviour of detainees, a view shared by others we interviewed, including the inspection team leader at HMIP who led the unannounced inspection at Brook House in October and November 2016."[261]

76. It is clear that the Category B prison standard is an important aspect of what Professor Bosworth describes a wider process of prisonisation which negatively impacted the security of the centre, not ensuring its security. It also caused the entirely avoidable and highly inappropriate misery and hardship on detainees as detailed above.

(iii) Regime and Conditions

77. The regime and conditions further reflect the harsh, austere and sub-standard prison like armaments. Reverend Ward gave detailed evidence about them at paragraphs 105-113 of his evidence[262]:

105. From my experience, the conditions and regime of Brook House presents an important context to which the abuse exposed in Panorama occurred. As I have said, Brook House was from the outset, designed to Category B prison specifications and to hold people for up to 72 hours; meaning the facilities and design was not conducive to ensuring the welfare of detainees for extended periods of detention.

106. At Brook House, there were three hard courtyards, a few snooker tables, a small gym, a library and a computer room. The facilities were not sufficient for the population, which often led to tensions e.g. over who was using the snooker table. As a result of the limited activities, detainees did not have many options to busy themselves and avoid thinking about their trauma and distress. I agree with the finding of para 1.56 of the 2018 Lampard Report[263]*, which states "activities available to detainees at Brook House do not meet the standard prescribed by rule 17(1) of the Detention Centre Rule 2001. The lack of activities and opportunities for exercise present a risk to detainees' welfare and wellbeing and to the general safety and security of the centre". This was my own experience.*

[261] CJS005923_0062
[262] DL0000141_0035-0038
[263] Independent investigation into concerns about Brook House immigration removal centre, November 2018 by Kate Lampard and Ed Marsden CJS005923_0015

107. The only other option for detainees to keep busy was paid work for £1 an hour, described by the HMIP as being mundane and not very worthwhile. The jobs offered were limited and very repetitive, and it is my view that paying detainees £1 for a job that could be paid minimum wage, reinforces the position that detainees are not equal to the staff or other human beings. It also allows the contractor to reduce its staffing costs if they do not need to employ as many permanent staff on contracts if detainees are doing the work.

108. When the detainees were not free to associate, they were locked in their cells from 9pm until 8am. There were also two roll-calls during the day. It was a system designed so that G4S could save costs by running a more skeleton staffing roster in the evening and morning hours and had little to do with welfare of detainees.

109. It was clear to me that locking detainees down into their cells for excessive and prolonged periods of time enforced the prison like environment and was damaging to mental health. The evening lock-in was always a pinch point of the operational day and from my experience people were generally distressed at the fact they had to face another night behind a locked door. On many occasions, we were not able to get detainees into their cells by 9pm. People understandably did not want to go behind the doors so early and for a prolonged period of time. I witnessed use of force and physical restraint during the locking-down of detainees to force them back into their cells, as if staff were herding animals. Negotiation strategies should have been employed and not physical force and restraint.

110. I raised concerns around the cell size, cleanliness and ventilation not meeting the required standards. The cramped cells with lack of adequate ventilation and detainees being locked in throughout the night with the smell of the toilet and potentially the TV being played all night, created tension and had a real effect on detainees' mental health. I recall a number of complaints from detainees where their cellmate would watch porn throughout the night and they would be subjected to viewing this despite their objection. Detainees would present as distressed and disturbed by being locked in these conditions. I can also recall many staff members complaining about morning unlock, when they entered detainee cells, because of the smell that resulted from locking detainees in all night, where they would be permitted to smoke, where there was an open toilet and where the cell lacked adequate ventilation.

111. I raised the issue of ventilation and cell size with Ben Saunders and Mike Bird, the Head of Facilities, in a meeting around the end of 2013 / start of 2014, around the

time they were considering three-man cells. My view was that to put three men in these cells would breach the international standard. I thought that the cells were already too stuffy and to add in a third person would only make the situation intolerable. I emailed Ben Saunders the international standards on cell size. Ultimately a decision was taken to implement the three-man cells after I resigned. The decision was clearly driven by the Home Office's enforcement imperatives and profit at the expense of welfare.

112. These concerns are supported by Lee Hanford's interview with Kate Lampard. When asked if ventilation was a problem by introducing an additional 60 spaces via three-man rooms, he commented that: "[32] I think the ventilation has always been quite an issue here anyway, because if you compare the windows here to a prison window, there is no triple vent, it's just forced air, but that's the design of the building… [34] Here they are completely sealed because we're so near the airport, whereas in the prison window you have that triple ventilation, so even though you can't open the window, you can actually create the ventilation window… [38] we didn't design this, it was a Home Office design, but once you check back to understand why these windows are different, it was all about the sound" [VER000266_0004-0005].

113. Where I had more operational control at Tinsley House, I made a number of changes to the environment and conditions, as I felt it was important to managing culture and behaviour. These included painting the corridors softer colours, providing stations that served unlimited tea and coffee, changing bedding from blankets to duvets, putting new carpets in the bedrooms, adding books in the corridors, putting leather chairs in the reception and throughout the Centre instead of plastic, re-designing the brochure, introducing signage and directions, providing a notice board for each commonly spoken language, increasing textbooks on immigration law, having spare fax machines, and providing flip flops. Whilst seemingly small, these were environmental changes that I believe had some impact upon the emotional environment. I focused on ensuring that trigger points could be 'softened' – e.g. where an individual would come into reception, I tried to lessen the emotional response by providing a soft chair and a drink. I believe this ultimately led to less distress. I tried to encourage these sort of changes at Brook House and did some limited work regarding improving the environment but it was not sustained. I put signage around the centre to make it easier detainees to navigate their way around and I also put vinyl transfer on to the walls of the CSU to try soften the environment, but it remained fundamentally a harsh prison like environment.

Lock-in regime

78. The regime and substandard conditions at Brook House were baked in to the design of the building and operational contract agreed with GSL/G4S in which the Home Office agreed to a lock-in of 11 hours between 9pm to 8am despite significant concerns that the regime was "*a desperate attempt to reduce costs at the expense of welfare*", "*excessive and not in keeping with the ethos of the rest of the estate: 21 hrs – 08HRS*", that "*the proposals give no justification for such a lengthy period of non-association*" and that they were "*rather harsh*".[264]

79. As Reverend Ward states at paragraph 108 of his statement, the harsh prison like lock-in regime *"was a system designed so that G4S could save costs by running a more skeleton staffing roster in the evening and morning hours and had little to do with welfare of detainees."*[265] These were the same concerns picked up from the procurement process by Mr Schoenenberger and his team when noting that the ultimately successful bid was "*a desperate attempt to reduce costs at the expense of welfare*", "*excessive and not in keeping with the ethos of the rest of the estate: 21 hrs – 08HRS*", that "*the proposals give no justification for such a lengthy period of non-association*" and that they were "*rather harsh*".[266]

80. In his live evidence, Mr Schoenenberger agreed that the lock-in regime was not compatible with Rule 3 of the Detention Centre Rules 2001 and agreed that it was a decision taken to cut costs at the expense of detainee welfare:

> *"7 Q... So a secure but humane accommodation with a relaxed regime with as much freedom of movement and association as possible. That stands, doesn't it, in quite stark contrast to your team's comments about the ethos seen in the bids of cutting corners and meeting only basic standards, and desperate attempts to reduce costs at the expense of welfare?*
> *A. I guess there is some contradiction there, I guess, yes.*
>
> ...
> *Q. Sure. So we looked at the lockdown times which were proposed, and most of them were from 9-ish pm until 8.00 am –*
> *A. Right, yes.*
> *Q. -- so that's almost half of the time –*

[264] DL000140_0069, 0078-0079
[265] DL0000141_0036
[266] DL000140_0069, 0078-0079

A. Yes, yes, okay. -- in the centre in locked rooms. And that contrasts, doesn't it, with the idea of as much freedom of movement and association as possible?
A. Yes.
Q. I appreciate that you were working on the basis of a short period of detention, as we've discussed, an average short turnover, but would you agree that the failure to provide a more -- a relaxed regime with as much freedom of movement and association as possible, which is required by the rules, would have even more serious repercussions if people are held for a prolonged period in a regime which, in fact, only meets basic standards and has compromised welfare in order to cut costs?
A. I think it would be fair to draw that conclusion, yes."[267]

81. When giving his live evidence on behalf of the Home Office, Phil Riley accepted that the long lock-in hours in combination with staffing levels meant that there clearly was issues with detainee welfare within the agreed contract:

"Q... "The assessors are satisfied that GEO offers the best all round response. However the long lockdown period which is shared with other bidders and tight 21 staffing levels, remain a concern." So that appears to be the final sign-off and the 23 final word on this bid at the time. So do you agree that welfare was an issue with this contract?
It was clearly an issue in the bidding process, yes, and, you know, the way the bid was put together."[268]

82. It had a significant impact as Reverend Nathan Ward states at paragraph 109 of his statement:

"*It was clear to me that locking detainees down into their cells for excessive and prolonged periods of time enforced the prison like environment and was damaging to mental health. The evening lock-in was always a pinch point of the operational day and from my experience people were generally distressed at the fact they had to face another night behind a locked door...I witnessed use of force and physical restraint during the locking-down of detainees to force them back into their cells, as if staff were herding animals...* "[269]

Conditions

[267] Philip Schoenenberger 23 March 2022, 16/7-25, 17/1-15
[268] Philip Riley 4 April 2022, 46/18-25, 47/1-11
[269] DL000141_0036-0037

83. The conditions of the cells that detainees were kept in– cramped and unventilated prison-style cells (many three persons to a cell), with odorous, unclean and unscreened toilet areas – was degrading and attributable not only to the intentional Category B-prison design imposed by the Home Office, but the drive for costing saving and profit between the Home Office and G4S which allowed cleaning and basic hygiene to be neglected[270] and indecent proposals such as the three-men cells to be imposed.

84. These cell conditions were combined with a centre overall that was woefully but intentionally under-resourced by the terms of the contract (with constant need for cost-cutting further reducing standards), and one designed as a short-term (72 hours) high security institution but which in reality held individuals for prolonged periods of time. The centre was not built or resourced for long-term residence. There is no space for adequate or meaningful activity provision and insufficient staffing and resources to manage a frustrated and despairing detainee population for any significant period of time.

Historic HMIP Concerns

85. It is notable that the concerns and warnings that Mr Schoenenberger and the rest of the procurement team made in 2007 about the excessive and unjust regime with significant under-staffing and poor activity provision all came to pass with a detriment impact on the welfare of detainees. Prior to the Relevant Period, the Home Office and G4S were given further repeated and concerning warnings from the HMIP in respect of the conditions and regime at Brook House which were constantly ignored and rejected. The HMIP's most significant concerns on regime and conditions are summarised below:

Full Announced Inspection of Brook House IRC by Her Majesty's Chief Inspector of Prisons ('HMCIP') (15-19 March 2010) (Published 12 July 2010) following a 5-day inspection:

86. *"The most common complaint about residential areas was the poor ventilation. The centre was a sealed building and detainees could not open the windows. Several told us that they were suffering from headaches because of the lack of fresh air in the rooms."*[271]

87. *"There were no communal toilets. We received a considerable number of complaints about this from detainees who found it degrading to have to share a toilet in their room with someone else present. They did not have the option of using communal toilets on the wings and the screening for the toilets was inadequate. In many cases detainees had made their*

[270] Ben Saunders gave as an example of cost saving in his live evidence of "being more economical with cleaning products" – Ben Saunders 22 March 2022, 165/5-6
[271] The HMCIP report of Brook House IRC, dated 15-19 March 2010 §2.7 – DL0000167_0024

own ad hoc arrangements, using Sellotape and curtain material."[272] These lead to recommendations that "*All rooms should be adequately ventilated*", and "*All toilets should have seats and should be screened so that detainees are afforded complete privacy*".[273]

88. "*…The 11-hour period that detainees were confined to their rooms was longer than in most other IRCs, and the lock-up times of 9pm each evening was inappropriately early.*"[274] *The HMCIP recommended that "The centre should reduce the length of time detainees are confined to their rooms each day, institute later lock up and increase the time detainees are allowed in communal areas*".[275]

Unannounced Inspection of Brook House IRC by HMCIP (12-23 September 2011) (Published 31 January 2012)

89. In 2012 HMCIP identified and recorded the same continued concerns:

i. *"Little had been done to differentiate the centre's environment from that of a prison. The residential units were visually harsh and noisy, and ventilation remained a considerable problem. Detainees' rooms were well equipped and spacious, but otherwise similar to prison cells, with poorly screened toilet areas – or not screens at all.*"[276]

ii. The recommendation in relation to reducing lock-ins was repeated, noting that: "*There had been no reduction in the time detainees were confined to their rooms, which was around 11 hours a day – longer than at most IRCs… The lock-up time each evening was still 9pm, which was earlier than in most IRCs.*"[277]

Unannounced Inspection of Brook House IRC by HMCIP (28 May – 7 June 2013) (Published 1 October 2013)

90. Taking place over 11 days once more, the same concerns were identified that had not been adequately addressed:

i. "*Detainees were out of their rooms for between 11.5 and 13 hours a day, but they were all locked up by 9pm. This was too early and it was unclear why detainees needed to be*

[272] §2.20 - DL0000167_0025
[273] §2.27 and 2.30 - DL0000167_0026
[274] §6.5 - DL0000167_0052
[275] §6.29 DL0000167_0055
[276] §HE.25 – DL0000171_0013
[277] §6.3 DL0000171_0051

locked in their rooms at all."[278] *They continued: "Some security procedures were disproportionate for the population. There was restricted movement on and off wings. Detainees were unnecessarily locked up each day for two 30-minute roll checks…"*[279] A recommendation was again made that: "*Detainees should not be locked into cells and should be allowed free movement around the centre until later in the evening.*"[280]

ii. "*Bedrooms were spacious but many were dirty and required decorating. A sheet was used to screen the toilet entrance which afforded little privacy. Many toilets were heavily scaled and required deep cleaning.*"[281] This led to a recommendation at 2.10 that "*Showers and toilets should be adequately screened for privacy and toilets should be deep cleaned.*"[282]

The Unannounced Inspection of Brook House IRC by Her Majesty's Chief Inspector of Prisons ('HMCIP') (31 October–11 November 2016) (Published 10 March 2017),

91. In the 2017 Report, following a 12 day inspection in 2016, the HMCIP made the same or similar findings and recommendations once more:

i. Under the heading "Security", the HMCIP reports that "*The centre had many physical security features of a category B prison. Detainees were held in cells on traditional prison landings and wings*"[283] and that, consistent with these Cs' evidence, "*Some security arrangements remained disproportionate to the risks posed by the population. Detainees were locked in their cells overnight, which was inappropriate.*[284] *Detainees were locked in their cells from 9pm to 8am and again for two half hour roll calls during the day. More detainees than at the last inspection were former prisoners (45% compared to 5%) and a number felt that their new status as detainees was not sufficiently acknowledged. In our survey, one detainee commented, 'Closing and opening time should be changed because we are not prisoners, we are just detained … I am feeling like a prisoner without crime.'*"[285]

[278] §S23 - HMIP000311_0016
[279] §1.55 - HMIP000311_0025
[280] §3.9 HMIP000311_0046
[281] §2.3 HMIP000311_0033
[282] *Ibid.*
[283] §1.40 - CJS000761_0024
[284] S8 – CJS000761_0014
[285] §1.41 - CJS000761_0024

ii. "*Poor ventilation and the general prison-like environment remained significant shortcomings.*"[286]

iii. "*Many cells lacked curtains and many in-cell toilets were not curtained off. Many cells had ingrained dirt, especially in toilets, and those on C wing were in the worst condition. The lack of ventilation was the most common complaint, and many cells were too stuffy overnight. A third bed had been fitted in 60 two person cells.*"[287] "*Many cells, especially on C wing, were in too bad a condition to be kept properly clean, and the flooring was cracked in some toilet areas. The roof vents on the wings had been opened occasionally in the summer but the chief complaint among detainees was the lack of ventilation in the cells: the windows did not open, creating a stuffy atmosphere in many cells in spite of the air conditioning system. Detainees also experienced an exacerbated sense of confinement through lack of fresh air and any personal control over the environment.*"[288]

iv. The HMCIP reported as a "Main concern", "*especially overnight when detainees were locked into cells"* and provided as a "Main Recommendation"[289] that "*Concerted action should be taken to soften the prison-like living conditions. Showers and toilets should be adequately screened, and toilets deep cleaned. Units should be well ventilated and detainees should have more control over access to fresh air*"[290]

v. Under the heading of "Security", the HMCIP found that "*The centre had many physical security features of a category B prison. Detainees were held in cells on traditional prison landings and wings*"[291] and that, consistent with these Claimants' evidence, "*Some elements of procedural security remained disproportionate to the risks of the population. Detainees were locked in their cells from 9pm to 8am and again for two half hour roll calls during the day*". [292]

vi. As a "main recommendation" the HMCIP set out that "*All security procedures should be proportionate to a detainee population and based on individual risk assessments.*"[293]

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[286] S13 - CJS000761_0015

[287] S15 - CJS000761_0015
[288] §2.2 - CJS000761_0031
[289] §5.2 - CJS000761_0049
[290] S36; see also §2.1 and §5.2 ('Summary of Recommendations') - CJS000761_0018, 0031, 0049
[291] §1.40 - CJS000761_0024

[292] §1.41 - CJS000761_0024
[293] §5.22 - CJS000761_0051

"*Detainees should not be locked in cells and should be allowed free movement around the centre until later in the evening.*"[294]

Repeated Rejection of Recommendations or Failure to Implement

92. The Home Office would constantly reject or fail to fully implement these recommendations by the HMIP on regime and conditions, often citing as reasons – the irretrievable design of the building, contractual restraints and cost. Examples of this can be seen in the Service Improvement Plans (SIP) which were the documents that set out the Home Office response to recommendations made by the HMIP[295]:

    i. 2010 SIP:
        i. On need for cell toilets to have seats and be screened (10.56): "*This was not part of the original building design specification. To retrofit toilet seats would require substantial resource. G4S have investigated methods of providing additional curtaining to afford complete privacy but have not been able to provide a cost effective solution which is both safe and secure.*"
        ii. Lock-in timings (10.113): "*Regime timings are determined by the operational contract in place between UKBA and G4S.*"

    ii. 2011 SIP:
        i. Need for adequate ventilation (10.39): "*The ventilation is an integral part of building design and is considered appropriate for these conditions*"
        ii. Toilets (10.43): "*The current building design does not allow for the toilets to have seats or for full screening of the toilet area*"
        iii. Lock-in timings (10.77) same response as 2010 above

    iii. 2013 SIP – Lock-in recommendation (5.60): "*Reject… The current regime times are dictated in the operating contract and would require additional resourcing if changed.*"

93. When asked about it in live evidence, Dr Hindpal Singh Bhui on behalf of the HMIP believed that the primary motivation of the lock-in regime, and why recommendations were rejected, as because of the cost savings on staffing: "*No, no, I was going to go on to say*

[294] §5.23 - CJS000761_0051
[295] These Service Improvement Plans were provided to the Inquiry by Duncan Lewis with the Rule 10 application for Dr Hindpal Singh Bhui of the HMIP and should be adduced by the Inquiry

that the obvious response to that will be to say, have more staff who are able to supervise, and then you can maintain security without locking people up overnight. So I agree it is, fundamentally, a staffing issue."[296]

2018 Shaw Report

94. The repeated concerns of the HMIP were ignored and the regime and conditions endured through the Relevant Period and beyond.

95. In July 2018, Stephen Shaw produced his follow up report on the welfare in detention of vulnerable persons.[297] Mr Shaw was highly critical of the regime and conditions at Brook House – including the ignoring of his 2016 warning to not introduce the third bed into cell, urging the Home Office to address these issues in light of the *Hussein* judgment:

> *"2.75. I was disappointed that the suggestion in my previous review that the Home Office should stop the planned introduction of a third bunk in some rooms at Brook House had been rejected. I did not find conditions in those rooms remotely acceptable or decent."*[298]
>
> *"2.77. In some centres, such as Brook House, Colnbrook and Harmondsworth, overcrowded, cell-like rooms with prison doors had the unacceptable feature of in-room toilets separated only by a curtain. It is troubling that such an arrangement was deemed acceptable when these institutions were designed and commissioned just a decade or so ago. In light of a recent High Court ruling relating to Brook House25, these conditions must be addressed. The Home Office has accepted the ruling and is putting in place measures to prohibit the practice of smoking inside immigration removal centres. In his ruling the case judge did not deem the practice of restricting detainees to their rooms as unjustified, and the impact is being assessed by the Home Office."*[299]
>
> *"Recommendation 7: No immigration detention facility should be built in future with a barely screened toilet inside a shared room, and this set-up should be upgraded in all existing facilities.*

[296] Hindpal Singh Bhui 24 March 2022, 173/20-25
[297] CJS0073862
[298] Stephen Shaw, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons', dated July 2018 – CJS0073862_0032
[299] Ibid

Recommendation 8: In future, capacity in the immigration estate should not be increased by adding extra beds to rooms designed for fewer occupants. Where this has already occurred (e.g. Campsfield House, Brook House), these extra beds should be removed, and capacity reduced or extra space created.

2.79 In many IRCs, I felt the regimes were unnecessarily restrictive, with extended night-time periods when detainees were locked in their units or – where there were toilets within rooms – locked in the rooms themselves. In some centres, I was disappointed to learn that the lock-down period had been extended, presumably due to staffing requirements. In this respect, Campsfield and Tinsley House demonstrated best practice: the rooms themselves were not locked and detainees retained access at all times to showers and toilets in their units. Moreover, at Campsfield the units were not locked overnight until 23:00. This is far more decent than the situation in other IRCs, and the proportion of FNOs at Campsfield shows that it is possible to manage diverse populations within relatively open conditions.

Recommendation 9: Detainees should have improved access to facilities on their units at night, and night-time lock-in periods should begin as late as possible."[300]

"A7.5 At the time of my previous review, it was planned to introduce a third bunk in a number of the rooms at Brook House but I urged that this should not proceed. I was very disappointed, therefore, to see that it had indeed taken place in 60 of the 238 bedrooms."[301]

A7.6 That decision has had further consequences. On 1 February 2018, the High Court ruled that conditions and aspects of the regime in Brook House contravened the European Convention on Human Rights and were discriminatory. The practice of locking detainees in small (4m x 3m) shared cells (each man had two others in their room) with an open lavatory for 11 hours a day, and thereby forcing practising Muslim detainees to pray in these conditions, was found (i) to contravene detainees' right to worship under Article 9 of the European Convention on Human Rights read with Article 14 which is unlawful unless justified; and (ii) unless justified, constitutes unlawful to indirect discrimination against Muslim detainees contrary to section 19 of the Equality Act 2010. It was noted that Claimants found that the rooms were 'smelly and dirty' and 'disgusting', and distracted them from prayer. No justification had yet been shown by the Home Secretary. This judgment also found that, by

[300] CJS0073862_0033
[301] CJS0073862_0184

allowing smoking in rooms indoors and any area which is enclosed or substantially enclosed at Brook House, the Home Secretary had acted unlawfully, and that the regulations permitting exemptions to the smoking ban in public places did not extend to privately run IRCs (though could be amended to do so if the Government wished).

A7.7 The Brook House site is cramped for the number of men it holds, and it remains prison-like in both appearance and regime. During my first visit, I felt the fabric of rooms was shabby, although communal areas within units seemed relatively clean (I understand that all bedrooms were refurbished by December 2017). The men I spoke to were upset by the fact the conditions were so akin to prison

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A7.8 Rooms were essentially cells, with prison doors and – most notably – in-room toilets separated only by a curtain. This is not decent.

A7.9 Detainees used bags to prop open their doors, as they could not be opened from the inside once shut. (In December 2017, handles were fitted to the inside of the doors.)

A7.10 The prison-like appearance of the personal spaces was echoed in the unit's communal areas where there were double layers of netting between the landings to reduce the risk of suicide."[302]

Experiences of Duncan Lewis Clients

96. The concerns raised by the HMIP and Stephen Shaw were the day-to-day realities of Brook House and accord with the experiences of the Duncan Lewis clients:

97. D1851:

i. He describes arriving in the early hours of the morning at about 2am to a prison-like structure with barbed wire and tall fences.[303] It took him several days to receive a working phone, leaving him unable to contact his legal representatives or his partner.[304] He describes arriving to a cell[305] that smelt of sweat, with sheets on the beds showing yellow stains and blood stains, with a toilet unclean

[302] CJS0073862_0185
[303] DL0000143_0004
[304] DL0000143_0004
[305] D1851 03 December 2021 69/22-70/1: "It's a cell. I'm sorry, I just need to make that point. It's probably called a room, but I think using the word "room" makes it hard for people who haven't experienced it to actually have a good understanding of what it's like. It's a cell. That is just what it is."

and stained and giving off a putrid smell.[306] He describes how there was no such thing as privacy or respect dignity in Brook House – there was no curtain covering the toilet which meant that if he or wanted to use the toilet, he would have to do this in front of his cellmate and vice versa.[307]

ii. He further describes the impact of prolonged lock-ins and how he would often be left without food given the slow process of unlocking the cells for mealtimes, with one occasion where he did not eat for about 18 hours.[308] He describes how this, in conjunction with the stressful environment "*created the impression of being tortured*".[309] He explained how: *"It was mentally draining trying to just get on with my life whilst in Brook House. I was constantly tired, always stressed and crying frequently. I was always on edge and I lost count of the sleepless nights I had. The food was poor, and I was locked up for the majority of the day. My freedom, even within the context of a detention centre, was non-existent. The officers and staff simply were not concerned with the safeguarding of my welfare or safety. As I have said the G4S officers were demeaning and rude. They spoke to me with utter distain and disrespect which was very demoralising and undermining. It destroyed my self-esteem and left me feeling angry but also worthless."*[310]

iii. He further describes in his live evidence of the levels of stress and anxiety that living in Brook House in such conditions caused: *"A. I did. And probably then I didn't recognise that was what it was because I've never experienced it before. And it's hard when you are in the middle of -- everyone around you are probably experiencing the same thing, and it's like that's the baseline of a normal lifestyle in detention. You are all stressed, depressed, struggling to find a way to get out of detention, but also being reminded every day that you could be picked up and thrown back to where you came from at any time. So, yeah, it's a hard one."*[311]

98. D643:

i. D643 in his witness statement set out the impact of the lock-in regime on his PTSD, compounded by the prison-built centre: *"I found lock-ins very difficult for my PTSD because during a lock-in people would be banging their*

[306] DL0000143_0006
[307] DL0000143_0017; D1851 03 December 2021 70/12
[308] DL0000143_0016
[309] DL0000094_0006
[310] D1851 Civil Witness Statement dated 27 January 2020, paragraph 74 – DL0000094_0012
[311] D1851 3 December 2021, 72/22-25, 73/1-6

doors. As set out above, I find loud noises triggering. I would curl up on my bed but I remember shaking with panic and sometimes I would hit my head on the door to try to knock myself out and escape from the noises which made me feel like I was in a war zone."[312]

ii. He describes times when sharing cells in 3-men rooms: *"Cells are supposed to accommodate 2 detainees and it was extremely cramped when there were 3 of us."*[313]

iii. He also describes the humiliation caused by sharing a cell with a toilet that was not screened: *"160. Throughout my period of detention at Brook House I was never in a cell with any sort of privacy screen or curtain in front of the toilet. I found it extremely humiliating. My cellmate and I would agree that we would only use the toilet during recreational times so that one of us could leave the cell and give the other some privacy. It meant that during lock-ins we would try to hold it in or wait until our cellmate was asleep. Often the toilets did not flush property so faecal matter would remain there for hours and the cell would smell awful. It was extremely degrading and humiliating. I remember complaining to the officers when the flushes did not work but they would tell me to sort it out myself. I would try to use the plunger but this was not always effective. Officers did not respect our privacy and would sometimes enter the cell when I was on the toilet. If this happened, they would not excuse themselves, they would laugh and leave the door open. This was especially humiliating when a female officer would come to our door. Female officers did not enter detainee cells unaccompanied, but I recall a few occasions when I was using the toilet and a female officer (I do not recall their name(s)) opened the door to my cell. I felt exposed and disrespected."*[314]

iv. He also described the cell as *"very poorly ventilated"* and gave an *"extremely frightening"* example of the consequences when his cellmate set alight some Home Office paperwork causing a fire and filling the cell with smoke and there was delay from officers in coming to assist: *"I remember that we had to lie on the floor as close to the ground as possible to try and breathe the air through the gap under the door. I found this extremely frightening, I thought I was going to die."*[315]

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[312] Witness Statement of D643 dated 14 February 2022, paragraph 157, DL0000228_0044
[313] Paragraph 159, DL0000228_0044
[314] Paragraph 160, DL0000228_0044
[315] Paragraph 161, DL0000228_0045

99. D1538 also set out his concerns and experiences of the regime and conditions in his witness statement of 13 February 2022:

> *"30. The toilet in the cell had no separation between it and the rest of the cell. There was a small partition but there was no curtain as far as I can recall, and no door. This meant that you could see straight into the toilet area, and if someone was using it you could see them use the toilet. This was very embarrassing. It was uncomfortable to be in the same cell as someone when they were using the toilet, as even if you didn't look, you could hear and smell everything. It was disgusting, and it made me feel embarrassed every time 1 needed to use the toilet. It also meant you had to be patient when you needed to use the bathroom but another detainee was using it, which could be awkward.*
>
> *31. The staff would lock us in our cells for the night. I cannot remember exactly what the times were, but I think it was from 9pm at night until 8am the next morning.*
>
> *32. We would also be locked into our cells twice more a day during the daytime so that the staff could do roll-counts. Also, whenever there were any issues on the wing, such as a medical emergency or when the staff were undertaking a forced removal of someone from the centre, they would lock us in our cells so we couldn't see or get involved. It was terrible being locked in so much. It made me feel like a prisoner. The feeling of being trapped in a small space reminded me of my experiences in Morocco and brought up many bad feelings in me about the abuse I suffered there. This is because lock-in reminded me of my experiences living on the streets in Morocco, sometimes in cardboard boxes — it was cramped, smelly, noisy, and very scary."*[316]

100. D2077 provided his experience of the conditions in his witness statement of 9 February 2022:

> *"75. I had been detained in two other detention centres but I felt that the environment at Brook House was far more oppressive and far harsher. They weren't even comparable in my eyes."*
>
> *76. I felt that at other detention centres, the guards and the regime were more relaxed and there was more respect. You were not locked up for such long periods and herded back to your cells and made to queue up like animals for food... In Brook House, you*

[316] Witness Statement of D1538, DL0000231_0007

would only have a short period outside to get some fresh air. The other centres had better facilities that were easier to access. I do not remember being able to do anything at all. You could not distract yourself from where you were.

77. I shared a room with another person. There were two beds in the room and a toilet in the corner. There was a kettle and the room was just extremely dirty. For example, if we ate something we just had to put everything in the bin and it would stay there until we were allowed outside. The bin would overflow. From the IRC records 1 am told that this was Clyde Wing.

78. The Centre was generally dirty. The rooms were filthy as they weren't cleaned or cared for properly. At other detention centres, they would tell you to leave whilst they cleaned the rooms but they didn't do that at Brook House. The walls and the doors were very old and dirty. Many people had stayed there before. The sheets were very old and used and looked as if they had been used many times beforehand. The beds had been ruined through years of use and were extremely uncomfortable. They were very difficult to sleep in.

79. I remember that the toilets were extremely old and dirty. They were stained and dirty and there was lots of germs in them. We were not able to easily get products to clean the toilet and nobody did this for me.

80. There was no ventilation so it smelt bad.

...

82. The room reminded me of a cage for animals.

83. There was a mirror in the corner of the room so that when you were in the toilet, it could be seen what you were doing. There was no privacy and officers would always be there.

84. It felt extremely restrictive and insecure. I did not feel that even dangerous criminals should be treated like this.

85. Fortunately, the other detainee who 1 was with was Iranian and he was helpful and was kind to me. Even so I could not cope in there. The environment in IRC Brook

House was completely toxic and oppressive. People had serious mental health issues. There were frequent self-harm and suicide attempts. It seemed as if almost every day someone had hurt themselves. I found this very alarming and distressing."[317]

101. D1914 again echoed these concerns about the condition and regime at Brook House, noting at paragraph 112: *"I felt all the time like I did not have enough air, like I could not breathe. I found the detention environment stressful, with long periods in lockdown, lots of noise and smells, not much air, many detainees taking drugs and falling ill, and poor access to healthcare."*[318] He described the in-cell toilet arrangements as *"disgusting", "very smelly"* and *"very uncomfortable"*, before explaining that the lock in *"affected me both physically and mentally. I felt trapped. There was very little to do, very few distractions, whilst locked in the cell. I was also in very poor condition given my health, which made this situation feel more uncomfortable and stressful."*[319]

102. The experiences of the Duncan Lewis CPs accords with other former detained persons that Duncan Lewis represented as witnesses:

i. D2033 explained in his witness statement of 18 January 2022 that there was no door to the in-cell toilet so that *"when someone was using the toilet, you could also head and smell the stench of the toilet. That made me feel an additional psychological blow and emotional torment."*[320] On the lock-ins, he stated: *"Although the door to my room was locked, I could hear a lot of angry people around me banging on their cells and shouting, which was very scary. Naturally nobody likes to be locked in against their will, but that was what it was. As humans, we like to be free, but they had imposed those conditions against me and there was nothing I could do about it. We didn't have the ability to make our own decisions on the wing, but I felt particularly bad when the security personnel ordered me to return to my room and locked the door on me."*[321]

ii. D668 – in his witness statement of 22 November 2021, D668 noted that absence of a toilet curtain and stated: *"The toilet was filthy; it was completely brown on the inside. As far as I am aware, it was never cleaned. There were no cleaning brushes or products provided to clean it myself. The window in the room could not be opened so there was no ventilation. The smell*

[317] Witness Statement of D2077, DL0000226_0021-0023
[318] Witness Statement of D1914 dated 14 February 2022, DL0000229_0030
[319] Paragraph 65, DL0000229_0076-0077
[320] Witness Statement of D2033, paragraph 28, DL0000149_0008
[321] Paragraph 31, DL0000149_0009

of the toilet made me feel nauseous and I vomited many times. We asked them if we could open the window but they said that we could not."[322] D668 described the lock-ins making him feel *"depressed because they triggered flashbacks,"*[323] something he mentioned to Dr Chaudhary in his Rule 35 assessment on 24 July 2017. Dr Chaudhary recorded this in his medical record of the appointment but not in the report itself: *"Stated that being held here in detention reminds him of when he had been arrested by the military and tortured especially at night when he is locked in his room and he can hear doors opening with keys"*[324] He explained further in his witness statement that he *"could not breathe when I was locked in the room. The terrible smell and lack of fresh air made it worse. I felt very anxious and used to cry"* and that having to use the toilet in front of his roommate *"made me feel humiliated and disgusted."*[325]

iii. D523 gave a witness statement to the Inquiry on 15 February 2022. He described feeling *"very, very uncomfortable and embarrassing"* to have to use the toilet in front of his roommate during lock-ins."[326]

iv. D313 gave a witness statement to the Inquiry on 21 February 2022. He described the regime as *"very similar to a prison as we were locked in for much of the day and we were treated like prisoners."*[327] Owing to his ill-health, D313 was in s single occupancy cell and described how difficult it was during the lock-ins on his own: *"At Brook House IRC I felt depressed and lonely as I had no one to talk to during long periods locked into my cell. The cell was cold and I had nothing to do. I would often self-harm whilst I was alone at night. I felt that I had no hope and I thought about ending my life. I didn't report how I was feeling, as there was no one I trusted enough to open up to. I didn't want everyone to know how bad my mental health was."*[328] D313 is seen on Callum Tulley's undercover filming[329] leading complaints on 19 June 2017 of detainees returning to their cells for lock-ins due to the heat and lack of ventilation (it appears on the clip to be a particularly hot day, D313 is shirtless and visibly sweating). D313 (referred to as 'Detainee 1' in the transcript) is captured saying: *"Go in the cells, it's too hot. You are made. All of use, we're not banging up. Fuck all that... It's not healthy, man... You bring us some fans up, gov. look at*

[322] Witness Statement of D668, paragraph 18, DL0000153_0004
[323] Paragraph 20, DL0000153_0005
[324] DL0000040_0038
[325] Paragraphs 21-22, DL0000153_0005
[326] Witness Statement of D523 dated 15 February 2022, paragraph 18, DL0000232_0007
[327] Witness Statement of D313, paragraph 28, DL0000233_0006
[328] Paragraph 35, DL0000233_0007
[329] KENCOV1037, V20176061900010 Clip 4, TRN0000083_0035-0037

us, we're sweating... Gov, two days, we were sweating our cunt off. Ask anyone in here.... We were sweating, water were coming down on us. And there's no way I could go in there... Just bring us some fans, and we will bang up"

v. D1618 gave a witness statement on 3 November 2021. He describes how he *"suffered a lot during the lock in periods. This was when my mental health symptoms were particularly bad. Whenever I looked at the time and saw that it was coming up to 9pm, I knew that someone was going to lock me in and I became scared."*[330] He described how he would struggle to sleep at night and would be awake until 3pm and that *"I knew I had hours ahead of me where I had nothing to do other than think about what might happen to me and about my fears of being returned to Afghanistan."*[331] He described his cell as being in *very bad condition and smelled really bad"* before explaining: *"There was a toilet in the room which did not have any screens. We usually held a blanket around for each other to have some kind of privacy. The toilet, which was stained a yellow colour, made the room smell horrible and there was no window for ventilation. It felt as though there was not enough oxygen to breathe properly."*[332]

Other Witness evidence

103. The difficulties caused to detainees by the harsh regime and conditions were confirmed by other witnesses. In a witness statement disclosed to the Inquiry dated 13 December 2019, Callum Tulley confirmed the following in respect of the cell conditions:

"6... I can confirm that whether or not the curtains were available, there were serious problems with the Velcro fixing for these curtains which meant they would not screen the toilets adequately at all. At the time that I was there the wings at Brook house were poorly resourced. There were many rooms on the wings that simply did not have curtains screening the toilets... I would visit cells with unscreened toilets on a weekly if not daily basis.

"9... Detainees would often complain about the smell in their cells and the lack of fresh air after they had been locked in for long periods of time. I can confirm that cells would smell particularly bad after morning unlock and it was extremely unpleasant. That was

[330] Witness Statement of D1618, paragraph 21, INQ000055_0004
[331] Paragraph 22, INQ000055_0005
[332] Paragraphs 11-12, INQ000055_0003

due to either ventilation issues, poor hygiene, unscreened toilets, prolonged time in cells, or a combination of some or all of these factors."

14. Detainees would complain about the lock-ins on a daily basis as we as the further delays caused by wrong roll counts."[333]

104. The Inquiry's expert, Professor Mary Bosworth, was highly critical of the cell conditions and regime in her report of 17 November 2021. She describes *"rooms that looks like cells, behind metal doors"* and *"a small opaque window which cannot be opened."*[334] She noted how: *Brook House operated a limited regime of activities which could only be accessed by men from specific housing units at particular times of day. Very little at all was on offer on the weekend.., the day was punctuated by regular roll count, during which the detained men were locked up again in their rooms. When the roll count was wrong, as it often appeared to be on the footage, the men would have been locked for even longer periods in their rooms."*[335] She goes on to find:

"9.6 The documentation that I have consulted suggests that the material conditions in Brook House in 2017 were inadequate in other ways too. The IMB were particularly concerned about the dirty conditions of the housing units and the noise, as well as overcrowding on the wings. A decision to increase the population by 60 men, who were placed in triple bunks, drew particular scrutiny from Verita in their 2018 investigation and report.

...

9.8 The design of Brook House Immigration Removal Centre is inappropriate for its purpose. The half doors of showers are undignified, while the toilets in the bedrooms and the inability to open the windows create unpleasant living spaces. Men on the footage and report that their living spaces became uncomfortably hot in the summer months. These claims are reinforced by details in the IMB minutes.246 There is limited access to natural light and outdoor space as well as only a small area for activities. The daily schedule is punctuated by roll calls during which men are locked back in their rooms."[336]

105. The regime and conditions at Brook House were also criticised by other former officers and staff members:

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[333] Witness Statement of Callum Tulley dated 13 December 2019, INQ000051_0029-0031
[334] Expert Report of Professor Mary Bosworth dated 17 November 2021, paragraph 9.1, INQ000064_0041
[335] Paragraph 9.4, INQ000064_0042
[336] INQ000064_0042-0043

i. Ian Castle, the former Home Office contact compliance manager in his live evidence described the impact staying at Brook House had on detainees: *"I think, if you spend more than 24 hours in Brook House, you're going to develop mental health issues. It's not a nice place to be."*[337]

ii. Former DCO Derek Murphy in his live evidence: *"It was just horrible…. It was hell on earth for detainees and it was hell for officers that had to work there… It was disgraceful. They should not never been in there. They were in a prison, that's all they were in. It was disgusting."*[338]

iii. Former DCO Dan Small in his live evidence commented on the impact of the introduction of 3-men rooms: *"Q. We know that was in March/April 2017. Was that a noticeable change? A. Oh, 100 per cent. If you were going to increase the capacity of detained persons at that facility, then surely you would increase the capacity of officers... The environment is horrific in that place… The environment there moulded you. It changes a person working in that environment, it makes you angry working there. You don't understand the relief I got when I left that place. I was thrilled that I'd finally left."*[339]

iv. Former DCM Steve Webb in live evidence: *"Some of them were –it was a mighty shock, you know, they'd been picked and up they've basically been put in prison with no open windows, very small courtyards, and it's all new and they might not be even able to speak the language… "*[340]

v. Former DCO Yan Paschali in his live evidence: *"It was a horrible place to work and a horrible place to live."*[341]

vi. Former DCO Owen Syred when asked about the impact of 3-men rooms: *"A. So what was clear was that, actually, just a cell with two people in it was stuffy, the air was stale, it smelt, there was no access to fresh air, there was no real privacy when they were using the toilet, and, therefore, if -- if the system doesn't work with two people in a room, adding a third person only increases the detrimental impact on living in there. If you're having to medicate people in*

[337] Ian Castle 15 March 2022, 38/16-18
[338] Derek Murphy 2 March 2022, 4/21-24, 20/22
[339] Dan Small 28 February 2022, 114/8-12, 115/21, 147/19-23
[340] Steven Webb 8 March 2022, 138/23-25, 139/1-2
[341] Yan Paschali 24 February 2022, 14/9-11

order to sleep with two people in the room, then actually adding a third person isn't going to make it any better. In fact, it will make it demonstrably worse. These are concerns which I actually raised at the time, and I drew the facts of some of the policies which were in existence around minimum sizes that should be given for cell space to Ben Saunders at the time, and suggested that, in fact, we weren't meeting those with two people, let alone three people."[342]

(iv) Control and Restraint / Use of Force

Inappropriate use of Prison Service C+R in IRC Context

106. The Inquiry is asked to consider whether the control and restraint techniques utilised from the prison context are appropriate to this IRC and the cohort and can appropriately use on a victim of torture or trauma and those with serious mental illness. Reverend Ward points that the same control and restraint techniques were deployed for perceived non-compliance, and disruptive behaviour, as self-harm and attempts at suicide and mental distress (paragraph 238 of NW's statement)[343].

107. In his witness statement, Dr Brodie Paterson set out in detail his views on the inappropriate use of prison service C+R techniques within IRCs, most notably at paragraphs 15-19 and 26-39. He summarises at paragraph 26 that the use of *"prison service C&R techniques within IRCs in relation to the use of force is, in my opinion, not appropriate because it is based on a system which: does not sufficiently recognize the particular vulnerabilities and unique context in which individuals are held in immigration detention, does not provide a hierarchy of interventions, is not compliant with the Equality Act 2010 or consistent with the law, practice and current thinking on the use of C&R techniques more generally in the clinical and mental health context and does not rely on an appropriate public health model."*[344] He goes on to note at paragraph 47 the result of prison C+R techniques becoming the norm to manage the IRC population was that *"high-tariff restraint interventions were used in Brook House when less intrusive / restrictive interventions should have been used"*.[345]

108. Investment needs to be made in developing a system which is able to deal with conflict and violence within residential settings, which has a stronger focus on prevention, de-escalation and the ethical use of force.

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[342] Owen Syred 7 December 2021, 147/21-25, 147/1-12
[343] Nathan Ward 1st Statement at DL0000141_0084-0085
[344] BHM000045_0005
[345] BHM000045_0011

Relevance of Mental Illness

109. Of critical importance to the Inquiry deliberations is the fact that C&R was often used as a response to and a form of management or containment of the symptoms of mental illness, and wrongly treated as non-compliance and disruptive. This was beyond the expertise and training of IRC staff. If a person has symptoms of mental illness that require C&R to manage them, this should be treated as clear evidence that they are unsuitable to be detained and can't be safely and humanely managed in the detention environment. This is all the more the case if the behaviour being managed is self- harm and suicide risk and the only tool to address that was removal often using force to segregation formally under Rule 40 or informally in the CSU/ E Wing.

110. Reverend Ward set out his concerns on these practices at paragraph 262 of his first statement. Having reviewed the use of force reports relating to restraints against D2159 on 5 April 2017[346] and D1527 on 4 May 2017[347], he notes: *"I am very concerned about the pattern of force being used for apparent non-compliance with no regard for the mental state of the detainee. In my view, there is no justification for this use of force but it reflects how force was generally used as the default at Brook House."*[348]

111. Dr Paterson is in agreement with these views, setting out his belief at paragraph 54 that *"given the mixed population within an IRC including a high proportion of individuals who are mentally vulnerable any use of control and restraint must be used on a limited and exceptional basis only i.e. in a medical emergency and to save life and should never be used as a matter of routine on the mentally vulnerable/unwell"*.[349] Dr Paterson notes at paragraph 53 that there is a need to train staff who restraint detainees with a mental disorder not just on "*how to restraint*" but also to include *"the impact of trauma, the impact of previous physical or sexual abuse, the indicators of excited delirium and the requirement to protect and promote human rights."*[350] Dr Paterson also finds at paragraph 59 that there was "*a corrupted toxic culture was allowed to develop within Brook House in which vulnerable individuals with mental health problems / mental illnesses were neglected and abused, psychologically and on occasion physically. Central to this particular variant was a pervasive disbelief shared by DCO, DCM and Senior Management within Brook house and within the Home Office itself in the legitimacy of asylum seekers mental health issues.*

[346] CJS005529
[347] CJS005530
[348] DL0000141_0092
[349] BHM000045_0012
[350] Ibid.

This resulted in a default approach by some staff to treat symptoms and behaviour related to mental illness and distress as non-compliance or disruptive or manipulative."[351]

112. In her witness statement to the Inquiry, Dr Rachel Bingham of Medical Justice also set out similar concerns at paragraph 144 of *"the recurrent misconception by Brook House staff of non-compliant behaviours as indicative of disobedience, rather as a manifestation of underlying vulnerability. Indicators of serious physical and mental illness, including lack of or limited mental capacity, appear to be masked or misunderstood as behavioural issues and relied upon to justify recourse to restrictive measures."*[352]

113. Equally, in his live evidence Dr James Hard expressed his view that a planned use of force against D1914 where he was treated as non-complaint as opposed to vulnerable and unwell was an example of measures *"done for the convenience of the custodial staff and not for his –or consideration of – his issues."*[353]

114. There was a clear institutional failure across staff at all levels to understand mental illness and how it should impact on whether to use force. A failure to understand detainees acting based on their mental illness and not as a disruptive or behavioural issue is evident from much of the live evidence given by officers still working at Brook House today under Serco. All of these officers confirmed they could not distinguish between these and that they have not received proper training on mental illness from neither G4S nor Serco (never mind the sort of training Dr Paterson has identified specifically in the context of use of force).[354]

115. In his live evidence on 9 March 2022, Steve Dix still appeared to be unable to distinguish between intentional disruptive behaviour and symptoms of mental illness despite now being an Assistant Director and in his 13th year of employment at Brook House. Mr Dix was challenged by CTI on his decision to place D1527 on Rule 40 on 4 May 2017 for going on D-wing netting and use force to move him there. He was asked whether D1527 being on the netting was more to do with his state of mental health rather than being deliberately disruptive but Mr Dix maintained that he simply *"couldn't say"* and that he believed Rule 40 was necessary "*based on the level of disruption".*[355] Mr Dix's complete indifference to D1527's mental health was evidence from the comments captured by Callum Tulley's undercover filming – when asked about the risk of D1527 jumping off the

[351] BHM000045_0013
[352] Witness Statement of Dr Rachel Bingham dated 3 February 2022, at BHM000033_0055
[353] Dr James Hard 28 March 2022, 87/2-8
[354] See for example: (1) Steve Loughton 1 March 2022, 103/5-9; (2) Shane Farrell 8 March 2022, 79/13-25, 80/1-25; (3) Steve Dix 9 March 2022, 5/18-25, 6/1-18; and (4) Stewart Povey-Meier 17 March 2022, 5/4-12
[355] Steve Dix 9 March 2022, 56/21-25, 57/1-18

netting in a potential ask of self-harm or suicide attempt, Mr Dix responds: *"Oh well, it's his own choice init"*[356] This was not a one-off comment by Mr Dix. That same day he would describe D1978 as a "*bald-headed Portuguese, bipolar nutter*",[357] a detainee he would later go on to lead a further unlawful restraint on (see further below). There were several other instances of officers failing to understand D1527's mental illness during restraints, most notably during the events of 25 April 2017. Steve Loughton described him as "sulking"[358] following a suicide attempt which resulted in force being used to cut a ligature off D1527's neck, whilst Charlie Francis would should "we're getting bored", "are you a man or a mouse" and "stop being a baby" whilst D1527 was crying and screaming on the floor following the chokehold assault"[359]

116. This sort of indifference shown by Dix, Loughton and Francis to D1527's vulnerability, mental illness and harm in use of force incidents was similar to that of DCM Chris Donnelly, another officer still employed at Brook House. In his live evidence on 23 February 2022, Mr Donnelly accepted delaying cutting down D865 who was ligaturing in a suicide attempt on 4 July 2017.[360] In a separate incident on 13 May 2017, he was also recorded saying the following to D687 in a use of force incident when D687 was ligaturing: *"Then we'll wait a minute until you pass out and we'll cut you down"*.[361] He was also recorded during a control and restraint against D1853 on 11 June 2017 stating: *"It doesn't matter about razors mate, swallow as many as you want."*[362]

117. Staff indifference and a failure to consider mental illness and vulnerability when deciding to use force appeared to be endemic and in his live evidence on 30 March 2022, Jon Collier confirmed that there was a failure within the national use of force manual and training scheme to teach on the consideration of vulnerabilities relating to mental illness or a history of trauma or torture. When asked why it was a failure, he responded: *"A. Because, obviously, it's a very sort of specific area, and I think it's probably the one -- well, one of the areas where staff can't really -- sometimes can't relate to it, having never experienced it, so it's an understanding of what people have gone through, how they experience it, what the long-term effects of it are as well, which I don't think -- you know, if you've had no education, you've had no guidance, you wouldn't be able to understand that and you would be unaware of it as well."*[363]

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[356] KENCOV1012 – V201705040022 clip 2 – TRN0000005_0001
[357] KENCOV1012 – V2017050400027 – TRN0000099_0044
[358] KENCOV1007 – V2017042500020 – TRN0000001_0008
[359] KENCOV1007 – V2017042500021 – TRN0000002_0009
[360] Chris Donnelly 23 February 2022, 115/11-12, 116/3-9
[361] KENCOV1016 – V2017051300011, TRN0000095_0033
[362] UOF147.17 BWC
[363] Jonathan Collier 30 March 2022, 140/15-24

118. Lessons have clearly not been learnt by the Home Office and it's contractors from the Article 3 breaches cases considered in Shaw 1 where in *HA*[364] and *D*[365] segregation and force to transfer to segregation was a feature of the finding of a breach of Article 3 in the context of deteriorating untreated mental illness.

Themes identified by the Inquiry's expert Jonathan Collier

119. In addition to the concerns above, we believe that the review of instances of use of force by Jon Collier has raised several concerning and recurring themes in relation to how force was used during the relevant period. In his live evidence, Mr Collier confirmed that most of the incidents he reviewed caused him concern.[366] What is additionally concerning is that almost all of the instances of unjustified and unlawful control and restraint discussed by Mr Collier in his live evidence were led by managers who still work at Brook House and who are highly likely to have carried on their concerning practices after the Relevant Period and still likely to be doing so now – these include Steve Dix, Steve Loughton, Dan Haughton, Chris Donnelly, Share Farrell, Ben Shadbolt, Dave Aldis and Stewart Povey-Meier. We refer you to the enclosed **Annex 2** which details the involvement in Article 3 mistreatment during the Relevant Period of staff members still working at Brook House for Serco.

120. In addition to the individual instances of unjustified, excessive and disproportionate force he identified, the recurring themes Mr Collier picked up were common to the excessive and unlawful force used on CPs such as D1527, D1914, D1538 and D1851. They included:

i. Not using force as a last resort;
ii. Using force for disciplinary removal in medical cases;
iii. Unjustified or unlawful application of use of force techniques (including pain-inducing techniques);
iv. Engendering a toxic masculine culture;
v. Collusion and cover-up of force;
vi. Inappropriate use of full PPE which only heightened the anxiety of force being used on mentally unwell individuals.

i. Not using force as a last resort

[364] *HA (Nigeria) v SSHD* [2012] EWHC 979– DL0000178
[365] *D v SSHD* [2012] EWHC 2501 – DL0000179
[366] Jonathan Collier 30 March 2022, 9/21-25, 10/1-10

121. In his first report, Mr Collier expressed concerns of the DCMs leading control and restraint not knowing *"how to de-escalate and exploring all other reasonable options before using force as a last resort."*[367] D1914's restraint on 27 May 2017 to move him to Rule 40 in advance of his flight was identified as a prime example of this with Mr Collier finding at paragraph 120 of his first report that: *"Using force was not the last resort as there was ample opportunity to continue with dialogue and engage with D1914. His flight was not until the next day and if they did not want to risk any attempts at postponing his removal they could have continually engaged and observed him."*[368] The incident involving D1851 and D390 was also identified by Mr Collier noting that *"Further engagement should have been made before resorting to using force. Force was not used as the last resort."*[369]

122. Further examples were identified by Mr Collier in his live evidence. For example, he noted that DCM Steve Loughton only attempted to negotiate with D149 for 100 seconds on 31 May 2017 before directing his team of officers to restrain him to move him to the CSU, a negligible attempt at de-escalation especially given he was no obvious threat or risk to staff, as noted by Mr Collier.[370] Similar criticisms are made in respect of DCM Farrell's negotiations with D2416 on 11 April 2017 which lasts only 26 seconds, despite the fact it was clear that D2416 was asleep when officers arrived and still trying to comprehend what was happening.[371] Mr Collier also stressed the need for greater de-escalation and negotiation time for those with mental health issues and the importance of using force only as a last resort: *"A. Yes. If someone has got a known medical condition and staff are aware of that, then I think there's a different strategy to be employed. As you say, it could be taking longer, it could be a different way of putting the points across. So asking questions in a slightly different way so that that person is more understanding of what's being asked of them. So I think it's important to understand that there's a wide range of skills and that it shouldn't be that staff just have a one go-to kind of method of resolving or engaging."*[372]

ii. Using force for disciplinary removal in medical cases

123. In his live evidence, Mr Collier set out concerns about using control and restraint in the normal disciplinary way for those requiring greater attentions or observations to manage medical issues. Mr Collier noted that: *"In my opinion, it's far harder to justify using force for someone who is being moved for a medical reason than it would be for somebody who*

[367] First Report of Jonathan Collier dated 14 January 2022, paragraph 636 – INQ000111_0145
[368] Ibid, INQ000111_0032
[369] Ibid, paragraph 260, INQ000111_0064
[370] Jonathan Collier 30 March 2022, 34/24 – 35/8
[371] Jonathan Collier 30 March 2022, 67/16- 68/1
[372] Jonathan Collier 30 March 2022, 146/6-15

is offering a threat to the establishment or threats to staff".[373] D1914 is a key example given by Mr Collier. However it was clear that staff did appear to be (wrong and unlawfully) using force for disciplinary reasons (moving to Rule 40 to facilitate removal) as well as medical reasons, albeit Mr Collier's reasoning is clearly correct that D1914's medical concerns made it *'far harder to justify using force'*. It was Mr Collier's believe in D1914's restraint that: *"I would have expected healthcare to have had more part of the engagement, to maybe go in straight away with the DCM to carry out the observations, do all the necessary tests that they need to take at that stage, before they decided to move him."*[374] He was also highly concerned by the prior authorisation of Dr Oozeerally sanctioning use of force against D1914, noting: *"I'm not sure that's quite within the remit of a healthcare professional to say force can be used"* and that he had never seen any sort of letter like this before in the prison sector.[375]

124. Mr Collier likewise raised concerns in a similar medical case, a disturbing use of control and restraint by a team led by DCM Steve Dix to take D2159 to E-wing on 5 April 2017 because healthcare had concerns about his mental health and food/fluid refusal. They wanted to observe him greater in E-wing and Chrissie Williams (the clinical lead at Brook House) authorised force being used to transfer him.[376] Camcorder footage[377] of the control and restraint shows that D2159 was entirely passive, lying on his bed upon arrival and could not stand up on his own because he was so weak. In his live evidence, Mr Collier was highly critical of the unnecessary use of force to transfer him to E-wing – his concern including (a) sending in a full PPE team when Mr Dix should have gone in to check on him with healthcare; (b) the use of a shield; (c) the use of handcuffs; (d) using force techniques such as 'figure hour' holds and 'wrist locks' instead of simply assisting D2159 to walk; and (e) again failing to engage and negotiate with D2159 before using restraints.[378]

iii. Unlawful and/or unjustified application of use of force techniques

125. Mr Collier also identified staff applying various restraint techniques wrongly or without justification, and in some instances using restraints that had been removed from the use of force manual because they were unlawful and dangerous.

126. This included inappropriate use of pain-inducing techniques, the clearest example being the use by DCM Michael Yates against D1527 of a thumb flexion/lock on 4 May 2017

[373] Jonathan Collier 30 March 2022, 113/14-17
[374] Jonathan Collier 30 March 2022, 128/8-12
[375] Jonathan Collier 30 March 2022, 129/3-15
[376] CJS007001_0001
[377] S1970002
[378] Jonathan Collier 30 March 2022, 117/4 – 121/20

when transferring him to segregation by force. DCM Yates' explanation is his use of force report was that D1527 was "*struggling and pushed his way to the wall*"[379], falling well short of the requirements for being able to justify this exceptional technique, i.e. if the only viable and practical way of dealing with a violent incident that poses an immediate threat of serious physical harm to officers or others. Mr Collier would Mr Yates' explanation to be entirely unjustified based on the risk at the time. He found: "*there is very little to state or to justify why that decision was made. But also why the supervising officer didn't record it in their report, why it wasn't reported there and why it wasn't address by the supervising officer about why staff felt it necessary to use that technique.*"[380]

127. In respect of other CPs, Mr Collier had serious concerns about how DCO Dave Webb (a use of force instructor) described how to use a shield in the build-up to the control and restraint against D1914, noting that the use of the 'bladed edge' referenced by DCO Webb was so dangerous that it could cause injuries at "*the most extreme*" including potentially a fatality.[381]

128. Mr Collier also had concerns about the application of handcuffs of detainees in a seated position, a technique that was outlawed and removed from the use of force manual in 2015 following the death of Jimmy Mubenga following restraint by G4S officers, but which G4S officers continued to apply at Brook House during the Relevant Period including against D1234 on 28 March 2017 (led by Steve Dix) [382] and D2054 on 28 June 2017 (led by Dave Aldis and Ben Shadbolt)[383]. Mr Collier was highly critical of such a technique being used given the fact it was removed from the manual owing to the danger to life and its role in the death of Mr Mubenga.[384]

129. However the starkest example of various inappropriate, unjustified and unlawful techniques being applied during a control and restraint can be seen against Duncan Lewis witness D149 on 31 May 2017 in an operation led by DCM Steve Loughton. This involved an attempt to relocate D149 by force to the CSU after he was accused of attempting to steal an officer's keys. This planned removal was highly dangerous, involved the deliberate, unnecessary and excessive infliction of pain on D149 outside use of force approved techniques, and, according to Mr Collier, could have led to D149's death.[385] Firstly, staff applied handcuffs incompetently such that the carry could not be performed properly and

[379] CJS005530_0018
[380] Jonathan Collier 30 March 2022, 135/22-25- 136/1-2
[381] Jonathan Collier 30 March 2022, 123/5 – 124/24
[382] HOM002496
[383] CJS005574
[384] Jonathan Collier 30 March 2022, 51/24-25, 52/1-25, 53/1-12
[385] Jonathan Collier, 30 March 2022, 44/8-18

application of pain not be controlled.[386]. Mr Collier explained that the incompetent application of handcuffs meant that pressure was created through D149's wrists just through application (before any deliberate pain techniques), pushing his elbows out and the arms away causing pressure on the outer side of the cuffs and therefore his wrists.[387] This caused D149 pain, as he made clear during the use of force by his screams, which apparently fell on deaf ears.

130. Secondly, Mr Collier was highly critical of the maintenance of D149 in a prone position for such a long time, which he found was a medical risk, potentially injurious and could have produced a fatality.[388] This position can lead to asphyxiation, a risk increased by the fact that D149's hands were behind his back.[389] Mr Collier explained that this position has, in other situations, led to death.[390]

131. Thirdly, Mr Collier identified a failure of the officers to give warnings before the application of pain inducing techniques. None of the warnings required before such application were provided to D149.[391] DCO Dave Webb acknowledged in his evidence that using pain techniques without an initial warning means you are "inflicting pain for no *reason*".[392] Further, Mr Collier explained wrest flexion on a cuffed person should only be used in extreme circumstances – not a case of someone refusing to be moved such as this one.[393] He concluded deliberate infliction of pain on D149 was not appropriate.[394] Fourthly, leg restraints were applied incorrectly. Mr Collier explained this resulted in unnecessary pain and discomfort to D149, and could have resulted in possible injury.[395]

132. That the officers involved in this restraint were aware of the severe pain caused to D149 during this restraint, which he vocalised throughout by screaming in pain,[396] is made clear in DCO Dave Webb's comment the following day, bragging to colleagues that he hurt D149's arm so severely that his screams could be hurt in other parts of the IRC[397] - *"I fucking hurt... big time. When I put him in a straight hold... in the officer downstairs heard him screaming... if you're going to be a fucking dick it's going to hurt innit".*[398] Mr Collier

[386] INQ000158_0060.
[387] Jonathan Collier 30 March 2022, 35/25 – 37/10.
[388] INQ000111_0024-28.
[389] Jonathan Collier, 30 March 2022, 41,22/42/4; 44/2-18.
[390] Jonathan Collier, 30 March 2022, 44/8-18.
[391] INQ000111_0027.
[392] David Webb, 3 March 2022, 160/17 – 25.
[393] Jonathan Collier, 30 March 2022, 38/2 – 39/17.
[394] Jonathan Collier, 30 March 2022, 39/18-20.
[395] Jonathan Collier, 30 March 2022, 43/12 – 44/1.
[396] See Disk 52 UOF 135.17 BWC.
[397] BBC000027.
[398] TRN000088_0020.

agreed that it appears DCO Webb was talking about the deliberate infliction of pain on D149, and that he was bragging about hurting D149.[399]

133. Healthcare failed to raise concerns during this restraint. The documentary records note that he suffered from reddened wrists and handcuff marks, and most likely suffered from soft tissue swelling.[400] The record of injury to a detainee stated he had markings / bruising to his wrists, blaming this on D149 resisting movement, rather than the incompetent use of force and in particular the incorrect application of handcuffs.[401]

134. There was also a complete failure in review and oversight mechanisms in relation to this incident. Mr Collier identified several examples of poor use of force techniques which could have resulted in injury to D149.[402] Despite this, DCM Steve Webb's subsequent review of the incident flagged no training needs or lessons learned.[403] Mr Collier was shocked at this, noting that staff clearly lacked the necessary experience in use of force. He explained that the staff incompetence made the situation a lot worse, and that governance and oversight systems are critical in identifying and remedying poor practice.[404] He warned that failure to provide additional training or identifying lessons learned from this incident meant a similar situation could have occurred which may have led to serious injury or death.[405]

135. The use of inappropriate and unlawful techniques during the Relevant Period were systemic, highly dangerous and a risk to life – the recklessness and regularity with which they were used goes towards a system that allowed them to be used routinely without challenge. All of the examples above were led and approved by senior and experienced officers still working at Brook House today – Steve Dix, Steve Loughton, Dave Aldis and Ben Shadbolt – and may well be continuing.

iv. Engendered a toxic masculine culture of violence and abuse

136. In Reverend Nathan Ward's statement, he describes the assaults and abuse as shown on *Panorama* as "*a gross manifestation of* [an] *institutional corrupt and toxic culture*"[406] which he experienced been 2011-2014 and which clearly prevailed in 2017. He continues:

[399] John Collier, 30 March 2022, 46/25 – 47/22.
[400] CJS000984.
[401] CJS004305_0001.
[402] INQ000158_0020.
[403] INQ000111_0024.
[404] John Collier, 30 March 2022, 29/23-30/16.
[405] INQ000111_0024.
[406] First Witness Statement of Nathan Ward dated 10 November 2021, Para 159, DL0000141_0055

"*... Whilst the footage inevitably focuses on a core group of staff, in my experience, it is likely the behaviour of staff was perpetuated by the system in which they were working in. It represents a system in which members of staff felt confident enough to take this action and even cover up outrageous abuse without repercussion... I do not believe from my knowledge that they could have conducted themselves in this way without the wider institutional culture of dehumanization and othering that was at play, which made this conduct accepted by many more staff.*"[407]

137. He gave evidence of a toxic-masculine and bullish culture, which he found the use of control and restraint as a prime example and even the training on it being a feature of such culture. Having noted his own experiences being trained by the National Tactical Response Group (NTRG) at paragraph 231, Reverend Nathan Ward sets out at paragraph 232-233 of his statement how the toxic masculine culture from national level filtered down to local G4S level at Brook House[408]:

"*... I witnessed staff being trained in degrading ways such as forcing them to dress up in boiler suits and helmets to do warm-ups, with press-ups if they made mistakes...*"

"*... I witnessed the visible adrenaline of certain staff who would regularly engage in C&R following the restraint. They seemingly enjoyed the adrenaline rush, and it was reflective of the alpha male attitude...*"

138. He found the training course overall for being a DCO was too focussed on C+R and that there was *"not a strong emphasis on alternatives based on de-escalation; Something I took issue with as I saw it as dangerous to encourage use of force as a first resort."*[409]

139. Reverend Ward's views accord with the evidence given by Dr Brodie Paterson in his witness statement dated 21 January 2022.[410] He sets out at paragraph 101 that "*The misuse of restraint, whether in the form of notionally approved techniques or various forms of violence, has been suggested to be a defining characteristic of a corrupted culture.*"[411] He gives the example of John Connelly, the local use of force instructor, and his use of extreme racist language in the stairwell on 17 May 2017 and bragging to other officers of his intention to assault the detainee they are waiting to use C+R on, and then cover up, at

[407] Ibid.
[408] Ibid at DL0000141_0082-0083
[409] Ibid at paragraph 236 – DL0000141_0083
[410] Witness Statement of Dr Brodie Paterson dated 21 January 2022 – BHM000045
[411] Ibid – BHM000045_0023

paragraph 103. He notes this to be *"indicative of a culture in which it appears the misuse of restraint to punish perceived infractions was endemic, modelled by those charged with promoting best practice including senior staff DCM and not challenged by others who witnessed it including both fellow DCO's or health care staff"*[412]

140. Dr Paterson then goes on to find at paragraph 104: *"The saturating effect of such cultures once developed may become so powerful that they redefine what staff would ordinarily interpret as abuse if not criminal behaviour as merely conformity (Leele and Gaile 2007). Newly appointed staff can come under significant implicit and sometimes explicit pressure not only to accept the inappropriate behaviour of other staff but to themselves engage in institutionally sanctioned violence in order to be accepted and trusted."*[413] Such a culture here is probably most well illustrated by the claims of DCO Kalvin Sanders in his live evidence on 4 March 2022 that he did not assault D1527 on 24 April 2017 but instead only bragged about doing so to fit in:

> *"A. ... what the truth is, you know, the comments I made to the DCOs were just my attempts trying to fit in. Of course, what the notes don't say is that the conversation before what I said was -- all led up to the recent C&Rs that everyone had done. Being new there, obviously, you know, I was just trying to sort of fabricate some story in which, you know, it would make me seem more interesting to them, you know? Being on a constant was the only sort of time that would -- it's close to anything that they had done, you know.*
> *Q. But, first of all, it wasn't a control and restraint, was it, it was a constant observation, so the story you're telling has nothing to do with C&R because it was a constant observation?*
> *A. Yeah, but -- I know, that's what I'm saying, but it's the closest, like -- what I said wasn't even true. You know, I didn't do anything. You know, it was just like -- it's a lie that I made up just to try and get people to like me, you know? I understand it's a mistake now, but what's done is done. I can't change that."*[414]

141. Other examples of this include:

i. Ed Fiddy and Joe Marshall on 13 August 2017 discussing the playback of C+R that Joe Marshall was involved in and laughing and joking how the detainee (likely D52) was screaming from the force: *"[Joe Marshall]: And all you can hear on the boy cam is just - , its fucking unbelievable. I pissed myself, most*

[412] BHM000045_0023-0024
[413] BHM000045_0024
[414] Kalvin Sanders 4 March 2022 124/20-25 – 125/1-15

unbelievable screaming… I know it sounds horrible, it sound really horrible. But I found that quite funny… [Ed Fiddy]:… I hate it when there like, 'I'm resisting, I'm resisting' I'm like shut the fuck up"[415]

ii. Sean Sayers feeling comfortable bragging about his assault of D313 to Ryan Bromley and Callum Tulley on 15 June 2017. In response to being told this, DCO Bromley's only response was to ask whether Mr Sayers had a "good team", i.e. would they help cover up his actions, to which Mr Sayers responded: *"No that's why I did it on my own."*[416]

iii. Dan Small gave a witness statement and live evidence to the Inquiry. He was one of the DCOs present on 17 May 2017 when Use of Force Instructor John Connelly was using racist language and bragging about his intention to assault a detainee. DCO Small recalls of this in his witness statement of 10 February 2022 at paragraph 45: *"I do not recall the exact words used by DCO Connelly but he told us that we were going to drag him around the corner and, essentially, beat him up. DCO Connelly had conducted our C&R training, and so was the senior officer with regard to C&R — it was an extremely uncomfortable situation and I was scared about what was going to happen. I categorically would not have carried out the actions he was suggesting, but Brook House was not an environment in which you could directly challenge a more senior officer without being labelled a "grass"."*[417] When asked about examples of being filmed himself making racist comments and his comment that Brook House had made him racist, Mr Small noted at paragraph 23: *"I believe I would have been referring to the fact that I had never made any racist remarks until I became a DCO at Brook House and witnessed the casual use of racist language by those around me, including some managers, on a daily basis. As an impressionable and emotionally immature young man, I felt subject to peer pressure to adopt this language and behaviour in order to impress colleagues. Now five years later, this causes me a great deal of shame."*[418]

142. Reverend Ward also sets out at paragraph 233 that he *"witnessed the visible adrenaline of certain staff who would regularly engage in C&R following the restraint. They seemingly enjoyed the adrenaline rush and it was reflective of the alpha male attitude."*[419] This

[415] KENCOV1023 (TRN0000030_0015)
[416] KENCOV1036, V2017061500019 CLIP 3, TRN0000093
[417] Witness Statement of Daniel Small dated 10 February 2022, BDP000003_0015
[418] Ibid at BDP000003_0008
[419] DL0000141_0083

accords with Dr Paterson's views that there was a culture at Brook House in which C+R was not used by staff as a last measure or resort, but for their own purposes: *"An institution in which the distress of others was the source not of concern but of humour. In which it was responded to not with compassion but derision and hostility. A number of staff seemed intent not on avoiding conflict but instead on engineering it in order to provide an excuse to use restraint in order to cause pain or to punish those evidencing distress... Such language, attitudes, and behaviours are clear evidence of a corrupted or toxic culture. Irrespective of the original root cause of the misuse of coercive measures, if such misuse is sustained over time such patterns of 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 "the way things have always been done around here" (Bloom, 2006a:32). The problem is not one of bad apples it is of a rotten barrel (Farquarson 2004)."*[420]

v. Collusion and cover-up

143. A further manifestation of this toxic and corrupted culture was that officers colluded in covering up use of excessive force. The most egregious example of this can be seen in respect of the chokehold incident against D1527 on 25 April 2017. That collusion served to exacerbate and heighten the breach of Article 3 mistreatment in that instance and is one of many factors that made that incident cross the threshold to be considered an act of torture. However the evidence disclosed to the Inquiry has confirmed that it was far from a one-off and there are several other examples of officers colluding and covering up evidence of force or colluding to provide greater justification for force than was in reality. Examples can be seen in uses of force incidents involving CPs D1538 and D1851.

144. D1538 was subject to excessive and unjustified force by DCM Shane Farrell in the arts + crafts room on 6 June 2017 after D1538 assaulted by D197.[421] Seemingly unaware initially that D1538 was the victim, officers entered the room and seeing that D1538 was visibly upset and angry, Mr Bromley and DCM Nick London put D1538 in arm restraints. Despite them having D1538 under control, DCM Shane Farrell proceeded to use excessive and unnecessary force to grab hold of D1538's head. The excessive head grab (done twice) was secretly filmed by Callum Tulley.[422] Mr Bromley was later filmed by Mr Tulley discussing the incident: "*Callum Tulley: I saw Shane put his head down. Ryan Bromley: [appears to make a knowing grimace of disapproval] I don't know. But the thing is it was*

[420] BHM000045_0022 at paragraphs 96-97
[421] CJS005615
[422] KENCOV1031 – V2017060600011

in front of everyone."[423] A further filmed conversation between Mr Bromley and Mr Tulley took place on 10 June 2017 where Mr Bromley describes Mr Farrell's force on D1538 as excessive: *"He took his head clean off"*.[424] Despite clearly believing that Mr Farrell's use force was excessive, Mr Bromley failed to report him and concealed it in his use of force report: *"At this point for the safety of the detainee DCM Shane Farrell acted as head officer, to protect the detainee from throwing his head back and forth"*.[425] In a witness statement prepared with Serco, the current employers of both Mr Bromley and Mr Farrell, Mr Bromley stated at paragraph 124: *"I had no concerns at all about DCO Farrell's actions. DCO Farrell is an experienced officer and from memory he carried out the control and Restraint in accordance with procedure in a professional way. He took D1538's head in exactly the way he should have done. For this reason I can only assume that Callum Tulley was mistaken in either his recollection or conversation."*[426] Having been shown the footage and transcripts of KENCOV1031 and KENCOV1033 in his live evidence on 7 March 2022, Mr Bromley still maintained his support of his Serco colleague Mr Farrell, describing his actions as "*Textbook"* and stating that *"I still stand by my report. And if there was any concerns, I would have reported it immediately... I have no idea why I said that to Callum Tulley... I have no knowledge of that incident and this conversation between me and Callum"*.[427] This in fact appears to be a 'textbook' example of Michelle Brown's concerns of current Brook House covering for each other to 'close rank'[428].

145. Examples can also be seen in collusion and misrepresentation by officers in the use of force reports relating to the control and restraint incident involving D390 and D1851 on 5 June 2017. DCOs Ryan Bromley and Sean Sayers appeared to collude in both making the false claim that D390 failed to listen to instructions from DCO Sayers to comply.[429] The video footage showed this to be entirely untrue.[430] In his live evidence, DCO Bromley continued to deny that he colluded with DCO Sayers and would not directly address the fact that what he said in his report was untrue.[431] DCM Ben Shadbolt also lied and exaggerated claims in his use of force report stating that as D390 was boiling a kettle in his cell "*you could see a large amount of steam from outside the room"*.[432] The video footage again showed this to be entirely untrue with no steam visible. Mr Shadbolt repeated this lie

[423] - Transcript at KENCOV1031 – V2017060600020 -TRN0000089- but it is vital the Chair reviews the footage itself to see Mr Bromley's facial reaction
[424] KENCOV1033 – V201706100007 – TRN0000091_0006
[425] CJS005615_0015
[426] SER000434_0031
[427] Ryan Bromley 7 March 2017, 124/1, 125/18-25, 126/1-5
[428] Witness Statement of Michelle Brown dated 24 February 2022, paragraph 126, INQ000164_0059
[429] CJS005624_0021, 0026
[430] UOF 137.17(2) (1:20mins- 1:32 mins)
[431] Ryan Bromley 7 March 2022, 114-117
[432] CJS005624_0008

at paragraph 198 of his Serco-approved witness statement despite having seen the footage.[433]

146. Collusion and cover-up can also be seen in DCO Sean Sayers' assault of D313 discussed above. Despite confessing the assault to DCOs Bromley and Tulley on 15 June 2017, the assault was not reported and DCO Bromley in fact joked about whether DCO Sayers had a "good team", i.e. would they help cover up his actions, to which Mr Sayers responded: "No that's why I did it on my own."[434]

147. DCM Chris Donnelly also accepted he had covered up important evidence in respect of significant delay he caused in failing to intervene sooner to cut down a ligature around the neck of D865 who had attempted suicide on 4 July 2017. He had omitted the delay in his use of force report.[435] When it was suggested by CTI that it looked like a cover-up, Mr Donnelly replied "Possibly." He then accepted he did it "*because I didn't want to make myself look bad"* before conceding that it would not have been uncovered had it not been for Mr Tulley's undercover reporting.[436]

148. Mr Collier identified the further cases in his review where it appeared there were efforts by the supervising managers to cover-up instances of unlawful control and restraint:

a. A planned control and restraint on 22 May 2017 against D52[437] in which officers took D52 by force from a visits room to E-wing in preparation for his removal directions was heavily criticised by Mr Collier on various points including the lack of negotiation and de-escalation by the supervising officer, DCM Dave Aldis, but also the decision to use form in the confined visits room[438]. Officers stated force was initiated because D52 was non-compliant. BWC footage[439] shows officers used force without clear instruction from Aldis who was leading the restraint and 'negotiation' with D52. However what was most concerning was that the footage showed DCM Aldis intentionally covering up his BWC whilst officers used force against D52 to pin him down. Mr Collier was deeply concerned by this in his live evidence on 30 March 2022: "*The only thing I can think of was that someone has deliberately covered the camera. That's the only conclusion I can draw at that stage… it goes against everything that the use of body-worn video camera stands for: to gather evidence, to give a factual sight of what's*

[433] SER000441_0028
[434] KENCOV1036, V2017061500019 CLIP 3, TRN0000093
[435] CJS004312
[436] Chris Donnelly 23 February 2022, 126/11, 127/3-8
[437] CJS005620
[438] Jonathan Collier 30 March 2022, 164/7-25
[439] UOF129.17 BWC

actually happening, the events as they are happening. So it's almost as though it's obstructing that process."[440] In his second witness statement (after entirely failing to address it in his first statement) approved by his employers at Serco, Mr Aldis provided an entirely implausible and inconsistent account making references to 'twisted camera heads' and passing the camera to DCM Brackenridge which are both shown not to be true by the footage.[441]

b. A planned control and restraint led by DCM Steve Dix on 23 May 2017 to transfer D1978 to CSU under Rule 40 removal from association. The handheld camera footage[442] confirmed Mr Dix asked D1978 if he would walk compliantly. D1978 appeared to confirm he would and walked towards door. However staff charged into the cell with full PPE and restrained D1978. Dix can be heard initially saying 'no, no, no' but then does nothing to prevent it and does not allow D1978 to subsequently walk compliantly. Mr Dix subsequently lied in the de-brief video claiming that D1978 was non-compliant and encroached his space. Mr Collier was highly critical of DCM Dix and his attempt to conceal this in his de-brief: *"... that wasn't the truth, was it, what he said in the debrief? A. No, and it would bring into question his integrity."*[443]

c. In respect of a planned control and restraint led by DCM Shane Farrell on 11 April 2017 to hand D2416 to escorts for his charter flight removal,[444] Mr Collier challenged claims made by several officers in their use of force reports that D2416 was being disruptive: *"35. I question why the DCM insisted for the head support to be applied for moving down the stairs when D2416 was compliant, although he was verbally challenging but not offering a threat or risk at the time. There is nothing to support the comment in paragraph 422 that D3416 was trying to use his feet on the railings to disrupt the movement at this stage and D2416 only attempted this when on the stairs (not seen on footage due to decency but referenced momentarily at 07:27)"*[445] This false claim was made three separate officers in their reports – DCM Ben Shadbolt, DCO Neil Timms and DCO Ben Wright – meaning the only explanation could be one of collusion.[446]

vi. Inappropriate use of full PPE

[440] Jonathan Collier 30 March 2022, 166/10-12
[441] INQ000197_0001
[442] Disc 48, 20170523210142_E1606N_0013.MOV
[443] Jonathan Collier 30 March 2022, 89/11-13)
[444] CJS005630
[445] Second Supplementary Report of Jonathan Collier dated 17 March 2022, paragraph 35, INQ000177_0009
[446] CJS005630_0010, 0014 and 0019

149. The unnecessary and inappropriate use of full PPE was a common feature criticised by Mr Collier in his first report, raised in control and restraints such as D1914,[447] D149,[448] D2159[449]D1234,[450] and D2054[451]. He believed G4S had adopted it as a necessary and routine part of all planned intervention and that it was never removed when the situation de-escalated.

150. Mr Collier summarised at paragraph 650 of his first report: *"Not every planned intervention I observed required staff to wear PPE as the detainee offered little threat of violence and was simply not complying. Once the risk has been reduced there is little evidence of PPE being"*[452] The control and restraint incident involving D390 and D1851 on 5 June 2017 was a prime example of this. Neither offered any evidence of threat when the decision was taken for each team for D390 and D1851 to apply PPE (D1851 is not even mentioned in the video-recorded planning of the incident, let alone risk assessed).

151. The impact on D1851 of the incident on 5 June 2017 was profound and was exacerbated by the decision of DCM Povey-Meier to ask his staff to wear full PPE. D1851 explained in his witness statement: *""3... My detention at Brook House was a profoundly disturbing experience and has caused me significant mental harm having never previously suffered from any mental health condition before I was detained. I have been diagnosed with Post-Traumatic Stress Disorder (PTSD), anxiety and depression as a result of the period in detention, and my experiences at Brook House IRC, for which I am still being treated and which still affects me to this day. (DL0000143_0001)... "35... [On the 5 June 2017 incident] They were wearing dark clothes and a jumper which covered their name badge. They were also wearing a helmet which covered their whole face but their eyes. I would not be able to recognise them if I saw then again because the only part of them that I could see were their eyes. The way they were dressed in full kind of riot gear and with heavy-duty plastic shields was menacing and overwhelming. They were like the army and it was like some kind of military raid... 46. This had a huge impact on me because up until this point all of the difficulty I was facing was mental strife; in that the struggle was trying to keep a positive attitude in a very difficult environment. However, this took on a completely different aspect in that they had physically touched me, which added an additional fear of the officers. I had been physically assaulted without any justification. This was the first time in my life that I had been treated in this way. One has to understand that this type of experience, for someone who does not involve themselves in violent exchanges, is an*

[447] Paragraph 101, INQ000111_0029
[448] Paragraph 84, INQ000111_0026
[449] Paragraph 127, INQ000111_0034
[450] Paragraph 141, INQ000111_0038-0039
[451] Paragraph 310, INQ000111_0077
[452] INQ000111_0151

extremely stressful situation to be in. I cried a lot after this. I did not feel safe in my cell anymore and I already did not feel safe outside of it (gangs in detention, violent criminals, drugs, violence amongst detainees, conditions in the detention centre)."[453]

152. D1851's evidence shows that this routine use of full PPE adds to the terror of control and restraint incidents to detainees and it's clear that it has a profound impact on detained persons, many of whom have a history of mental illness, trauma and torture.

(v) Misuse of Rule 40 and Rule 42

153. On a daily basis detainees were removed from association and held in temporary confinement on E -Wing and in the CSU. Sometimes paperwork was completed which purported to authorise these removals pursuant to rules 40 and 42, sometimes they were just taken there *de facto*. In either case it was extremely rare that these powers were used lawfully or appropriately. The practice by which removal from association and temporary confinement were deployed was routine blunt management tool that was arbitrary and was frequently without lawful authority or justification. It was a direct consequence of the systems failures in detention policy leading to high numbers of mentally ill people in detention with no effective means to treat their medical needs and prisonization. Removal from association was frequently the occasion for use of force and E Wing was the context in which physical mistreatment and abuse occurred (although by no means exclusively). In itself segregation particularly for the mentally ill is harmful. This uses and misuse of the segregation power was a key feature of the wider inhumanity of the environment and in the inhuman and degrading treatment in individual cases.

154. In analysing whether there were breaches of article 3 in individual cases, and the DL CP's submission that the environment was liable to render anyone detained exposed to an inhuman environment, a central question for the inquiry is, whether the suffering went "*beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment*". To answer that, it is necessary to understand whether "treatment or punishment" was "legitimate". That involves an understanding of whether the detention itself was unlawful, and if it was not, whether treatment within the detention was lawful or not. The simple answer is that the vast majority of uses of rule 40 and 42 were not legitimate: they were not lawful or justified:

[453] DL0000143_0001, 0009, 0012-0013

i. With only a handful of exceptions, every use of rule 40 and 42 was not authorised by a person with authority to remove a person from association or to confine them.
ii. They were also not lawful because the powers were misused: they were used as "consequences" or "repercussions" for behaviour (which is not what they were authorised for) or as a misconceived and inappropriate mechanism for controlling detainees.
iii. The Inquiry has also heard evidence of the deployment of rule 40 or 42 treatment for the administrative convenience, for example ahead of a removal the following day. That was also a misuse of the powers.
iv. There is also a more substantial but more subtle misuse of the powers in that in truth what was being done was to use those methods in an inapt attempt to manage people who were not properly understood or recognised to be mentally ill. That should have been a primary consideration in deciding whether to use those powers because the likely impact of subjecting a mentally ill person or a suicidal person to that treatment was to exacerbate the suicidality and mental illness.

(i) Lack of Authority for the Use of the Rule 40 and 42 Powers

155. Analysis of the use of rule 40 and 42 exposes outlawry in Brook House of an extraordinary scale. Almost anybody who was subjected to rule 40 or rule 42 was subjected to that violent, terrifying and humiliating treatment including a strip search unlawfully. That unlawfulness is critical to the question of inhuman and degrading treatment with which the Inquiry is centrally charged because the question is whether the treatment went "*beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment*"[454]. In *Keenan* the ECtHR found a breach of article 3 in the context of a *lawful* disciplinary punishment by segregation at the end of a four-month sentence against a background of a lack of psychiatric input, defects in medical care, and known suicide risk.

156. In Brook House people were also, as in Keenan's case, suffering defects in medical care, a lack of psychiatric input and known suicide risk. However, the position in Brook House was worse because the safeguard against inhuman treatment is that people in such circumstances should be released from detention (unlike persons subject to a lawful sentence imposed by a court). Furthermore, and critically, unlike *Keenan* detainees at Brook House subjected to rule 40 and 42 were not subjected to it lawfully. and were therefore exposed to a form of humiliation and suffering beyond the inevitable element of

[454] *Kudla v Poland* (2000) 35 EHRR 198

suffering connected to the inevitable suffering in detention. The widespread unlawful, unregulated and unmanaged use of rule 40 and 42 is now addressed in further detail.

157. Rules 40 and 42 provide respectively (emphasis supplied):

> **40.**—(1) Where it appears necessary in the interests of security or safety that a detained person should not associate with other detained persons, either generally or for particular purposes, **the Secretary of State** (in the case of a contracted-out detention centre) or the manager (in the case of a directly managed detention centre) may arrange for the detained person's removal from association accordingly.
>
> (2) **In cases of urgency, the manager** of a contracted-out detention centre may assume the responsibility of the Secretary of State under paragraph (1) but shall notify the Secretary of State as soon as possible after making the necessary arrangements.
>
> (3) A detained person shall not be removed under this rule for a period of more than 24 hours without **the authority of the Secretary of State.**
>
> (4) An authority under paragraph (3) shall be for a period not exceeding 14 days.
>
> (5) Notice of removal from association under this rule shall be given without delay to a member of the visiting committee, the medical practitioner and the manager of religious affairs.
>
> (6) Where a detained person has been removed from association he shall be given written reasons for such removal within 2 hours of that removal.
>
> (7) The manager may arrange at his discretion for such a detained person as aforesaid to resume association with other detained persons, and shall do so if in any case the medical practitioner so advises on medical grounds.
>
> (8) Particulars of every case of removal from association shall be recorded by the manager in a manner to be directed by the Secretary of State.
>
> (9) The manager, the medical practitioner and (at a contracted-out detention centre) an officer of the Secretary of State shall visit all detained persons who have been removed from association at least once each day for so long as they remain so removed.
>
> **Temporary confinement**
>
> **42.**—(1) The Secretary of State (in the case of a contracted-out detention centre) or the manager (in the case of a directly managed detention centre) may order a refractory or violent detained person to be confined temporarily in special accommodation, but a

detained person shall not be so confined as a punishment, or after he has ceased to be refractory or violent.

(2) In cases of urgency, the manager of a contracted-out detention centre may assume the responsibility of the Secretary of State under paragraph (1) above but shall notify the Secretary of State as soon as possible after giving the relevant order.

(3) A detained person shall not be confined in special accommodation for longer than 24 hours without a direction in writing given by an officer of the Secretary of State (not being an officer of a detention centre).

(4) The direction shall state the grounds for the confinement and the time during which it may continue (not exceeding 3 days).

(5) A copy of the direction shall be given to the detained person before the 27th hour of the confinement.

(6) Notice of the direction shall be given without delay to a member of the visiting committee, the medical practitioner and the manager of religious affairs.

(7) Particulars of every case of temporary confinement shall be recorded by the manager in a manner to be directed by the Secretary of State.

(8) The manager, the medical practitioner and (at a contracted-out detention centre) an officer of the Secretary of State shall visit all detained persons in temporary confinement at least once each day for as long as they remain so confined.

158. While the rules appear to limit authority for rule 40 and 42 to the Secretary of State, functions of the Secretary of State may be delegated to an immigration manager or contract monitor, as confirmed by the Court of Appeal in *TM (Kenya) v SSHD* [2019] EWCA Civ 784. By letter dated 22 February 2022, the Secretary of State confirmed that her authority was delegated to her Contract Monitor in the relevant period, Paul Gasson[455].

159. In the case of urgent use of rule 40 and 42, "the Manager" may assume the role of the Secretary of State and authorise their use. It is also possible for a contractor to submit a scheme of delegation to the Secretary of State by which the functions of the manager could be delegated to others as well, upon approval by the Secretary of State. On 4 April, the last day of evidence to the Inquiry, the Home Office confirmed that there was no scheme of delegation under rule 65 of the Detention Centre Rules 2001[456].

160. The legal position is therefore:

[455] HOM0332162

[456] Philip Riley 4 April 2022 84/23-25, 85/1, confirming Home Office letter of 28 March 2022 (HOM0332161)

i. Rules 40 and 42 could be authorised by the Secretary of State. The Secretary of State did not personally authorise any use of rule 40/42. The Secretary of State has said in correspondence from the Government Legal Department dated 22 February 2022, that she delegated that function to her Contract Monitor whom she identified as Mr Paul Gasson.

ii. In cases of urgency "the Manager" as defined by section 148 of the Immigration and Asylum Act 1999 (who was identified as Ben Saunders) could assume the responsibility of the Secretary of State and authorise rule 40 and 42 provided he informed the Secretary of State as soon as possible. There is provision in rule 65 allowing for a scheme of delegation for "the Manager" to delegate any of their powers and duties under the Detention Centre Rules to another officer, including of that function where the scheme is approved by the Secretary of State.

161. According to the law therefore, at most only Paul Gasson and Ben Saunders could authorise rule 40 and 42 in the relevant period. Ben Saunders did not in fact authorise any uses of those powers. The Home Office has said in correspondence that from 25 October 2016 until 17 July 2017, the scope of the power to authorise rule 40 and 42 was defined by what it called "Detention Centre Rules 40 and 42: Interim Instruction" which stated that "Authority for the initial use of Rule 40 or 42 must be granted by an appropriate Home Office Immigration Enforcement Manager of EO grade or above in the first instance".[457] The effect of the Interim Instruction was to limit the power to authorise rule 40 and 42 to Home Office officials and not G4S even in cases of urgency. As above, that is perhaps not material because Ben Saunders in fact did not purport to authorise any use of rule 40 or 42 (according to the data in respect of 146 incidents disclosed as summarised in the DL table appended as **Annex 3**). It does show, however, how jealously guarded and what a significant step the use of those powers was seen to be both by the legislature in tightly regulating who could use them and – at least at an executive and policy level- by the Home Office who reserved the power to itself and who did not permit delegation of the powers to junior G4S officials.

162. There should in the relevant period up to 17 July 2017 accordingly have been no use of rule 40 or 42 without authority from Home Office officials, or at best its use should only have been authorised by Ben Saunders personally in cases of urgency. The Home Office has explained at paragraph 10 of its letter of 22 February 2022 that from 18 July 2017 DSO 02/2017 paragraph 40 applied: "*In normal circumstances, any use of Rule 40 or 42, for an*

[457] HOM0332163

initial 24 hour period must be authorised by a manager (Executive Officer or above) from the Compliance Team in a contracted out centre."[458] This is a reference to normal circumstances being that removal from association should be authorised by the Home Office. The Home Office goes to quote from paragraph 41 of the DSO that stresses that G4S (which in the absence of a scheme of delegation meant the Manager Ben Saunders) would only have been able to authorise *"[i]n cases of urgency, and if the circumstances are such that it is impracticable to seek the authority required in paragraph 40 in advance."*[459]

163. The DL CPs have analysed the paperwork of every use of rule 40 and 42 in the period that has been disclosed and tabulated that in the Excel table submitted to the inquiry on 5 March 2022. Of 146 incidents, 4 were given initial authorisation by Paul Gasson and in one case he gave authorisation to an extension beyond 24 hours. None were authorised by Ben Saunders. Accordingly, 141 of the 146 uses of rule 40/42 were without lawful authority.

164. The law is already clear and established that a lack of appropriate authorisation would make a Rule 40 decision unlawful – see *Muasa v SSHD* [2017] EWHC 2267 (see para 71), as subsequently confirmed by the Court of Appeal in *TM (Kenya) v SSHD* [2019] EWCA Civ 784. As stated by Holman J in *Muasa*: "*70... To argue that the absence of the required authorisation is merely "procedural" or "technical" is indeed to treat the authorisation as a rubber stamp. It is not. The requirement of authorisation by the Secretary of State independent of the manager or management of the centre is clearly a fundamental safeguard under rule 40.*" Anybody other than Mr Gasson who purported to remove a detainee from association or to confine them temporarily was acting without any legal power to do so and committing a heinous tort, including assault and other trespasses to the person. Given the evidence that such actions were usually accompanied by serious violence and humiliation including strip searches, the picture which emerges is of repeated lawless violence every day of the relevant period, with most of it perpetrated against the most vulnerable people.

The Evidence of Understanding of Rule 40 and Rule 42

165. At the request of the DL CPs a number of witnesses were asked about the use of Rules 40 and 42 and the process and levels of authority for that treatment. The picture which emerges is that there was no consistency of understanding; nobody in Brook House appreciated the legal position; and nobody in the Home Office or anywhere else sought to enforce or monitor the proper use of those powers. To allow such violence to go unchecked

[458] HOM0332162_0004
[459] Ibid.

and unregulated was a catastrophic failure of management and direction by the Home Office. True, it had sent out its Interim Instruction in October 2016 which made clear that G4S was not to authorise any uses of rule 40 and 42 and on 18 July 2017 issued its DSO and true it did not agree to any delegation of the powers. But that was at a level of paperwork: these instructions were not implemented and the Home Office paid no heed to whether the pieces of paper were understood or obeyed. Paul Gasson in his live evidence wrongly believed the Home Office were authorising in the majority of cases, i.e. other than cases where deemed urgent.[460] It is to be wondered whether the Home Office believes important laws and directions should somehow take effect upon the utterance of magic words rather than by executive implementation, practical guidance, monitoring and management. This tendency to believe that sending pieces of paper will remediate failure was seen on 1 April 2022 in Mr Riley's attempt to head of criticism of decades of failure in the rule 34 and 35 system by sending a letter to medical services reminding them to comply with the law.[461]

166. Sarah Newland (a Duty Director)'s evidence was the high point in demonstrating an understanding of rule 40 and 42. Her evidence was:

> "*In terms of who authorised the use of rule 40, it would have sat at the duty director level for something that wasn't as a result of a spontaneous incident. So rule 40 enables the contractor to take urgent action, you know, as a result of perhaps a physical fight, but any planned use of it that wasn't sort of in urgent circumstances had to be agreed with the Home Office.*"[462]

167. Leaving aside the interim instruction, and subject to the qualification that at least up to 17 July 2017 and arguably thereafter "Duty Director level" should have been only "the Manager" – namely Ben Saunders - that is the only approximately accurate description of the legal position given in evidence by anyone who worked at Brook House.

168. Ben Saunders, the Manager and only G4S employee who was in a position to authorise rule 40 and 42, led the chaos and lawlessness from the top. He does not appear to have understood that he was responsible for authorising urgent use of rule 40 and 42. His evidence on 22 March 2022, was that "*typically the duty manager or the duty director*"[463] could authorise rule 40… "*My understanding is that DCMs did, with consultation with a duty director*"[464]. His understanding was wrong. It is curious that he did not understand the

[460] Paul Gasson 15 March 2022, 204/2-7
[461] HOM0332160
[462] Sarah Newland 21 March 2022, 212/7-13
[463] Ben Saunders 22 March 2022, 185/17-18
[464] Ibid 186/4-5

position, where Sarah Newland (at least broadly, did). His understanding was also not consistent with the practice in the overwhelming majority of cases. He was taken to the PSU investigation dated 30 July 2018 of complaints made by D1538, which included a complaint that he had been improperly removed from association on 3 June 2017.[465] Despite not substantiating D1538's complaint of wrongful use of Rule 40, the Home Office investigating officer did raise concern regarding G4S wrongly using the 'urgency' procedure when there was sufficient time to obtain authorisation from the Home Office.[466]

(ii) Use of Rule 40 as "Repercussions" or "Consequences"

169. It is clear from the evidence given by those working at Brook House that rule 40 was routinely used as a measure of consequence for perceived 'behaviour'.

170. Steve Dix deserves particular censure in this regard because he was a DCM responsible for many unlawful uses of rule 40. From the disclosure to the inquiry he 'authorised' rule 40 or rule 42 on 13 occasions[467] and was involved in several more, particularly those authorised by Nick London during the relevant period, all of them unlawful. He has since been promoted to assistant manager and his evidence showed that he remained unaware of the proper use of rule 40 and 42. His repeated misuse of rule 40 reflects both a misuse of power on an individual level and also an institutional failure: one to which he himself adverted in noting that he had never had any training on how to use rule 40 and 42.[468] His belief as to the nature of his powers was also explored:

> *"19 Q. On what basis do you regard yourself as having the*
> *20 authority to authorise a removal from association?*
> *21 A.* ***So managers have the -- can authorise spontaneous use of***
> *22* ***rule 40. If you have time to be planned, then obviously***
> *23* ***it can go to the authority to authorise.***
> *24 Q. You say it goes to the authorities. Who do you mean?*
> *25 A.* ***The Home Office."***[469]

The idea that DCMs could authorise spontaneous use of rule 40 is simply incorrect. There was no rule permitting it and no scheme of delegation permitting that.

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[465] CJS003348
[466] CJS003348_0025-0026
[467] CJS001691 on 15 April 2017; CJS001664 on 16 April 2017; CJS001653 on 19 April 2017; CJS001717 on 19 April 2017; CJS001681 on 25 April 2017; CJS001649 on 28 April 2017;; CJS001026 on 4th May 2017; CJS002660 on 30 May 2017; CJS001673 on 5 June 2017; CJS001757 on 19 June 2017; CJS001732 on 17 July 2017; CJS001004 on 17 July 2017; CJS001734 on 29 August 2017;
[468] Steve Dix 9 March 2022, 4/13-18
[469] Ibid, 57/19-25

171. Further, Mr Dix's notion of "spontaneous" appears to have included planned removals from association. His evidence about his authorisation for removing D1527 from association on the 4th May 2017 exemplifies his misunderstanding, misuse and disregard of the law:

> *"14 Q. You said that he was calm, he went to a friend's room to*
> *15 calm down. Was he calm at that point?*
> *16 **A. At which point?***
> *17 Q. You said he removed himself, "after approximately*
> *18 30 minutes, he went to a friend's room to calm down".*
> *19 When you first saw him in that room, when you went to go*
> *20 and see him, had he calmed down?*
> *21 **A. I can't overly recall his state of mind or whether he***
> *22 **was calm or not when I spoke to him.***
> *1 **A. At the time, obviously, when someone is on the netting,***
> *2 **then obviously the procedure was for them to go to***
> *3 **rule 40.***
> *4 Q. That was a procedure, was it?*
> *5 **A. Yes.***
> *6 Q. Where did this procedure come from? As in, who*
> *7 authorised this type of policy -- would you say it was*
> *8 a policy?*
> *9 **A. I'm not sure if it's a policy. It was, you know, due to***
> *10 **the fact of the level of disruption he caused on the***
> *11 **netting and the wing. You know, people that do that***
> *12 **generally go -- move to the E wing/CSU department."***[470]

172. Mr Dix's view that "obviously the procedure was for them to go to rule 40" is a complete mis-statement of the law and does not reflect any possible lawful or even good practice.

173. Of this approach, Dr Hard said:

> *"A. Yes. I don't see the logic of the risk management part of it because it feels like it was done almost as if there was nothing else to do, "So therefore we will do X", which*

[470] Steve Dix 9 March 2022, 55/14-22, 56/1-12

is to remove from association. It didn't appear to have a finite or understood purpose to me."[471]

"A. I don't know about a first resort, but it just seems to be the custom and practice in place that "That is what we will do next."

Q. Because they don't know what else to do?

A. Yes. Or that they have any other mechanisms, apparently."[472]

174. Mr Dix's consequential use of rule 40 is also inconsistent with his own claimed belief that he had authority to use rule 40 in spontaneous instances: his own records show that D1527 was calm and that the removal from association was on his part a planned consequence of going on the netting: Mr Dix went to the cell to find D1527 ready with a gang of accomplices to remove him from association in full knowledge that was the plan. His own records indicate as much (emphasis supplied):

- RFA decision: "*Detainee D1527 has been relocated to Care and Separation Unit on rule 40 after jumping on Delta Wing netting. Mr D1527 removed himself after approximately 30 minutes, he went to a friends room to calm down.* ***I spoke to Mr D1527 about his behaviour and the consequences of his actions,*** *he refused to comply with the instructions given."*[473]

- UOF report: "*Upon arrival I saw detainee D1527 on the first floor netting who was shouting in his own language and very irate. Mr D1527 refused to engage with any staff members really... A short while later I went back to that room to speak to D1527 about his actions he was frustrated with staff members but I tried to explain the reason they could not leave him alone was because of the way he was behaving. I explained due to his behaviour he would need to comply and go to the CSU on rule 40 he said "No"* ***I explained if he refused then potentially as a consequence of his actions force could be used..."***[474]

175. Rule 40 removal from association as a "consequence" of actions or behaviour is not legitimate. It must also be noted that other officers produced highly inconsistent accounts

[471] Dr Jake Hard 28 March 2022, 67/3-7
[472] Ibid, 164/11-16
[473] HOM000251_0002
[474] CJS005530_0008

and deployed pain-inducing techniques on D1527 speaks not to a confusion over the scope of rule 40, but to knowing misuse.

176. Paul Gasson, the person whom the Home Office says was their delegate and who therefore was personally empowered to authorise rule 40 decisions, also did not have a proper understanding of the process. His evidence was given on 15 March 2022. His evidence was that rule 40 could be authorised by G4S officers "*in matters of urgency, for example, where the officers had to react immediately because maybe they were being refractory, they were being violent, perhaps even self-harming... if there was, like for example, a fight... or even an assault on an officer*".[475] When pressed he said he believed a "*detainee custody manager*" could authorise rule 40 in cases of urgency.[476] He thought it was a delegated function that they were given[477]. That view, again, is not reflected in any document shown to the inquiry and is contradicted by the Home Office's own account in responses to rule 9 questions dated 22 February 2022 and 28 March 2022.[478]

177. Among those who had no idea of the purpose of rule 40 were the medical staff. Dr Oozeerally's evidence was that individuals on ACDT would often be managed on E-Wing[479]. No doubt that is true as a matter of practice,. E-Wing and Rule 40 were used as a system for managing the suicidal and the mentally ill, but that was never the proper function of them. Dr Oozeerally demonstrated no knowledge that it was not a lawful deployment of the powers to remove a person from association. He also showed no appreciation of the fact evinced in Brodie Paterson's evidence[480] (see below) that the fact that a person required management of self-harm or suicidality was a strong indicator that they ought to be released from detention (his neglected part in that being to complete rule 35(2) reports).

178. Ian Castle gave evidence on Day 31, 15 May 2022. His tenure was mainly after the relevant period, but his ignorance of the rule 40 process is nonetheless illuminating. Mr Castle considered that he, as Detention Area Manager, was responsible for authorising rule 40 extensions[481]. Yet he was not a Home Office delegate- the Home Office's own rule 9 response is that was Paul Gasson. Nor was he "the Manager" under statute. Nonetheless this was part of his job and he thought there might have been one or possibly two occasions when he had not simply rubber stamped an extension of rule 40 beyond 24 hours.[482] That blithe renewal of isolation for the detainees was in the context that his own view was that

[475] Paul Gasson 15 March 2022, 201/22-25, 202/5-7
[476] Ibid, 204/12
[477] Ibid, 224/18-20
[478] HOM0332161
[479] Dr Hussein Oozeerally 11 March 2022, 80/11-12
[480] BHM000045
[481] Ian Castle 15 March 2022, 33/4-6, 19-21
[482] Ibid, 36/19-25, 37/1-15

"*if you spend more than 24 hours in Brook House, you're going to develop mental health issues. It is not a nice place to be.*[483]" and that "*I can't disagree with the words that the IMB have said*" (referring to the IMB finding that the whole population was subject to inhumane conditions in 2020).[484]

179. Lower down the chain, the evidence of Nathan Ring on Day 19, 25 February 2022 shows that Mr Ring was asked, having mentioned it, about "punishment":

"13 Q. What punishment was available in the detention centre
14 for a misbehaving detainee?
15 A. ***It would depend on what they'd done, but rule 40.***
16 Q. That was it?
17 A. ***Yes.***
18 Q. Was it regarded as a punishment?
19 A. ***I don't -- personally for me, I don't think so, no.***
20 Q. Well, it is a word you used. I'm just interested why
21 you equate the word "punishment" with going onto
22 rule 40?
23 A. ***Repercussions, then, sorry, that's probably a better***
24 ***word. That would be the only repercussion. It's not***
25 ***a punishment as such."***[485]

180. The idea of rule 40 as "repercussions" is a misunderstanding of rule 40.

181. Sandra Calver concurred that officers held this misunderstanding of the function of rule 40 and its misuse. Her evidence was, on Day 21, 1 March 2022 as follows:

"14 Q. Did you think mixing these two groups of people on
15 E wing was appropriate?
16 A. ***It's not appropriate to mix vulnerables with people that***
17 ***are then refractory as well. Sometimes it eats into***
18 ***your space available. If you have a lot of refractories***
19 ***and they are extremely refractory, they would have been***
20 ***in the CSU area."***[486]

(iii) Rule 40 and 42 for Administrative Convenience

[483] Ibid, 38/16-18
[484] Ibid, 56/2-3
[485] Nathan Ring 25 February 2022, 18/13-25
[486] Sandra Calver 1 March 2022, 166/14-20

182. Sandra Calver also gave evidence of the use of rule 40 and 42 for the improper purposes of facilitating removals to an airport. Day 21, 1 March 2022, her evidence was as follows:

> *"10 Q. Was E wing regarded as a sort of informal segregation*
> *11 away from the wing? So not under the formal ways of*
> *12 rule 40 and rule 42, but informally taking them away*
> *13 from the normal residential wings?*
> *14 A.* ***I think the officers often -- if they knew that somebody***
> *15* ***had intended that -- had stated that they weren't keen***
> *16* ***to go on their flight, then sometimes they felt it would***
> *17* ***be easier to remove from a smaller area than to have***
> *18* ***to -- if their flight was at a time when it's normal***
> *19* ***unlock, rather than having to close down a whole wing to***
> *20* ***get that one gentleman out, it may be easier to take***
> *21* ***from a smaller wing."***[487]

183. Pre-emptively moving someone into temporary confinement or removal from association to make it easier to remove them the next day is also not within the terms of rule 40 and is a yet further misuse of the power. That was precisely the use made of rule 40 in the case of D1914 (see his individual submission).

(iv) Removal From Association and Temporary Confinement for Management of Mental Health

184. The misuse of rule 40 and 42 augmented the climate of terror; the 'us and them' attitudes, the brutalisation of the detainees and environment as a whole. Use of rule 40 and 42 was part of a matrix of purposelessness in which G4S and its officers were given little or no direction by the Home Office as to the point of what they were doing, the powers at their disposal or how to properly use those powers. In response to an unmanageable environment for which they were not prepared or equipped G4S staff developed a cultural deployment of removal from association and temporary confinement as mechanism for managing what they called "behaviour" but which was often a misunderstood manifestation of mental illness. Rule 40 and 42 were thus made to fit the circumstances in which they found themselves running what was in part for many detainees akin to mental asylum, but with no expertise in mental health anywhere in the building. The evidence heard by the inquiry was as to how damaging the abuse of those powers was: indeed removal from

[487] Ibid, 165/10-21

association and temporary confinement were invariably likely to exacerbate the mental health crises which precipitated them.

185. There was little understanding of mental health as the cause of "behaviour" and "actions". That is not to imply it could reasonably be expected of officers (the DL CPs do not suggest that a few more training sessions would remotely make a difference). Rather the problem is they were confronted with complex mental health issues that were well beyond their competence and purview. Thus, for example when Mr Dix was questioned about his decision to remove D1527 from association on 4th May he gave the following answers:

> "*Q. Did you consider at all the fact that D1527 was on the netting was something to do with his state of his mental health rather than that he was just trying to be disruptive?*
>
> *A. No. As I say, I don't recall the incident particularly well. I don't know the reasons why he was on the netting".*[488]
>
> *"Q. Do you think that him being on the netting could have been more of a mental health issue rather than he was being deliberately disruptive?*
>
> *A. I couldn't say.*
>
> *Q. Why was rule 40 necessary at that particular time?*
>
> *A. Based -- as I said, based on the level of disruption, it was deemed necessary at that time that he was moved down to that area of the building.*"[489]

186. Similarly, the evidence of the healthcare team showed little comprehension of mental health issues. Karen Churcher is seen on footage referring to the incident on the 4th May as being about nothing more than a dirty plate[490] and D1527 being "*a highly stressed individual; it didn't take much to upset him*"[491]

187. As to the effect of these measures on the mentally ill and suicidal populations, Dr Bingham's evidence was that removing mentally ill detainees from association for example as a response to jumping on the suicide netting (which is invariably properly seen as a

[488] Steve Dix 9 March 2022, 56/21-25, 57/1-2
[489] Ibid, 57/11-18
[490] KENCOV1012 – V201705040022 clip 2 at 8:48
[491] Witness Statement of Karen Churcher dated 4 March 2022, paragraph 91, DWF000022_0019

manifestation of a moment of mental health crisis) actually '*exacerbates*'[492] the mental health problems (see also Theresa Schleicher[493]). Dr Hard agreed:

"*1-4 Q. That's particularly of concern because, as we have touched upon previously, segregation and isolation are factors that exacerbate mental health problems in some cases?*

5 A. In some cases, definitely.

6-8 Q. They can cause deterioration in many mental health conditions, including those that we see as prevalent in IRCs, such as PTSD, depression, anxiety?

9 A. Yes"

…

12-16 Q. They are associated, that is, segregation and isolation are factors associated with increased thoughts of self-harm and thoughts of suicide related to an environment that's socially isolating. Would you agree with that?

17 A. Yes, and devoid of stimulation.

18-21 Q. So what is being carried out as a response to those types of underlying conditions and incidents of self-harm actually exacerbates that behaviour; is that your understanding?

22-23 A. I would feel there is a high level of risk of that, yes, absolutely."[494]

188. Dr Hard's view was:

"*14-19 Q. Everything appeared to be centred on risk management, didn't it? We can look at certain aspects of that. But if it is not -- the interventions aimed at dealing with mental ill-health, self-harm and suicidal ideation are not therapeutically based, they were effectively in order to risk manage those behaviours. Would you agree?*
20-21 A. They certainly didn't seem to be very detained-person-centric in terms of their needs, no.

22 Q. There was a security focus?

23 A. Yes. Absolutely, yes."[495]

[492] Dr Rachel Bingham 14 March 2022, 13/15-25, 14/1-10
[493] Theresa Schleicher 14 March 2022, 99-100
[494] Dr Jake Hard 28 March 2022, 165/1-23
[495] Ibid, 65/14-23

189. The evidence has also shown a pattern whereby mistreatment by temporary confinement and removal from association was deployed primarily against the most vulnerable individuals in ways that maximised and redoubled the mental illness and crises which precipitated the use. Brodie Paterson's witness statement explains the effects of segregation on mental health thus:

> "*73. The impact on mental health may be significant with a systematic review of the literature finding that rates of post-traumatic stress disorder after the use of restrictive interventions including isolation varied from 25% to 47% (von Werthen et al 2019). Any negative effects are likely to be increased when the individual has a pre-existing mental health condition with asylum-seekers with a history of torture identified as particularly vulnerable to negative mental health outcomes from isolation (Royal College of Psychiatrists 2016:4). However, a history of life-threatening events more generally has also been found to be associated with an increased risk of traumatization / re-traumatisation as a consequence of isolation (Steinert et al. 2007, Kira et al. 2008).*
> *74. Consequently, the use of segregation must be considered with considerable caution in the care of those with a mental disorder especially in the presence of self-harming or suicidal behaviour irrespective of the setting (Chieze et al. 2019). Careful assessment of the potential effects of seclusion by a clinician as opposed to a manager however senior is warranted in order that a risk-benefit analysis informs the decision-making process and that it represents both the last resort and the least restrictive intervention (Gaskin et al. 2007).*
> *75. Such concerns were raised in the first Shaw report (Shaw 2016) with suggestions that a multi-disciplinary review of such decisions was required. The evidence in the Panorama documentary was that, if this mechanism was introduced, it had failed. Segregation appeared to be being used to manage behaviours such as self-harm which was a completely unacceptable practice. The National Preventative Mechanism (2017:12) recommend that 'There must be a clear, rigorous risk assessment carried out by competent individuals (including health care professionals where appropriate) to support decision-making around isolation. In my view this guidance did not appear to be being complied with.*
> *76. The use of such interventions is, however, also a source of concern in many settings because expediting segregation with a person who is refusing and actively resisting may lead to the use of restraint by staff attempting to move the person. Moving an individual who is being restrained involves a number of technical challenges which create a significantly increased risk of injury to all those involved*
> *77. As with any scenario involved increased risk the preferred strategy will therefore be avoid it whenever this is practicable. This requires that an organizational strategy to reduce it based yet again on the principles of public health is needed. The*

literature suggests there are two key strategies that may reduce the need for seclusion in mental health and these are essentially the same for an IRC. Firstly, staff need to maintain an active presence in the unit on the floor in order that they can establish working relationships involving trust creating an element of relational security and get to know detainees well enough in order to detect early and possibly subtle changes in their mood (Taylor et al., 2012). If detected, earlier interventions using less restrictive measures such as empathy, distraction, de-escalation or even where prescribed, medication may avert a crisis. Secondly, there needs to be an explicit focus on the culture with the aim of promoting a culture of routine, predictability, calmness, and collaboration, rather than control (Bowen, Privitera, and Bowie, 2012). The success of such interventions requires explicit proactive management of the milieu an active commitment to relational security and an adequate number of well trained and well-led staff and a low staff turnover allowing consistency of presence. Unfortunately, it appears all may have been lacking in Brook House IRC (Testimony Owen Syred)

78. However, the literature also tells us that whilst such interventions may be harmful in and of themselves, how they are carried out and the perceptions of the individual being segregated of the attitudes and motivation of those carrying out the segregation may significantly mediate its impact. It appears that DCO's "were never told why people were ill with mental health conditions were moved to solitary confinement" (Testimony of Callum Tulley). It is though in my opinion likely based on what appears to have been the widespread culture of disbelief that the perception of at least some staff was that such behaviour was attention seeking or manipulative and the act of removal to segregation provided an opportunity to punish the person for exhibiting the behaviour. In so doing to exorcise their own frustration and anger. Consequently, it appears that scenarios that may have been capable of resolution by dialogue and de-escalation were instead used as to legitimize the use of restraint including pain compliance.

79. This suggests the existence of a regime in which the routine use of C&R and segregation itself were used as punishments for behaviour framed as wilfully bad as opposed to indicators of severe mental illness. Such practice would be a direct breach of Rule 42. Relocation to Rule 42 accommodation must take place only if the available information strongly indicates that relocation is deemed necessary in the interests of security or safety and must never be used as a punitive measure.

80. In many ways segregation when combined with constant observation may be considered the equivalent of intensive care for an individual experiencing a physical disorder and should be provided by qualified, experienced, clinical staff with the additional training required. In my view where the risk of self-harm or suicide is so high as to warrant the use of constant observation the detainee is no longer

fit to be detained and should be transferred to an appropriate mental health facility or released.

83. The use of segregation and restriction on association in the management of individuals who are actively attempting self-harm or are acutely suicidal are of particularly grave concern. Multiple case reports have evidenced that providing the level of supervision required to safely manage the risk of suicide is hindered not helped by isolation (Nelstrop et al. 2006). The use of jointly developed safety plans developed in conjunction with those in crisis over the time period covered by this inquiry should have been a core aspect of good practice and used routinely by the health care team within Brook House (National Institute of Clinical Excellence 2011, Cole-King 2013 Nuij, 2021). I noted no reference to the use of such plans in the IRC setting. Compassionate empathy and hope inspiration are central to addressing the trauma, distress, shame, hopelessness, and despair that may underlie such behaviours (Cutcliffe and Barker 2002). Such interventions require contact, engagement, and significant skills and should be undertaken by clinical staff of appropriate seniority (National Confidential Inquiry Into Suicide and Safety in Mental Health 2015).

84. The use of segregation and restriction of association in Brook House IRC and in particular in E wing is therefore of serious concern. Multiple respondents talk about a barren noisy cold environment and although there appears to be higher staffing ratio mechanical observation in and of itself create the culture needed. The necessary infrastructure represented by a compassionate therapeutic culture, an expert workforce, an appropriate policy framework, regular clinical supervision for the staff involved and an appropriate external regulatory framework appear absent. I note the recommendation that staff working with vulnerable detainees must receive appropriate 'Advanced mental health training' (Independent Monitoring Board Brook House 2019:5). Something previously recommended by the board in their 2017 report. However, such training is in my opinion wholly unlikely to create the knowledgably, skilled compassionate workforce needed to resolve needed to stabilize and promote recovery in those in acute mental health crisis."[496]

190. The removal of D1527 from association on 4th May at the behest of Steve Dix is illustrative of a number of the features identified by Dr Paterson. At paragraph 96 Dr[497] Paterson describes:

[496] Witness Statement of Dr Brodie Paterson dated 21 January 2022, BHM000045_0016-0019
[497] BHM000045_0022

"96. Evident at multiple points throughout the documentary is the use of dehumanising and derogatory language to refer to detainees. Terms such as 'thy', used by DCO A, 'Scrotum' used by DCM, and 'penis' used by a DCM to refer to a detainee refusing food. The material presented in the Panorama document will, of course, represent a selection from that filmed but that evidences an institution seemingly bereft of compassion. An institution in which the distress of others was the source not of concern but of humour. In which it was responded to not with compassion but derision and ***hostility. A number of staff seemed intent not on avoiding conflict but instead on engineering it in order to provide an excuse to use restraint in order to cause pain or to punish those evidencing distress."***

191. Giving evidence on 28 March 2022, Dr Hard when asked about removal from association and E-wing said "*Yes, it seems to be done for the convenience of the staff and not for the benefit of the detained person.*"[498]

192. D149's treatment on 31 May 2017 is an example of a detained person being subjected to inhuman and degrading treatment as a result of the methods, policies and practices implemented by the Home Office and G4S in respect of both the use of control and restraint and removal from association. The video of this incident can be viewed at Disk 52 UOF 135.17 BWC[499]. On that day, DCO Tulley stated that D149 sought to take his keys.[500] In response, DCM Loughton orchestrated a planned removal of D149 to the CSU.[501] This planned removal was highly dangerous, involved the deliberate, unnecessary and excessive infliction of pain on D149 outside use of force approved techniques, and, according to the Inquiry's expert on use of force John Collier, could have led to D149's death.[502]

193. Following this, D149 was placed in isolation for 84 hours, spanning the course of five days.[503]

194. No one at all authorised removal from association under Rule 40(1), (2) or 42 at the time D149 was relocated to CSU at 5.30pm.

195. DCM Steve Pearson purported to authorise D149's removal from association under Rule 40 at 9.52pm on 31 May 2017.[504] This was unlawful because DCM Pearson had no

[498] Dr Hard 28 March 2022, 66/13-15
[499] CJS0073778
[500] CJS004298.
[501] CJS004315; CJS005978.
[502] Jonathan Collier, 30 March, 44/8-18.
[503] CJS001820_001 – located on R40 on 31 May 2017 9.52pm, removed 4 June 2017 10.10am.
[504] CJS001820_002.

authority to authorise Rule 40 – he was not the Secretary of State's delegate in a position to authorise a planned removal from association under Rule 40(1) (nor for the avoidance of doubt was he the centre manager, albeit that is irrelevant as this was not a case of urgency). Steve Loughton was informed of the need to move D149 at 2.30pm,[505] with Steve Loughton discussing the move with D149 around this time.[506] The use of force commenced at 5.16pm[507] - there was thus more than sufficient time to seek the Home Office's authorisation for Rule 40. The alleged justification for this use of Rule 40 was "the safety and security of the centre".

196. Authorisation beyond 24 hours was authorised on the same grounds. Authorisation beyond 72 hours was authorised by senior manager Terry Gibbs, "for the purpose of monitoring his behaviour before he is let out of CSU",[508] which is not a lawful reason for implementing Rule 40 and was not authorised by Paul Gasson as required. The mental toll this removal from association took on D149 can be seen by events on 31 May 2017, where he manufactured a ligature,[509] although this was dismissed by staff as a protest against being placed on Rule 42 rather than a symptom of mental ill health and acute distress.[510] Karen Churcher, the mental health nurse, went to see him on 1 June 2017 on CSU, but discharged him after he stated he did not wish to engage with mental health services.[511] On 2 June 2017 he called 999 and said he was going to hang himself.[512]

197. Even after he was released from Rule 40, he was kept on E-wing in de facto segregation prior to his transfer out of Brook House,[513] up until his transfer on 19 June 2017.

198. A further source of insight into the culture of the misuse of rule 40 and 42 is at paragraphs 272 – 283 of his first statement Reverend Ward.[514]

199. The misuse of rule 40 and 42 augmented the climate of terror; the 'us and them' attitudes, the brutalisation of the detainees and environment as a whole. There does not appear to be a day when E Wing and CSU were not full. Use of rule 40 and 42 was part of a matrix of purposelessness in which officers were given little or no direction as to the point of what they were doing, the powers at their disposal or how to properly use those powers.

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[505] CJS005650_0001.
[506] CJS005650_0008.
[507] CJS005650_0001.
[508] CJS001820_0003.
[509] CJS001820_0016.
[510] CJS000514.
[511] CJS000908_0004.
[512] CJS004010.
[513] CJS004901_0003.
[514] Witness Statement of Reverend Nathan Ward dated 10 November 2021, DL0000141_0095-0099

In response to an unmanageable environment for which they were not prepared or equipped they developed an ad hoc culture in which the limited mechanisms of controlling the environment which were available to them were deployed unlawfully and inappropriately. Rule 40 and 42 were made to fit the circumstances of running a de facto mental asylum in which they found themselves. The evidence heard by the inquiry is as to how damaging the abuse of those powers was: indeed removal from association and temporary confinement were invariably likely to exacerbate the mental health crises which precipitated them. The lawless misuse of these powers was a significant factor contributing to an environment which was overall inhumane and which was liable to engender inhuman or degrading treatment for anyone detained there.

Causal Factor 4: Toxic and Corrupted Institutional Culture of Dehumanisation, Xenophobia and Racism

Toxic, masculine and bullish culture

200. In Reverend Ward's evidence to this Inquiry, he explained based on his experience from working from within G4S and indifferent custodial settings include directly at Brook House, how in his view the mistreatment and abuse suffered arose from a corrupt and toxic institutional culture that was dehumanising and racist. The continuum of various forms of mistreatment sanctioned and perpetuated the kinds of brutalised and brutalising attitude and behaviour exposed by Panorama and confirmed in wide-ranging evidenced now available to the Inquiry. He said:

"*159. The assaults and abuse we witness in the Panorama are a gross manifestation of the institutional corrupt and toxic culture...Whilst the footage inevitably focuses on a core group of staff, in my experience, it is likely the behaviour of staff was perpetuated by the system in which they were working in. It represents a system in which members of staff felt confident enough to take this action and even cover up outrageous abuse without repercussion. I see this core group as the people who exercised the 'physical' sense of power, who would be relied on to attend incidents and to take the lead on using force but, I do not believe from my knowledge that they could have conducted themselves in this way without the wider institutional culture of dehumanization and othering that was at play, which made this conduct accepted by many more staff.*

160. I think it is important to recognise that individuals behaving like this are likely to become the dominant group in part at least in response to fear and the threat from the unsafe environment that was also a prominent feature of the experience of Brook House; with insufficient staff numbers, training and skills to properly and safely manage the

population. This was evident when 1 was working there between 2012 and 2014 but other factors such as prevalence of illegal drugs and additional numbers of detainees would only have exacerbated the levels of fear and threat and general chaos experienced by staff in later years. In this context, the mentality of 'us and them'... intensifies further and contributes to more conflict and tension, and a reliance on those with physical power and dominance among the staff group whose behaviour then becomes normalised and accepted... "[515]

201. Reverend Ward also gave evidence how the culture was reflected in staff interactions with detainees. He gave evidence of a particular incident in October 2012, which was demonstrative of the dehumanisation and bullying culture, which he said was "*aimed to torment and belittle detainees*" and which was done under the purported supervision and management of DCM Adam Clayton.[516] On this particular occasion DCOs had been "*throwing and bounding a tennis ball, a bottle and other items*" outside D4289's cell on E Wing, after he had been located there owing to his mental ill-health and had made a ligature whilst in his cell there, followed by DCO Willoughby wearing a 'Derek Trotter' mask during completing constant supervision observations.[517] An investigation into this incident was done by Michelle Brown[518] but Reverend Ward cannot recall what if any action was taken in response to her recommendations.[519]

202. Reverend Ward also described the particular issues he had with Residential Manager, Juls Williams, who he said "*didn't embody the values of respect and dignity*" and that he had "*inappropriately close*" relationships with a number of members of staff, whom he "*protected and favoured*".[520] In Reverend Ward's view, such a dynamic was representative of the hierarchies that operated in Brook House, which "*fostered a sense of collusion and impunity*".[521] Nathan Ring, whose abusive behaviour and language towards detainees can be seen in Panorama[522], and has been further explored by this Inquiry, Reverend Ward described as someone "*who was valued for his toughness with detainees and became a dominant figure whose conduct was accepted and not challenged*" and who had "*fundamental disrespect and disregard for the dignity and well-being of detainees*".[523]

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[515] DL0000141_0055.
[516] DL0000141_0058.
[517] DL0000141_0058.
[518] CJS005900 (please note that this document has not yet been adduced to the Inquiry. We request that it is adduced so it can be considered alongside these submissions)
[519] DL0000141_0059.
[520] DL0000141_0059.
[521] DL0000141_0060.
[522] See Britain's Undercover Secrets, Panorama, e.g. 40 – 41 minutes, 46 – 51 minutes.
[523] DL0000141_0060.

203. Owen Syred gave similar evidence about the existence of a protected clique:

"*If you were part of his* [Juls Williams] *social and drinking circle you were ok. Graham Parnell (a DCM) was someone in this group and I mention several incidents concerning Mr Parnell below. It was very cliquey and some of the DCMs were far too close to the DCOs within their social circles, which led to a culture where inappropriate behaviour was not challenged. An example of this is Nathan Ring (a DCM who is shown on the Panorama documentary) who behaved inappropriately but no one picked him up on it*"[524]

"*There was a culture of laddish behaviour among large numbers of DCOs (I made this comment to Kate Lampard and Ed Marsden when interviewed for the Verita investigation following the Panorama documentary, and I note that there are numerous references to "laddish" behaviour within their report).*"[525]

204. Other witnesses also told the Inquiry that there continued to be a group of staff members who were protected by senior management and were allowed to abuse detainees or colleagues with impunity. For example, David Waldock, a DCO, said:

"*The culture at Brook House was very hierarchical in the sense that you had Steve Skitt Running the show. He had 30 years' in the prison service and Brook House was run very much as I imagine a prison is run. Although Ben Saunders was technically at the top, from my perspective it was Steve Skitt who shaped the culture of Brook House. Beneath him you had a circle of favoured officers who were protected in the instance of any complaints being made against them, either by colleagues or detainees. Against that you had officers (of which I was one) who had stood up and made complaints about how things were being run, and they were targeted and ultimately pushed out. In my view the officers who thrived at Brook House were bullies who enjoyed working in a culture which not only failed to punish bullying behaviours but actively promoted and encouraged them, as the Panorama programme revealed.*"[526]

205. Reverend Ward further said in his insightful written evidence to this Inquiry:

"*174. The truth is, there was a limited pool of staff that we were able to recruit from*

[524] Owen Syred, INN000007_0006, Para 26
[525] Owen Syred, INN000007_0026, Para 109
[526] David Waldock, BDP00007_0006, Para 16

A majority of staff had few qualifications, many came from baggage handling at Gatwick airport, and they were working in complex and institutionally corrupt environments with people with complex needs, many of whom should not have been in detention at all if the Home Office was doing its job properly. The DCOs would rise through the ranks to become DCMs and there was an entrenched culture which did not benefit from fresh perspectives. This was worsened by the fact that G4S had a recruitment scheme whereby if you recruited someone and they remained in the job for a certain amount of time, you would receive £250. This encouraged staff to recruit their friends, which would inevitably entrench these cultures."

Dehumanisation

206. This toxic and corrupted culture was the dominant culture within Brook House and was a facet of a wider dehumanization that pervaded the environment and culture. It manifested in many ways but indicative of it institutional and pervasive nature is the in the violent, abusive and derogatory language and attitude routinely expressed to and about detained people. The Inquiry will have many of the most graphic and chilling examples firmly in mind. The four below are merely illustrative of how it was normalised every day conversation between staff:

"*Ed Fiddy: I do - **I do love watching the playbacks**.*

*Joe Marshall: **I know it sounds horrible, it sound really horrible. But I found that quite funny**. I remember the one that I'd done in the CSU . Exactly the same thing, took him onto his front ,not his back, obviously put his arm round, and then mate, **his screaming, I couldn't help it I was laughing**. **You know 'Allah, they are killing me' sort of puts me in the mood for it** again but I end up thinking, am I fucking retarded? You've got to be mentally retarded*
Ed Fiddy: I hate it – I hate it when there like, 'I'm resisting, I'm resisting' I'm like shut the fuck up.
Joe Marshall: [Inaudible]
Ed Fiddy: I mean we had one, the initial [Inaudible] didn't really annoy me, it was just him, he kept he was fucking in like this, holding his hands [Ed Fiddy mimics a detainee curling into a ball]." [527] (own emphasis added)

"*Derek Murphy: And I went into his room, I said, 'Oy, get the fuck out of bed. Clean this shit up. You ain't going nowhere until you clean this up, you little prick'. And I said, **'If you don't clean it up within the hour, I'm going to come and smash the***

[527] TRN000030_0015-16, KENCOV1023.

fucking shit out of you and you ain't doing no flying. *'. So, I left him and walked out. [inaudible] he's still in fucking bed [inaudible**] threw it at him, got the quilt off him and threw it [inaudible] 'Get the fuck out**'. 'Okay, okay, okay'. Clean all of this in a nice bundle. [Inaudible]. Oh, hang on a minute. Got my bags and 'Put it in a fucking bag before you go'. He did."*[528] (own emphasis added)

"Nathan Harris: I reckon they should do what they do on Con Air masking tape, bag 'em, job done... Just tape over the mouth, bag over the head [inaudible]

...

Nathan Harris: I was just saying to these guys do what they don in Con Air, just fucking tape 'em and bag 'em

...

Derek Murphy: [Inaudible] in America. Put them in the chair, facing the wall [Inaudible] they can't fucking move.
Nathan Harris: They've got cuffs on the arms and that, haven't they
Derek Murphy: When it comes to taken them out, can't even walk and they're crying. [Inaudible] put them in a chair... Andrew, Andy, Jesus Andy that's vile
Nathan Harris: We should – We should just go, we should just go back to putting them to sleep mate really. [Mimics injecting himself] put em all to sleep... Get the gas, chuck in there, they're all knocked out [inaudible] needle in, he wakes up in fucking wherever. [Inaudible] ain't it."[529]

207. Reverend Ward described it as follows :

"137. *The dehumanisation of detainees was perpetuated by language of 'othering' which was fed down through Home Office hostile policies to the IRC. Individuals were referred to as 'detainees' rather than 'residents'; and the 'rooms' looked like and were called 'cells' by staff. This dehumanised prison-style language could also be seen in the phrases used for the night state ("bang up" and "lock down") and removal from association (being sent to "the block"). During Charter Flights, staff would refer to individuals as being 'loaded' onto flights, as if they were cargo. This dehumanisation of detainees which was present when I was*

[528] TRN0000082_0005.

[529] TRN000084_0010.

employed there is seen so often and repeatedly in the Panorama footage (both in the documentary, the wider unused footage and the transcripts) and in such graphic terms that there can be no other conclusion that the language used by staff and the disgraceful treatment of detainees can be nothing other than standard and accepted practice. ...

141. I believe the design of the centre and the processing of detainees in a functional way also contributed to their dehumanisation. The physical layout of Brook House is plain and designed around the task of processing individuals. When placed in this setting from the outset, detainees are depersonalised; they are provided an identity number, have their personal belongings removed and given generic, institutional clothing (if they do not have their own) and bedding. Staff interact with detainees often using their identity cards to get information required, which dissuades human interaction. Care is formalised and staff only see detainees during 'wing office opening hours'. This subtly reinforced the idea that staff did not care as people, and only as a function. Only in that context can you understand how the staff could treat detainees, not only in such a manner that was seen at its most extreme in the Panorama documentary, but also in the more repeated mundane day-to-day regime - disrespect was hard wired in. ..

143. From my experiences at Brook House, I also witnessed a culture of perceiving non-compliant detainee behaviours as disobedience rather than a manifestation of trauma or distress. Disturbed behaviour was also seen as non-complaint, deliberately disruptive or attention seeking rather than symptoms of mental illness."[530]

208. Reverend Ward's view is consistent with that of Professor Bosworth's account of 'prisonisation' at Brook House. On several occasions in Professor Bosworth's evidence, she explained how staff came to identify Brook House as a prison, objectify and dehumanise those detained there . For example, she said:

"*... I think it's quite clear that it did affect the treatment of detainees because I think what it does, if you put people – if you lock people up in a*

[530] Nathan Ward, DL0000141_0047-0049

building that looks like a prison, you tell those people and the people who are looking after them that they are criminals, and so then there's a sort of symbolism to it, which I think you – in Brook House, we also – there's a lot of evidence to show that that kind of symbolism was reinforced in the training materials, in the language that people were using. It's also reinforced by the fact that there are some people in Brook House, at any given time, who have served a criminal sentence in a prison. So they get kind of bundled together in explanations for who the detained population are. I think – I mean, I refer to it in my report as 'prisonisation', the idea that the custody officers are actually working in an institution that was effectively a prison with people who were, therefore, criminal and dangerous"[531]

209. Professor Bosworth also said:

"*... Well, I think it's another key contributing factor to the anxiety and frustration of the detained population. I think it is not too hard to imagine, you know, if I was placed in a custodial facility that looked like a prison and I couldn't communicate with anybody, I think it would be terrifying.*"[532]

210. In terms of the response of officers to the challenges of their job, Professor Bosworth said:

"I think the main way in which officers respond to the challenges of their job is to create an emotional barrier, an emotional distance, between themselves and the detained population, and I think that this ends up leading them — or the danger is, it ends up leading them towards not really appreciating the difficulties that the detained population are actually facing, and seeing that when people are angry or distressed or frustrated, they see that as just them being difficult rather than them actually being people in need and in crisis"[533]

211. As Reverend Ward did[534], Professor Bosworth identified the pervasive derogatory language as a key indicator of institutional attitudes to detained people and culture. She said it was damaging:

[531] Mary Bosworth, 29 March 2022, 13/7-14/2
[532] Mary Bosworth, 29 March 2022, 16/5-10
[533] Mary Bosworth, 29 March 2022, 43/21-43/6
[534] Nathan Ward, DL0000141_0047 - 48.

- "*...I think the use of counter-terrorism language around 'conditioning' or even, you know, the terminology of 'security incident reports', I think that is also present in prisons. I think that – I think, in a removal centre, that sort of language does quite a lot of damage because it elides populations that are actually really distinct but which are easy to push together because of, you know, nationality, actually, and also sometimes because of racism... So I think there's a way in which it becomes very easy to move from national stereotypes to sort of fears around terrorism, which then, of course, just distance the population.*"[535]

212. Finally, Dr Bosworth connected the dehumanisation of detainees in this way with the abuse uncovered by Panorama:

> "*...Well, I think it just -- it contributes to the risk of abuse because it simply means that people are not recognising other people as being like them. So, you know, in the way you wouldn't -- you wouldn't yell at a stranger because you wouldn't want the stranger to yell at you, that doesn't seem to be the case always in the footage. So people seem to perhaps lose the sense that the people in their care were like them in a kind of fundamental way, based on their shared humanity...* "[536]

213. Reverend Ward's understanding and the analysis of Professor Bosworth was also supported by Dr Brodie Paterson, who explained how the wider immigration context contributed to dehumanisation at Brook House:

> *"106. De-humanisation is more likely to happen more where the victim is already a member of a marginalised or stigmatised group or where action is justified on the basis of the transgressions of that individual or group. As Arendt (1951) observed, labelling in some circumstances creates 'moral distance'. This serves to render those affected by the label less than human and thus undeserving of the natural human pity that might otherwise serve to prevent abuse. Unfortunately, there is little doubt that a series of narratives have served over time to distance or other asylum seekers from 'us' (van Dijk,2000a, van Dijk2000b). Of particular significance to the context of an IRC such as Brook house is a theme in the narrative distinguishing between 'genuine' asylum*

[535] Mary Bosworth, 29 March 2022, 37/22-38/5
[536] Mary Bosworth, 29 March 2022, 54/15-23

seekers, i.e. those seeking refuge and bogus asylum seekers framed as only entering the country for economic benefits and deserving of sanction and punishment (Layton-Henry, 1992; Sales, 2002 Greenslade, 2005). This narrative has gained prominence as a result of UK government policy since 2012, which has sought to create a 'hostile environment'. The aim being to create a life "so unbearable for undocumented migrants that they would voluntarily choose to leave" as their access to public services becomes increasingly restricted (University of Portsmouth, 2021: n.p.). Central to the frame underpinning the policy is that of threat. Immigration is depicted as threatening British values, culture and living standards, public services, and security through rising extremism and criminality (Hubbard 2005). Community integration and public order are framed as being at risk if tough action is not taken (Goodman 2008). These themes are considerably more heightened in discussions of non-white and more culturally distinct individuals (Dempster and Hargrave, 2017)."[537]

Institutional Racism

214. It is for this reason that both Reverend Ward and Professor Bosworth document and identify institutional racism as present and operating as a corrosive and pervasive aspect of the toxic and corrupted culture at Brook House.

215. In the seminal Macpherson Report, following the Public Inquiry into the racist murder of Stephen Lawrence, institutional racism is defined as:

> "*The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.*"[538]

216. Reverend Nathan Ward explained his understanding of this term in his oral evidence to this Inquiry as follows:

> "*... So institutional racism, from my perspective, is where you have engrained in the DNA, the fabric of the institution, the overarching culture of separation of racism as well, and when we study racism and the sociology behind it, the new forms of*

[537] Dr Brodie Paterson, BHM000045_0024, Para 106
[538] 4262.pdf (publishing.service.gov.uk) – 6.34.

institutional racism as well, where we refer to groups based on nationality and kind of conflate that down, is how I would describe it... "[539]

217. From the wealth evidence this Inquiry has heard, it is clear that the practices and conditions at Brook House met meet both of the above definitions. In reaching the conclusion that institutional racism was present at Brook House, Reverend Ward said:

"I believe there was a dehumanisation of detainees based on the environment itself at Brook House and the effect this had on staff/ detainee relationships and interactions. Given the make-up of Brook House and the diversity levels of staff and detainees, I would also say that this dehumanisation contributed to the institutionalised racism that was present in Brook House.

...

As I have explained in detail, I do not believe that even the contractual arrangements provided the resources and regime to ensure an appropriate and professional service to people, who by their very nature are 'non-white British', but also who are vilified and demonised as a group and hidden away from society and the general population." [540]

218. Reverend Ward analysed the incident in which John Connolly used overtly racist language prior to a control and restraint as evidence of institutional racism. Revered Ward explained that what was particularly striking was the failure of the officers present to take any action in relation to it:

"*... I think the issue is the inaction of others to challenge, and that, for me, is one of the profound signs that this isn't a few rotten apples in the barrel, that this is taking place within an institution and a staff culture where it is endemic, and, actually, "Evil reigns when good people stay silent", and the silence of the good people, the good members of staff, is just as tragic as the actual vile behaviour demonstrated by the few.*"[541]

219. Further support for the finding of institutional racism can be seen in Reverend Ward's evidence to this Inquiry of insidious xenophobia and racism permeating Brook House

[539] Nathan Ward, 7 December 2021, 176/11-18.
[540] DL0000141_0051.
[541] Nathan Ward, 7 December 2021, 177/12-24.

during his employment with G4S. Although he did not personally witness any verbal abuse that was overtly racist (which is not to say that it was not occurring at Brook House prior to Reverend Ward's resignation; it likely was, but it was not done in front of him), he witnessed the use of "*cultural* [and offensive] *stereotypes*" based on nationality, which in turn impacted how staff would deal with different nationality groups. He further noted that staff did not know about or did not care about cultural matters, such as food or prayer, and instead used these stereotypes or generalisations to manage the population, which was "*an important feature of the 'us and them' mentality*".[542]

220. In an internal stakeholder survey which was carried out in 2013[543], 34.4% of respondents stated that they were White British, while 35.7% of respondents stated that they were White English. The overwhelming whiteness of Brook House staff (the 'us'), particularly when compared with the racial diversity of detainees (the 'them'), is worthy of note when considering the concept of institutional racism, as is the high level of identification with English as opposed to British ethnicity and/or nationality. Such a picture has to be a factor in the development of an institutionally racist culture, particularly in the context of border control[544] and set against the backdrop of the policy of a hostile environment.

221. Reverend Ward in his written evidence also referred to allegations of racism against individual staff members, and evidence from the same internal stakeholder survey evidencing high levels of racism, discrimination and a racially charged environment.[545]

222. This Inquiry has now heard evidence from a number of sources that confirm Reverend Ward's evidence of a culture of racism very much operating at Brook House amongst staff in 2017 which adversely affected both detainees and other staff members.

223. The DL Core Participants have collated in Annex 5 the multiple examples of overtly racist and xenophobia derogatory language and attitudes of G4S staff which establish its pervasive and entrenched nature. Some examples suffice:

[542] DL000061_0052.
[543] DL0000142 for the survey, the results of which are summarised at DL000061_0045-46, 52.
[544] DL000061_0052.
[545] DL000061_0053-54.

a. Dan Small: "*Am not going to black central.*"
Dan Lake: "*Why?"*
Dan Small: "*[Inaudible]. Too many blacks, its eighty percent black.*"[546]

b. John Connolly: "Say, '*Listen here, nigger. Listen to me… '*"[547]

c. Callum Tulley: "*Apparently there is over 20 dead in this attack. Or no, is it not attack, 98 dead I think.*"

Dan Small: "*Yeah. 12 foreigners.*"

Callum Tulley: "*Eh?*"

Dan Small: "[Laughs] *12 foreigners, man*".

…

Callum Tulley: "*Exactly, you are not English. Should the country be better off without them, then, do you?"*

Dan Small: "*Yeah. I certainly do that*"[548]

224. The case of D643 warrant very careful attention in assessing the prevalence and gravity of the racist words and deeds in Brook House. His written and oral evidence was both as compelling as it was alarming. D643 told the Inquiry about the overt and shocking racist abuse he received and witnessed, including detainees being referred to by officers as "*the blacks*" ("*why don't these blacks go back to their country?*"; "*all blacks are the same*") and repeated use of the word "*nigger*". D643 was able to identify some of the officers concerned as Graham Purnell, Joseph Marshall and Luke Instone-Brewer. D643 confirmed as Revered Ward did, an experience differing treatment based on nationality and racial stereotyping of detainees.[549] Other examples of such practice are also included in Annex 5 to the generic submissions.

225. When examples of such racist abuse were put to him in oral evidence, Ben Saunders had to agree that such language was not "*good humour*" or "*banter"* and that it was "*not acceptable*".[550] He also accepted that racist and abusive behaviours can be seen in Panorama[551], although it would have been quite difficult for him to deny that was the case.

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[546] TRN0000079_0010.
[547] Footage from Panorama (28:40 minutes).
[548] TRN0000092_0050.
[549] D643, DL0000228, Para 142
[550] Ben Saunders, 22 March 2022, 104/13-15
[551] Ben Saunders, 22 March 2022, 135/3-4

It is of note that Mr Saunders had been informed by Owen Syred of a complaint of overt racism and use of the N word which had led to a campaign of harassment and intimidation of Mr Syred himself castigated as a snitch and "N (word) lover". Appallingly no effective action was taken by Mr Saunders.

226. The pervasive nature of the institutional racism and an 'us and them' mentality at Brook House can be seen by the fact that racism towards black and ethnic minority staff members occurred , as well as detainees.

227. Conway Edwards, the G4S Diversity Manager at Brook House, told this Inquiry that he had been the victim of discriminatory treatment based on race. A clear example of 'othering' can be seen in the evidence he gave of an occasion when he was depicted wearing black, while all other members wore blue, and his evidence that when he became Diversity Manager, he was given a different office from the previous person in that role[552], this provides a clear example of racial 'othering'. Conway Edwards also described his things going missing and finding rubbish all over his desk, a bin having been emptied on it.[553] Conway Edwards also gave evidence relating to discrimination towards other BAME staff members in relation to staff searching.[554]

228. Shayne Monroe, who had been a DCO, gave evidence of discrimination inherent in the staffing structures and the system of promotion:

> "*A. There was no representation. There was hardly any black or Asian or nonwhite management in that building. The one black manager that was there was the race and diversity manager.*
>
> *Q. Is that Conway Edwards?*
>
> *A. Yeah, which wasn't surprising to me, that that was his role. DCOs had gone for higher roles and just never got them, and it did feel like a "face fits" type of environment.*"[555]

[552] Conway Edwards, SER000459_0014-0015
[553] Conway Edwards, SER000459_0014-0015
[554] Conway Edwards, SER000459_0014-0015
[555] Shayne Munroe, 4 March 2022, 29-30/19-25, 1-2

229. In perhaps the most damning indictment of a culture of racism, Dan Small, a DCO who had been filmed making racist remarks, said that working at Brook House had made him into a racist:

> "*... I had never made any racist remarks until I became a DCO at Brook House and witnessed the casual use of racist language by those around me, including some managers, on a daily basis. As an impressionable and emotionally immature young man, I felt subject to peer pressure to adopt this language and behaviour in order to impress colleagues...*"[556]

230. Professor Bosworth has given the Inquiry a detailed analysis of the evidence of a highly racialised environment in Brook House:

> "*So here I'm talking about how -- I mean, I suppose I'm basically talking about racism, but it's -- I think -- I mean, I've certainly seen this in my research and it was evident in the material that I read and watched for the inquiry that, you know, in a circumstance where the officers find it very hard to actually have a meaningful interaction with people, then what they often rely on are just views that they would already have about the national group, and so you sort of see this in, you know, generalised comments about particular nationalities, which I think -- so -- and I think that's the predominant form that racism takes in IRCs. It's not that often -- at least, in my experience, it hasn't been that often that people will necessarily use a racial epithet in a discussion with a detained person because, you know, most people know that that's, you know, not on.*
>
> *But what they will do is they will kind of generalise about all -- you know, "All Albanians are like this, all Jamaicans are like that". That view is racist, but, also, that view makes it very hard for them to actually deal with the person in front of them as an individual.*"[557]

231. The Inquiry is invited to find that institutional racism was in operation at Brook House during the relevant period and no effective acknowledgment or steps have yet been taken by either G4S or the Home Office to address it. This is not a matter that will resolve itself. It is a major concern. Not least because it is a recurrent feature of immigration enforcement as previous undercover reporting, PPO investigations at Yarlswood (2004 and 2014),

[556] Dan Small, BDP000003_0008, Para 23
[557] Mary Bosworth, 29 March 2022, 35-36/7-25, 1-4

Oakington (2005) and the inquest into the death of Jimmy Mubenga have previously recorded and revealed (2013).[558]

G4S responsibility for the institutional culture

232. Reverend Ward is clear in his evidence that the issues relating to this toxic culture were known to the Senior Management Team responsible for Brook House as well as high-ranking Corporate Officials such as Jerry Petherick and Peter Neden:

> *162…I would say that the general culture and ethos was known but largely unmonitored and unchallenged in Brook House. Management meetings were perfomance related, and included figures for sickness, complaints, removals etc. There was no effective method or time for the culture and practice to be reviewed and challenged. It was not a priority or on the agenda at Brook House. The focus was much more on finances and meeting the Home Office's objectives around removal and responding to that pressure. When I raised issues around poor culture, including staff being asleep on shift, not complying with good practice on CSU and phones not working in the command suite (all of which are indicative of a culture of complacency and negligence), it was generally ignored.*
>
> …
>
> *Generally in Brook House, there was a toxic-masculine and bullish culture. From the perspective of the staff themselves, the toxic and corrupt institutional culture, mired by bullying and dominance, is exemplified in the internal stakeholder survey completed in around April 2013…* [559]

233. Reverend Ward himself raised the fact that institutional culture at Brook House was poor and as long ago as 2014

> *"I raised the fact that institutional culture at Brook House was poor unprofessional during my employment and upon my resignation. It was frustrating because the culture was accepted and entrenched and I saw no inclination by senior managers to do anything about it. There was also no apparent incentives placed on those above them from the Home Office or G4S to change the culture. The combination of a lack of strong, principled leadership and indifference meant there was no real counter balance to all the factors that*

[558] Witness Statement of Emma Ginn at [119-121], BHM000041_0043
[559] DL0000141_0056

created this toxic environment and which lead to a culture of impunity and an accountability deficit which I fear is still in place today without some radical changes having taken place"[560]

234. As indicated above Reverend Ward also complained- to no avail how the toxic and masculine culture inherent in the training on control and restraint adversely impacted on G4S staff culture:

> "*The toxic masculine culture which filtered down to G4S was evident. I witnessed staff being trained in degrading ways such as forcing them to dress up in boiler suits and helmets to do chin-ups, with press-ups if they made mistakes. I complained about the C&R training to Wayne Debnam and Ben Saunders at the time as I felt it was inappropriate, humiliating, and set the wrong culture for the centre. They stopped the warm-up practices for a certain period of time. I complained about the C&R training more than anything, as I saw it as being central to the running of Brook House, which to my mind was wrong and perpetuated a negative, macho-aggressive culture.*"[561]

235. DCO Yan Paschali also gave evidence that the culture was known to G4S senior management and indeed the Home Office:

> "*But then, what did management and senior management and the Home Office for that matter, there was members of staff that worked there. I think their offices were upstairs, not that we'd ever see them, but they would come down occasionally. Everybody knew what the culture was like. No-one challenged it. No-one did nothing about it.*"[562]

236. Michelle Brown told the Inquiry: *"I would describe the culture amongst SMT as stressful, male orientated and untrusting*"[563], while Derek Murphy said, "*I can't remember would told me to man up, but that was the culture there: you either put up or shut up.*"[564]

237. Reverend Ward was clear that he saw G4S as responsible for the culture described above:

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[560] DL0000141_0052-62.
[561] DL0000141_0082.
[562] Yan Paschali, 24 February 2022, 27/14-20
[563] Michelle Brown, INQ000164_0011, Para 14 – relevant page not published on Website
[564] Derek Murphy, 2 March 2022, 8/14-15

"175. When I stated in the Panorama, "we need to look at the people that have put these people in place and allowed them to do what they've done" [53:23-53:32], I was referring to how it would be very easy to narrow our focus on individual members of staff as a few 'bad apples'. As I have sought to explain, I think this would be very much the wrong approach and would not lead to a proper understanding of the key factors that create the conditions for such a culture to be established and for such abuse to take place. Scrutiny should be much wider to ask the question as to how 'bad apples' got there and remained entrenched in the system. When I said this quotation, I was thinking of issues such as the vetting and training systems; and in particular the fact that poor attitudes and dysfunctional cultures were allowed to become established and left unchallenged by those in more senior positions. The Inquiry must look at those in leadership positions in G4S and the Home Office, with overall responsibility as well as those on the ground."

...

177. I think it is significant that despite the serious failings at Medway, Ben Saunders was appointed to run Brook House in 2012 and indeed remained in this post despite the Medway Panorama programme, the subsequent Police investigation in 2016 and the Medway Improvement Board of 30 March 2016 (1NQ000010), which draws similar parallels to the failings of Brook House."[565]

238. Senior G4S corporate management hold overall responsibility for the toxic institutional culture. Peter Neden, G4S Regional President UK and Ireland, acknowledged that senior management failed to ensure that detainees were being properly cared for at Brook House:

"Q. ... On reflection, do you think you over-relied on external reports or reporters to satisfy yourself about the welfare of detainees?

A. I think it is absolutely clear that I and the management team of G4S failed in our responsibility to keep people safe in Brook House, so we must have over-relied."[566]

239. Peter Neden also accepted that the fact it took Callum Tulley to uncover the abuse amounted to a complete organisational and systemic failure to identify the abuse:

[565] DL000041_0061-62.
[566] Peter Neden, 22 March 2022, 56/19-24

"Q. … does the fact that it took an undercover reporter to obtain that evidence suggest that the system wasn't working?

A. There was clearly a failure in the system, for which I'm deeply sorry."[567]

240. Jerry Petherick also accepted that there had been a complete failure to identify the abuse at all levels:

"Q. The other point I'd like you to consider is, it's not just one person hiding this. It's a number of people. And it is a number of people in the whole Brook House estate. And yet it's still being missed. You must have thought about this quite a bit and, "How did we miss this? How did we not learn the lessons of Medway? Why didn't we look a little more closely?" What's the answer to all of that?

A. I can't give an absolute, coherent answer, because there are a number of levels, there are a number of organisations, but let's just talk directly about the onsite. I would have expected the signs to have been picked up, to have been acted on, and I had other members of my team going in, the IMB, and I knew, as I have said in my statement, one of the IMB members was a former colleague governor, an experienced governor."[568]

G4S's on notice but Systemically failed to take Action

241. This culpability is not just institutional but functional. Reverend Ward set out in detail his attempts to raise his concerns about Brook House – remembering that his attempts were all informed by the complete failure of G4S to act on the concerns he raised about Medway STC – and, crucially, the failure by G4S to take any notice or meaningful action:

"302 *The steps I did take to raise my concerns were largely ignored and I was side-lined, but included:*

a. Raising concerns with the Deputy Director, Duncan Partridge;

b. Raising concerns with the Director, Ben Saunders;

c. Raising concerns with the Home Office Monitor at Tinsley House, Deborah Western;

[567] Peter Neden, 22 March 2022, 46-47/24-25, 1-3

[568] Jerry Petherick, 21 March 2022, 143-144/15-25, 1-5

d. Raising concerns with the regional HR Manager, Steph Philips;

e. Raising concerns with the Managing Director, Jerry Petherick;

f. Raising concerns with Kent Police which 1 was told were shared with Sussex Police and the Serious Fraud Office;

g. Raising concerns with the Home Affairs Select Committee."[569]

13. He further explain how this manifested in suppression of concerns and deterrents to complaint and a culture of impunity:

> *"303. I believe that staff on the ground are dissuaded to complain or use the whistleblowing strategy, due to a culture of fear that is instilled. Staff are worried about their safety and/or have a fear of being isolated and left alone on the wing. In the internal survey I completed in April 2013, someone stated, feel that those who challenge management are excluded from progression'. This makes people feel as though they are unable to speak out against the dominant culture. I have witnessed staff who have spoken out being marginalised, in particular DCOs on the ground. The staff at Tinsley House as a whole were side-lined by not wanting to work at Brook House or fear of their safety.*
>
> *304. I also refer you to my police statements at Annex 2, where I state on page 19 (DL0000140) "If staff were seen to act on concerns outside of the control of the centre's management this was dealt with by excluding them from the centre itself either through raising spurious Security issues or by raising other significant concerns. An occasion noted was when a Health Care Manager was suspended from site after they raised safeguarding concerns outside of the centre... Other examples were where independent advocates were also side-lined after they raised concerns. This all led staff within this centre to tow the line or fear for not only their job but also criminal prosecution'. Whilst this is in relation to Medway STC, I believe it is representative of the wider culture of G4S. It is also evident in the account given by Stacie Dean in her emails at Annex 13."*
>
> *305. The fear comes from the dominant institutional culture within G4S and the fact that those whom you may complain about are also the people who you will need the support of if anything goes wrong. When you observe a system which allows wrong things to continually happen without challenge, when you see people continually get away with bad things, then you soon understand that you aren't challenging the individual but the system itself. You understand that if you do challenge it, then you*

[569] D0000141_0105

are putting yourself against the system itself, which is enough to put fear into the bravest of souls.

306. In my view, it is the culture of impunity at all levels of the system that is a significant factor in why toxic institutional cultures are established and abuse occurs. The Inquiry must investigate who has actually been held accountable, why accountability is so limited and why those at the highest levels within G4S and the Home Office have not faced any disciplinary action and why there is no political accountability for the misconduct, appalling treatment and repeated failures.

307. I am not aware of whistleblowing allegations at Brook House resulting in the sanction or removal of staff.

308. The fact that there has been no criminal prosecutions arising from the events at Brook House is also a major accountability deficit that impacts on people's trust and confidence in the system. The fact that no one at all has been prosecuted despite so much misconduct being captured on film inevitably destroys any faith in the system.

309. The lack of accountability and sanctions to date - is my primary reason for participating in the Inquiry and why I consider it so important. However, I strongly believe that things will not fundamentally change unless people are held to account at all levels of the system and serious consequences occur for the individuals and the corporate bodies. I do not understand how G4S could continue being the contract provided for almost 3 years after the Panorama broadcast which included a two year extension; and equally why any contract could continue to be run with G4S after the Medway and Brook House reporting. I also do not understand how managers within G4S with oversight for these centres or on site, like Ben Saunders, Steve Skitt, Juls Williams or Steve Dix were not dismissed but were able to continue in their roles or take up posts elsewhere. I also do not understand how senior civil servants responsible for these contracts such as Paul Gasson or Mr Schoenberger and for detention services generally have not been disciplined but remained in post.

310. Until concerted action is taken and is seen to be taken, complaints made will be ignored or more likely won't be made at all because people will have no confidence in the system."[570]

242. That gravity of the systemic failure at every level of by G4S to ensure a safe and humane environment at Brook House is compounded by and what makes it truly scandalous is the fact that there were numerous opportunities to uncover the toxic culture and abuse earlier but they failed to listen to whistleblowers. In addition to the failure to listen to Reverend

[570] DL0000141_0105-107.

Ward, the Inquiry has also heard that Michelle Brown and Stacie Dean tried to raise concerns but these too were ignored by both on-site G4S leadership and Jerry Petherick and Peter Neden.

243. Stacie Dean told the Inquiry:

"*8. I have been asked to respond to the point that Ms Brown raised concern at an SMT meeting at which I was present. I do recall regularly that Ms Brown was one of the SMT members who repeatedly raised concern about staff treatment of detainees. Both myself and Ms Brown were concerned that some members of staff as well as detainees were being regularly subjected to bullying behaviour from some staff. The response of the SMT was consistently uninterested, I do not recall specific dates or times but do remember the general approach to any of us raising concern or complaint would be fairly generic and non-committal and the lack of any action was frustrating. At times I think the view from some SMT members was that the situation was amusing so it was far from taken seriously.*

9. Having been asked why I sent a complaint to Peter Neden rather than Jerry Petherick and whether I have a copy of this I can confirm that I do not have a copy of the grievance I sent to Peter Neden but remember that I sent this to him rather than Jerry Petherick as Jerry was fully aware of the culture and issues at Brook House and chose to take no action or provide any support. I had no faith at all that anything further would be done. As far as I can recall I did not receive a response from Mr Neden although was contacted very swiftly by the G4S legal team to talk to me about the under-reporting and profit issue I raised. This appeared to be the only concern for the company. Having been asked to provide more information on this, I can't remember anything further than is contained within the letter regarding this unfortunately."[571]

244. Michelle Brown identified the same problem in her evidence:

"*In addition, I investigated and substantiated several complaints regarding staff bullying each other, staff bullying Detainees, displaying racist and inappropriate conduct — dating back as far as 2012 but there was little / no outcome. I continued to raise concerns with Ben Saunders and Steve Skitt. I did not see an improvement and as*

[571] Stacie Dean, INQ000172_0003

previously disclosed in my statement, I used the Whistleblowing hotline to report. I honestly did as much as I possibly could but that clearly wasn't enough"[572]

245. The wholesale failure of G4S senior leadership to listen to Reverend Ward, Michelle Brown and Stacie Dean (and probably others), is what led to the abuse occurring in the first place and what permitted it to continue with impunity. The Chair is invited to find that G4S's failure to take any appropriate action to prevent abuse and deter future abuses makes them directly and organisationally responsible for the mistreatment abuse that occurred both institutionally and functionally.

G4S absorbed the aims and objectives of the Home Office and treated them as their own

246. Another factor that played a part in the G4S failure act and to protect the welfare of detainees relates to its subservient relationship with the Home Office that led it to prioritise Home Office imperatives even at the expense of as safe and humane Centre. Reverend Ward explained:

> "*162…Management meetings were performance related, and included figures for sickness, complaints, removals etc. There was no effective method or time for the culture and practice to be reviewed and challenged. It was not a priority or on the agenda at Brook House. The focus was much more on finances and meeting the Home Office's objectives around removal and responding to that pressure. When I raised issues around poor culture, including staff being asleep on shift, not complying with good practice on CSU and phones not working in the command suite (all of which are indicative of a culture of complacency and negligence), it was generally ignored."*[573]

247. Several senior managers described the management of Brook House as customer-led. Ben Saunders told the Inquiry:

> "*A. I think this came from some feedback as part of the 360, and I think what people making those comments found me to be, you know, focused on contractual delivery, ensuring that we delivered against the contract and that we hit the targets that we were being set by the customer or the organisation.*"[574]

[572] Michelle Brown, INQ000164_0057
[573] DL0000141_0056.
[574] Ben Saunders, 22 March 2022, 79/13-17

248. Steve Skitt, G4S Gatwick IRC Deputy Director, agreed with that view:

"*18-19 Q. Was it anything that G4S could have put its foot down about and said, "No, this is not happening"?*

20-21 A. No, I wouldn't have thought so, no. We were providing what the customer had asked for."[575]

249. Michelle Brown, another senior manager, summarised the atmosphere in the centre:

"*Ben led a culture that G4S should always look to please our customers — which was the Home Office and the stakeholders of G4S - where in fact, in my opinion, our customer was the Detainees as whatever their circumstances or how or why they were detained or current government policies - they were essentially the reason Brook House existed*"[576]

250. While G4S bear responsibility for what happened, it is clear that the actions of the company were driven by the motivation to make profit and meet the political and operational priorities of the Home Office. The underlying decision-making which created the conditions in which the mistreatment and abuse occurred was the ultimate responsibility of the Home Office. The Home Office is therefore also directly organisationally and politically responsible for the mistreatment and abuse that occurred at Brook House. This is addressed next.

Causal Factor 5 : Arrangements and Institutional Relationship Between Home Office and G4S

<u>Enforcement over Fundamental Rights and Welfare /Cost Cutting and Profit over protection</u>

251. The nature of the contractual and business relationship between the Home Office and G4S was one with an emphasis on rewarding removals and penalising anything that hampered removals, with no meaningful contractual emphasis on welfare or avoiding harm.[577]

[575] Steve Skitt, 17 March 2022, 134/18-21
[576] Michelle Brown, INQ000164_0009, Para 11 – relevant page not published on Website
[577] Nathan Ward witness statement, paragraphs 25 (DL000141_0009) and paragraph 93 (DL000141_0032)

252. From the very outset, Brook House was driven by cost savings for the Home Office and profit for GSL/G4S. The Inquiry has the procurement process documents[578]. The cheapest bid won the contract (see paragraphs 83 and 84 of Reverend Ward's statement[579]) coming in at 35% below budget[580], something Phil Riley reluctantly accepted on behalf of the Home Office was too heavily weighted towards cost saving and that it encouraged "*people to put in a cost-efficient bid, because that drives down the cost and pushes up the score… the bids have done all they can to minimise costs, including staffing costs overnight. I accept that.*"[581] This hardwired into the Centre a number of key factors in particular a harsh and prison like lock down regime, inadequate day time activities and critically low staff numbers to deliver the low-cost budget.

253. At paragraphs 83 to 104, Reverend Ward sets out how the contractual arrangement to run Brook House with a prison-like regime was driven by profit and cost-savings over detainee and staff welfare[582]. He splits these into the following sections:

> *The Tendering process and the G4S BID*
>
> *83. I have seen the documents relating to the bid process for Brook House which confirm my experience of how it was set up to put costs saving for the Home Office and profit for G4S above the rights, welfare and dignity of those detained. It appears that GSL won the bid because they offered the cheapest bid. I have direct knowledge of the consequences of these contractual arrangements, cost savings and profit first approach.*
>
> *84.The documents show that the Home Office selected GSL (later acquired by G4S) as they offered a bid that came in 35% below what the Home Office had budgeted for. The Home Office's evaluation of the bids was weighted and split so that 50% would be based on the commercial proposals and 50% based on the quality of the bid (split into operational delivery at 25%, staff at 15% and maintenance at 10%). This weighting of the bid was how GSL won the contract. It seems having significantly the cheapest bid made up for the poor quality of their proposals to run the centre.*

[578] DL000140_0040-0087
[579] DL000141_0028
[580] DL000140_0047
[581] Philip Riley 4 April 2022, 48/12-25, 49/1-21
[582] DL000141_0027-0035

85. The Home Office was therefore proceeding from the outset knowing that GSL would be providing a service at 35% under what they had budgeted for. Although it is of course sound and prudent for a government body to seek value for money in procuring contracts when spending public funds, this is still a dramatic cost saving on their budget and led to what I experienced first and namely that Brook House was under-resourced, under-staffed and with limited provision for detainees. This is confirmed in the evaluation of the bid by the Home Office itself, as I go on to explain.

86. The Home Office went into the Brook House contract with their eyes wide open about the poor quality of GSL provisions and the potential effects this could have on detainees including for their safety and welfare. I have had sight of the Home Office's internal evaluation of contractor proposals for Schedule D of Brook House, which my solicitors have provided to the Inquiry. The regime proposed by GSL with a lengthy lockdown time was recognised by senior Home Office civil servants John Thomson[583], Phil Schoenenberger[584] and Marina Enwright[585] as a "desperate attempt to reduce costs at the expense of welfare"; as "excessive and not in keeping with the ethos of the rest of the estate: 21 hrs -08hrs... the proposals give no justification for such a lengthy period of non-association" and were "rather harsh". GSL proposals for activities during association were also described as "extremely poor, there was no programme, the incentive scheme lacked imagination... "

87. The Home Office had significant concerns about staffing levels, noting that "We are seriously concerned at the GSL proposal to reduce DCO levels at 2100hrs through to 0800hrs which has clearly been done in order to accommodate the lock down hours which are at the same time. The Centre, after 2100hrs, will be staffed by [redacted] DCO trained officers and this includes [redacted] duty managers. We do not consider this to be an adequate number of staff as the Centre is still likely to be receiving detainees into the early hours of the morning and discharging a good number of detainees throughout the night. Their ability to address standard operational functions such as constant watches and RFA/TC has not been addressed during the night hours." GSL's staffing levels overnight were deemed to "border on the unsafe". The Home Office described the proposals by GSL (and others that had provided similar bids) as follows: "An ethos of cutting corners and meeting basic standards was evident from much of what we read and we are especially disappointed at the extended lock down

[583] Mr Thompson went on to be Operational Head of Migration Policy in 2015.
[584] At the time of the BID Mr Schoenenberger was Head of DEPMU and the author of the documents. He later became Assistant Director of Detention Services until approximately 2018.
[585] Ms Entright continues to work in Detention Operations

hours proposed by these four of bidders. This appears to be a desperate attempt to reduce cost at the expense of welfare."

88. The Home Office's concerns about GSL's bid are self-evidently stark but were not enough to dissuade them from agreeing the contract given the extremely low cost of the bid and it is clear the bid was won on the basis of 50% of the evaluation being based on commercial interests. It is all the more concerning that the Home Office's concerns about the bid all came to pass with the HMCIP from 2010 repeatedly criticising the unsafe, harsh regime and poor conditions[586]. These same basic problems were evident when I was working there in 2011-2014 to a greater or lessor extent, and were the same concerns repeated by HMCIP in 2016[587] , Stephen Shaw in his reports in 2016[588] and 2018[589] and by Kate Lampard in 2018[590]. Lampard documented significant concerns about the dangerously low staffing levels and inadequate activity provision in breach of Rule 17 DCR 2001. This lead her [591]to conclude that the physical constraints, lack of facilities and environment made it "unsuitable to hold the number of detainees is does" and "unsuitable to hold any detainee for more than a few weeks"[592].

89. In my opinion, the Home Office should be held to its design specification of 72 hours, and any period beyond that would require fundamental changes to the layout, regime and staffing levels to ameliorate the impact of the harsh environment. In reality, where detainees ended up being held for much longer at Brook House, concerns over the regime, conditions, activities and staffing levels become much more profound.

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[586] *Full Announced Inspection of Brook House IRC by Her Majesty's Chief Inspector of Prisons ('HMCIP') (15-19 March 2010) (Published 12 July 2010) following a 5-day inspection* – see e.g. paras 2.7, 2.20, 2.27, 2.30, 6.5 and 6.29 – DL0000167_0024, 0025, 0026, 0052, 0055
Unannounced Inspection of Brook House IRC by HMCIP (12-23 September 2011) (Published 31 January 2012) – see e.g. paras HE.25, 6.3 – DL0000171_0013, 0051
Unannounced Inspection of Brook House IRC by HMCIP (28 May – 7 June 2013) (Published 1 October 2013) – see e.g. paras 1.55, 2.3, 3.9. – HMIP000311_0025, 0033, 0046
The Unannounced Inspection of Brook House IRC by Her Majesty's Chief Inspector of Prisons ('HMCIP') (31 October–11 November 2016) (Published 10 March 2017) – see e.g. paras 1.40, 1.41, 1.46, 2.1-2.2, 2.65, 5.2, 5.22-5.23 – CJS000761_0024, 0025, 0031, 0039, 0049, 0051

[587] Ibid *The Unannounced Inspection of Brook House IRC by Her Majesty's Chief Inspector of Prisons ('HMCIP') (31 October–11 November 2016) (Published 10 March 2017)* - CJS000761

[588] Stephen Shaw, 'Review into the Welfare in Detention of Vulnerable Persons', January 2016 – see para 2.7 where Brook House is described as being 'constructed to category B prison standards', 'somewhat claustrophobic' and 'feel and look of contemporary gaols'. See also paras 3.3, 3.5 and 3.16 – INQ000060_0034, 0045, 047

[589] Stephen Shaw, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons', dated July 2018 at 2.75-2.77 and A7.4-A7.12 – CJS0073862_0032, 0184-0185

[590] Prepared by consultancy firm Verita, entitled: *Independent investigation into concerns about Brook House immigration removal centre* (4 December 2018) – see para 1.26 on staffing, and 1.56 on activity provisions - CJS005923_0009, 0015

[591] Ibid 1.26, 1.32,1.34,8.3-8.4., 8.29, 8.44. and 8.71 above – CJS005923_0009-0011, 0096, 0104, 0107, 0113.

[592] Ibid at paras 1.57 and 15.3 - CJS005923_0015, 0252

These factors laid the groundwork for the serious problems that developed and became endemic to Brook House."

254. In his live evidence on 23 March 2022, Mr Schoenenberger confirmed his agreement that there was a contradiction between the proposals to run Brook House that so concerned his team in the procurement process (but which became part of the contract) and Rule 3 of the Detention Centre Rules 2001:

"Q. So a secure but humane accommodation with a relaxed regime with as much freedom of movement and association as possible. That stands, doesn't it, in quite stark contrast to your team's comments about the ethos seen in the bids of cutting corners and meeting only basic standards, and desperate attempts to reduce costs at the expense of welfare?
A. I guess there is some contradiction there, I guess, yes."[593]

255. As set out above, Phil Riley reluctantly accepted on behalf of the Home Office that the procurement was too heavily weighted towards cost saving and that it encouraged "*people to put in a cost-efficient bid, because that drives down the cost and pushes up the score... the bids have done all they can to minimise costs, including staffing costs overnight. I accept that.*"[594] This practice seemed to be confirmed by G4S Corporate Witness Gordon Brockington when speaking candidly with Kate Lampard in an interview on 9 March 2018 (so candidly G4S unsuccessfully sought a restriction order to prevent its use by the Inquiry). At paragraphs 61-62 of the interview he discusses an example of under-staffing to make sure the bid was cost-efficient and could win:

"61. A. Let's just say, the specification says you need four officers to deliver this service. You know as incumbent because of the cohort of individuals you are looking after, the design of that wing, the levels of violence that there might be, etc., you know you can currently only deliver that safely with eight people. They will ask for four, and we will say 'it's not deliverable with four, so we will put eight in our model'. That makes you uncompetitive, so you are less likely to win the bid, but our governance won't allow us not to put in eight because our governance dictates that it has to be signed off by our operations team, who will ultimately be delivering this.

62. You have that tension between putting in a competitive, compliant bid, which is both compliant with the terms and conditions of what they're asking for and compliant with

[593] Philip Schoenenberger 23 March 2022, 16/7-14
[594] Philip Riley 4 April 2022, 48/12-25, 49/1-21

the service that they are asking for, often juxtaposed to what your commercial ambition is, to try and get to a winning price. That is where and how we build our governance."[595]

256. Mr Brockington would later try to temper this evidence in his second witness statement of 10 February 2022, claiming at paragraph 3 that he was just speaking on a "*purely hypothetical basis.*"[596] But it's clear that even if a hypothetical example, it reflected G4S's corporate and commercial position and one in which they would knowingly under-bid for services and provide less than they know is operationally needed to ensure they remained commercially competitive. During the Brook House procurement process in 2007-2008, it was clear that the Home Office were prioritising cost-saving measures above all else and bidders like GSL and G4S were only too happy to go along with it and was reflected in the harsh regime and limited facilities at Brook House.

257. In his witness statement dated 25 February 2022, Phil Schoenenberger confirmed that the bid was won on "*based on their financial scores*".[597] Mr Riley in his live evidence suggested that the Home Office have now tried to move away from tendering focussed on price and that the split is now more greatly weighted in favour of quality.[598] But again as so candidly emphasised by Mr Brockington in his interview with Kate Lampard, private contractors know that it's ultimately still price that will always win the bid: *"Rest assured the vast majority of government tendering, regardless of whether it says it's 50:50 price: quality, it's price, let's face facts."*[599] Mr Brockington again tried to temper these comments when giving live evidence on 31 March 2022 (giving less candid and transparent evidence than in the Verita interview he thought was confidential). However he still made the following telling observation: *"What I can say, harping back to, probably, 2007, I think there was a far bigger drive by government to get a low price, which I would argue isn't necessarily value for money; I think that is a very different question."*.[600] Mr Brockington's live evidence thus supports the view that the Home Office's drive during the procurement process for Brook House was to obtain the lowest price possible. This would go on to have a fundamental impact on the regime and welfare of detainees for all the reasons Reverend Ward has highlighted (as set out above) and as seen during the Relevant Period. As to Mr Brockington's emphasis in live evidence that his comments to Kate Lampard were only about Home Office practice only in 2007 (stating in live evidence that there is now *"a far*

[595] Gordon Brockington Interview with Kate Lampard for Verita Report, dated 9 March 2018 – VER000255_0006
[596] Second Witness Statement of Gordon Brockington dated 10 February 2022, paragraph 3, CJS0074043_0001
[597] Witness Statement of Philip Schoenenberger dated 25 February 2022, paragraph 13, HOM0332132_0004
[598] Philip Riley 4 April 2022, 35/14-20
[599] VER000255_0010, paragraph 121
[600] Gordon Brockington 31 March 2022, 75/25, 76/1-4

bigger drive by government for value for money and quality[601]*"*), this is plainly untrue given that Mr Brockington's interview was in 2018 and he was clearly talking about present practices.

258. This was a position in any event confirmed by G4S UK and Ireland Regional President Peter Neden who confirmed at paragraph 42 of his witness statement of 6 February 2022 that: *"the Home Office was also keen to reduce operational costs as price was, in nearly every case I can remember, the determining factor in awarding contracts."*[602]

259. Reverend Ward further discussed how in his experience the terms of the contract between the Home Office and G4S had in-built measures that prioritised cost-cutting and profit at the expense of detainee welfare:

Cost-Cutting/Profit Making

> *"90. The contract was also set up to encourage GSL and later G4S to cost-cut further and to share any savings with the Home Office. Schedule S of the contract explicitly compels the contractor to look for cost savings and report them immediately to the Home Office. Therefore, if profit went above the original contracted price, G4S should declare that not as extra profit, but as a cost saving to the authority.*
>
> *91. This initiative engendered costs-savings that was at the expense of detainees. For example, I remember attending a Senior Management Team meeting on 11 March 2013 where Ben Saunders confirmed plans to try to differentiate between those who would be residing in Brook House on a more long-term basis and those who were arriving at the IRC to be removed on a charter flight. They wanted to propose issuing bed and cutlery packs etc. only to the former and not the latter group to produce cost savings. This is one simple example of how these cost savings measures could be implemented at the cost of basic human decency and providing basic provisions such as bedding.*
>
> *92. G4S became very efficient at saving costs on a contract they had already won on the basis they were significantly under budget. In the '360 Degree Contract Review', produced by Ben Saunders in 24 June 2014, and disclosed to core participants*[603]*, Ben Saunders noted how G4S were able to secure a contract extension to May 2017 based on "offering clustering and efficiency savings to the customer (Brook House Efficiency*

[601] Ibid, 76/15-16
[602] Witness Statement of Peter Neden dated 6 February 2022, paragraph 42, INQ000119_0010
[603] CJS000768

Savings £246k p,a, Clustering Savings £61k p.a), (Overall £800k pa savings from Brook House, Tinsley House and Cedars) This amounts to £1.5m savings at Brook House and £4m across Gatwick over 5 years." What this means in practice was that G4S were able to offer clustering savings by re-structuring staffing across Brook House, Tinsley and Cedars which reduced the total number of staffing roles (such as family suite officers, a facilities officer and security) and changed responsibilities of certain staff and their roles. It was part of this re-structuring that changed my role from Head of Children's' Services to Head of Tinsley House.

93. In addition they introduced a key vend, an automated fingerprint system to release keys, meaning staff members were no longer required to perform the role of handing out keys. This led to a reduction in staff and the number of Assistant Custody Officers by 4. It was clear that the Home Office valued G4S's ability to save costs for both the Home Office and themselves and it led to them extending the contract on this basis, despite many criticisms from the HMIP (and elsewhere) on regime and conditions. These cost savings ultimately allowed G4S to gain margins and profit beyond that allowed in the contract, which I discuss further below. Any such proposals or changes that were made to the contract would have to be approved by Jerry Petherick and possibly others above him.

94. I also witnessed improper recording of information in relation to cost savings. For example, in around 2011-2012 I received an email, which I do not have access to now, from a G4S accountant with the asset list for Cedars' pre-departure list, asking me to highlight items that were charged to the Home Office but that we would never actually buy in the end. I ignored the request.

260. The need for constant cost savings in the pursuit of profit was confirmed by G4S UK and Ireland Regional President, Peten Neden, in his live evidence on 22 March 2022, including in respect of simultaneously making savings for the Home Office whilst doing so:

"All members of the management team were encouraged to find ways of operating contracts more efficiently; partly for the benefit of G4S and partly for the benefit of the clients and, therefore, the taxpayer."[604]

"Q. But "more efficiently" means more profit for G4S or less money spent by the Home Office; yes? That's what "more efficiency" means? A. It only means within the life of

[604] Peter Neden 22 March 2022, 31/22-25

that individual contract. If you were to look at that over a longer period of time, our client was very interested in us making efficiencies through the life of the contract, which may turn into profit share, ie, some for the company, some for the client, within the contract period, but, more importantly, from the client's point of view, at the next bidding of the contract, all of those cost savings would be baked into everybody's bid."[605]

261. When asked by CTI about prioritising cost savings over detainee welfare, Mr Neden worryingly could not seem to see that there was a link: *"A. I think detainee welfare and cost savings are different things. Q. They are not necessarily different things, though, Mr Neden, are they? Because if savings are being made by not having sufficient staff and that affects the treatment of detainees, which is what this inquiry has heard from both staff and detainees, that this is cost savings and detainee welfare being the same thing, isn't it? A. Yes, but you said "if", and I'm not sure that that's the case"*[606] Mr Neden appears to be suggesting that it is only a problem "if" cost savings are done to reduce detainee welfare. He appears entirely unable to understand or accept that even if done for different reasons or intentions, the cost saving measures agreed by the Home Office and G4S did affect the regime and detainee welfare.

262. Centre Director Ben Saunders confirms feeling this pressure and the priority to focus on profit-making. In his witness of 17 February 2022, Mr Saunders states at paragraphs 66-67: *"I was required to run Gatwick IRCs, manage the customer and deliver the contract in a way that the initial contract bid anticipated with the expectation that I was to deliver more than the set profit margin with year on year improvement... The focus of G4S seemed to be on targets, profit and on contract delivery. All targets were finance focussed. My briefing from Jerry Petherick when I became Centre Director was that more rigour was required in respect of contract management and leadership at the Centre."*[607] He expanded in his live evidence on 22 March 2022: *"Well, there was certainly focus on contractual delivery and meeting contractual requirements, minimising any penalties through effective contract delivery, and there was a focus on profit."*[608]

263. In his live evidence, Mr Saunders was asked about comments he made to Verita in his interview with them on 13 June 2018 about the Home Office's treatment of detainees and the 'hostile environment', including that *"the Home Office didn't really care about the people we looked after... the Home Office entity corporately was mostly concerned about*

[605] Ibid, 32/1-12
[606] Ibid, 52/4-14
[607] Witness Statement of Ben Saunders dated 17 February 2022, paragraphs 66-67, KEN000001_0013
[608] Ben Saunders 22 March 2022, 80/6-9

the removal process and the functionality of it…"[609] When asked to comment on this interview remarks, he linked them to concerns about how the contract worked with the Home Office and how detainee welfare was not prioritised:

> *"Q…Does that accurately reflect your experience of the Home Office line?*
> *A. I think I did experience elements of that. Yeah, I was concerned always about the care of detained persons, and I took that as a responsibility of mine, to make sure that we looked after them humanely, and clearly we have failed in that, but that was always the intention, and we succeeded in some cases, many cases. I think -- yeah, in terms of the contract conversations I would have with the Home Office, certainly there was a focus on elements of delivery that linked with the immigration process. So official visits, for example; you know, ensuring that arrivals and discharges were completed effectively were clearly a focus.*
> *Q. Yes.*
> *A. And, yeah, I did have some experience of where it felt that, you know, there wasn't sufficient consideration about the welfare of some individuals, that particularly…"*[610]

264. There have been multiple examples within the evidence provided to the Inquiry of Home Office cost saving and G4S profit at the expense of a humane regime and detainee welfare. Two of the examples that most commonly arose related to staffing levels (addressed further below) and the additional 60 beds project.

Expansion of Capacity

265. In relation to the decisions to increase bed capacity at Brook House, Reverend Ward set out in his statement:

> *95. One of the main efficiency savings and profit-increasing measures that was agreed during my employment was the expansion of the capacity of Brook House. First, this was the introduction of an additional 22 bed spaces whilst I was still there in March 2013, taking the detention capacity up to 448 spaces. The G4S 360 contract review confirms at page 24 that this led to an increase in revenue of £482,000 per annum and £28,000 profit per annum. This was made despite the obvious pressures and demands on the staff from the existing population and the inadequate staff ratios.*

[609] Ben Saunders Verita Interview dated 13 June 2018, paragraphs 249-255, VER000226_0020
[610] Ben Saunders 22 March 2022, 124/5-25

96. Whilst I was still there, plans also started to be made to increase bed space by an additional 60 beds by introducing a third bed in 60 of the cells. As I set out at below, I had already raised serious concerns about the cell sizes, the impact on detainees' mental health and whether they met international standards. Stephen Shaw equally raised concerns about the introduction of 3 man cells in his 2016 report after visiting Brook House in May 2015,[611] and set out his disappointment in his 2018 report that it went ahead, stating "I did not find the conditions in those rooms remotely acceptable or decent".[612] The introduction of these additional 60 bed spaces via three-man cells, at the clear expense of detainee welfare, ultimately went ahead in 2015/16 because it was a cost-effective way for the Home Office to advance their overriding aims of increasing the detention estate and removals which also allowed G4S to increase their profit. Ben Saunders confirms at page 24 of the 360 Degree Review that it was estimated that the introduction of these additional 60 bed would overall increase revenue by £1.5million per year with a profit margin of £91,000 per year.

97. In addition, Lee Hanford confirmed to Kate Lampard in his interview for her report [VER000266] that the 60 new beds were a cost saving exercise by the Home Office to the detention estate: "[Lee Hanford -24]: It was around that same time where government were trying to get more for less. It's all post the 2012 drive from where we've seen a lot of prison closures, and increased population across prisons. I think as another government agency they explored similar solutions. [Kate Lampard – 25]: Austerity. [Lee Hanford- 26] Austerity."

98. I find it difficult to understand how Jerry Petherick (and anyone else responsible for the decision in G4S and the Home Office) could had given approval for the addition of the 60 beds at Brook House. In my view it was negligent and reckless to do so. It was done without regard for the impact on detainees and I understand no equality impact assessment was undertaken.[613]

266. In addition to these concerns raised by Stephen Shaw and Lee Hanford above, Kate Lampard also set out concerns regarding the additional beds in her 2018 report, noting in particular the concerns of staff and the fact the 17 additional staff the Home Office agreed for G4S to help with the increased capacity remained vacant (despite the Home Office having paid for it).[614] The HMIP had also cautioned against the decision in their 2016 report

[611] See para 3.5 – INQ000060_0045
[612] Para 2.75 - CJS0073862_0032
[613] *R (Hussein and Rahman) v SSHD and G4S* [2018] EWHC 213.
[614] CJS005923_0101, 0102

prior to their installation: *"Ii would add a cautionary note on an issue that is not the subject of a specific recommendation but has the potential to adversely affect the conditions in which some detainees are held: the proposal to bring into use the third bed which has been installed in 60 of the two-person cells. Many staff and detainees were of the view that this would lead to a decline in living standards. This is a view shared by my inspectors."*[615]

267. Multiple witnesses were questioned by the Inquiry on the additional beds:

i. Hindpal Singh Bhui of the HMIP described having three detainees in a cell as "playing with fire' but means G4S will make more money from the contract" in a meeting with Ed Marsden for the Verita report on 6 October 2017.[616] When asked what he meant by 'playing with fire', Dr Singh Bhui confirmed ni his live evidence: *"I think, you know, putting three detainees into a cell designed for two -- I think overcrowding is always bad. It creates incidents. It means people get more frustrated. And we had already raised a lot of concerns about ventilation. So I think that was a real concern."*[617]

ii. In her witness statement, Michelle Brown set out safety concerns in respect of the decision: *"59... I remember attending a three persons mock-up room that was intended to be replicated on all the ground floor rooms to increase the bed capacity by 60. I took one of my Safer Community Managers Scott Payne with me to the unveiling. I was initially struck by how cramped the rooms were and the design ie the ladder could be a slip hazard, lack of locker space and side support to prevent a Detainee rolling / falling out of bed. Scott and I identified ligature points and that if all three beds were being used then not all occupants were able to see the television. In addition, I was concerned about the safe removal of a Detainee from the top bunk in the event of any potential Control and Restraint incidents. I shared my concerns with Ben and Steve — I did this immediately after viewing the room..."*[618]

iii. When pushed on whether the decision by G4S to agree to the additional beds was motivated by profit, Jerry Petherick sought to defend G4S' position in the pursuit of profit: *"Q. But, nonetheless, you're not going to say, Mr Petherick, whether it was £28,000 or £2.8 thousand, that there wasn't a profit in it for G4S*

[615] HMIP000613_0007
[616] VER000193_0001
[617] Hindpal Singh Bhui 24 March 2022, 173/20-25
[618] INQ000164_0036

by the increased capacity? A. Absolutely. As I said earlier, I'm not embarrassed about that because there was increased workload, and so forth"[619]

iv. Lee Hanford was asked by the Inquiry about his Verita comments quoted in Reverend Ward's witness statement above. In his witness statement of 17 February 2022, Mr Hanford confirmed at paragraphs 77-79: *"The Home Office wanted to increase the population and it was a good opportunity for G4S. A key driver of the Home Office during negotiations was to reduce the blended rate of the cost per detainee place... There was no resistance to the Programme from a G4S perspective. This expansion was perceived to be an opportunity to respond positively to our customers' requests to increase bed spaces at Brook House and Tinsley House."*[620] Mr Hanford's evidence was that it was a good opportunity for G4S and for the Home Office to reduce the cost per detainee place. Although he does not address it directly however, it is clear Mr Hanford's witness evidence clearly supports the notion the bed expansion was G4S profit and Home Office cost-saving at the expense of detainee welfare – given what he told Verita, and as he goes on to note at paragraph 84: *"I stated that there was not sufficient activity space in Brook House for 448 detainees, let alone 508 (VER000239, page 16). The facility was not designed to accommodate people for long periods of time. There was not enough space to provide activities for so many people for long periods."*[621]

v. Peter Neden was defensive in live evidence when asked about the additional of 60 beds to Brook House. Despite having previously confirmed he had responsibility for decisions related to "contract profitability",[622] he appeared to have little memory of the decision. He could not remember if he was aware of Stephen Shaw or the HMIP's 2016 concerns prior to them being installed, he could not remember why they decided to proceed despite such warning, but when asked if this was an example of G4S compromising on detainee welfare to increase profit he could remember that: *"No. I believe it was an example of us trying to meet the needs of the Home Office."*[623]

vi. In his live evidence, Steve Skitt stated that in his "personal view" he did not agree with the three-men rooms albeit that was because he believed all custodial

[619] Jerry Petherick 21 March 2022, 60/1-6
[620] CJS0074048_0021
[621] CJS0074048_0022
[622] Paragraph 41 of witness statement, INQ000119_0010
[623] Peter Neden 22 March 2022, 49/20-25 – 50/1-12

sites should be single rooms.[624] Mr Skitt did also accept in his witness statement of 4 March 2022 that the decision *"would clearly have an impact on space available for detained persons."*[625] When asked if G4S could have resisted the Home Office's request for the third bed, Mr Skitt – echoing Mr Neden's comments above – stated: *"No, I wouldn't have thought so, no. We were providing what the customer had asked for."*[626]

vii. In his live evidence, Phil Riley confirmed that the additional beds were removed in light of Shaw's 2018 review: *"A. In light of Stephen Shaw's second review, in 2018, we considered how we were using the estate and we made a number of changes. We took the third beds out of centres, Gatwick and Heathrow, we closed Campsfield House because the rooms there were crowded and I wasn't happy with them, and we put an operating cap of 80 per cent occupancy on a centre, except in exceptional circumstances. So we changed our approach to it, but we were able to do so."*[627] When ask why the Home Office proceeded with the decision in first place to introduce them despite Shaw's 2016 views and that of the HMIP, Mr Riley fell back on his excuse that he could not answer because he was not in post them: *"I don't know, Mr Altman, because I wasn't there at the time but, anyhow, I can speculate that, you know, extra capacity was needed and that options were reviewed."*[628] When asked if it was a mistake, Mr Riley again fell back on not being in post: *"I couldn't characterise it as a mistake, no, because I don't know what the options were at the time."*[629]

268. Mr Riley's answers are clearly unsatisfactory. He was put in place as the Home Office corporate witness. These were foreseeable issues that he should have familiarised himself with. In the absence of any cogent and evidenced explanation from the Home Office, it must be assumed that the decision – based on the evidence of others -was taken to save costs. The evidence showed that the decision impacted detainee welfare and were a significant factor in Holman J's findings in *R (Hussein and Rahman) v SSHD and G4S* [2018] EWHC 213.[630]

Profit Margin

[624] Steve Skitt 17 March 2022, 132/19-25
[625] Paragraph 84, SER000455_0029
[626] Steve Skitt 17 March 2022, 134/18-24
[627] Philip Riley 4 April 2022, 68/15-23
[628] Ibid, 69/19-25
[629] Ibid, 70/1-4
[630] DL0000174

269. At paragraph 99 of his statement, Reverend Ward noted in respect of Ben Saunders pursuing profit, at the request of G4S management, beyond that stipulated in the contract:

> *99. The profit margin under the contract was meant to be 6.38%. In the 360 Degree Review of 2014, Ben Saunders confirmed the contract margin to be 6.38% but boasted that the 'actual' contract margin was 18%, achieved having "restructured our staffing, introduced clustering and efficiency savings such as key vend, introduced over 100 Notices of Changes since bidding the contract and added a further 22 beds to change from 426 to 448 beds at this current time".*

270. The witness evidence of Mr Saunders has now confirmed that this what he was asked to do by G4S: 67: *"I was required to run Gatwick IRCs, manage the customer and deliver the contract in a way that the initial contract bid anticipated with the expectation that I was to deliver more than the set profit margin with year on year improvement."*[631]

Contractual Penalties and Priorities

271. From paragraph 100, Reverend Ward set out concerns in relation to how the flaws in the contract agreed between the Home Office and G4S in respect of penalties for contractual failures and how it impacted on what elements of contractual performance were prioritised:

> *100. Penalty points and fines were contained in the contract. I was always very struck by the system devised for penalising breaches of the contract, and the perversity of the priorities it set. A single penalty point at Brook House equated to £1.36 compared to £0.65p at Tinsley House. Schedule G set out the performance evaluation and the circumstances that measures would be applied within the contract. At Brook House, a failure to admit or release a detainee resulted in 500 penalty points (£680), a substantiated serious complaint 300 points (£408) and not submitting an incident report was 100 points (£136). There were no penalty points for abuse of detainees, something the National Audit Office pointed out in their 2019 report when they deemed the contract "not fit for purpose"*[632]*. There were, however, points for self-harm resulting in injury and requiring healthcare intervention but only where there was a failure to follow laid down procedures for the safety of detainees as set out in Schedule D. This carried a penalty of 400 points (£544) although I am unaware of points ever*

[631] KEN000001_0013

[632] See National Audit Office, *The Home Office's management of its contract with G4S to run Brook House Immigration Removal Centre*, July 2019 at paragraph 27: DL0000175_0010

being awarded under this section of the contract even though self-harm requiring healthcare intervention was a frequent occurrence at Brook House.

101. My solicitors have provided me with Home Office Freedom of Information responses (ref: 39339 and 55266) which I enclose as Annex 4.[633] *This confirms the number of self-harm incidents at Brook House requiring medical treatment for each year from 2010-2017 and also accords with my understanding of the incidence of self-harm, although the figures may be under reported. Figures ranges from 39 in 2010 to 84 in 2014 and 54 in 2017. At least for the time I worked at Gatwick IRCs, I was unaware of G4S being fined for any such self-harm incident.*

102. Another point that I think is significant, is that the penalty points in Schedule G fixed a fine of £30,000 for an escape, versus £10,000 if a detainee died. This just shows the relative worth of welfare over security and how little the lives of the detainees were valued, against the imperatives of removal and how the incentives/profit costs were weighted against protecting life and welfare.

103. This raises clear questions about the priorities and suitability of these contractual arrangements and the ability of the laid down procedures to ensure safety and welfare of detainees. The contract as a whole makes clear the Home Office's own priorities, the message it sends to the IRC's about those priorities, as well as the limited consequences for serious failings and conduct for failures to protect detainees.

104. It is notable that this similar issue was picked up in the Medway Improvement Board's Report in relation to Medway STC, run by G4S, which states at paragraph 5.9, 'that penalties imposed by the YJB for not complying with all terms of the contract can be quite severe and, quite similarly, do not necessarily support a vision of a nurturing and rehabilitative environment' At 5.10, 'the Board feels that the terms of the contract mean the contractor is penalised for incidents that do not necessarily improve safeguarding or rehabilitation and that avoiding contractual penalties has become more important than considering what purpose the provisions behind the penalty serves for the young people'.

272. Reverend Ward's concerns about the penalty points on self-harm were put to Jerry Petherick in live evidence after it became clear that no penalty points had been awarded against G4S for this. Mr Petherick stated that it would have been a "high bar" for G4S to

[633] DL0000140_0088-0097

be penalised.[634] CTI asked Mr Petherick about clear and obvious examples – such as D1527 on 25 April 2017 and D1914 on 5 July 2017 – were the bar would and should have been met before asking: *"When there were such incidents, who sat down and went through 226 pages of schedule D, just to confirm that there was no failure to follow laid-down procedures for the safety of detainees? A. I doubt whether anybody sat down and went through 250 pages. My expectation is that the establishment management team, at the right level, and the Home Office came to a view on that... Q. My question, really, is, Mr Petherick, how does anybody, however it was done, decide that self-harm resulting in injury results in 400 penalty points without understanding what laid-down procedure they had to be in breach of in order for the penalty point to be awarded? A. I think, to be quite honest, you'd have to ask the people who were having that conversation. Q. Should I be asking Ben Saunders, for example? A. As the director of the establishment, I would expect that"*[635]

273. CTI did go on to ask Ben Saunders the next day, 22 March 2022, about how G4S would self-report self-harm incidents and what would meet the threshold. Mr Saunders claimed that every incident of self-harm would be reported to the Home Office as "*part of the regular monthly reporting*" and "*as part of the Safer Community meeting... So we did report every incident of self-harm, including those with injury, to the Home Office as part of our regular reporting*"[636] When CTI pressed on why this did not result in any penalty points against G4S for self-harm, Mr Saunders responded: *" A. I think our interpretation of the contract was that, if a self-harm incident involved -- you know, resulting in injury was to be contractualised in terms of penalties -- Q. That's a terrible word, Mr Saunders. A. I know, but that's kind of what you are alluding to, is how we report contractually, in terms of failures and penalty awards, incidents of -- where people have seriously harmed themselves. So, actually, you know, we went to a lot of trouble and care to make sure that we looked after people who felt the need to self-harm, and that -- which was reflected back to us very positively. I think -- so in terms of, you know, the contractual element to this reporting, we interpreted the contract as we would incur penalties in terms of schedule G should the self-harm resulting in injury have resulted from a failure in our staff to follow the laid-down procedures."*[637] Mr Saunders maintained that all self-harm incidents would be reported to the Home Office, through the Safer Community meetings chaired by Michelle Brown before noting: *"I ultimately signed off the reporting to the Home Office on a monthly basis, and that was done in conjunction with the Home Office. You know, the*

[634] Jerry Petherick 21 March 2022, 112/23
[635] Ibid, 113/13-20 – 114/1-13
[636] Ben Saunders 22 March 2022, 157/16-25, 158/1-4
[637] Ibid, 158/18-25, 159/1-5

Home Office -- as you say, I don't know particularly how much scrutiny they paid to incidents. Not a huge amount, I would suggest."[638]

274. Paul Gasson gave his live evidence on 15 March 2022. When asked about how as the Home Office compliance contract manager, he would check for breaches of contract from self-harm resulting in injury, he responded: *"A. I don't know, to be honest with you. I don't know if we did. I don't remember doing that... I didn't go back and check I think is the answer you're probably looking for."*[639]

275. Ian Castle, who managed the Home Office contract compliance team when he joined during the Relevant Period, gave live evidence the same day. It was put to him that there were zero penalty points for self-harm resulting in contract in 2017 and he was asked what steps he took to ensure that was accurate given contrary evidence at the time from the IMB: *"A. None. Q. What about your team? A. I don't know. I can't recall. I'm not sure whether I even know, sorry."*[640] Mr Castle agreed in evidence that *"from a purely financial perspective, that G4S were disincentivised from reporting any contract failures, because each one would cost them money"* and that *"so it's vital to ensure that, despite that, they nevertheless accurate self-report failures"*[641] When challenged that this must have therefore included the Home Office checking that self-reporting was accurate, Mr Castle stated: *"A. I think the problem that we would have there would be, if something is not reported, that method is the only way that we have, short of having -- either having a member of staff with each of the G4S members of staff walking around to make sure that they're being straightforward and honest, or to review every moment of CCTV and body-worn cameras during a day. So, yes, we did rely on honesty and integrity from G4S."*[642]

276. The evidence the Inquiry has seen however is that G4S could not be relied upon to act with honesty and integrity and it was clearly not in their financial interests to self-report failures, particularly given – as Ben Saunders states – they paid little scrutiny and were more concerned about removals. When combined with the failures in respect of Rule 35(2), it is clear that there were significant failures of oversight by the Home Office into the welfare of detainees at risk of self-harm and suicide and that G4S faced no consequences for their poor management of such individuals.

[638] Ibid, 159/19-25
[639] Paul Gasson 15 March 2022 161/21-25, 162/9-10
[640] Ian Castle 15 March 2022, 19/13-25, 20/1-7
[641] Ibid, 20/19-25, 21/1
[642] Ibid, 21/5-12

277. This similar lack of integrity in reporting penalties was also raised by Michelle Brown in her witness statement who suggested that there had been historic attempts to cover up contractual failures – continuing beyond the Relevant Period, with Sarah Newland – the current Deputy Director with Serco – at the heart of it. At paragraph 100, she stated: *"I would say there was a desire to mitigate performance points, however from my own perspective, I was open and honest and accepted if there was a failure and offer no mitigation — which is demonstrated in the performance table in CJS004584. I believe this gave me credibility with the Home Office in terms of being open and honest in failure of service as opposed to tying to blag it. Upon taking on the role of Business Intelligence Manager in 2019, I was pressured not to declare audit failings to the Home Office or wider G4S going back as far as 10 years that had historically been signed off as "compliant". I felt in an untenable position as I was not prepared to put my name to falsifying documents which resulted in accusations from Sarah Newland, my Line Manager at the time, of not delivering in my role and being awkward."*[643]

278. Further details of Ms Brown's concerns on covering up audit failures to avoid contract penalties were set out in her grievance letter to Serco when she resigned in 2020. She explained how after a meeting with the Home Office in April 2019 about concerns about how audits had been historically conducted, she reviewed various audits on G4S' self-reporting on contractual compliance and explained she was *"shocked by the quality and accuracy of them"*. She confirmed she dip tested other audits and found that *"baselines were assessed by the auditing DCM as compliant and then signed off by another member of SMT, Dan Haughton, as compliant, despite having full knowledge we had never delivered or met the requirement."* After feeding back her concerns to then Centre Director Phil Wragg, she notes that: *"Phil merely advised me to write to the authority, maintaining there was no "agreed standard" of quality, therefore, all audits were deemed as complete by G4S and the penalty award should be mitigated."* She explained further that when preparing the audits schedule for the next financial year, she *"discovered that G4S had never completed any DSO (Detention Service Order) audits which had been stipulated in the contract for the past 10 years. This meant an additional 54 audits were required to be completed on top of 90 that were expected. Again, I fed this back.*[644]*"* Such failures are grave when considering that the DSOs provide significant safeguards for detainees and guidance on matters that have caused the Inquiry serious concerns – e.g. the use of Rule 40, the management of adults at risk, and Rule 35. Mr Brown went on to give further examples of both Sarah Newland and Phil Wragg expressly directing her not to report contract penalties she had identified and to report them as compliant. She explains how

[643] INQ000164_0052-0053
[644] SER000461_001-002

they pressured her to do so, and even explains being called by Sharon Holmes, a senior compliance manager at G4S, who told her: *"declaring non compliances actually looks bad on you Michelle". I took this as pressure not to be transparent not only to the wider business but to the authority — which I took offence at.*" [645]

Staffing Levels

279. Staffing levels were a key aspect of the contractual relationship. At paragraphs 114-122 of his first statement Reverend Ward gave evidence of the staffing levels (and their misrepresentation). His evidence has been supported by much of the evidence heard by the inquiry. Reverend Ward told the Inquiry:

> "*There was a major issue of under-staffing at Brook House; an issue which I believe directly links to the culture and abuse of detainees. It is more likely that the ethos and operation of Brook House would have been more resilient if the contract was being run properly and there were adequate staff. People would not be so tired, stressed and overworked from doing overtime*" [646]

280. Reverend Ward explained that the consequence of this is that staff/detainee ratios were not sufficient to manage the centre safely. The issue became particularly acute as the capacity at Brook House was increased from the design intent of 426 to 448 in 2013 and then in 2016 to 508 detainees and at the time of Panorama.[647]

281. Staffing levels at night were a major concern. Reverend Ward told the Inquiry that some nights there were only six staff members on a shift, which was insufficient to deal with multiple constant watches, to call ambulances and provide for escorts and to deal with an influx of detainee arrivals.[648] In order to operate the centre with so few staff, it was necessary to impose a long 'lock-in'. Reverend Ward provided documents to the Inquiry which demonstrate that at the time of the initial bidding even the Home Office regarded that proposed night-state as "*border on the unsafe*".[649]

282. Callum Tulley gave evidence which was consistent with Reverend Ward's account.[650] He told the Inquiry that short-staffing occurred on a daily basis, with wings that were meant to be managed with three staff members in practice being managed by one or two staff

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[645] SER000461_004-005
[646] Nathan Ward, DL0000141_0039, Para 114. This has parallels to the Woolf report, referenced at paragraph 65
[647] Nathan Ward, DL0000141_0039, Para 119
[648] Nathan Ward, DL0000141_0039, Para 120
[649] Nathan Ward, DL0000141_0039, Para 122
[650] Callum Tulley, INQ000052, Para 71

members. It was a problem because each wing would have around 100 detainees and with only one or two staff members on each wing it was impossible to ensure that all the tasks undertaken by DCOs, ranging from ACDT observations to handing out toilet roll.[651]

283. Callum Tulley told the Inquiry that this led directly to abuse of detainees:

> "*Such an unmanageable work load for staff meant they were often irritable, stretched, overworked, unapproachable and tired. This would often lead to staff taking their frustrations out on detainees.*"[652]

284. Callum Tulley's video footage includes a DCO describing how she was left alone managing a wing after three weeks in the job.[653] In another example, Callum Tulley speaks with another DCO who was left in charge of a wing containing 128 detainees after working at Brook House for a month.[654] There is no evidence before the Inquiry to suggest that there were sufficient staff at Brook House during the relevant period.

285. It is clear, therefore, that staffing levels were a contributory factor to the abuse uncovered at Brook House. Due to the under-occupancy of Brook House, because of the circumstances of the pandemic, it is virtually impossible to tell whether anything has actually improved in relation to staffing.[655] IMB told the Inquiry that concerns remain about the quality of current staff as occupancy levels rise again.[656]

286. Further in respect of staffing, evidence given to the Inquiry has confirmed that G4S were knowingly and intentionally under-staffing in the pursuit of greater profit, and that the Home Office failed to stop this practice and must have known it was occurring.

287. At paragraphs 115-118 of his witness statement,[657] Reverend Ward gave a number of examples where G4S contractually benefitted from under-staffing and would often manipulate the contract to increase profit from under-staffing. This included:

i. The contract provided a fixed fee for salaries based on a full-staffing complement that G4S would be paid regardless of whether G4S was actually fully staffed. G4S could therefore profit from not filling staffing roles because

[651] Callum Tulley, INQ000052, Para 71
[652] Callum Tulley, INQ000052, Para 71
[653] Unidentified female DCO, TRN0000093_0024 – relevant page not published online
[654] DCO identified as 'Victoria', TRN0000035_0001-0002 – not published online
[655] Steven Hewer, SER000451, Para 50
[656] Mary Molyneux, 25 March 2022, 168/11-15
[657] DL000141_0039-0040

the fixed fee was larger than the penalty contracts for under-staffing and any associated over-time (paragraph 115);

ii. Contract manipulation by reporting staff as being operational when they were not to avoid penalty points, including counting staff members who were on training days (paragraph 117). He also recalled a practice of staff being recorded at Brook House when they were working at Tinsley House (paragraph 118).

288. These practices of contractual manipulation have been confirmed by Sarah Newland and Michelle Brown in their evidence to the Inquiry.

289. In her witness statement of 11 March 2022, Sarah Newland (Head of Tinsley House in RP, now Gatwick IRC Deputy Director)stated at paragraph 126:

> *"I was aware that Brook House would often be run below staffing headcount, with staff vacancies left open. Whilst required staffing targets would usually be met operating in this manner (for example, through the use of overtime and cross deployment), the practice meant that salary costs were saved by G4S. From the Trading Reviews I attended, I got the impression that there was pressure from those higher in the management structure to make these saving where possible, so that such savings could be offset against other more onerous contracts held by G4S."*[658]

290. Ms Newland also raised additional practices in her interview with Verita on 5 March 2018 of moving staff to Brook House from Tinsley House when short-staffed because "*Commercially it is better to have staffing penalties at Tinsley because, frankly, it costs less. A hundred points at Tinsley is, I think, a half to a third of what it would be at Brook*". Ms Newland confirmed that practice was "*daily*" but it had only just stopped at the time of her interview (March 2018) "*because we were in quarantine, so they are not allowed to cross-deploy.*"[659]

291. When asked about these contractual manipulations in live evidence on 21 March 2022, Ms Newland agreed these practices were "*a manipulation of the true staffing figures done by G4S in order to reduce financial penalties*",[660] and confirmed her belief that these intentional lowering of staff impacted on the welfare and safety of staff and detainees and agreed it was *"evidence of prioritising profit by G4S over detainee welfare."*[661]

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[658] Witness Statement of Sarah Newland 11 March 2022, paragraph 126, SER000458_0028
[659] Sarah Newland interview with Verita dated 5 March 2018, paragraphs 158-163, VER000223_0012
[660] Sarah Newland 21 March 2022, 190/24-25, 191/1-2
[661] Sarah Newland 21 March 2022, 192/7-15

292. Michelle Brown also confirmed the practice of moving staff from Tinsley to Brook House to lower penalty points in her witness statement of 24 February 2022, confirming at paragraph 52 on moving staff from Tinsley to Brook House: *"Tinsley House often operated at low occupancy, resulting in less hours required to meet the outlined contracted hours, therefore, deployment was required to assist in boosting Brook House figures. In addition, as there was a difference in penalty point costs and as Tinsley was lower, I was told by Ben that if staffing was short across both sites, then to take the hit at Tinsley House."*[662]

293. In his Verita interview on 31 January 2018, Central Detail Manager John Kench also revealed that after the expansion of capacity of 60 beds, the Home Office were paying for 17 additional staff but G4S never filled the vacancies: *"You know about that? We were getting paid for that and we were never filling it, never, never been filled. The most we have had in that section of that 17 staff is three. I was asked at one stage, can we save any more money on this? I said you are already saving, well, not saving it you are getting paid for it and we are not using it."*[663]

294. Ben Saunders confirmed the practice of profiting from staff vacancies in his Verita interview: *"Staffing vacancies generated some profits because you were saying on costs that you had already looked at."*[664]

Causal Factor 6: Overriding Institutional and Culture of the Home Office

295. There are competing analyses of the causes of mistreatment between the Home Office on the one hand, and the detained persons and Medical Justice on the other.

296. To the Duncan Lewis Core Participants, the mistreatment with which this Inquiry is concerned is article 3 breaches which arise as a result of an environment in detention which is itself inhumane and so far from the relaxed regime intended for immigration detention that it is liable to expose anyone to article 3 mistreatment. When a given detainee is detained there it is not an ordinary detention: it is usually without purpose, inappropriate or even unlawful;[665] once they are detained it is maintained even though it becomes clear that they should not have been detained (particularly if they are vulnerable);[666] there is a failure to recognise or respond to individuals' vulnerability or individual circumstances and in cases

[662] INQ000164_0033
[663] John Kench interview with Verita dated 31 January 2018, paragraph 124, VER000227_0009
[664] VER000226_0009
[665] Please see Causal Factor One of these submissions for further explanation and examples.
[666] Please see Causal Factor Two of these submissions for further explanation and examples.

of mental ill-health and self-harm the response is often use of force; and there is unlawful use of rule 40 and rule 42 which exacerbates the underlying harms.[667] In combination, these factors amount to article 3 mistreatment.

297. In Mr Riley's evidence, advancing the corporate position for the Home Office, he has a much narrower understanding. His understanding is that mistreatment arose only where direct physical violence was inflicted by DCOs, for which those DCOs rather than any systemic issues are responsible. His view at paragraphs 6-8 of his statement is:

> "*I remain clear in my opinion that the misconduct in question was perpetrated by a small minority of staff who, according to the testimony of current and former G4S staff, were not reflective of the whole workforce or the culture of the company. Several of these people were, quite rightly, dismissed by G4S. I commend the organisation for taking swift action against those individuals*"
>
> *Even with the benefit of hindsight, I do not consider that there had been any indication that the abuses in question were in any way inevitable... The absence of obvious, visible warning signs may also account for Home Office staff not reporting any apparent abuses during the relevant period...*
>
> *Whilst the ill treatment of detainees was perpetrated by G4S (and not Home Office) staff, 1 accept that there may be legitimate questions asked of a system that allows individuals like these to have been allowed to pass through the Home Office's certification process and commence work in an IRC. There were clearly organisational failings on the part of the Home Office, mostly in the areas of performance management and assurance, which subsequent reports into our oversight of Brook House have rightly highlighted.*"[668]

298. The Home Office view is thus not only a difference of opinion as to the causes of the mistreatment, but as to what the mistreatment comprised. "The misconduct in question" is to the mind of the Home Office, the aberrant behaviour of staff. As to the cause of the mistreatment, there is a wilful refusal to see that as connected to issues of management or system: the presumption is that if the bad apples could be removed, the barrel that is left is wholesome. Thus, none of the Home Office evidence addresses systemic issues such as how or why it has failed to ensure compliance with rules 34, 35, 40, 42, 45 of the Detention Centre Rules 2001 or the Adults at Risk Policy, or any of the other wider questions of

[667] Please see Causal Factor Three of these submissions for further explanation and examples.
[668] HOM332005_002-3.

culture and institutional frameworks, let alone any consideration of the merits of those cultures, rules and policies.

Foreseeability

299. The immediate flaw with the Home Office approach is that this Inquiry arises because of the investigative duty under article 3. The Home Office approach is at odds with all previous analyses of article 3 mistreatment in immigration detention. In all of the seven cases in which the High Court and Court of Appeal have found article 3 mistreatment,[669] it has been because mentally ill and vulnerable detainees are subjected to detention without proper recognition or management of mental illness or vulnerability. Some of these cases are addressed below.

300. One way to test the credibility of the Home Office stance that it could not have foreseen what descended on Brook House, is to ask whether it is really the case that "*Even with the benefit of hindsight… there had been no indication that the abuses in question were in any way inevitable*".[670] The Duncan Lewis Core Participants submit that on the contrary, hindsight was not necessary and that there had been ample forewarning of the widespread inhuman and degrading treatment and the torture that eventuated. The elements of physical abuse which the Home Office believes to be the sole focus of this Inquiry were not a one-off result of a particular handful of staff, but a foreseeable consequence of failures to address systemic failures in its operation of immigration detention - failures of which the Home Office was repeatedly warned.

301. Some of the warning signs that might have been open to the Home Office include the following:

a. Following an undercover report by the BBC, Stephen Shaw conducted a PPO Inquiry into allegations of racism and mistreatment of detainees at Oakington Reception Centre,[671] identifying what he called "*a sub-culture of abusive comment, casual racism, and contempt for decent values*" at Oakington.[672]

b. In 2006, following undercover reporting of racism and other incidents at Yarl's Wood, HMIP undertook an inspection of healthcare at Yarl's Wood IRC and published the themed report *Inquiry into the Quality of Healthcare at Yarl's Wood Immigration Removal Centre* which found, in a prefiguration of the evidence heard of the situation over a decade later at Brook House[673]:

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[669] *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, *ARF v SSHD* [2017] EWHC 10 (QB), *VC v SSHD* [2018] EWCA Civ 57.

[670] HOM322005_003.

[671] PPO (July 2005) *Inquiry into Allegations of Racism and Mistreatment of Detainees at Oakington Immigration Reception Centre and While Under Escort*.

[672] PPO (July 2005) *Inquiry into Allegations of Racism and Mistreatment of Detainees at Oakington Immigration Reception Centre and While Under Escort* pages. 3,35,59,68-70 and 105.

[673] Quoted in BHM000041_0005.

"*the delivery of healthcare was undermined by a lack of needs assessment, weak audit and clinical governance systems, inadequate staff training (particularly in relation to trauma) and insufficiently detailed policies and protocols, for example with regard to food refusal… mental health care provision was also insufficient… .the inadequacy of healthcare systems in the IRC was compounded by the unresponsiveness of the IND to clinical concerns about an alleged history of torture or adverse medical consequences of continued detention. When clinical concerns were raised, the information was not systematically addressed or actioned.*"[674]

These two undercover reports and subsequent investigations were a decade before the undercover exposure of Brook House, but anyone who had been alert to the failure to address the underlying causes in their wake would also have noticed that there were repeated warning signs in the years leading up to Panorama that the underlying problems had not been addressed.

c. In *R (D) v SSHD* [2006] EWHC 980 (Admin), Davis J (as he then was) first considered what was by 2006 already a longstanding state of affairs by which the Home Office and its contractors had failed to give effect to rules 33-35 of the Detention Centre Rules 2001 in safeguarding torture survivors from inappropriate and unlawful detention. He held (paragraph 127):

"*This case has served publicly to highlight a persistent and sustained failure to give effect to important aspects of the Detention Centre Rules and publicly to highlight a departure from published policy.*"

In light of the evidence heard before the Brook House Inquiry of failures in the rule 33-35 process Mr Justice Davis's description remains an apt description of Brook House in 2017 and indeed in the present day: "*a persistent and sustained failure to give effect to important aspects of the Detention Centre Rules and… a departure from policy*".

d. In 2008, giving a judgment upheld by the Supreme Court on the false imprisonment by the Home Office of a man detained for 22 months in which no review of his detention was undertaken, Munby J said in (*R (SK) v Secretary of State for the Home Department* [2008] EWHC 98 (Admin):

[674] HMIP (2006) Inquiry into the quality of healthcare at Yarl's Wood Immigration Removal Centre: 20-24 February 2006, paras. 1.3-1.6.

"... I agree that SK has indeed been unlawfully detained for substantial periods....

I have to say that the melancholy facts that have been exposed as a result of these proceedings are both shocking and scandalous. They are shocking even to those who still live in the shadow of the damning admission by a former Secretary of State that a great Department of State is 'unfit for purpose'. They are scandalous for what they expose as the seeming inability of that Department to comply not merely with the law but with the very rule of law itself.

SK will evoke sympathy in few hearts but everyone is protected by the law, by the rule of law. It matters not what a person has done. Outlawry has long been abolished. As Lord Scarman said in R v Secretary of State for the Home Department ex p Khawaja [1984] AC 74 at page 111:

> *"Every person within the jurisdiction enjoys the equal protection of our laws. There is no distinction between British nationals and others. He who is subject to English law is entitled to its protection. This principle has been in the law at least since Lord Mansfield freed "the black" in Sommersett's Case (1772) 20 StTr 1."*"

Mr Justice Munby's words, some fourteen years later, remain apt: "*the melancholy facts that have been exposed as a result of these proceedings are both shocking and scandalous*"; the Home Department remains (as its own Secretary of State described it), "*unfit for purpose*". Most damningly this Inquiry again exposes matters which "*are scandalous for what they expose as the seeming inability of that Department to comply not merely with the law but with the very rule of law itself*". Munby J felt compelled to remind those from the Home Department reading his judgment that "*Outlawry has long been abolished*" and that "*he who is subject to English law is entitled to its protection*", yet those seem still to be basic principles worthy of repetition.

e. In 2011, David Elvin Q.C. giving judgment in *R (S) v Secretary of State for the Home Department* [2011] EWHC 2121, the first of a series of six cases in which the High Court found that there had been breaches of article 3 ECHR by immigration detention, held at paragraph 211-215:

> "*With regard to the negative aspect, I find that S was subjected to inhuman or degrading treatment... Even the recommencement of serious self-harming by S did not stir the UKBA to effective and urgent action.*

... The medical advice here was not that there were certain steps which should be taken to make detention workable but that detention itself was the problem, and S's mental health issues could not be addressed whilst in detention.

I also find breaches of the positive aspect of Article 3, in that the Defendant failed here to have in place measures which were designed to ensure that S was not subjected such treatment. Such procedures which were in place were not utilised to deal effectively with S's condition nor sufficient to ensure a timely response to it."

Here can be seen a prefiguration of what happened in Brook House in 2017: no effective action being taken upon a detainee self-harming; a failure to release those who should not be detained; a failure to have in place measures to ensure the vulnerable are not subjected to detention, and a failure to operate such procedures as are in place in a proper fashion. Yet this judgment, and even the Shaw review which followed, did not prompt such action as was required to *actually* prevent these abuses.

f. Later that year in *R (BA) v SSHD* [2011] EWHC 2748 Elizabeth Laing Q.C. (as she then was) sitting as a Deputy Judge of the High Court held at paragraphs 236-7:

"*In my judgment there was a deplorable failure, from the outset, by those responsible for BA's detention to recognise the nature and extent of BA's illness. This may well have contributed to the complete absence of any monitoring of BA's condition in the early stages of his detention (from 1 February to 30 March 2011).*

... The Secretary of State had put BA in this position, by detaining him when it was known that it was likely that such detention would set in train this chain of events.

... I do consider that there has been a combination of bureaucratic inertia, and lack of communication and co-ordination between those who were responsible for his welfare. The documents disclosed by the Secretary of State have also shown, on one occasion, a callous indifference to BA's plight."

g. Once again, in looking back at the "*deplorable failure*" it is impossible not to see here a prefiguration of the events of 2017. In 2017 there was still a widespread failure to recognise the nature and extent of the mental illness of detainees; a complete absence of any monitoring of such conditions; "*bureaucratic inertia*" "*lack of communication*" and "*callous indifference*". It remained the Secretary of State who put vulnerable individuals in detention when "*it was known that it was likely that such detention would set in train*" chains of events involving inhuman

treatment. The warnings from D1527's solicitors and doctors given contemporaneously to and throughout his detention are a resonant example.[675]

Mr Schoenenberger claimed in a manner emblematic and fitting of the Department he represents, never to have been told about the judgment or its reference to his "*callous indifference*". Nor did he remember his own words quoted by the judge at paragraph 113:

> "*He continued, chillingly, "...on our Monday conference call, we will discuss informing the RRT as there will be significant press interest if he does subsequently pass away. We have made sure that healthcare are keeping good and accurate details of his care and this record will be available to the PPO should he die*"[676]
>
> Again, it is hard not to hear in these words of Mr Schoenenberger a prefiguration of the attitudes of staff on the ground in 2017 to the potential death of detainees ("*if he dies, he dies*"[677]).

h. A year later, in *R (HA (Nigeria)) v SSHD* [2012] EWHC 979 Rabinder Singh Q.C. (as he then was) sitting as a Deputy Judge of the High Court held that HA had been subjected to article 3 mistreatment in Brook House itself. The case concerned a familiar pattern: the Home Office was informed following several assessments by doctors that a seriously mentally ill detainee needed transfer to a mental hospital, but that did not occur for several months despite "*disturbed and strange*" behaviour including drinking from the toilet, and diagnosed psychosis and paranoid schizophrenia (paras. 26, 30, 70). Meanwhile nurses within the detention centre blithely recorded "*nil psychotic symptoms*" and that his behaviour was attributable to his personality (para. 32).

   Yet again, the treatment of that mentally ill detainee did not result in any radical realignment of practice. Rather, what the Inquiry has heard in evidence about the treatment of mentally ill detainees in Brook House echoes the findings of the High Court about article 3 mistreatment five years earlier.[678] At times the Home Office

[675] As set out in e.g. HOM002997; HOM000345; HOM000101_0005.
[676] *R (BA) v SSHD* [2011] EWHC 2748.
[677] TRN0000015_00021; Philip Schoenenberger, 23 March 2022, 65/16-66/12.
[678] See, for example, the treatment of the mentally unwell Duncan Lewis Core Participants including D2077 as set out in DL0000226 who was detained for three weeks in the Relevant Period despite clear signs of acute mental ill health, culminating in him sewing his lips together, D1914 as set out in DL0000229, whose detention was maintained following a suicide attempt, and D643 as set out in DL0000228, whose detention was maintained despite evident signs of mental ill health and distress.

has sought to suggest that the problems in Brook House were bespoke to Brook House itself[679]. That is plainly not the case, but even if it were, it was on specific notice of mistreatment in that institution as in others.

i. *R (D) v SSHD* [2012] EWHC 2501 was also a case of a mentally ill man detained at Brook House whose detention violated article 3 ECHR because of the failure to treat his mental illness and the consequent recourse to rule 40 and 42 of the Detention Centre Rules 2001 as a system of managing that mental illness.

j. Considering these judgments (and others), Stephen Shaw in his foreword to his 2016 report into the Welfare of Vulnerable Detainees cautioned:

> "*More could be done too to develop a clearer identity for the immigration removal centres (IRCs) and an agreed statement of purpose... Current policies and processes do not always distinguish the role of an IRC from a prison. One emblematic example: rule 42 of the Detention Centre Rules...* "[680]

302. The Home Office could, on reading Mr Shaw's 2016 Report, have been prompted to take the action necessary to address the article 3 breaches that prompted it, and might have averted the events of 2017. But instead, the Home Office response was to *reduce* the protection for 'vulnerable' to a definition which had already been rejected as unlawful and contrary to the clinical evidence in the case of *EO*[681]and introduced the Adults at Risk Policy which narrowed the circumstances in which a vulnerable person might be released on grounds of their vulnerability (as to which see Emma Ginn's Witness Statement at para 46[682]).

303. The above examples are a small fraction of the High Court judgments and reports on immigration detention which could have prompted a Department of State that was concerned to ensure people are not subjected to inhuman and degrading treatment to reform its practices and policies. Others are set out in the table of rule 35 cases appended. Other organisations and individuals that raised concerns include the PPO,[683] HMIP,[684] the

[679] HOM332005_002-3.
[680] INQ000060_0009.
[681] *EO & Ors, R (on the application of) v Secretary of State for the Home Department* [2013] EWHC 1236 (Admin).
[682] BHM000041_0017.
[683] E.g. Investigation into allegations of Racism, Abuse and Violence at Yarl's Wood Removal Centre (2004)
[684] E.g. The HMCIP report of Brook House IRC (2010),

National Audit Office,[685] Coroners,[686] the Joint Committee on Human Rights,[687] the Home Affairs Select Committee,[688] Kate Lampard, the Tavistock clinic[689] etc. Some of these are listed for example in the witness statement of Emma Ginn for Medical Justice at paragraph 42.[690]

304. There is no possible argument that the Home Office had not been warned. The overwhelming majority of what has been seen in evidence as to the mistreatment of detainees was the subject of prior criticism and warning and indeed its failure to heed the warnings was also itself the subject of repeated criticism.

305. Returning to Mr Riley's evidence, it seems that the Home Office does not understand that what happened was not only foreseeable, but *foreseen.* This is partly because it does not understand the connection between its systemic failures to operate the detention estate in a lawful manner and the abuse that eventuated. It does not understand the purposelessness experienced by the guards, or the pressures that the mass detention of mentally ill and vulnerable detainees created in the environment, preferring to craft a narrative in which its own failure plays a very limited role in what happened.

306. Thus, the Home Office remains unable to understand its failings, still less to remediate them.

The Home Office Response to the *Panorama* Revelations

307. The Home Office's conduct since 2017 and indeed in this very Inquiry displays more of the same institutional inertia. While the Immigration Minister was prepared to accept that the scenes in *Panorama* were "*appalling*",[691] he conducted no comprehensive Inquiry into what was seen or how it had been allowed to happen and their Department fought tooth and nail to resist this Inquiry from happening at all.[692] The delay caused by the Home Office's stance played a significant role in delaying the Inquiry, with the effect that many witnesses claimed to be unable to remember inconvenient matters.[693] The headline point in

[685] E.g. The Home Office's management of its contract with G4S to run Brook House Immigration Removal Centre (2019)
[686] E.g. the Coroner Report into the death of Jimmy Mubenga (2013).
[687] Joint Committee for Human Rights Call for Evidence on Human Rights Judgments (2013); Joint Committee on Human Rights Inquiry into Mental Health and Deaths in Prison (2017).
[688] E.g. https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/913/91310.htm#_idTextAnchor138.
[689] Review of Mental Health Issues in Immigration Removal Centres (2013).
[690] BHM000041_0015-16.
[691] See https://www.bbc.co.uk/news/uk-england-sussex-44221797.
[692] R (on the application of MA and BB v SSHD) [2019] EWHC 1523.
[693] See, for example, Derek Murphy, 2 March 2022, 22/14; 88/9, 101/25; Gordon Brockington, 31 March 2022, 35/16-18;. Jerry Petherick, 21 March 2022, 12/11-12, 178/3-5.

terms of Home Office response since 2017 are:

- There has been no acceptance of, or finding of, culpability by any persons in senior roles within the Home Office or G4S, nor any acceptance of ministerial responsibility
- G4S's contract was extended by two years following the *Panorama* revelations. It retained the contract for health care until August 2021.
- There have been no changes to management structures within the Home Office nor any to personnel prompted by the scandal.
- There has been no reform of the Professional Standards Unit or the Independent Monitoring Board.
- No commitment to strengthen the powers of the HMI and to commit to accept and acting upon its recommendations.
- Despite being widely identified as the only solution capable of addressing systemic failure to protect the rights and welfare of immigration detainees, the Home Office has resisted and here has been no time limit on detention imposed through policy or primary legislation.
- Schedule 10 to the Immigration Act 2016 contains provisions for automatic consideration of bail to be considered after four months but excludes ex-offenders.
- There has been no reform of the Adults at Risk Policy published in 2016. Stephen Shaw was clear in his 2018 review that the *intention* of the policy (noting his words on the gap between intention and action in this area) was to significantly reduce the number of vulnerable people detained. Mr Shaw's 2018 review stated in terms that the policy does not function as envisaged and on the contrary that increasing the evidential burden to establish vulnerability has increased the number of vulnerable people who are detained.[694]
- While the Home Office asserts that measures have been taken in respect of the rules 34 and 35 process[695], this is unsubstantiated and contradicted by the IMB 2020 report[696] there is nothing like the overhaul that Stephen Shaw recommended in both 2016 and 2018. An immediate alternative to the rule 35 mechanism including doctors independent of the IRC system to conduct the assessments (recommendation 21)[697]. In his 2018 review, Mr Shaw again recommended new arrangements for rule 35 stating "I have little expectation that further tweaks to the current Rule 35 process – such as yet more training or monitoring – will be

[694] Stephen Shaw 2018 report, see 2.112-2.130, CJS0073862_0044-0047
[695] See Witness Statement of Philip Riley, paras 53-55, HOM0332005_0017-0018
[696] DL0000140_0128-0131
[697] INQ000060_0108

sufficient to deliver confidence for any of the parties. It requires a more fundamental shift in practice."

- The Home Office response to date is to publish Detention Services Orders but there is no evidence of any concrete change in practice on ACDT, use of rule 40 and 42 despite Stephen Shaw's earlier recommendations (recommendation 23[698]; recommendation 24 and recommendation 37[699].

308. The IMB's view at the end of 2020[700] was that the environment at Brook House remains inhumane, yet the Home Office took little or no action in response to that report. The IMB's Mary Molyneux was asked if she had seen any change in approach from the Home Office following their 2019 and 2020 reports, particularly in respect of the latter and the concerns they raised about the charter flights programmes at the end of 2020: *"A. I think local Home Office people on the ground, yes, but when you're talking about trying to get changed policies and Adults at Risk, frustratingly, no. It will be in the annual report again this year, and I think it is the same thing -- issues we see NGOs having with them. But we will keep coming back. It needs to be looked at."*[701]

309. The Minister for Immigration Compliance, Chris Philp MP, responded to the IMB's letter on 25 November 2020.[702] After setting out some background on the Dublin Regulations, Mr Philp went on to deny the conditions were inhumane and degrading and to justify the charter flight programme:

> *"I should reinforce that detention and removal are essential parts of effective immigration controls.... As you will be aware, there are established procedures in place in every IRC and Short-Term Holding Facility to minimise instances of self-harm with formal risk assessments on initial detention and systems for raising concerns at any subsequent point. Those refusing food or fluid are managed in line with the Detention Services Order 3/2017, 'Care and Management of Detainees Refusing Food and Fluid' and monitored closely. Nonetheless, these people are in the UK illegally and we continue to seek their removal, with the appropriate safeguards in place.*
>
> *... I should also highlight that any delays with Rule 35 assessments, though regrettable, do not impede our ability to consider a person's immigration case in full. Rule 35 reports are considered by the Home Office for the sole purpose*

[698] INQ000060_0117
[699] INQ000060_0147
[700] DL0000140_0113
[701] Mary Molyneux 25 March 2022, 156/11-16

[702] IMB000206

of determining the suitability for continued detention, and not the appropriateness of ongoing enforcement action or the merits of an immigration case...

The Dublin Regulation set limits on the time in which a return can be completed and the maximum time a person can be detained for the purposes of their return. If someone is in the UK illegally and has chosen not to make a voluntary return, it may be necessary to enforce their departure from the UK. We only remove people when it is safe to do so...

The use of charter flights is a standard part of immigration enforcement activity, and they are used by many other countries, not just the UK. We use charter flights as well as regular scheduled flights, to best meet operational needs and maximise value for money. The UK only ever returns those who both the Home Office and, where appropriate, the courts are satisfied do not need our protection and have no legal basis to remain in the UK. ...As the Home Secretary said in her recent speech to the Conservative Party Conference, the asylum system is broken, and we stand by our obligations to safeguard the most vulnerable people fleeing oppression, persecution and tyranny. These people are in the UK illegally and we continue to seek their removal, with the appropriate safeguards in place."[703]

310. Ms Molyneux in her live evidence believed the letter from the Immigration Minister did not answer the IMB's letter in any meaningful way[704]. When asked whose fault it was that there had been safeguard failures at the end of 2020 at Brook House, she responded:

> *"A. I think the problem was more that the Home Office kept bringing these men in. The Home Office were aware of the problem. So when a safeguard failure -- when I said overload, it -- the Home Office knew this was happening. This wasn't the first they'd heard of it. You know, they had heard the minister -- I mean, senior people had heard. I know they had heard from Serco concerns about the numbers and the numbers of self-harm. In spite of that, numbers kept coming through for these charter0 flights. And, you know, it is not so much about1 process. Our letter was about the impact. It's headed2 "The Impact". It is all about what is happening to the people. We were not challenging particular processes or4 saying, "You cannot remove people under the Dublin Convention". It was, "This is what's happening". You know, it was a concern*

[703] IMB000206_0001-0002
[704] Mary Molyneux 25 March 2022, 159/20-21

about safety, that there is going to be more of this if you persist. The reply is all8 about process. "We have the right, we have the process", so there is just a total disconnect and not,0 in my view, acknowledgement of the problem and the issues we had raised."[705]

311. Nor has the Home Office sought to reform the PSU, the IMB or HMIP. Yet, it must have been clear not least from the judgment of May J that there is something lacking in these organisations who did not identify or investigate the abuse uncovered by *Panorama* and on the contrary praised the progress being made at Brook House.

312. Two years on from the events in *Panorama,* on 21 March 2019, the House of Commons Home Affairs Committee published its report, *Immigration Detention* (HC 913).[706] The Committee identified *"serious problems with almost every element"* of the immigration detention process and indicated that *"substantial reforms*" were needed (para. 20) and concluded that the Home Office had *"utterly failed"* (para. 270) in its responsibility to oversee and monitor the safe and humane detention of individuals in the United Kingdom.

313. The Inquiry should be in no doubt that it is the Home Office which is primarily and predominantly responsible for the inhuman and degrading conditions and treatment at Brook House. Specifically, it is the Home Office's knowing or reckless decision not to heed warnings, meted out to it on a regular basis, of the failure of its systems in immigration detention. It refuses to change. There is only one solution to that which is that it has to be forced to change. It was only statutory prohibitions on the detention of children and pregnant women that has ended the particular abuse of those vulnerable groups.[707]

Manifestations of Home Office Recalcitrance in the cases of the DL CPs

314. The Home Office's refusal to engage in meaningful self-reflection and reform is manifested in each of the cases of the detained Duncan Lewis Core Participants, which present a spread of the detained population from failed asylum seekers at the end of their asylum appeals, to businessmen scooped up from living an ordinary lawful life in the UK.

315. The Home Office's powers are discretionary: nothing obliges it to use its detention powers in any specific sort of way. That is a crucial point to understand: all of the abuse the Inquiry has seen, all of the suffering that persists at this very minute, is as a result of

[705] Ibid, 162/1-21
[706] https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/913/913.pdf.
[707] BHM000041_0053.

choices by the Home Office to detain people against a background of refusing to secure suitable and legally required safeguards in its detention system. The abuses of power in which the Home Office recklessly or deliberately chooses to engage are various, but none of them necessary.

316. The Home Office is not obliged to detain people like D643 for as long as two years. The Home Office could have released him, but chose not to: indeed it chose not to even after he was thrice granted bail in principle on grounds of mental ill health (13 December 2017[708] and 9 February 2018[709], March 2018[710]) in each case *after* Panorama and at the very time the Minister was saying he was appalled by what it showed . Indeed, the Home Office could simply have heeded the bare minimum legal obligations upon her: the Secretary of State for the Home Department is obliged by the second "*Hardial Singh*" principle not to detain people for an overly long periods of time. She is not obliged to test the boundaries of those legal limits, but in D643's case even the grant by an independent judge of bail was not enough to prompt release and he had to seek judicial review. The Home Office could impose on itself a discipline of respecting the decisions of bail judges, but it chooses to risk illegality (and in D643's case has settled a false imprisonment claim). The Home Office could impose on itself hard and fast rules as to how long people are detained so that they are not confronted with the psychological uncertainty and anxiety of indeterminate periods of detention, so that their mental health does not progressively deteriorate, so that they have rights in detention which afford a sense of dignity and humanity. However, the Home Office chooses not to use its powers in that way.

317. The Home Office is not obliged to detain people like D1851 who have a legal right to be in the UK; including a family and a job. Indeed the Home Office concedes his detention was unlawful[711] and accordingly it was very strictly obliged not to detain him. British law and British institutions are supposed to provide respect for liberty so that nobody is detained even for a single day where they should not be. The Home Office is not obliged to operate a detention centre in such a way that it is impossible for people who are falsely imprisoned like D1851 to access legal advice or a sensible caseworker.[712] He was an articulate, educated, fluent English speaker with roots in the UK and a clear case for release, yet it took twelve weeks to obtain release involving - on his evidence – having to run from his cell the moment it was opened at 8am so as to reach the welfare queue to give a sealed judicial review to the Home Office.[713] The Home Office did not need to operate the

[708] DL0000228_0055.
[709] DL0000228_0056.
[710] DL0000228_0056.
[711] DL0000143_0001.
[712] DL0000143_0027.
[713] D1851, 3 December 2021, 107/20-108/9.

detention system in that way: it chose to.

318. Prior to his detention in Brook House D2077 had actually been released from a prior detention following a rule 35 report. Thereafter the Home Office could have respected its own decision to release. But instead, it chose to reclassify the rule 35 report as "level 2 evidence" so as to permit re-detention.[714] The result was exactly that which the rule 35 process was designed to avoid: re-traumatisation and appalling acts of self-harm of a deeply troubled young man who is now recognised to have been a refugee. The Home Office chose to recklessly to gamble with legality, to gamble with the impacts on D2077. His suffering was needless and avoidable.

319. The Home Office does not need to detain people like D1527 for whom it has no travel documents ready to remove them so that removal is not a realistic prospect in a reasonable period of time. Indeed, it is an established legal principle (the third "*Hardial Singh* principle") that it is unlawful to detain people where there is no realistic prospect of detention in a reasonable period of time. But the Home Office chose, recklessly, to detain him for what it could foresee would be an unknown period of time, without any sort of progress with documenting D1527 with his national authorities.

320. It was a matter of choice for the Home Office to detain D1527 while he was already on ACCT. It could have taken a precautionary view that a person who was already being watched for suicidal and self-harm should not be detained. But it chose to run a system whereby those held in prisons presumptively continue (under policy and practice) to be held administrative detention thereafter.

321. In D1527's case, for all the flaws in the rule 35 system, after persistent advocacy from his lawyers, Dr Oozeerally did after two weeks relent and complied with his legal duty to file a rule 35(3) report (sent to the Home Office on 18 April), [715] but the Home Office chose to ignore the rare functioning of the system warning and maintained the detention of D1527 anyway.[716] In his case fixing the medical services' neglect of the rule 35 process would not have been a cure: it was the Home Office decision-making that failed him. Indeed, that was the case throughout the detention as the Home Office refused to budge as evidence mounted from doctors and others that D1527 should not be detained. Even in a case of a medical report attesting to near-daily suicide attempts and a likely successful attempt,[717] it took a High Court hearing to compel his release.

[714] DL0000226_0002, 6 – 10, 12 – 15.
[715] CJS001123
[716] HOM000644
[717] HOM002997_0064.

322. A more rational Home Office could take the view that where an EU national has already won a case in the High Court establishing an article 8 right to family life which entitles him to stay in the UK with his family and not to be extradited, that there should be no attempt to deport him. Indeed, a more rational Home Office might foresee that an attempt to deport in such circumstances was doomed to failure. Yet in D1914's case, in defiance of legality or indeed common sense, the Home Office detained him with the intention of deporting him anyway. At the ultimate appeal against the deportation order, the Home Office was unable to offer any explanation to the Immigration Tribunal why he should be deported and the appeal was allowed on the same article 8 grounds as the extradition proceedings.[718]

323. In his case a more rational Home Office might also in any event have considered that pending an appeal he should not be detained, particularly given his health conditions. But instead it took four months of detention with dire consequences for D1914 before it ultimately was able to realise that what it was doing was harming him.

324. The Home Office chooses to run the immigration detention system in a way which wilfully takes the risk that people are being detained unlawfully and that it is harming them in the process. It is reckless about compliance with the law, and it is reckless about the impact on people's lives. It acts with insouciant disregard of constitutional protections of the liberty of the subject. The cavalier, indeed callous, indifference to human liberty would appal any right-thinking person in this country if only they had a detailed understanding of how the Home Office really operates.

325. It is no accident that the Home Office continues to behave this way in spite of relentless criticism and warnings. It is a manifestation of a deep ideological commitment to prioritising removals over almost anything else.

326. The Home Office could put in place measures that safeguarded against the detention of vulnerable people. Legislative measures to limit the detention of pregnant women have been effective (save with minor aberrations)[719] . A similar rule to that in Section 60 of the Immigration Act 2016 limiting detention of other vulnerable cohorts under immigration powers to exceptional circumstances immediately prior to removal and for no more than 72 hours, unless extended up to a maximum of seven days with ministerial approval, could be introduced. A process similar to the Family Returns Process (again limiting detention of families to 72 hours in exceptional circumstances) could be introduced.[720] In particular,

[718] DL0000229_0072.
[719] BHM000041_00055-56.
[720] BHM000041_00054.

such a system could provide for "gatekeeping" that works as it does in the Family Returns Process where a meeting with detainees are held in advance and vulnerabilities are properly identified. It is a matter of choice that no such measures are put in place. Indeed, that it is a matter of choice is all the more stark when one considers that the Adults at Risk Policy and rule 35 process have been specifically designed to respect the deeper principle that highly vulnerable and traumatised people should not be detained.

327. The Home Office could have responded to the article 3 High Court cases, or the rule 35 cases, or the countless other independent reports and criticisms by finding out what was wrong and repairing it before 2017. That it chooses not to take action to understand and remedy the flaws in the system is most starkly demonstrated by the many years in which no rule 35(2) reports were made across the entire detention estate.[721] Similarly, rules 40 and 42 have long safeguarded against the use of removal from association and temporary confinement and sought to ensure that such draconian powers are used only by the Home Office, or exceptionally by the Manager of the detention centre. But the Home Office evidently took and continues to take no, or at best inadequate measures to ensure its detention system complies with these laws and allowed an unruly system to operate in its place.[722]

328. Rule 65 allows the Home Office the exclusive right of approval over any scheme of delegation. A power it never used, but instead appears to have allowed ad hoc systems to run unchecked.

329. Rule 45 provides that DCOs must report on any abuse or impropriety which comes to their knowledge. The Home Office could well have seen that this law was never complied with. That much is obvious from the evidence heard and from the complete absence of evidence that a DCO ever complied with that statutory duty even for example following the choking of D1527 on 25 April 2017. The Home Office would - if it had bothered to look - have been aware of the complete lack of any culture or practice of making such reports. But it chose not to inquire and it chose not to enforce a system of respect for rule 45 of the Detention Centre Rules 2001. Its decision not to enforce compliance with that duty persists even today, well after Panorama.

330. The revelations in Panorama were shocking but not unprecedented or unexpected. The Home Office could have decided to take a hard look at itself following six findings of article 3 ECHR mistreatment in the High Court, or several dozen findings of breaches of rules 34

[721] LIB000003 (please note that this document is yet to be adduced to the Inquiry).
[722] Please refer to the detailed submissions on the failures in Rules 40 and 42 found in Causal Factor 3 of these submissions.

and 35; or several hundred cases settled or lost where detainees were falsely imprisoned. It could have taken heed of the wealth of investigations and reports that exposed the panoply of problems with the way in which the Home Office runs immigration detention, but it chose not to.

331. The Home Office is the principal culprit and obstacle to change. Perhaps it is not entirely a matter of obstinacy, recalcitrance, and bureaucratic inertia. Perhaps, the Home Office is also deluded. Certainly, a level of fantasy was seen at work in Mr Riley's attempt to head off criticism of more than a decade of failure in the rule 35 system by writing a single letter to medical services reminding them of their legal duties.[723] The belief that doing that would effect a meaningful reform is perhaps genuine. Perhaps it was not cynical and minimal, but a magical trust in the power of paperwork. But it also seems that Mr Riley simply has no understanding of the nature of the problems. His original evidence was thoroughly enmeshed in the notion that the problems witnessed "on Panorama" were the result of conduct of G4S employees and that they had now all been removed from post.[724] He admitted to not paying much attention to the Inquiry[725] and perhaps he will not read the report either.

332. What is clear is that the only way that the Home Office can be reformed is by the force of law: its wide powers of detention must be regulated and restrained

333. That is perhaps because there is a deeper impediment still to lasting change: the political ideology of marginalisation and criminalisation of migrants that the Home Office enacts through immigration detention. Mr Ward identified this as resulting in a "*dominant culture of hostility*"[726] towards immigrants and in his evidence, he linked the abuse of those detained at Brook House to the hostile environment policy.[727] The way in which the Home Office implements that ideology is one characterised by a disregard of the law; callous indifference to individual rights or individual suffering; bureaucratic incompetence; and recalcitrance to change.

334. It is perhaps little more than a hope that there will be lasting reform of immigration detention without reforming the ideology it enacts. However, even a hope of staving off the next scandal should be embraced. What will not change anything, and what will simply invite the continued merry-go-round of exposure of scandal, report, and failure to reform,

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[723] HOM0332160.
[724] E.g. HOM332005_003.
[725] Phil Riley, 4 April 2022, 8/9-12, 10/9, 12/2-3.
[726] DL0000141_0009.
[727] DL0000141_0008, 9, 43 - 44.

is to acquiesce in the perception that the mistreatment was limited to deliberate actions of a "small minority" of staff who have already been isolated, or to conspire in the pretence that numerous minor recommendations can repair the damage.

Terms of Reference 6: Adequacy of Complaints and Monitoring Mechanisms

335. By the Sixth paragraph of the Terms of Reference, the Inquiry is required to consider the adequacy of complaints and monitoring mechanisms.

336. The complaints and monitoring systems were self-evidently inadequate. The ill-treatment that occurred at Brook House was borne out of a toxic culture that was not identified by any of the mechanisms designed to identify causes for concern within the institution. Nobody at the highest levels within G4S and the Home Office has faced any disciplinary action. There have been no prosecutions.

337. Nathan Ward expressed the lack of accountability:

> *'I strongly believe that things will not fundamentally change unless people are held to account at all levels of the system and serious consequences occur for the individuals and the corporate bodies. I do not understand how G4S could continue being the contract provided for almost 3 years after the Panorama broadcast which included a two-year extension; and equally why any contract could continue to be run with G4S after the Medway and Brook House reporting. Nor how managers within G4S with oversight for these centres or on site, like Ben Saunders, Steve Skitt, Jules Williams or Steve Dix were not dismissed but able to continue in their roles or take up posts elsewhere. I also do not understand how senior civil servants responsible for these contracts, such as Paul Gasson or Mr Schoenenberger, and for detention services generally, have not been disciplined but remained in post'.*[728]

338. Several of the officers involved in mistreatment of detained persons during the Relevant Period still work at Brook House for Serco. It appears that only those directly implicated by the Panorama documentary were punished and dismissed by G4S and the Home Office in their subsequent investigations. The material disclosed during the Inquiry – including un-broadcasted Panorama footage but also G4S body-cam and CCTV footage – has revealed several other officers' involvement in mistreatment. Many of these officers not only still work at Serco, but they have been promoted to key senior positions – like Steve Dix and Steve Loughton, whilst the likes of Steve Skitt and Dan Haughton continue in

[728] First Witness Statement of Reverend Nathan Ward, paragraph 309, DL0000141_0106-0107

senior roles. We have provided as **Annex 2** to these submissions, a detailed note on these staff members and their actions, as well as identifying themes within their witness evidence which support significant concerns by former SMT member Michelle Brown that current Serco staff would "*close rank*" and not speak the truth about *"current conditions for Detainees and staff"*[729]

IMB

339. The oversight was ineffective in two ways: firstly, it was evident that the oversight mechanisms simply did not uncover the extent of the problems in Brook House and secondly, even when problems were identified the reports were often ignored. The Independent Monitoring Board (IMB), for example, was ineffective and unable to accurately and effectively scrutinize the system. IMB staff/volunteers did not appear to be adequately trained and skilled to have a critical presence in custodial environments or to establish a positive ethos and culture[730]. There is also evidence that the relationship between G4S senior management and the IMB was also too close, their independence was compromised, and the general feeling was not to worry about the IMB as they did not have as much 'clout'.

340. The evidence seen and heard by the Inquiry demonstrated that:

i. It is difficult for organisations such as the IMB to undercover covert behaviour, especially where staff may alter their behaviour in the presence of members from an independent oversight body.

ii. Even where the IMB did identify and raise issues, the Home Office failed to respond.

iii. Maintaining a regular presence on the ground risks compromising independence and the perception by detainees of independence.

341. Hindpal Singh Bhui of IMB accepted what was suggested in the Verita report that the IMB overestimated how well the centre was doing in 2016 and that this may have been due to a risk of over-empathising, with the Home Office and G4S staff. Mr Singh Bhui attributed that to the fact that it is run by volunteers.[731] He noted the IMB do not do a 'deep

[729] INQ000164_001,052 - First Witness Statement of Michelle Brown - 24 February 2022
[730] E.g. Jacqueline Colbran 25 March 2022, 3/21-25-5/1-12 where confirms no IRC-specific training, and 73/1-18 where confirms no training on monitoring use of force despite it being a key component of their oversight role
[731] Hindpal Singh Bhui, 24 March 2022, 141/8-17.

dive' like HMIP, and being onsite everyday risks them not seeing what is in front of them.[732]

342. Peter Neden accepted that management over-relied on HMIP and IMB reports[733] but it was also apparent that action was not taken by G4S when the IMB did raise concerns, as they did for example in 2016 about failures in the Rule 35 process[734] and went so far as to suggest that the oversight bodies were as equally culpable as the Home Office for the abuse within Brook House. Luke Wells, the service director for G4S memorably responded in live evidence to the 2020 IMB report by stating that "inhumane is subjective".[735]

343. Phil Riley, the Director of Detention and Escorting Services for the Home Office refused to comment on evidence that the IMB raised concerns both about Brook House in their 2016 and 2017 reports about conditions in CSU being poor and unsuitable for vulnerable detainees, without improvement.[736] He did concede that repeated comments in consecutive years were a cause for concern.[737] Michelle Smith stated that her interpretation of the IMB 2020 report was as a critique of Home Office policy to continue to pursue charter flights – it was not a criticism of staff.[738] In both instances the reports have done nothing to prompt material change.

344. Professor Bosworth set out several concerns in respect of the IMB as an effective oversight mechanism. She gives examples from the Inquiry disclose of the IMB making *"criticisms of the detained men"*, of inappropriately using *"prison jargon"*, and suggestions of being too close to G4S and the Home Office: *"members also made it clear in interviews with Verita that they valued the close working relationship they had developed with G4S and with the Home Office."*[739] She noted "*no evidence in the IMB material of an explicit engagement with human rights either as a legal framework, or as a set of principles and values"*[740] – this despite being part of the UK's National Preventative Mechanism created as part of the UK's OPCAT duties in respect of positively preventing torture. She concluded that: *"Unfortunately, the documents submitted to the Inquiry do point to a shared culture with officers among the committee at the time. The lack of trust of the detained men, the concerns about the work of GDWG, and the use of prison terminology all paint an organisation that was not fully independent and thus was not performing*

[732] Hindpal Singh Bhui, 24 March 2022, 140/18-141/1.
[733] Peter Neden, 22 March 2022, 56/15-24.
[734] Peter Neden, 22 March 2022, 141/9-23.
[735] Luke Wells, 31 March 2022, 197/24-25.
[736] Phil Riley, 4 April 2022, 77/18-24.
[737] Phil Riley, 4 April 2022, 78/23-24.
[738] Michelle Smith, 23 March 2022, 160/5-8.
[739] Expert Report of Mary Bosworth dated 17 November 2021, paras 10.12-10.16, INQ000064_0047-0048.
[740] Ibid, 10.17

adequately as a safeguard for human rights.[741]" In her live evidence, Professor Bosworth set out her following concerns about the IMB failing to pick up on concerns of mistreatment during the Relevant Period:

> *"A. So, I mean, I think if they're not witnessing it, you know, so if officers aren't doing and saying these things right in front of them, which they would be -- I would imagine that officers wouldn't, then the only way in which they would be aware of it would be either through conversations, informal conversations, with officers and/or conversations with detained people or if detained people put in complaints. I think that -- my understanding of the role of the IMB is they, at least at this period, didn't have – didn't take a view on and have a sort of formal way of talking to staff. So staff were outside their monitoring role, which I think is something that should change, if it hasn't already, and I think there is some evidence, and I feel like somebody mentioned it in their evidence, that detained people are not always aware of the IMB, and they don't -- they may not literally know who they are, but they also may not understand what their role is, and that is a little bit of a similar0 example -- it is a little bit like the sort of way in1 which G4S has all those policies on paper but they don't necessarily translate into practice. So I feel as though, given that the IMB are physically in the building and walk around, then -- and5 speak to people, then I think it is curious and concerning that they didn't -- that they were -- that they just didn't know about it, and it maybe speaks to something that -- which I think they are addressing much more in terms of how they interact with the detained population."*[742]

345. Nathan Ward noted that "*…if we want to ask the effectiveness of the IMB, one would ned to ask the question, what action was taken following the 2020 report?*"[743] He warned against over-reliance on oversight and monitoring systems – "*the horse has already bolted*".[744]

346. Jamie Macpherson explained how in his experience, men in detention were hesitant to complain because they viewed the IMB as an extension of G4S.[745] He explained that IMB's free access to the wings led to detainees feeling that IMB were part of the system.[746] Hindpal Singh Bhui also described some of the factors inherent to immigration detention which discourage making complaints, in particular, fears it may impact on an immigration case. He noted that simply placing more forms in an institution would not resolve this

[741] Ibid, 10.33, INQ000064_0052
[742] Professor Mary Bosworth 29 March 2022, 135/16-25, 136/1-20
[743] Nathan Ward, 7 December 2021, 195/6-19.
[744] Nathan Ward, 7 December 2021, 195/6-7.
[745] Jamie McPherson, 8 December 2021, 196/6-10.
[746] Jamie McPherson, 8 December 2021, 196/20-197/1.

issue.[747] He also acknowledged there was an issue with an institutional culture of disbelief.[748]

347. Anna Pincus of GDWG gave evidence that the IMB did not provide an adequate level of oversight and scrutiny during the relevant period; were not sufficiently independent from Brook House management; and were not sufficiently independent *per se*.[749] Callum Tulley's evidence was instructive when he explained why he did not raise his concerns to the IMB or HMIP – as there are no cameras in cells, so it would boil down to his words against a manager's. He had no evidence of the abuse, or colleagues who would support him.[750] These fears seem to mirror the approach the PSU took to the evaluation of evidence.

348. The Core Participants' experiences of the IMB were reflective of these criticisms. Formerly detained men had no recollection of the IMB or their role, whilst Nathan Ward viewed them as ineffective:

i. **Nathan Ward**: explained that he felt the IMB was ineffective, inadequately trained, and focused on optics and the surface level. They only got a snapshot of the centre. He felt the IMB were too close with management.[751]
ii. **D1527:** the IMB failed to protect D1527 despite being brought to their attention. They noted he was on food and fluid refusal in May 2017, and noted they should keep an eye on him – something they did not do.[752] He gave evidence that he could not recall discussions with the IMB, and they were not an effective oversight mechanism in his case.[753]
iii. **D1914**[754]**, D1538**[755]**, D2077**[756]**, D1851**[757] and **D643**[758] had not heard of the IMB.

<u>HMIP</u>

349. The HMIP's effectiveness is plainly limited. A number of the recommendations it has made since 2010 relating to the prison like environment, the lock down regime, and the

[747] Hindpal Singh Bhui, 24 March 2022, 146/9-146/23.
[748] Hindpal Singh Bhui, 24 March 2022, 171/7-17.
[749] Anna Pincus, 9 December 2021, 112/13-24.
[750] Callum Tulley, 30 November 2021, 104/6-25.
[751] DL0000141_0108-109.
[752] DL0000209_00102-103.
[753] DL0000209_0117.
[754] DL00002209_0091.
[755] DL0000231_0039.
[756] DL00000226_0039.
[757] DL0000143_0029.
[758] DL0000228_0013.

conditions of the cells, were not acted upon.[759] Even if the recommendations were addressed the changes were superficial and transient. If the HMIP is really to act as a robust safeguard, it requires some form of robust enforcement powers.

350. HMIP annual reports demonstrate the issue with the HO being willing to act on recommendations in practice:[760]

• 2011/12 Annual Report – confirms progress on BH 2010 report – pg109 – 185 HMIP recommendations, 57 achieved (31%), 50 partially achieved (27%), 78 not achieved (42%)

• 2013/14 Annual Report – confirming progress on last BH report (not clear if referencing 2012 or 2013 report) – pg98 – 129 recommendations, 52 achieved (40%), 19 partially achieved (15%), 58 not achieved (45%)

• 16/17 annual report – confirming progress on BH 2017 report – pg102 -75 recommendations, 28 achieved (37%), 19 partially achieved (25%), 26 not achieved (35%)

• 19/20 annual report – confirming progress on BH 2019 report – pg114 – 45 recommendations, 16 achieved (36%), 10 partially achieved (22%), 19 not achieved (42%).

351. Evidence heard and seen by the Inquiry demonstrated that HMIP's effectiveness is limited in the context of a Home Office which shows little enthusiasm for self-reflection and picks and chooses recommendations to implement. Further, oversight bodies can in fact be harmful because their findings can provide a crutch for the Home Office to rely on, as they did repeatedly during the course of the hearings, that they failed to recognise the issues in the Relevant Period.[761]

352. When Hindpal Singh Bhui was asked about evidence from Nathan Ward and Callum Tulley that officers were put on their guard, extra staff brought in, and other steps taken to make the centre operate more effectively prior to inspections, he confirmed that inspectors are aware that changes can be made between the second and first week[762]. He acknowledged that inspections are only over a short period of time and it is difficult to uncover deliberately concealed behaviour and that HMIP has no regulatory or enforcement

[759] See above section in 'Causal Factor 3: Prisonisation' on 'Historic HMIP Concerns' and 'Repeated Rejection of Recommendations or Failure to Implement' which set out the historic rejections by the Home Office of HMIP recommendations on these areas

[760] Relevant annual reports quoted can be found here: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections?s&prison-inspection-type=annual-reports

[761] Gordon Brockington, 31 March 2022, 8/17-25.

[762] Hindpal Singh Bhui, 24 March 2022, 117/15-119/3.

powers to make the Home Office or IRC accept and implement HMIP recommendations [763]

353. Professor Bosworth also highlighted the fact that effective inspections was "*dependent on the cooperation of the institution for accurate documentation*",[764] a difficulty the Inquiry has had first hand-experience of in obtaining accurate and timely documentation from G4S. She also highlighted some concerns about the HMIP being filled up with inspectors from a prison background[765], a concern she developed in live evidence: *"I think it is part of the same set of issues that I have been discussing, which is, I think it runs a risk that1 it kind of shapes people's view of the detained population. If they themselves have come out of a Prison Service or they have been -- or they have previously monitored prisons, then they are going to see these institutions as being like prisons, and they are not. So, yes, I think it is a problem."*[766]

PSU

354. The PSU cannot be considered an independent and effective oversight body, as May J noted in her judgment. It lacks functional independence. Reports during the Relevant Period, including for D1527[767], D1538[768] and D668[769] were not disclosed to the complainants and instead provided to the Home Office's Detention Services – despite their actions as the Home Office detaining department being part of each individual's complaint. Each detainee instead received a summary response from Detention Services, thus compromising the PSU's independence.

355. The Inquiry heard and read evidence from former officers, Home Office staff, detained men, and experts which made clear that organisations such as the PSU are institutionally incapable of independent, rigorous investigations which could make a material difference.

356. Mr Khan of the PSU admitted that he was ultimately responsible to the Home Secretary and she is ultimately also responsible for serious misconduct at an IRC.[770] He also

[763] Hindpal Singh Bhui, 24 March 2022, 119/13-120/11.
[764] 10.18, INQ000064_0049
[765] Ibid
[766] Professor Mary Bosworth 29 March 2022, 137/19-25, 138/1
[767] CJS001107
[768] CJS003348
[769] HOM002748
[770] Mohammed Khan, 24 March 2022, 5/6-10.

accepted that the PSU is not deemed sufficiently separate from the Home Office under DSO 01/2011 to meet investigative obligations under articles 2 or 3.[771]

357. He revealed there was no requirement for investigation officers to make enquiries about whether there are or have also been complaints against the relevant officer.[772]

358. He also revealed that officers would not necessarily invite a complainant to review and comment on camera footage used to justify PSU conclusions[773], he was unable to explain why the full report was not provided to complainants[774] and was unable to say whether it was policy for the PSU to send the outcome of the investigation firstly to the Home Office and asking them to pass it onto the contractor, before it is sent to the complainant, despite evidence this did happen.[775]

359. He noted that cases that should have been referred to the PSU were not being referred in a timely way – an issue described by Mark Hartley King as "*the way things are being mishandled at Brook is not great*".[776] He also acknowledged it was not appropriate, as happened in D87's case, for an investigating officer to notify an interviewer that they had already decided there were no issues relating to the treatment of D87.[777]

360. Ms Wilkinson was very keen to stress she could only look at the evidence in front of her as an investigating officer.[778] This repeated refrain illustrated an astonishing lack of proactivity and the failure to show any institutional curiosity or concern about complaints. She admitted that, on reflection, she should have taken a wider approach.[779] She explained that officers would not necessarily be aware of other complaints made against an officer under investigation,[780] and that she did not take previous unsubstantiated allegations into account when assessing a complaint.[781] She also revealed that she had not considered whether evidence provided by G4S staff stating that they had not witnessed abuse might be self-serving[782] and that she set a very high bar for finding

[771] Mohammed Khan, 24 March 2022, 4/5-24.
[772] Mohammed Khan, 24 March 2022, 7/18-8/4.
[773] Mohammed Khan, 24 March 2022, 11/10 – 12/19.
[774] Mohammed Khan, 24 March 2022, 17/14-22.
[775] Mohammed Khan, 24 March 2022, 20/5-19.
[776] Mohammed Khan, 24 March 2022, 26/21 – 27/4.
[777] Mohammed Khan, 24 March 2022, 31/20-21.
[778] Helen Wilkinson, 24 March 2022, 62/18-21; 66/15-21; 77/14-19; 81/5-6
[779] Helen Wilkinson, 24 March 2022, 80/16-24.
[780] Helen Wilkinson, 24 March 2022, 64/17-18.
[781] Helen Wilkinson, 24 March 2022, 66/15-21.
[782] Helen Wilkinson, 24 March 2022, 76/17-24.

evidence substantiated, for example requiring that there was evidence provided of dates and times to check against the complaint's account.[783]

361. The lack of utility and rigour in the PSU process was starkly illustrated during Mr Paschali's live evidence. He had stated to the PSU that he had said to D1527, "don't move I don't want to put you to sleep". Under live questioning, had admitted that he had, in fact, said the complete opposite.[784] The PSU process is evidently inadequate if it requires a public Inquiry to discover the truth. Further, it was possible for officers involved in complaints who had since left to simply refuse to attend interview – as Mr Ring did in the case of D1527.[785] The PSU has no powers to compel people to interview.[786]

362. The inefficacy of the PSU is further illustrated via some of the experiences of individual CPs:

i. **D1527**: The PSU report into events of the 4 May 2017[787] was inadequate. It claimed that the detention officers had given consistent accounts, which they had not, and the accounts bar one were left untested. The PSU failed to interview DCM Dix, choosing instead to rely on his written report.[788] The report found no evidence of unlawful force against D1527 on 4 May, relying on the reports provided by officers to support this conclusion, as there was not CCTV footage of the use of force.[789] The PSU only substantiated complaints where supported by broadcast Panorama footage. The PSU found DCM Yates' use of a pain-compliance technique to be justified on the basis that "*CCTV supported his account of the level of disruption at that time*", finding "*no evidence that excessive force was used, or that staff were unprofessional during the use of force.*[790]" This is a highly concerning finding suggesting that the PSU wrongly believed the pain-compliance techniques are justified against detained persons who show a level of disruption. Jon Collier in his live evidence made clear that this was wrong and that DCM Yates' use of a pain-inducing technique against D1527 was unjustified and disproportionate.[791]

[783] Helen Wilkinson
[784] Ioannis Paschali, 24 February 2022, 81/12-23.
[785] CJS001107_007.
[786] Mohammed Khan, 24 March 2022, 10/25-11/9.
[787] CJS001107.
[788] CJS001107_0008.
[789] CJS001107_0030.
[790] CJS001107_0030 at 7.88
[791] Jonathan Collier 30 March 2022, 135/10-25, 136/1-8

ii. **D1538**: The PSU report into events of 3 and 28 June 2017 was inadequate.[792] It found that his complaints into events of 3 June 2017 were unsubstantiated, despite CCTV footage viewed by this Inquiry demonstrating that DCO Fiddy had grabbed him by the neck, a key detail which had been omitted from the use of force reports.[793] His complaint that DCO Murphy had made a homophobic comment to him was also found unsubstantiated because he lacked "definitive" evidence of his version of events[794] – an impossibly high threshold. The Inquiry heard evidence about numerous complaints against Darren Thomsett by detained people – but these were not taken into account when assessing the plausibility of him making a derogatory comment to D1528. The failures continued, when the letter providing a summary of the investigation was sent to D1538 from the Detention and Escorting Services Unit, thereby undermining independence.[795] That summary also misrepresented the findings of the report, glossing over its recommendations on review of the urgent procedure for Rule 40.[796] D1538 is just one example of many PSU reports where investigators interpreted evidence in a way that was more generous towards officers than detainees, and where the appeared to have already decided in the officers' favour prior to initiating an investigation.

363. Other features of the PSU's role and mandate that considerably limit its utility as an oversight body are:

(i) The investigations are limited in scope and often fail to consider the complaint in full. For example, both D1527 and D1538 set out areas of complaint which were in part ignored by the PSU (none of the systemic complaints of D1527 were addressed; the complaint regarding Darren Thomsett's use of force by D1538 was not addressed, nor were the issues he raised in his interview with the PSU about the incident of 6 June).

(ii) They regularly failed to interview all or any of the staff involved in the complaint – none in D1538's case, and only one current staff member (Yates) for D1527.

[792] CJS003348.
[793] Ed Fiddy, 7 March 2022, 171/17-25.
[794] CJS003348.
[795] DL000060.
[796] DL0000060 v CJS003348_0026.

(iii) Complainants are not given the chance to review or challenge the evidence of detention staff (neither D1527 nor D1538 were offered this), despite evidence from officers usually being the bulk of the evidence relied upon for conclusions. and there is a failure to proactively seek out other witnesses from the detainee population, but instead relying on the accounts of multiple detention officers.

(iv) There is an arbitrary and partial resolution of factual disputes, with decision makers consistently finding in the favour of officers without clear explanation as to why

(v) A failure to investigate wider, systemic issues which individual complaints point to.

(vi) There is Interdependence between the PSU and Secretary of State during the course of investigations – with, in some cases such as D1527 or in the case of an unnamed detainee [797], the Home Office designing the terms of references and asking the PSU to investigate[798].

(vii) There was an over-reliance on G4S' own investigation of its staff[799].

Reliance on Oversight mechanisms as 'cover'

364. Jerry Petherick said in his live evidence that he would have expected, had anything been seriously awry, for the signs to have been picked up by IMB.[800] Philip Dove sought to deflect criticism of G4S for failing to identify or act on the abuse shown in Panorama and for categorising incidents of ill-treatment as 'isolated' by reference to information provided by the IMB (and the HO)[801] and by pointing to the lack of criticism of healthcare training in HMIP and IMB reports.[802]

365. Peter Neden, the former Regional Chair of G4S said that he was conscious of the risk of abuse prior to Panorama but that:

[797] HOM0322395
[798] E.g. see CJS001107_0003 at 1.3 which confirms PSU investigation TOR for D1527 was set by Alan Gibson, Head of Detention Services
[799] E.g. see CJS001107_0015 at para 6.61
[800] Jerry Petherick, 21 March 2022, 8/18-22.
[801] Philip Dove, 31 March 2022, 48/10-23/.
[802] Philip Dove, 31 March 2022, 105/7-16.

"My assessment was that we had the right structures in place to ensure abuse couldn't take place. I was also -- I also took comfort from the knowledge that there was an IMB present in all of the facilities that G4S ran, and that the inspectorate made unannounced visits to each of the facilities on a timely basis."[803]

366. Gordon Brockington in his live evidence consistently sought sanctuary in the HMIP findings in 2017 that the establishment was reasonably good'.[804] He referenced them as the experts in their field,[805] apparently seeking to pass on the responsibility for identifying failures from the Home Office and G4S to oversight bodies. In response to questions about failures in Rule 35, Philip Dove equally relied on HMIP's lack of criticism of this operation of the rules as a defence.[806] Phil Riley stated that there were not indications that the abuse was inevitable, noting the post Panorama IMB report which stated they had not seen indications of abuse.[807]

367. Ben Saunders stated that he met regularly with the IMB and they flagged no concerns[808] he stated that they were 'very helpful eyes and ears'[809] and that, during the relevant period[810]:

'I was, at the time, convinced that we had some very good practice, some very good staff, that was supported by audits, inspections, IMB presence, reports…'

368. When asked how he did not realise what was happening on his watch, he noted audits, inspections, IMB etc. did not raise the issues which supported his impression that the centre was running without the issues identified in Panorama[811]. Michelle Smith gave similar evidence, when asked why she was not aware in failures in provision of activities, she responded that this had not been identified by the IMB or her team.[812]

369. Paul Gasson also described IMB as the Home Office's "eyes and ears".[813]

370. In response to whether they monitored the overall welfare of detainees, Michelle Smith stated she would have expected HMIP or IMB to have reported on that – but there was no

[803] Peter Neden 22 March 2022, 6/18-23
[804] Gordon Brockington, 31 March 2022, 30/6-20, 8/17-25, 42/1-6.
[805] Gordon Brockington, 31 March 2022, 42/7-20.
[806] Philip Dove, 31 March 2022, 2-9.
[807] Phil Riley, 4 April 2022, 13/10-22.
[808] Ben Saunders, 22 March 2022, 109/6-22.
[809] Ben Saunders, 22 March 2022, 109/21-22
[810] Ben Saunders, 22 March 2022, 109/9-13
[811] Ben Saunders, 22 March 2022, 105/2-13.
[812] Michelle Smith, 23 March 2022, 127/5-15.
[813] Paul Gasson, 15 March 2022, 223/11-20.

requirement in the Home Office team to report on this [814] She noted that the abuse shown in Panorama was of a covert nature, which neither the Home Office or G4S or the IMB picked up on.[815]

ToR 1: Identification of and Responsibility for Mistreatment

371. The terms of reference require the inquiry "to reach conclusions with regard to the treatment of detainees where there is credible evidence of mistreatment contrary to article 3 ECHR, namely torture, inhuman or degrading treatment or punishment and then to make such recommendations as seem appropriate. In particular, the inquiry is required by the terms of reference to investigate firstly:

> "The treatment of complainants, including identifying whether there has been mistreatment and identifying responsibility for any mistreatment."

372. In light of the analysis of the causes and contributory factors above, the DL CPs submit that Brook House was not the relaxed regime mandated by rule 3 of the Detention Centre Rules2001 ; the environment was not one which was ordinarily incidental to lawful detention and it was an environment which was itself inhumane and at least degrading for all those detained there for more than a few days.

The Environment of Brook House was Inhumane and Degrading

373. The Chair is invited to find that detention in Brook House in 2017 was intrinsically *liable* to involve suffering or humiliation "*beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment*".

374. The DL CPs do not say that as soon as somebody walked in the door they suffered article 3 mistreatment, but rather that the starting point is a recognition that the environment and conditions at Brook House were not ordinary conditions associated with immigration detention (or indeed with a defined period of custodial detention) and so any person detained there for any significant period of time was at least *liable* within that inhumane and degrading environment to suffer inhuman and degrading treatment.

[814] Michelle Smith, 23 March 2022, 129/22-24.
[815] Michelle Smith, 23 March 2022, 158/22-159/2.

375. In *Kudla v Poland* (2000) 35 EHRR 198 the ECtHR defined inhuman treatment and degrading treatment to include treatment that "*caused either actual bodily injury or intense physical or mental suffering*". The touchstone threshold for a breach of article 3 in a detention case is whether the suffering and humiliation experienced by the detainee is "*beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment*". That minimum threshold incorporates consideration of the individual's circumstances, including his particular vulnerability by reason of his mental illness and his individual needs for medication and treatment. The Grand Chamber of the European Court of Human Rights held in its judgment in *Rooman v Belgium* [2019] ECHR 105 at [141-147] that "ill-treatment" for the purposes of Article 3 does not require physical ill-treatment:

> (5) The Court has held that 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 (see, in particular,.., the detention of a person who is ill in inappropriate physical and medical conditions may in principle amount to treatment contrary to Article 3.
>
> …
>
> (2) 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 (see *Selmouni v. France* [GC], no. 25803/94, § 99, ECHR 1999-V… it has recognised that detainees with mental disorders are more vulnerable than ordinary detainees, 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. …
>
> (6) The Court also takes 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 detainees 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…
>
> (7) In this connection, the "adequacy" of medical assistance remains the most difficult element to determine. The Court reiterates that the mere fact that a detainee 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 detainee'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 detainee'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.

376. Detention in Brook House was intrinsically liable to involve suffering or humiliation "*beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment*". The "inevitable element of suffering or humiliation" is that which could be expected from a form of lawful immigration detention which should be in accordance with published detention policy and safeguards. It must also be environment that is meets the requirements of the statutory provisions in rule 3 of the DCR 2001 s as follows:

Purpose of detention centres

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.

377. It is, as the Chair will be amply aware, obvious that the regime at Brook House did not provide secure but humane accommodation in a relaxed regime with as much freedom of movement and association as possible – a fact recognised by Home Office Assistant Director Phil Schoenenberger himself in his live evidence on 23 March 2022[816]. Nor did it encourage them to make productive use of their time. Nor could the regime there be identified as one hat respected dignity of secured sensitivity especially when handling issues of cultural diversity. The closest that managers such as Deputy Director Steve Skitt and DCM Chris Donnelly came to understanding issues of cultural diversity is to apply

[816] Philip Schoenenberger 23 March 2022, 16/7-25, 17/1-15

racial stereotypes such as his claim that Chinese and Vietnamese detainees tended to prefer to be in a room with a triple bunk.[817]

378. In making the submission that there was an inhumane and degrading environment liable to subject anybody detained there, the Chair should have reference to the extensive evidence we have set out above in respect of each causal factor, and includes the following key concerns:

i. Detaining individuals who should never have been detained under immigration powers and/or held in Brook House IRC in the first place;
ii. Having no adequate or effective mechanism for screening, identifying and dealing with individuals with mental illness at Brook House and ensuring that such concerns are adequately raised with the Home Office to ensure that they are released. The complete systemic failures on Rule 34 and 35 have been laid bare by the Inquiry;
iii. Designing and implementing a system designed on risk management as opposed to identifying vulnerability and ensuring release. This includes the prolonged management of self-harming and suicidal detainees through the ACDT and Part C processes, as opposed to ensuring their consideration for release through Rule 35(1) and (2) given the clear unsuitability for detention. It also includes using inappropriate mechanisms of force, segregation and E-wing (or all in combination) to manage mental illness as refractory or disruptive behaviour, a key factor identified by Dr Hard[818] and others[819].
iv. The evidence obtained by this Inquiry on these mechanisms in any event in relation to use of force and segregation have shown a systemic misuse and misunderstanding of when they could be applied, without adequate oversight by the Home Office. In respect of use of force, Jonathan Collier's live evidence confirmed that most of the incidents he had been asked to review during the Relevant Period had caused him concern.[820] On segregation, the evidence as now confirmed by the Home Office and G4S was that during the Relevant Period almost all Rule 40 decisions were improperly authorised under the R40(2) urgency procedures by detention centre managers who had no authority to do so.[821]

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[817] Steve Skitt 17 March 2022, 137/23-25; Chris Donnelly 23 February 2022, 72/16-21
[818] See for example Dr James Hard 28 March 2022, 65/14-23, 66/13-15, 77/3-7, 164/11-16, 165/12-23
[819] See for example Witness Statement of Dr Brodie Paterson dated 21 January 2022 at BHM000045_0022, paragraphs 96-97: *"A number of staff seemed intent not on avoiding conflict but instead on engineering it in order to provide an excuse to use restraint in order to cause pain or to punish those evidencing distress."*
[820] Jonathan Collier 30 March 2022, 140/15-24
[821] HOM0332161; CJS0074121; DL0000242

v. Inappropriately holding those detained under administrative powers in a building designed to a Category B prison specification. The Inquiry's expert, Professor Mary Bosworth, deemed that the Category B design of Brook House is *"inappropriate for its purpose"* and makes *"the delivery of a humane and supportive regime very difficult."*[822] The stark, noisy and austere design of the wings and cells was entirely unnecessary and is counter-intuitive to the security aims it claimed to serve.[823]

vi. Consistently and routinely using Brook House to hold detainees for longer than the 72 hour period in which it was intended which only exacerbated the design, conditions, and regime in which it was procured out to be run. Jerry Petherick's live evidence confirmed that the Home Office's decision to resile from the 72-hour detention was *"really when the frailties of the design became apparent"*[824]

vii. Locking detainees in their cells for 11 hours a day – 9pm to 8am – essentially in the pursuit of saving staffing costs.[825] This was the view of Phil Schoenenberger and his procurement team when they assessed the GSL bid that G4S ultimately took over, describing the regime proposals as "*excessive*", *"very harsh"* and *"a desperate attempt to reduce costs at the expense of welfare."*[826] Mr Schoenenberger agreed in live evidence that the lock-in regime was not compatible with Rule 3 Detention Centre Rules 2001,[827] with Phil Riley finally accepting on behalf of the Home Office that the long lock-in hours in combination with staffing levels meant that there clearly was issues with detainee welfare within the agreed contract.[828]

viii. The lock-in regime was compounded by the unsanitary conditions of the cells, with witnesses giving evidence to the Inquiry of unscreened, dirty and smelly in-cell toilets, a lack of ventilation, and noisy and stark prison doors and atmosphere caused by the Category B design. All of Duncan Lewis' former detained clients gave first hand-experience of their experiences of trying to survive the lock-in hours in such conditions, with the likes of D643[829] and D668[830] highlighting the mental health impact of the re-ignition of trauma that

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[822] First Expert Report of Professor Mary Bosworth dated 17 November 2021 – INQ000064_0043, paras 9.8-9.9
[823] See for example the example given by the Head of Security to Kate Lampard that *"TSFNOs held in the more attractive and less restricted environment of Tinsley House did not present the same degree of problematic behaviour as those at Brook House. She acknowledged that it was likely that the environment of Brook House affected the behaviour of detainees."* CJS005923_0062
[824] Jerry Petherick 21 March 2022, 55/4-25, 56/1-20
[825] A view succinctly put in live evidence by the HMIP - Hindpal Singh Bhui 24 March 2022, 173/20-25
[826] DL000140_0069, 0078-0079
[827] Philip Schoenenberger 23 March 2022, 16/7-25, 17/1-15
[828] Philip Riley 4 April 2022, 46/18-25, 47/1-11
[829] Witness Statement of D643 dated 14 February 2022, paragraph 157, DL0000228_0044
[830] Witness Statement of D668, DL0000153_0005

it caused. D1851 described it as it *"created the impression of being tortured"*[831] whilst D2077's cell *"reminded me of a cage for animals."*[832] These accounts were supported by former officers such as Callum Tulley[833] and Owen Syred.[834]

ix. The evidence the Inquiry has received from all sources on the introduction of 3-men cells appears to universal agreement that it only made conditions fundamentally worse for detained persons. Hindpal Singh Bhui of the HMIP described the decision to introduce them as "playing with fire"[835] The decision ignored the warnings of Stephen Shaw[836] and the HMIP[837] from 2016 not to implement it, and the decision was only reversed in 2018 following litigation[838] and significant criticism by Stephen Shaw in his 2018 report.[839]

x. The lawless environment with high levels of general violence, threat and intimidation.

xi. Drug use leading to terrifying and frequent medical emergencies.

xii. A climate of fear, insecurity and powerlessness due to the use of no notice Charter flight removals. Lee Hanford covered this extensively in his live evidence, citing concerns such as: staff having to be 'disingenuous' with detainees about the times of their removal leading to relationship breakdown; fears when seeing large numbers of their own nationality arriving in the centre; not enough time to say goodbyes to family and friends; people 'living day by day'; coinciding with increases in uses of force etc.[840]

xiii. Compounded by the routine use of force including excessive force to effect transfer to E Wing and for removal, even in respect of the most vulnerable people further creating fear, anxiety and distress for both subject to and witnessing this.

xiv. High level of self-harm, suicidality and disturbed behaviour of the large numbers with mental illness causing acute distress and anguish for both those experiencing and witnessing this.

379. The combination of factors that resulted in an inhumane and degrading environment liable to subject anybody detained at Brook House was allowed to grow and develop by the Home Office and appeared to be an intentional feature of Brook House and part of a wider

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[831] DL0000094_0006
[832] Witness Statement of D2077, DL0000226_0021-0023
[833] Witness Statement of Callum Tulley dated 13 December 2019, INQ000051_0029-0031
[834] Owen Syred 7 December 2021, 147/21-25, 147/1-12
[835] VER000193_0001
[836] para 3.5 – INQ000060_0045
[837] HMIP000613_0007
[838] *Hussein & Rahman v SSHD* [2018] EWHC 213 (DL0000174)
[839] Stephen Shaw, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons', dated July 2018 – CJS0073862_0032, 003, 0184
[840] Lee Hanford 15 March 2022, 84/19-90/20

drive to create a hostile environment. They knowingly ignored and rejected historic concerns raised repeatedly and consistently by the HMIP, the IMB, Stephen Shaw and even their own procurement team led by Mr Schoenenberger, on issues such as building design and use, regime, conditions and staffing. Court decisions have raised multiple instances of historic breaches of Article 3 ECHR[841] and systemic failures in respect of Rules 34/35 that the Home Office failed to heed and learn from. A table of Rule 34/35 cases are set out in **Annex 4**.

380. The focus and drive for removals and to have low cost removal centres that assist them to do so has been too great a consideration for them to adequately address these issues to date. The Home Office feigned ignorance of such matters in their oral closing submissions, stating that "*The inquiry has helped to shine a light on issues, the importance of which may not have been fully appreciated or fully understood. The questioning by Ms Simcock on the issue of rule 34 and rule 35, for example, has identified problems with the interpretation and application of those rules.*"[842] These are long-standing issues known to the Home Office that they have sought historically to defend. As recently as 2019, they were defending the systemic failures arising from failing to produce Rule 35(2) reports, in *IS (Bangladesh)* [2019] EWHC 2700 where at para 203 Johnson J commented: "*The Claimant advances a powerful case that the current system is simply not working. The evidence strongly suggests that there are many people in immigration detention who are suspected of having suicidal intentions. It does not necessarily follow from the fact that a detainee is placed on the ACDT regime that a r35(2) report should be sent. A non-medical member of staff may open an ACDT in circumstances where the medical practitioner might be entirely satisfied that there is no question of suicidal intention. So one would not necessarily expect a precise match between the number of ACDT forms and the number of r35(2) reports. However, absent some very clear explanation, one would ordinarily expect a significant proportion of those who are subject to the ACDT regime to also be subject to a r35(2) report. The discrepancies in the figures are, as Mr Armstrong submits, striking.*"

381. In any event, it is clear that Brook House is simply not a fit place to detain anyone for any period of time without the risk of exposing them to inhumane and degrading treatment. This was the position during the Relevant Period, it was the IMB's view at the end of 2020[843], and remains the position now. Former DCO Derek Murphy described the centre as "*hell on earth for detainees*"[844]. The Home Office's Ian Castle confirmed: "*if you spend*

[841] E.g. *HA (Nigeria) v SSHD* [2012] EWHC 979 (DL0000178) and *D v SSHD* [2012] EWHC 2501 (DL0000179)
[842] Home Office closing submissions 6 April 2022, 4-10
[843] DL0000140_0113
[844] Derek Murphy 2 March 2022, 4/21-24, 20/22

more than 24 hours in Brook House, you're going to develop mental health issues."[845] Individuals simply cannot be detained at Brook House without being harmed. D1851 had no previous history of mental health issues before he arrived at Brook House. His experiences there have caused him long lasting harm . He gave powerful testimony on 3 December 2021 about the impact being detained at Brook House has had on his life:

> *"A. Finding the right word is a pretty hard one, but I think the easiest one would be "crushing"... , because it made me a different person...*
> *A. Yeah, some of the experience, but not really tell the mental effect it all had, because it's easy to say what you saw, what you experienced, but I think for me, as1 someone who has never been in such a situation of such ever in my life, it totally made me someone else until today, and I'm still struggling, and the pain was -- I shouldn't have been there. There were several chances to avoid me staying there for long or even getting there. I tried everything. Everything they asked me, I provided, but they never listened. They didn't do anything. Even until today, they still haven't apologised. They said they accepted that I was detained unlawfully, but no apology even until today, and I just I ask myself the question, I came from a country whereby they tell you the law doesn't care, whatever, I came to the UK believing there is a law. Okay, people make mistakes, but there is a law that will protect you, no matter what. Until today, my view has changed. I just don't think it exists. And -- yeah, the story is there, what I experienced, what I saw everyday, the spice, drugs, people collapsing, emergencies, people looking like zombies every day, piling on each other. Even when I was in the real world, I didn't see that, but seeing that every day, for God's sake, it shapes you. I don't pray anyone experiences it, and part of the reason why I came into this inquiry is to please do something about it. There are probably still other people experiencing the same thing, especially innocent people, where you're in detention whereby convicted people came there and they are telling you that their experience in the prison that they came from is better than their experience in the detention centre. That will probably give you an5 idea of what it is like.*
>
> ...
>
> *And it was hard because I remember then I was home and I think it's easy -- it's easy to explain because, when I left detention, like I said, I didn't actually understand what was happening to me, why I was in Brook House. It was after I was released. As I stepped out into the real world, I remember my first step was stepping into Gatwick train station. That was where I first noticed something is different because people were walking by me and I was scared. I got startled when people walked by. And that felt weird. But I just thought, well, let me just go back. I was just excited to be out of the place. But after*

[845] Ian Castle 15 March 2022, 38/16-18

I got home, I realised everything was different. I didn't want to leave the same spot I was. I didn't want to -- wouldn't go out of the house. Just spoke with friends. If they invited me out, I wouldn't go. The worst part was hearing a bang and me jumping. It happened for several times, and I remember -- another one I remember was being at home and watching a programme on TV, it was about life in prison or something like that. And, funnily enough, the programme was just a remembrance of -- was just there remembering me that where I was was a prison. First, I remember seeing the plates they were using. It was a normal prison. The plates they were using, it was the same type of plate as the plastic plates we used to eat in, in Brook House. The ketchup they used, exactly the same. I broke down. I broke down. It was terrible."[846]

382. The Inquiry should follow their own expert, Professor Bosworth[847], in being bold and taking this unique opportunity to make fundamental recommendations about how long individuals can and should be held.

Recommendations

383. By the third paragraph of the Terms of Reference, the Inquiry is required to determine: *Whether any changes to these methods, policies, practices and management arrangements would help to prevent a recurrence of any identified mistreatment.*

384. Ultimately, the litmus test of this Inquiry will be in the recommendations. In the past recommendations from Stephen Shaw and others have been detailed and extensive although largely operational and the Home Office has chosen to implement those it wishes, although incremental changes have not been maintained. That model will not do again. The CPs suggest a much simpler and effective approach. The first recommendation should be to examine the necessity of the use of detention in immigration removal centres per se. The modern world is equipped with more subtle and effective mechanisms for enforcement. The DL CPs submit that first and foremost the cessation of the use of IRCs should be recommended.

385. The individual DL CPs wholly support the recommendation of Professor Bosworth in her report to the Inquiry at paragraph 2.28:

> *"2.28 These conditions [the current low number of detainees due to the pandemic] offer a unique opportunity to bring in two wide-ranging changes. First, the*

[846] D1851 3 December 2021, 60/5-8, 103/8-25, 104/1-15, 113/2-25, 114/1-4.
[847] Dr Mary Bosworth, INQ000064_0011 Paras 2.27-2.28

government could, finally, follow international human rights standards and bring in a time limit to immigration detention. A time limit would significantly reduce the kinds of distress shown in the video footage and would make the purpose of these institutions clearer. This, in turn, would bolster a professional staff culture and help to prevent a recurrence of the events of 2017."[848]

386. As Professor Bosworth makes clear, introducing time limits for immigration detention would in fact work to everyone's benefit. The obvious choice is a 28 day as an outer limit for all endorsed by the Joint Human Rights Committee[849] and the Home Affairs Select Committee[850] and indeed the House of Lords in a vote in Parliament last year.[851]

387. For those with vulnerability, this Inquiry should recommend that those with a known particular vulnerability to harm should not be detained. If they are detained and vulnerability is only later identified, they should be promptly released and not held for any longer than 72 hours if removal directions are in place or else the time is taken to organise their safe release into the community. There is a model of strict limits in the statute regarding the detention of children of a maximum of 24 hours, pregnant women are 72 hours thereafter approved by a Minister and for a period of 7 days. Family returnees' policy is likewise 72 hours with a 7-day maximum with ministerial approval (see witness statement of Emma Ginn)[852] and as described in the evidence of Reverend Nathan Ward[853].

388. For such a recommendation to be effective, there would also need to be proper implementation of a duty of inquiry so that vulnerability is identified prior to detention. Dr Hard endorsed a system of pre-detention screening to ensure that vulnerable people are diverted away from the detention system.[854] Medical Justice[855] also support the end of detention of vulnerable people and even Dr Oozeerally, whose evidence in general has been discredited for failing to recognise the failure of the current system, acknowledged that pre-detention medical screening would be an improvement.[856]

389. Strict time limit periods would provide detainees with the sense of dignity and psychological reassurance that comes with having rights. They would also give staff what

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[848] Ibid
[849] https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/1484/148410.htm#_idTextAnchor073
[850] https://publications.parliament.uk/pa/cm201719/cmselect/cmhaff/913/91310.htm#_idTextAnchor138
[851] https://hansard.parliament.uk/commons/2020-10-19/debates/97E83258-6E39-432F-8AE0-C2D7E0B1966F/ImmigrationAndSocialSecurityCo-Ordination(EUWithdrawal)Bill#:~:text=Lords%20amendment%206%20would%20limit,immigration%20detention%20to%2028%20days.
[852] See witness statement of Emma Ginn at paragraphs 149-152, BHM00041_0054-0056
[853] Nathan Ward, DL00000141, Para 350
[854] Dr James Hard, 28 March 2022, 69/8-19, 72/17-19, 175/15-25 and 179/5-9
[855] Dr Rachel Bingham, 14 March 2022, 54/4-8
[856] Dr Oozeerally, 11 March 2022, 16/12-14

Professor Bosworth calls a clarity of institutional purpose. It would help staff understand what it is they are doing: not warehousing, but facilitating the immigration system in a civilised way. Panorama, and the evidence to this inquiry reveals that staff like detainees have also been victims of the uncertainty, the anxiety, and the lack of dignity and respect that pervades immigration detention. Senior G4S managers Jerry Petherick,[857] Michelle Brown[858] and Lee Hanford[859] as well as Sandra Calver[860] identified that the main problem for detainees is the uncertainty that surrounds the length of detention. Dr Oozeerally called for a one-week limit on immigration detention.[861] The harm caused by indeterminate detention was identified by Yan Paschali,[862] Steve Webb,[863] Steve Skitt,[864] and Ed Fiddy.[865] No evidence was given to explain or justify an unstructured and open-ended power to detain.

390. Medical experts are also against indeterminate (or indefinite) detention. The Inquiry has heard from Dr Hard,[866] Dr Bingham,[867] and Dr Katona[868] and who all agree that, in the view of the medical community, indeterminate detention should come to an end. Their views are supported by the NGOs who work in immigration detention (Medical Justice,[869] GDWG,[870] and BID[871]).

391. Dominic Aitken[872] reached the same conclusion following his time conducting research at Brook House, as did Callum Tulley[873] after exposing the abuse of Brook House. Kate Lampard said people should be detained at Brook House for no more than a few weeks.[874]

392. Strict time limit periods would not only provide detainees with the sense of dignity and psychological reassurance that comes with having rights, but it would also give staff what Professor Bosworth calls a clarity of institutional purpose. It would help staff understand what it is they are doing: not warehousing "the mad and the bad" but facilitating the

[857] Jerry Petherick, 21 March 2022, 98/12-25
[858] Michelle Brown, INQ000164_0054, Para 106 – relevant page not published on Inquiry website
[859] Lee Hanford, 15 March 2022, 82/9-11
[860] Sandra Calver, 1 March 2022, 187/1-5
[861] Dr Husein Oozeerally, DRO000001_0013, Para 115
[862] Yan Paschali, 24 February 2022, 15/16-25
[863] Steve Webb, 8 March 2022, 139/11-18
[864] Steve Skitt, 17 March 2022, 48/8-17
[865] Ed Fiddy, 7 March 2022, 147/12-19
[866] Dr James Hard, 28 March 2022, 178-179/20-25, 1-9
[867] Dr Rachael Bingham, BHM000033, Para 171
[868] Dr Cornelius Katona, BHM000030, Para 96
[869] Theresa Schleicher, 14 March 2022, 90-91/19-25, 1-16
[870] Anna Pincus, DPG0000002_0079-0080, Para 228
[871] Pierre Maklouf, DPG000038_0029, Para 92(a) – document not published on Inquiry website
[872] Dominic Aitken, 8 December 2021, 69/12-21
[873] Callum Tulley, 30 November 2021, 55/15-21
[874] Kate Lampard, CJS005923_0015, Para 1.57 – relevant page not published on Inquiry website

immigration detention system in a (more) civilised way. Panorama, and the evidence to this Inquiry reveal that staff, like detainees, have also been victims of the uncertainty, the anxiety, and the lack of dignity and respect that pervades immigration detention when no time limit is in place. A time limit would help enhance decency and values for staff as well as detainees and indeed it would ultimately help the Home Office itself to focus its resources more effectively.

393. In the submission of the Duncan Lewis CPs, if there is to be a time limit in the alternative to ending detention in immigration removal centres, the maximum should be 72 hours[875]. Even a period of 72 hours is likely to have an injurious impact on a person's mental health,[876] even without having a pre-existing vulnerability.

394. In any event, it is clear from evidence heard in this Inquiry that the fabric of Brook House, as a centre designed to category B prison standards and to only hold people for up to 72 hours, is unsuitable for detaining anyone and must be closed with immediate effect. Brook House is a restricted institution, where detainees are held in cells with limited natural light and fresh air, and noises refract around the centre. Witnesses have described attempts to 'soften' the environment, but the reality is that the design specifications of the centre and its very structure cannot be changed. The Duncan Lewis CPs maintain that the centre does not comply with Rule 3 of the Detention Centre Rules, that the *'purpose of a detention centre is to provide for the secure but humane accommodation of detained persons in a relaxed regime with as much freedom of movement as possible'*. The Duncan Lewis CPs endorse Mary Bosworth's findings in her report, *'The design of Brook House Immigration Removal Centre is inappropriate for its purpose'*[877] and, *'the restrictions of a Category B prison make no sense for those held under Immigration powers. They make the delivery of a humane and supportive regime very difficult'*.[878] Brook House as an IRC is unsuitable and must be closed.

395. In short, the DL CPs submit that the Inquiry should not adopt the practice that has pertained through countless reports of the IMB, the PSU, Stephen Shaw, the PPO, HMIP etc. of making recommendations for numerous changes in policy in practice yet which retain the basic structural problems that cause the mistreatment. The point of this inquiry is not to conspire in the pretence that these problems can be resolved in that way. It is to eliminate the mistreatment for good. To that end there are only really three possible fixes

[875] For adults – for children, if immigration detention is going to continue, the position in respect of the maximum time limit of 24 hours should remain as it is.
[876] Dr Rachael Bingham, BHM000033, Para 171; Ian Castle 15 March 2022, 38/16-18
[877] Mary Bosworth, INQ000064_0043, Para 9.8
[878] Mary Bosworth, INQ000064_0043, Para 9.9

that will make a genuine difference: to end the use of immigration detention centres; alternatively to limit the time for which detainees may be detained; and in any event to close Brook House.

Stephanie Harrison Q.C.
Gordon Lee
Una Morris
Alex Schymyck
Garden Court

Alex Goodman
Landmark Chambers

Duncan Lewis Solicitors

3 May 2022