IN THE BROOK HOUSE INQUIRY

INDIVIDUAL CLOSING STATEMENT ON BEHALF OF D643

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1. D643 was born in St Vincent and the Grenadines. Diagnosed with combat PTSD arising out of his service in the British Army[1], he was patently unsuitable for detention given his vulnerability and particular risk of harm in detention where he could not receive adequate medical care and treatment for his PTSD.[2] Despite this, he was detained and spent a total of 558 days in Brook House, over four separate occasions.[3] On the final occasion, D643 was detained for 504 consecutive days[4] – a shocking length of time for someone to be detained in an Immigration Removal Centre ("IRC") designed to hold people for periods of only up to 72 hours.[5] He was detained in Brook House for the entire relevant period and for substantial periods before and after it. It was only after D643 brought litigation that the Home Office finally released him. The Chair will note D643's evidence that the mistreatment of detainees continued throughout his detention,[6] demonstrating that the relevant period is just the tip of the iceberg as far as abuse at Brook House is concerned.

2. The detention of D643 was unlawful and during his time at Brook House he was subject to inhuman and degrading ill-treatment and punishment in breach of Article 3 ECHR, including unlawful use of force (which amounted to assaults), unlawful use of segregation, exposure to risk to life and limb, egregious healthcare failures and racism. D643 was trapped, for every one of those 558 days within the toxic culture that pervades Brook House. That experience and those incidents, considered alongside D643's documented mental health vulnerabilities, the exacerbation of his mental illness, and

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[1] DL0000228_003.
[2] DL0000228_008.
[3] DL0000228_002.
[4] DL0000228_003.
[5] See, for example, Hindpal Singh Bhui, 24 March 2022, 176/12-14, Nathan Ward, 7 December 2021, 134/20-135/19.
[6] DL0000228_003-38.

lack of adequate medical care and treatment, individually and/or cumulatively violated the systemic, operational and investigative obligations under Article 3 ECHR.

3. D643 took the courageous step of participating in this Inquiry because he was determined to do what he could to ensure that no-one else ever suffered again as he had in Brook House, and to play his part in ensuring there is meaningful reform of the wider system of immigration detention. He felt a strong sense of duty to use the opportunity to speak not only on his own behalf, but also on behalf of so many other people detained in Brook House, who were unable to provide evidence on the abuse and mistreatment they suffered.

4. As an articulate man who speaks fluent English, D643 is aware that he is particularly well-placed to speak about the events at Brook House. Despite the enormous challenges he personally faced in doing so, he also gave oral evidence to this Inquiry. As mentioned in the Oral Closing Statement on behalf of D643, he was very pleased at being given that opportunity,[7] and to finally be able to put on the record what happened to him in detention. All D643 wanted was to be listened to and taken seriously without the pervasive air of cynicism, disbelief and callous indifference to his suffering, that was present in in the inhumane environment at Brook House. His experiences in Brook House have stayed with him and affect him to this day. This was evident from the distress he exhibited in his oral evidence five years after these events.

Overview of this individual Closing Statement

5. The Chair is referred to the Closing Statement on Behalf of D1527, Reverend Ward, D1851, D1914, D2077, D1538 and D643 (hereinafter the "Group Closing Statement"), which includes submissions on the prolonged, unlimited extent and purposelessness of detention; clinical care failures; the unlawful use of segregation; unlawful use of force; the failures in the safeguards such as Rule 34 and 35 (which were designed to identify vulnerable detainees like him); institutional racism; unlawful and excessive use of force; and the continued impunity of officers involved in the abuse and mistreatment of people detained at Brook House.

[7] D643, 5 April 2022, 93/9-10.

6. These closing submissions will build on the submissions made orally on behalf of D643 on 5 April 2022 and in the Group Closing Statement and will follow this structure:

   (i) D643's background and pre-existing vulnerabilities
   (ii) Fact-finding in relation to D1643's evidence
   (iii) The evidence
      a. D643's background and pre-existing vulnerabilities
      b. The decision to detain D643 and maintain detention
      c. Regime and conditions
      d. Healthcare failures
      e. 7 November 2016
      f. 28 March 2018
      g. Racist, abusive and toxic culture
      h. The impact on D643 of detention at Brook House
   (iv) Conclusion

7. D643 invites the Chair to review the following key evidence alongside this individual Closing Statement:
   i. D643's witness statement[8]
   ii. D643's live evidence[9]
   iii. D643's oral closing submissions[10]
   iv. D643's Rule 35 reports dated 9 December 2016[11] and 29 January 2017[12]

Fact-finding in relation to D643's evidence

8. D643 is a witness of truth and he invites the Chair to accept his evidence as true in its entirety. The evidence provided by D643 both in his witness statement and in oral evidence has been credible, reliable and compelling. His evidence has not only been internally consistent in terms of what he has told this Inquiry and what he said about Brook House previously; it has been supported by other, significant evidence the Inquiry has heard.

[8] DL0000028.
[9] D643, 22 February 2022, 1 – 91.
[10] D643, 5 April 2022, 82/1 – 94/19
[11] DL0000219
[12] DL0000220

9. D643's evidence therefore provides "*sufficiently strong, clear and concordant inferences or similar unrebutted presumptions of fact*". Further, it is "*elaborate and consistent … mentioning the specific elements ...credible and reasonably detailed*".[13] The evidence provided by D643 is very "*clear and detailed*", "*other similar unrebutted facts have been established*", his "*account of mistreatment* [is] *consistent with other account*[s]...[he] *has given* [and] *with other evidence independent of his account*". There is wide-ranging "*evidence...to support* [D643's] *complaint*[s] *of mistreatment*" of high "*quality*". In relation to D643's evidence, there are instances where "*rebuttal evidence ought to have existed and does not*" and he invites the Chair to draw appropriate "*inferences...from their absence*".[14]

10. Appropriate inferences to draw from the absence of evidence in D643's case include that those who deny matters and ought to have provided rebuttal evidence to support their denial did not do so because the allegations made by D643 were true and the only evidence available would have proved their truth (i.e. there is before this Inquiry no rebuttal evidence but the evidence that should have existed is not available for suspicious or incredible reasons). Another appropriate inference would be that a denial amounts to no more than a bare denial, for which there is and never was any evidence to support it.

11. It is also open to the Chair to find that witnesses whose evidence contradicts that of D643 have not only been factually inaccurate but that they have been dishonest and deliberately so. It is incumbent on the Chair that, where there are instances of nonsensical, unreasonable or implausible evidence, she find accordingly and records such witnesses as lacking in all credibility.

The Evidence

D643's background, history and pre-existing vulnerabilities

[13] 18e, CTI Note on Approach to Findings of Fact under Art 3 ECHR 250322.
[14] 18g, CTI Note on Approach to Findings of Fact under Art 3 ECHR 250322.

12. D643 served in the British Army between 2001 and 2012. During his service, he had tours of duty in Kosovo, Bosnia, Afghanistan and Iraq.[15] D643 was injured in Iraq in 2005 when a vehicle he was travelling in overturned.[16] On another occasion in Iraq, he was on patrol with an officer who was killed when his Land-Rover was blown up. He has also seen friends killed and maimed in action.[17] D643 first began to experience the symptoms of Post-Traumatic Stress Disorder ("PTSD") in 2007 when he returned to the UK from Iraq and suffered from flashbacks, insomnia, anxiety and depression.[18]

13. As a result of the mental health illness arising from his PTSD, D643 made a very serious attempt on his life whilst in Germany in 2011 and spent three weeks in hospital, before being discharged from his service in 2012 on medical grounds.[19] Following discharge, D643 received specialist therapy from 'Combat Stress' to attempt to manage his PTSD. Whilst D643 was in HMP Channing Wood, around May 2015, he was referred for treatment for his PTSD.[20]

14. D643 was awarded compensation under the Armed Forces Compensation Scheme from the Ministry of Defence for the debilitating effects of his PTSD in 2017.[21]

15. Despite D643's obvious vulnerabilities and likelihood of harm, he spent over 18 months in total in immigration detention.[22]

The decision to detain and maintain detention

16. D643 should never have been detained. The Detention Gatekeeper in September 2016 failed to conduct a full and proper assessment of his suitability for detention at the end of his custodial sentence - the GCID records indicate that the Gatekeeper apparently had no knowledge of his diagnosed medical conditions, stating that he "*claims to have depression and PTSD however there is no evidence of this*".[23] The Home Office's failure to take into account relevant medical history and known diagnoses when

[15] DL0000228_001-2.
[16] DL0000228_003.
[17] DL0000228_003.
[18] DL0000228_003.
[19] DL0000228_003.
[20] DL0000228_003.
[21] DL0000228_003.
[22] DL0000228_003.
[23] DL0000228_0015.

considering the suitability of detention is consistent with the experience of far too many other people held at Brook House. It was a systemic failure in the safeguards leading to an unlawful decision to detain, exposing D643 to an entirely foreseeable and predictable risk of harm capable of subjecting him to treatment in breach of Article 3 ECHR.[24] D643's PTSD made him entirely unsuitable to be detained from the outset; his detention at Brook House would only go on to exacerbate his serious mental illness and symptoms of PTSD for which he could receive no appropriate or adequate medical care.[25]

17. The Group Closing Statement sets out the failures in safeguarding procedures at the time of the decision to detain in further detail, in particular in Causal Factors 1 and 2. Together with these submissions, they show that D643 was just one of many, many exceptionally vulnerable detainees at Brook House, who was failed by systemic flaws in detention policy and practice and the unwillingness and inability of the Home Office and G4S to operate safeguards relating to pre-detention screening properly. D643 invites the Chair to find that the complete systemic failure in safeguarding procedures constitutes a violation of both the systems and the operational obligations under Article 3 ECHR.

18. Witnesses gave evidence to this Inquiry of the urgent need for robust information sharing mechanisms as well as a screening mechanism, which would identify people who were not fit to be detained, prior to them ever being detained. Dr Hard argued it was "*essential*" that information be gathered pre-detention so that a proper assessment of vulnerability can be conducted.[26] Theresa Schleicher[27] and Dr Oozeerally[28] also called for pre-detention medical screening. Had an effective mechanism been in place, D643 would have been spared over 18 months of the abuse, mistreatment, and health deterioration he suffered at Brook House.

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[24] See, for example, D1914 who was detained despite having a serious heart condition, D2077 who was detained despite previously having been released due to his vulnerabilities, and D1527 who was detained despite being acutely suicidal.

[25] See, for example, Dr Hard who acknowledged a risk of people with PTSD being "positively harmed" by detention, Dr Hard, 28 March 2022, 71/25- 73/3; Dr Bingham who stressed people with PTSD should be managed in a place they feel safe, not a custodial setting, Dr Bingham, 14 March 2022, 40/14-24; Professor Katona who explained that PTSD cannot be managed in detention and can be exacerbated – BHM000030_0032; Dr Oozeerally's admission that people with PTSD are definitely at a greater risk of deterioration in a stressful environment, Dr Oozeerally, 28 March 2022, 150/4-10; and Sandra Calver who admitted staff were not equipped to identify symptoms of trauma, Sandra Calver, 1 March 2022, 186/11-16.

[26] Dr Hard, 28 March 2022, 20/21 – 21/1.

[27] Theresa Schleicher, 14 March 2022, 83/4-11.

[28] Dr Oozeerally, 11 March 2022, 16/12-14.

19. The same failures were repeated throughout D643's detention, with detention reviews containing inaccurate or incorrect information, failing to engage with his medical condition, and not conducting a full and proper assessment of his suitability for continued detention.[29] For example, the purported review of D643's detention on 11 March 2017 repeats the dangerous inaccuracy that he merely "*claims*" to have PTSD, despite this having been conclusively diagnosed and evidenced in two Rule 35(1) assessments.[30] The Home Office failed to feed updated medical information into his detention reviews, or to ensure adequate information-sharing across departments, to safeguard against the unlawful detention of D643, where detention was seriously injurious to his health. This pattern of failures echoes the experience of many other men who gave evidence to this Inquiry[31] and confirms Dr Hard's conclusions of a complete deprivation of safeguards. [32]

20. The Home Office compounded the failures in its screening mechanisms, detention policy and safeguards by repeatedly failing to release D643 despite receiving information that should have led it to do so:

    i. D643 received a Rule 35(1) report on 9 December 2016 which recorded his health was likely to be injuriously affected by detention.[33] The Home Office response to this records, inexplicably, that he was "*fit to be detained*". There was also a failure to classify D643 as an Adult at Risk ("AAR").[34] This was a complete and reckless disregard of the Home Office's own policies on safeguarding vulnerable individuals.

    ii. D643 received another Rule 35(1) Report on 29 January 2017, again finding that his health was likely to be injuriously affected by detention, warning that the risks to his health were "*very serious*".[35] Despite this, the Home Office maintained detention, falsely claiming he had been referred to a psychiatrist and,

[29] DL0000228_0041-46.
[30] DL0000228_0041.
[31] See, for example, D1914, whose detention reviews failed to properly set out or assess his health condition.
[32] Dr Jake Hard 28 March 2022, 141/2-23
[33] DL0000228_0026.
[34] DL0000228_0026.
[35] DL0000228_0035.

incorrectly and in contradiction of the report, stating his condition was being managed by medication.[36]

This was in any event again the Home Office showing complete and reckless disregard for their own detention policies. They essentially applied the 'satisfactorily managed within detention' test that was intended to be removed by the introduction of the AAR policy, at the recommendation of Stephen Shaw in his 2016 report. Mr Shaw was strongly critical of using satisfactory management as a means of maintaining detention: (own emphasis added) *"it is perfectly clear to me that people with serious mental illness continue to be held in detention and that their treatment and care does not and cannot equate to good psychiatric practice (whether or not it is 'satisfactorily managed'). Such a situation is an affront to civilised values.* ***Recommendation 11: I recommend that the words' which cannot be satisfactorily managed in detention' are removed from the section of the EIG that covers those suffering from mental illness.*** *"*[37]

iii. The evidence given to this Inquiry has shown that the improper and continued use of the 'satisfactory management test' post-AAR policy was systemic and was one of the key policy failures during the relevant period. When Ian Cheeseman - who both assisted Shaw with his 2016 report and was the architect of the AAR policy - was asked about it in his oral evidence, he confirmed the test was removed but still used in practice:

> *"Q. Concerns were certainly raised with you about the move away from category-based -- the category-based approach to an indicators of risk plus evidence of harm, though, weren't they, and that that effectively went back to a practice of whether someone could be satisfactorily managed within detention. Do you agree with that?*
>
> *A. Yeah, I think so. I mean, the "satisfactorily managed" issue is interesting, because the EIG 55.10 referred to "satisfactorily managed" in respect of people with mental health conditions and physical health conditions. We actually removed that from the formulation, to a degree,*

[36] DL0000228_0037.

[37] Stephen Shaw, 'Welfare in Detention of Vulnerable Persons by Stephen Shaw, January 2016, paragraph 4.36, INQ000060_0090-0091.

in the Adults at Risk policy, but I was reminded this morning, when I read the document that was provided to me this morning, which was the 2016 version of the caseworker guidance, that it was kind of still there but in another form.

Q. Yes.

A. And so -- I mean, I have to kind of agree with you, that it wasn't removed.

...Q. If there was a connection, that is certainly the opposite of what Shaw was trying to achieve, wasn't it? He was trying to route vulnerable people out of detention to ensure that harm wasn't caused to them by protecting them with safeguards. Would you agree with that?

A. Well, Mr Shaw's recommendations in respect of the policy were -- well, yes, I mean, I can't disagree with that, yes, sorry"[38]

iv. D643 provided the Home Office with three separate medical experts' reports which opined that he was not fit to be detained. The Home Office response to his representations made no reference at all to the experts' reports.[39]

v. D643 was assessed as unsuitable for detention on 22 March 2018 by Dr Chaudhary.[40] The Home Office response was not to release D643, but instead to query Dr Chaudhary's assessment and request further information regarding the management of his healthcare condition in detention.[41] This again fundamentally breached the terms of the AAR policy.

21. Thus, even where the systems in place identified D643's vulnerabilities (which they so rarely did) and clearly identified him as unfit for detention, there were nevertheless repeated failures to do the right thing and release him. Safeguards are of no effect in the face of a detaining authority which is determined to maintain detention come what may, which obfuscates its own policies and which has no regard for the welfare of those it detains. If immigration detention must continue, the culture of the Home Office requires a radical overhaul to have anything even approaching respect for fundamental

[38] Ian Cheeseman 15 March 2022, 191/3-20, 192/9-17
[39] DL0000228_0050-51.
[40] DL0000228_0061.
[41] DL0000228_0063-64

rights and dignity within the system. This must be enshrined in law and clear limits placed on this power in law and policy so that it is not left to the discretion of the Home Office for when and how long to detain. D643 invites the Chair to find that the system failures in policy and safeguards to release him, despite the wealth of available information that he was not fit for detention, constituted a violation of the operational obligation under Article 3 ECHR.

22. The system not only failed D643 in that he should never have been detained and that the Home Office was in receipt of information which ought to have led to his release, but even when he was granted Bail in Principle by an independent judge on three occasions, the Home Office continued to fail to release him. This was despite comments from First Tier Tribunal Judges noting the need for the Home Office to treat D643 with "*due care and respect*", and the "*exceptional*" circumstances of his case.[42] Its refusal to release a man recognised by the independent judicial system as requiring bail, relying on their own incompetence in securing a bail address for him, is just one shocking example of the Home Office's disregard for D643's health and liberty. Causal Factor 1 of the Group Closing Statement describes in greater detail how the evidence before this Inquiry makes it clear that the Home Office does not have in place in principle and does not operate in practice a system whereby detention is only used for the shortest period possible, nor with any respect for common law and ECHR principles stressing the utmost importance of the right to liberty and the protection of the vulnerable from known and entirely foreseeable harm and injury to health.

23. D643 was never removed from the UK. The 558 days he spent in detention served no practical purpose. It only served to cause harm. He did not offend when released; he did not abscond. Like all of the DL Core Participants, his detention was pointless and served no immigration purpose.[43] This is further reflected in D643's successful false imprisonment claim which he brought in 2019, and the Home Office settled for £45,000. The settlement did not specify what period of his detention it was accepted was unlawful and it was not accompanied by an apology.[44] Had it not been for this

[42] DL0000228_0055-56
[43] Please see Causal Factor 1 of the Group Closing Statement for further details.
[44] DL0000228_0077.

Inquiry, D643's shocking experiences would not have been recorded in just one of countless unlawful detention cases which no-one would ever have heard about.

Healthcare failures

24. In many respects D643 had huge advantages over many of the other detainees – he spent 11 years in the British Army, he speaks fluent English and understands how to operate in a hierarchical, structured and process-driven environment.[45] He had experienced detention in other IRCs and in prison[46] and had been tasked by the British Army to assist with the detention of people in Iraq.[47]

25. Despite all of this, D643 experienced catastrophic failures in accessing adequate healthcare at every turn, which experience is wholly in keeping with the systemic failures set out in the Group Closing Statement. Failures by doctors to give him a proper physical and mental health examination on entry as they were statutorily bound to do by Rule 34 of the Detention Centre Rules 2001, failures to take the most basic of steps to check his previous medical records when he was inducted and a complete failure to identify, diagnose and even to attempt to treat his mental health problems, including his complex combat-related PTSD.

26. There is a clear clinical consensus that immigration detention is damaging to mental health particularly for those with a pre-existing vulnerability including mental illness.[48] However, a range of witnesses with institutional knowledge of detention admitted in their written and oral evidence that Brook House was an entirely unsuitable place for people with serious mental health conditions like D643. For example, Ian Cheeseman noted that "*There was a general acceptance that detention had the potential to impact negatively on people, especially those with mental health conditions*".[49] Ian Castle

[45] DL0000228_002
[46] E.g. DL0000228_004, 18.
[47] D643, 22 February 2022, 30/4-15.
[48] See for example Mr Shaw's findings in the Shaw Report 2016 at 4.1-4.16 and 4.35-4.40 as well as Mary Bosworth's literature review on the impact of detention on mental health at Appendix 5 to the report – INQ000060_0083-0085, 0090-0091, 0305-0334. See also the witness statements of Dr Rachel Bingham at e.g. paragraphs 35-36 and 45-64, BHM000033_0010-0022, and Professor Cornelius Katona which set out the Royal College of Psychiatrists position at . paragraphs 11-21, BHM000030_0006-0011
[49] Ian Cheeseman, 16 March 2022, 165/25-166/2

admitted that ""*If you spend more than 24 hours in Brook House you're going to develop mental health issues*".[50]

27. In particular, this Inquiry heard and saw a wealth of evidence that Brook House, was entirely ill-equipped to deal with people with PTSD. Notably, Sandra Calver revealed she had not received any particular training on how to manage patients with PTSD[51], and that she would not be able to distinguish between someone who was being "*non-compliant*" and someone whose behaviour was a result of their PTSD.[52] She accepted that PTSD was a prevailing mental disorder amongst detainees, but that she and her staff were not able to identify symptoms of trauma, nor had they been trained properly in it.[53] Ms Calver acknowledged that failure to recognise and manage these symptoms affected the ability of healthcare staff to keep detainees safe.[54] The evidence is that it is not just that recovery is impossible for those in detention with PTSD, Dr Hard and others confirmed that detainees are positively harmed by being detained in those circumstances and so it was with D643.[55]

Initial screening, Rules 34 and 35

28. D643 entered Brook House on the fourth occasion having had three previous healthcare inductions and having been diagnosed with PTSD whilst he was in the British Army and subsequently whilst in prison and in The Verne. Unbelievably there was no mention of PTSD in his health screening records, despite him having informed Brook House healthcare on previous documented occasions when he was there about this diagnosis[56] and of the previous treatment he needed and had received.[57] Having had a Rule 35(1) report issued just two weeks earlier at The Verne on the basis of his PTSD, shockingly there was no mention of that diagnosis, the Rule 35(1) report or the medico-legal report that triggered it in his medical records upon being detained at Brook House on 21st December 2016. It took almost two years for healthcare to finally assess him as unfit for detention.

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[50] Ian Castle, 15 March 2022, 39/16-19.
[51] Sandra Calver, 1 March 2022, 33/22 – 24.
[52] Sandra Calver, 1 March 2022, 103/5-13.
[53] Sandra Calver, 1 March 2022, 186/6-16.
[54] Sandra Calver, 1 March 2022, 187/6-12.
[55] Jake Hard, 28 March 2022, 165/1-17.
[56] For example DL0000228_0006, 8, 26.
[57] DL0000228_0027.

29. His initial healthcare screening was plainly inadequate and failed to meaningfully address his medical needs, failed to identify the risk of exacerbation, his suicide risk and risk of self harm. D643 accurately described the healthcare screening as appearing to be simply a "*tick-box*" exercise.[58]

30. We now know that D643's experience fits and confirms a pattern of systemic failure to conduct adequate healthcare screenings or to comply with Rule 34 of the Detention Centre Rules. As is set out in detail in the Group Closing Statement, Rules 34 and 35 of the Detention Centre Rules are not complicated – despite the claims of some witnesses to the contrary.[59] To fail to apply one of the few safeguards that vulnerable detainees had to protect them, made it inevitable that people who should not be detained were – as Sandra Calver acknowledged in her evidence.[60]

31. Dr Hard gave evidence that the treatment (or lack of it) of D643 indicated both "*a systemic failure in the screening process and the application of the Rule 34 and 35 process and was indicative of a lack of a system to identify and cross-refer to previous medical history*"[61]. The inadequacy of this system was described when Sandra Calver stated the appointments in 2017 were only five minutes long – and are now only ten minutes long, [62] acknowledging that this was not enough time to do conduct a full mental and physical health examination.[63] Karen Churcher gave evidence that it was not an environment where it was possible, or even appropriate, to attempt to give trauma-based therapy[64] - and this must have been known from the outset of D643's detention.

32. D643 invites the Chair to find that the failure to conduct an effective screening and Rule 34 assessment amounted to a violation of the systemic and operational obligations under Article 3 ECHR.

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[58] D643, 22 February 2022, 33/24-25.
[59] See for example, Philip Dove, 31 March 2022, 109/15 – 119/18 who implausibly suggested there were different interpretations of Detention Centre Rule 35; or Sandra Calver who suggested Rule 34 requires a nurse appointment in two hours and a GP appointment in 24 - Sandra Calver, 1 March 2022, 160/2-4.
[60] Sandra Calver, 1 March 2022, 213/8-16.
[61] Dr Jake Hard 28 March 2022, 141/2-23
[62] Sandra Calver, 1 March 2022, 207/4-11.
[63] Sandra Calver, 1 March 2022, 208/16-21. See also Dr Hard, 28 March 2022, 18/12-19/11.
[64] Karen Churcher, 10 March 2022, 46/7-10.

33. Having been failed by the Rule 34 process, D643 was further failed by the refusal on three separate occasions of the Brook House GPs to write him a Rule 35 report.[65] As he explained in oral evidence, the doctors simply "*weren't listening*" to him.[66] His experience of medical disbelief and cynicism towards detainees was borne out by the evidence of Dr Oozeerally, who shockingly revealed he felt that Rule 35 was misused by advocacy groups[67], rather than as a critical safeguard to route vulnerable people out of detention. He revealingly explained that "*it's not about believing*" and "*it's not a case of, patient walks in*"[68] – all evidencing his failure to believe his patient, or, as D643 felt, to properly listen to him. He refused to confirm or deny whether he felt detainees were manipulating the Rule 35 system.[69] He, inexplicably, denied that a patient reporting a deterioration in his PTSD symptoms should trigger a Rule 35(1) assessment – the only explanations for which can be that either he simply did not believe D643's account of his deteriorating health condition – and / or that he did not care.

34. Dr Hard also agreed that if someone like D643, who spoke fluent English and was able to identify precisely what he required to treat his PTSD (having received treatment before) could not obtain the treatment he required, it would be practically impossible for someone who did not share those advantages.[70]

35. The GP did deem it fit to flag that D643's health was deteriorating almost a year later, but he chose to make this notification via a Part C.[71] D643 refers the Chair to Causal Factor 2 which sets out the unlawful and dangerous practice adopted at Brook House by the GPs of circumventing the Rule 35 process via Part Cs.

36. D643 submitted a complaint about the refusals to conduct Rule 35 reports.[72] His complaint also set out who he has sought assistance from Drs Oozeerally and Chaudhary and set out the impact of detention on his PTSD, including that was getting suicidal thoughts. He made multiple complaints about how each doctor had dealt with him and the refusal to prepare an updated Rule 35 report. A meeting to the discuss the

[65] DL0000228_0011, 45, 56..
[66] D643, 22 February 2022, 18/7-17.
[67] Dr Oozeerally, 11 March 2022, 104/16 –108/9.
[68] Dr Oozeerally, 11 March 2022, 94/23 – 96/3.
[69] Dr Oozeerally, 11 March 2022, 103/19-22.
[70] Dr Hard, 28 March 2022, 142/19-25.
[71] DL0000228_0061.
[72] DL0000221.

complaint took place with Sandra Calver and Dr Chaudhary on 23 March 2018. The medical record of the meeting notes:

> *""Pt complaining that he tried to explain to the doctor that he needed a rule 35 and he felt frustrated as the doctor said he could not help him. He has shown the doctor documents regarding his documents[sic] and fel due [sic] doctor wasn't interested.*
> *He was upset to learn a letter had been done stating he was fit to fly (which he had no cc test with) and fit to be detained (which he wanted to contest)*
> *He mentions he had stopped coming to healthcare as he felt they were not listening to him.*
> *He admits he got two reminder to come to get his medications but felt that by not going no one appeared concerned.*
> *He mentioned not coming here often but comes when he is struggling and this has not been recognised.*
> *He says he would like someone to listen to what he is saying. He feels like a cjhild [child] being told what to do but not being listened.*
> *We explored his treatment needs and he appears to be needing PTSD specialised treatment. We explained that this cannot be offered from the detention centre and normal procedures would be to explain this to home office which has been done in a part c.*
> *We have given him another letter stating he is not fit for detention.*
> *Patient happy with how the complaint was handled and agreed he didn't want it to go any further.*
> *Pt 10 happy that issues were dealt with."*[73]

37. In his witness statement, D643 notes of that meeting that he was "*not happy with the way the issues were dealt with"* but decided to note take it further at the time.[74] It is important to note that they did not challenge his experience of healthcare and took no steps to address this. They agreed that his treatment needs for PTSD could not be offered from the detention centre. They knew he was unfit to be detained but did not issue a Rule 35 report which could and should have resulted in him being released.

[73] DL0000228_0062
[74] Para 212, DL0000228_0063

38. The Chair is invited to find that the failure to fully address the substance of D643's complaints, which raised allegations of violations of Article 3 ECHR and serious allegations relating to failures in a crucial safeguarding mechanism in detention, constituted a violation of the Article 3 investigative obligation.

39. D643 either informed healthcare that he was feeling suicidal or was identified by members of the healthcare team as having suicidal ideation on at least four separate occasions whilst in Brook House and on at least four other occasions he was presenting with symptoms that were consistent with suicidal ideation or intention.[75]

40. Yet no Rule 35(2) report was ever produced. Dr Hard stated that when D643's experience is considered together with those of D801, D687, D1527 and D1914 it is evidence of a complete systemic failure of the Rule 35(2) safeguards.[76] A systemic failure, as Dr Hard emphasised, in the context of a self-evidently life-threatening scenario. As Dr Hard put it, through the course of this Inquiry and having seen the evidence, he had come to the understanding that the protective mechanism was wholly inadequate.

41. In fact, no Rule 35(2) report was completed for any person detained at Brook House between 2013 and 2017.[77] The Home Office did not and has not since raised any concerns with Dr Chaudhary about the lack of Rule 35(2) reports and the limited number of Rule 35(1) reports emanating from Brook House.[78] Witnesses including Nathan Ward voiced their confusion that no such reports were produced, despite the high numbers of self-harm, regularity of ACDTs, and number of attempted suicides.[79] There was a complete systemic failure in the operation of this safeguard in the context of self-evidently life threatening scenarios of suicide risk - failures which continues to this day.[80] Jerry Petherick the G4S Managing Director admitted in oral evidence that

[75] See, for example DL0000228_0012,13,43,46.
[76] Dr Hard, 28 March 2022, 144/21 – 145/7.
[77] LIB000003 – please note that this document is yet to be adduced to the Inquiry.
[78] Dr Chaudhary, 11 March 2022, 242/11-14.
[79] DL0000141_0070.
[80] E.g. see page 20 of the IMB 2020 report into Brook House - Brook-House-AR-2020-for-circulation.pdf.

he was not aware of a process by which self-harm incidents such as this lead to consideration of whether there was failure in the laid-down procedures for the safety of detainees, and he dismissed the suggestion it would be reasonable to review every self-harm incident in light of the length of the contract.[81]

42. As is set out in the Group Closing Statement it is of course not enough to simply point the finger at the two careless doctors. Those medical reports were provided to the Home Office yet detention review after detention review kept authorising detention. Everybody was getting their lead from the Home Office's priorities.

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

44. Further explanation and description of the systemic and dangerous failures in the Rule 34 and 35 process are set out in the Group Closing Statement. Together with these submissions, they show that D643 was just one of many, many exceptionally vulnerable detainees at Brook House, who was failed by the unwillingness and inability of the Home Office to establish and with G4S to ensure the effective operation of these safeguards properly.

45. All of the applicable detention safeguards designed to protect vulnerable detainees failed in D643's case. D643 was therefore failed by the system that was supposed to protect him. D643 therefore invites the Chair to find that the detention safeguards including the healthcare provision at Brook House violated the systemic obligation under Article 3 ECHR. Further, D643 invites the Chair to find that the failure to provide him with adequate healthcare also violated the operational obligation under Article 3 ECHR.

Attitude and Culture of healthcare staff

[81] Jerry Petherick, 21 March 2022, 113/1 – 115/13.

46. D643 describes being particularly upset at the approaches of Drs Chaudhary and Oozeerally and sets out his interactions with them, in detail, in his witness statement. A number are worth emphasising in particular.

    a. On 12th June 2017 Dr Chaudhary confirmed to the Home Office that D643 was 'fit to be detained and fit to fly' despite having not examining D643, not referring to any of his mental health difficulties and not having seen him for 3 months.[82]

    b. In July 2017 D643 tried to give healthcare three separate experts' reports written by reputable experts and commissioned by his solicitors, that confirmed that he was not fit for detention. The doctors refused to look at them.[83]

    c. In January 2018, D643 tried to tell Dr Chaudhary that he was suicidal and needed help but was turned away and told the doctor could not help him. No Rule 35(2) report was even contemplated and in February 2018, D643 went to Dr Oozeerally and attempted to get help on the basis that his mental health was deteriorating. Again, no help was proffered and D643 was told that the doctor "*had no time to waste on him*". No Rule 35 assessment and report was produced.[84]

    d. On 12th March 2018, despite all that had gone before, despite the experts' reports, the obvious mental health deterioration and the length of his detention. Dr Oozeerally wrote to the Home Office stating that D643 was "*fit for detention*", "*fit to fly*" and is getting "*adequate care*". This was despite the fact that Dr Oozeerally had not examined D643 and he was not in fact receiving any care at all from healthcare at this time.[85]

47. Just 10 days later on 22nd March 2018, Dr Chaudhary wrote to the Home Office and informed them that D643 was indeed in need of specialist PTSD treatment which was not available in detention and he was therefore not fit to be detained. This was 457 days

[82] DL0000228_0047.
[83] DL0000228_0045, 49.
[84] DL0000228_0059.
[85] DL0000228_0061.

since D643 had entered Brook House with a previous diagnosis of complex combat-related PTSD. It would be another 47 days before he was in fact released.[86]

48. Both Drs Chaudhary and Oozeerally as set out above assessed D643 as fit to fly and / or be detained. These assessments were made in the face of the evidence of two Rule 35(1) Reports as well as three experts' reports declaring otherwise.[87] D643's experiences accord with other detainees, such as D1914[88], who were assessed as fit to fly / be detained despite the weight of the medical evidence to the contrary.

49. D643 refers the Chair to the submissions made by D1914 in his Individual Closing Statement[89] in relation to the breach of medical ethics as well as doctor / patient confidentiality. In particular, the Chair is invited to reject the evidence of Dr Oozeerally regarding the propriety of such a practice and urged that clear guidance is urgently issued to clarify the role of medical practitioners in relation to immigration detainees and the requirements of confidentiality.

50. D643's account is not only of a complete dereliction of duty by the medical practitioners in whose care he was, it was also symptomatic of the dehumanising and degrading attitude of healthcare staff and is consistent with evidence heard throughout this Inquiry, including from D1914,[90] D1538,[91] and D2077.[92] The healthcare team as well as custodial staff were mired in a persistent and dangerous toxic culture of disbelief, indifference and disregard about health conditions of detainees – which manifested for example in: the repeated, erroneous fitness to be detained letters (see above); failures in several cases to administer medication promptly;[93] outright denial of health conditions of patients – for example D643 described how managers accused him of pretending to be ill to avoid deportation;[94] and of a healthcare focus on facilitating removal, with Dr Oozeerally focusing appointments on whether he had a plane ticket.[95]

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[86] DL0000228_0061.
[87] DL0000228_0049-51.
[88] DL0000229_0029.
[89] Paras. 17 – 30.
[90] See DL00000229_0079,
[91] See DL00000231_0036 – 37. Please note that only select pages of this statement have thus far been placed on the website.
[92] DL00000226_0036-39.
[93] DL00000226_0018-20.
[94] DL0000228_0020.
[95] D643, 22 March 2022, 58/20-59/17

In the circumstances, the Chair is invited to find that the systemic and operational obligations under Article 3 ECHR were violated by this mistreatment.

Oversight

51. The failures in D643's healthcare came to the attention of the IMB in October 2017, where a member sought more information on the Rule 35 for D643 in light of his PTSD. Mary Molyneux recalled asking whether he should have a Rule 35 given his diagnosis, and receiving a response from a nurse that a Rule 35 was not a "*right*". Despite noting down this interaction, the IMB took no further steps to investigate the incorrect and very troubling attitude of this nurse who admitted they may not be referring people for Rule 35 appointments – when they should have been. She accepted that she should have raised the issue with Sandra Calver and the Home Office.[96]

52. This interaction is reflective of the consistent themes outlined in greater detail in the Group Closing Statement, namely that the oversight mechanisms such as the IMB did identify and not challenge even if they had concerns much of the systemic safeguard failures and abusive conduct taking place. Even when it did, it was ignored or no effective action took place.[97]

Regime and conditions

53. In D643's evidence to this Inquiry he described the routine, everyday cruelties of Brook House in the form of the extreme, dehumanising and humiliating conditions.

54. D643 in his written evidence to this Inquiry set out the impact of the harsh extended lock-in regime on his PTSD, compounded by the prison-like structure and environment:

"*I found lock-ins very difficult for my PTSD because during a lock-in people would be banging their 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.*"[98]

[96] Mary Molyneux, 25 March 2022, 128/8-131/24.
[97] Paras 335 – 370.
[98] DL0000228_0044

55. D643 described times when he was forced to share a cell with two other detainees as "*extremely cramped*".[99]

56. Echoing many other witnesses who gave evidence to this Inquiry, D643 described how at no point during his time in Brook House did he ever have the use of a toilet in the cell with any form of curtain or privacy screen. He describes how humiliating and degrading it was to have to use the toilet in these circumstances in front of his cellmate(s) (and vice versa) and how guards would sometimes enter the cell and laugh.[100]

"...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 ... 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."[101]

57. D643 also described being refused toilet roll and other essential items and how highly distressing it was to have letters pushed under the cell door in the dead of night, so that the detainees in the cell would wake up and fear that the letters contained bad news about a removal flight or a decision on their immigration status. He explained the sheer frustration of detainees not being able to contact their lawyers because of poor internet connection and other inadequate communication facilities.[102]

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[99] DL0000228_0044
[100] DL0000228_0044
[101] DL0000228_0044
[102] DL0000228_0040-0041

58. Further details of these conditions and the regime are set out in the Group Closing Statement.[103] There is clear corroboration of D643's account of the substandard and as Stephen Shaw described them in his 2018 Review[104] *indecent* - conditions to be found in the evidence of numerous other witnesses. The conditions and regime contributed to the inhumane and humiliation environment as well as the abuse and mistreatment of detainees including D643, at Brook House, since it reflected the culture of disrespect and dehumanization and in and of themselves were degrading in breach of Article 3 ECHR.

Use of Force on 7 November 2016

59. On 7 November 2016, D643 was subject to a use of force where officers sought to move him from Brook House to HMP Exeter. D643 had previously explained to officers that he could not return to prison as he was still awaiting a response from his immigration caseworker. Despite this, four escorts subjected him to a prolonged, painful and unlawful use of force.[105]

60. D643 provided moving evidence on the profound impact of this incident during his live evidence, which caused him physical and psychological distress.[106] He explained how officers found him whilst he was at church, lying to him and claiming he only needed to tell the escorts that he was not going, and he could return to church. When he went to meet escorts, he was assaulted by the officers, who grabbed his throat, threw him to the ground, handcuffed him, put him in a headlock and pressed their knees into his throat such that he could not breathe – triggering his PTSD, making him feel like he was in a "*war zone*",[107] and leaving him thinking "*just 'die, die, die'*".[108] He was so despairing that he head-butted the wall to try and knock himself out to get out of the situation.[109]

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[103] Paras 77 – 105.
[104] Stephen Shaw, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons', dated July 2018 – 2.78 and A7.8, CJS0073862_0032, 0185
[105] DL0000228_0022-25.
[106] See D643, 22 February 2022, 25/3 – 31/8.
[107] See D643, 22 February 2022, 28/18.
[108] See D643, 22 February 2022, 29/4-5.
[109] See D643, 22 February 2022, 28/17-21.

61. In his evidence he decried the complete failure of the officers to make any medical assessment of whether and if so how to conduct the use of force in light of his known PTSD diagnosis.[110] Staff failed to conduct a proper assessment of his head injuries, due to alleged 'non-compliance'[111] – which D643 explained in live evidence arose from his acute distress and PTSD in the situation – "*my head wasn't in the room – my head was, I'm getting killed up here*".[112]

62. Mr Collier did not analyse this incident but if he had, D643 submits that he would have found it to be unlawful and excessive. It fits into the themes identified by Mr Collier of not using force as a last resort, unjustified and unlawful application of use of force techniques, engendering a toxic and masculine culture, and inappropriate use of PPE with no or no proper regard for the vulnerability of the detained person.[113] In addition, D643 is just one of many examples of the entirely inappropriate use of force on people with mental illness, and the incorrect and dangerous categorisation of mental illness and non-compliance or refractory behaviour. The Group Closing Statement sets out the witness evidence on this, including evidence from Dr Paterson, Reverend Ward, Dr Hard, and Dr Bingham, in greater detail.[114]

63. For example, in his witness statement Dr Brodie Paterson gave warnings on the use force on those with mental illness, 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"*.[115] 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."*[116] These were concerns shared by Dr Rachel Bingham of Medical Justice who noted at paragraph 133 of her statement:

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[110] See D643, 22 February 2022, 30/16 – 24.
[111] DL0000228_0024.
[112] See D643, 22 February 2022, 30/21-24.
[113] Please see paragraphs 106 – 152 of the Group Closing Statement for further details.
[114] Please see paragraphs 109 – 118 of the Group Closing Statement.
[115] Witness Statement of Dr Brodie Paterson, BHM000045_0012
[116] Witness Statement of Dr Brodie Paterson, BHM000045_0012

"The use of force is inimical to the clinical management and treatment of these vulnerable detainees. Not only can restraint practices lead to a worsening of an individual's symptoms, but it can deter them from engaging with treatment or clinical support. The best way to avoid such harm being caused is of course to avoid restrictive practices in the first place."[117] Officers took no account of D643's PTSD symptoms and the consequences of their actions upon his mental health or how his PTSD would have affected how D643 would have acted in such an acutely stressful situation. Of course, the individual officers were untrained in recognising mental illness and they were incapable of understanding how D643's PTSD should have impacted on the decision to apply force. They could not distinguish between mental illness and claimed disruption.[118] Their actions reflect a more systemic failure in which the Home Office have inappropriately authorised prison control and restraint techniques to be used on such a vulnerable detained population.

64. On the totality of the evidence the Inquiry has heard, it is clear that the officers' (who currently remain unidentified) actions constituted an assault on D643. The use of force was administered unlawfully and with no assessment of its necessity or proportionality on the basis of his PTSD. D643 invites the Chair to make a finding to that effect: the force was unreasonable, unnecessary and disproportionate and it violated Article 3 ECHR in the circumstances. D643 also invites the Chair to request details as to the identity of the officers involved - D643 does not know if any of these officers still work at Brook House, but if they do, the circumstances of the same violate Article 3 ECHR too.

65. The fact that this occurred outside of the relevant period is not a bar to addressing this matter because: i) it is part of D643's overall experience and the adverse impact of detention and the Article 3 assessment in his individual case ; and ii) it is indicative and evidence of the general pattern that is not confined to the relevant period and that is important in addressing any assertion that there was something peculiar to the period

[117] Witness Statement of Dr Rachel Bingham, BHM000033_0050

[118] See multiple examples in live evidence of officers confirming lack of training on this area and their inability to distinguish mental illness with claimed disruption: (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

in April to September 2017 that caused or contributed to the mistreatment e.g. particular staffing levels.

66. D643 made a complaint about the incident the following day, part of which reads[119]:

'They grab me all four of them one of them put the hand cuffs on my left hand and start pressing down on it make it really painful, the bigger guy out of them pressing down on my neck make it hard to breath, I then shouted that I can't breath sic/, but he was not easing up. They manage to get a jacked on me and lie my hands in front of my body cross way in the strait jacket style while still pressing down on my head and pulling down on the hand cuffs by then I was in so much pain all I am thinking about is ways I can kill myself. I didn't want to live anymore. "

67. D643 received no response to this letter of complaint.[120]

68. D643 urges the Chair to note and record the failure to respond to this complaint. It took great courage and hard work for D643 to write this complaint whilst detained, given his mental ill health at the time, and the toxic and intimidating culture of Brook House. The Chair is invited to find that the failure to respond appropriately or act upon his complaints, which raised allegations of Article 3 breaches, also constituted a breach of the investigative duty.

Use of force and removal from association on 27 March 2018

69. On 27 March 2018, D643 was involved in a verbal altercation with another detainee after D643 sought to prevent him from bullying another detainee.[121] After the alleged bully threatened D643 with a weapon, D643 sought to defend himself with a broom, before the two detainees were pulled apart by officers. Officers then informed D643 that he was to go be removed from association in accordance with Rule 40 DCR. D643 refused – as he explained in his live evidence, the situation had de-escalated and there was "*no problem*" anymore between them.[122]

[119] DL0000228_0023-0025.
[120] DL000022_0025
[121] D643, 22 February 2022, 80/22 – 86/18.
[122] D643, 22 February 2022, 81/14-25.

70. Two hours later, he was subject to a terrifying planned control and restraint by six officers in full PPE to effect his move to CSU under Rule 40. They rushed at him, with one hitting him so hard on the head with his shield that he fell unconscious. Once he awoke, he found his face pressed down against a wall, with his hands cuffed and legs folded. Unsurprisingly, this was a deeply triggering incident for him – "*my brain was shut down uncontrollable all I could think about is die…I felt that I in a war zone and I been capture [sic] by the enemy*".[123] As officers walked him to E-wing, they deliberately slammed his head into door frames. In his live evidence he described how he was "*screaming in pain*" during this incident.[124] It was a further example of officers failing to recognise the impact of their actions on a mentally unwell man, and the impact caused by the Home Office's systemic failures to allow highly inappropriate prisonisation techniques of control and restraint and segregation to manage mentally unwell individuals.

71. The force used was unlawful, excessive and disproportionate. However stepping back from that, it was unlawful in the first instance because it was undertaken pursuant to an unlawfully authorised Rule 40 decision. G4S have not disclosed the Rule 40 decision itself but the Home Office's GCID records confirm they were informed of the Rule 40 decision through an IS91 RA Part C. It confirms the authority for the Rule 40 decision was taken by DCM Stewart Povey-Meier: *"IS91RA Part C received from Brook House ICE states: " Placed onto an ACDT due to banging head on toilet wall, due to a planned removal and use of rule 40 due to altercation with fellow detainee. D4993 Placed on hourly observations. " "Placed onto a Rule 40 due to altercation with detainee D4993 where forced used to separate two detainees, and weapon (Broom handle) was used to try and hit D4993 with." Stewart Povey-Meier Brook House IRC."*[125]

72. We refer the Inquiry to the Group Closing Statement on behalf of all DL CPs on the 'Misuse of Rule 40 and Rule 42' from paragraph 153. The evidence obtained from the Inquiry confirms that there was no scheme of delegation approved by the Home Office for G4S under Rule 65 DCR under which the Centre Manager could delegate his Rule

[123] DL0000228_0072
[124] D643, 22 February 2022, 84/20.
[125] HOM032309_0011

40(2) powers to his DCMs. This was confirmed by the Home Office in writing and in live evidence.[126] The DSO 02/2017 in place at the time of the Rule 40 decision against D643 only allowed the Centre Manager or Duty Manager to issue urgent Rule 40(2) decisions. As a DCM at the time, DCM Povey-Meier was neither the Centre Manager nor a Duty Manager and had no authority to authorise Rule 40. It also appears that there was sufficient time in any event to seek authority from the Home Office under Rule 40(1) given that there was sufficient time for a planned control and restraint to be prepared to move him to the CSU – meaning that the use of the Rule 40(2) procedures were unjustified.

73. The crux of this is that given there was no lawful authority to remove D643 from association on 28 March 2018, the force used by officers against him to carry that was for this reason alone unjustified and unlawful, and should be deemed an assault.

74. D643 was not certain which officers were involved in this incident. He complained verbally to Simon Murrell of the Home Office of the excessive use of force during a Rule 40 review. Despite this being a clear complaint of assault, Mr Murrell directed G4S to informally investigate as opposed to referring the matter to the PSU.[127] An internal G4S document of the complaint records: *"Simon Murrell emailed to ask "Have you received a complaint from D643? He was complaining of excessive use of force when relocated during the full centre search". He also emailed Mark Demian "Mark – Did you review the footage of the relocation?" There was nothing on our system & Detention Services had nothing... As the detainee made a verbal complaint whilst in CSU about excessive force Simon Murrel asked – can this be looked into?"*[128]

75. The G4S internal investigation was carried out by DCMs Mark Demian and Dave Killick. They identified Steve Dix (who led the control and restraint), Shane Farrell, Abid Qureshi, Reginald Clark, Jason Murphy, Alex Powell and Darren Grant as involved. They found that *"the use of force was controlled in a safe manner. DCM Dix ran the use of force well"* and that *"The use of force was necessary, reasonable,*

[126] Philip Riley 4 April 2022 84/23-25, 85/1, confirming Home Office letter of 28 March 2022 (HOM0332161)
[127] CJS0072723_0002, quoted in DL0000228_0075.
[128] CJS0072723_0002, quoted in DL0000228_0075.

proportionate and no more force the necessary [sic] was used".[129] They then went on to note: *"Apart from the common things missed of [sic] the use of force paperwork, one hand written report looks a bit messy and one of the officers hair hanging out the back of his helmet, to the best of my knowledge there is nothing wrong with this UOF."*[130] It is not noted what the "common things missed" off use of force paperwork related to. Mark Demian responded to D643 in writing on 23 April 2018 that it was necessary, reasonable and proportionate and stating *"If you would like to raise a formal written complaint, you are welcome to do so".*[131] It is unclear why neither G4S nor the Home Office forwarded this complaint to the PSU for investigation, even after D643 following up in writing to complain.[132]

76. On the totality of the evidence the Inquiry has heard, it is clear that the officers' actions constituted an assault on D643. D643 invites the Chair to make a finding to that effect: the force was pursuant to an unauthorised use of Rule 40 and thus unlawful; the force itself was in any event unreasonable, unnecessary and disproportionate and it violated Article 3 ECHR in the circumstances. The failure to properly investigate the excessive force, and direct the complaint to the PSU, only aggravated this violation further and resulted the incident being fully investigated. Instead Mr Murrell of the Home Office allowed G4S to investigate its own officers. It also constitutes a failure of the Article 3 investigative duty.

77. As above, although Mr Collier did not assess this incident, it displays the consistent themes he identified in use of force at Brook House, including using force unjustifiably to transfer to segregation, not using force as a last resort, unjustified and unlawful application of use of force techniques, use of force on mentally unwell individuals, and a toxic and masculine culture.[133] Disturbingly, this incident demonstrates that officers sought to deliberately inflict pain on D643 – and found doing so entertaining. This echoes the experience of other people who gave evidence to the Inquiry of deliberate

[129] CJS0072723_0002, quoted in DL0000228_0075-76.
[130] CJS0072723_0002 - please note that this document has not yet been adduced to the Inquiry.
[131] CJS0072723_0002 - please note that this document has not yet been adduced to the Inquiry.
[132] Para 229, DL0000228_0071.
[133] Please see paragraphs 109 – 118 of the Group Closing Statement.

infliction of pain, including D149[134] and D1527.[135] In particular, Mr Collier raised concerns about the incorrect application of handcuffs and their application in the supine position[136] and the automatic use of PPE even where unnecessary.[137] It is also another example of an excessive and unjustified use of force led by DCM Steve Dix, whose leading of control and restraints were heavily criticised by Mr Collier. A summary of these incidents involving DCM Dix can be found from page 9 of Annex 2 to the Group Core Submissions. It is also significant because it occurred 6 months after the broadcast of Panorama in September 2017 and shows that no effective steps had been taken to address any of the underlying causes of the misuse of the powers to segregate and to use force in particular on vulnerable people. The dismissal of individual officers had done nothing to change the underlying toxic culture with regard to the use of force and the of dehumanisation of detained persons.

Healthcare

78. D643 also recalled the presence of medical staff during this use of force, who failed to intervene or call for "hands off". The Inquiry has heard evidence in numerous cases of healthcare staff abjectly failing to comply with their safeguarding duty to intervene and act in the best interests of their patient.[138] Dr Bingham stressed the important role of healthcare staff regarding their duty to raise concerns during a use of force, especially against vulnerable detainees.[139]

79. D643 was then held in segregation for 17 hours, describing how in this time he felt due to his PTSD that he had been captured by insurgents and was self-harming by banging his head against the wall.[140] He does not recall being provided with written reasons relating to his removal in breach of Rule 40(6). He posed no risk to the safety or security of the centre as he had not been aggressive and in any case the situation had been neutralised two hours prior. It appears that Rule 40 was used to punish D643 for his altercation with another detainee.

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[134] See para 129 of the Group Closing Statement
[135] Please see the individual submissions on D1527, who submits that the incident on 27 April 2017 amounted to torture.
[136] INQ000111_00146.
[137] INQ000111_00156.
[138] See, for example, the failure of healthcare staff to intervene when D1914 displayed symptoms of ill-health during the use of force on 27 May 2017.
[139] BHM000033_0048.
[140] DL0000228_0076.

80. Officers sought to further punish him by refusing him food whilst he was in detention, as he set out in his live evidence.[141]

81. The evidence of Dr Hard as to the impact of segregation being to worsen feelings of self-harm and suicidality is expressed clearly in this unlawful and unnecessary use of isolation by the outlaws that operated as officers in Brook House. As Dr Hard explained:

"*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?*

A. In some cases, definitely.

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

A. Yes.

Q. Is that right?

A. Yes.

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?

A. Yes, and devoid of stimulation.

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?

A. I would feel there is a high level of risk of that, yes, absolutely"[142]

82. The use of Rule 40 against D643 on 27 March 2018 had all the hallmarks of the criticisms by Dr Hard of its use at Brook House. Dr Hard was critical of the routine use of Rule 40 not as a last resort but as a risk management intervention and one used more as a convenience for the staff than as a necessity in the interests of safety and security:

[141] D643, 22 February 2022, 85/1-14.
[142] Dr Hard, 28 March 2022, 165/1-23.

"Yes, it seems to be done for the convenience of the staff and not for the benefit of the detained person."[143]

"*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 is to remove from association. It didn't appear to have a finite or understood purpose to me."*[144]

"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."[145]

83. The unlawful use of segregation on D643 on 27 March 2018 therefore further violated Article 3 ECHR. As we set out further in Group Closing Submissions from paragraph 153, the use of segregation may violate Article 3. 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.

84. Further, it is clear from all of the evidence that the use of segregation in this way was part and parcel of a continuous violation of the systemic obligation under Article 3 ECHR. With only a handful of exceptions, every use of Rule 40 and 42 in the Relevant Period was not authorised by a person with authority to remove a person from association or to confine them. The Group Closing Statement gives further details about the impermissible use of Rule 40 as punishment for behaviour, a method of control, a response to detainees with mental health issues, and for administrative convenience. It was a significant contributory factor in the wider inhumanity of the environment, as well as inhuman and degrading treatment of detainees at Brook House, including D643.

[143] Dr Hard 28 March 2022, 66/13-15
[144] Dr Hard 28 March 2022, 77/3-7
[145] Dr Hard 28 March 2022, 164/11-16

85. Again, D643 made a formal complaint about the use of force and removal from association, this time via his solicitors.[146] He received a response on 23 April 2018[147] which claimed G4S had received no written complaint from him, and found the use of force lawful. The response failed to explain why the use of force was used at all, or the justification for use of Rule 40. No reference is made to his mental health.

86. D643 urges the Chair to note and record the inadequacy of the response to this complaint. D643 was in a stronger position than most detainees to make a complaint, in that he speaks English, had a legal representative, and has experience operating in a hierarchical and controlled environment. His case shows that even where detainees are able to complain – where so many cannot – their complaints are ignored or brushed aside. He invites the Chair that, given that D643's complaint clearly raised incidents which were themselves a violation of Article 3 ECHR, the failure to conduct an effective investigation into the same violated the investigative obligation. This also shows the failure of the PSU to identify and address its own failures to identify mistreatment and patterns of mistreatment exposed by Panorama. It confirms the, continuation of the PSU's inadequate methods and practices that did not root out abusive conduct and contributed to the climate of impunity that pervaded the unlawful use of force and other abusive practices at Brook House.

87. There is nothing in the evidence to indicate that the PSU methods, practices and culture has significantly changed and improved since 2018. The Inquiry is asked to look closely at the 17 complaints that are referred to in the Liberty investigates material raised during the period of Dublin Removals and the subject to the IMB Rule 61 DCR Notice and the 2021 Report[148].

<u>Racist abuse and toxic culture</u>

Racism

[146] DL0000228_0072
[147] Following the informal and internal investigation of DCMs Mark Demian and Dave Killick - CJS0072723.
[148] DL0000140_0113-0149

88. D643 recounted shocking incidents of racist abuse during his detention at Brook House which were indicative of the institutional racism which permeated Brook House and perpetuated the degradation and abuse of those held there.

89. For example, he described in his witness statement and his live evidence an incident in October 2016, when he was so ill from food poisoning that he had cold sweats, chest pain, and he passed out in his cell. He described being woken to hear a G4S officer say to him[149]: ''*Why don't you go home, you fucking nigger, why are you pretending that you are sick?'*. He also heard officers using this same overtly racist word against other detainees.[150] After reviewing photos of G4S officers, he was able to identify the culprit as Graham Purnell.[151] The Inquiry has seen and heard evidence from many witnesses about the regularity of racist language towards detainees, including John Connolly's use of the word "*nigger*" as captured by Callum Tulley on Panorama.[152] The use of this word is not only highly offensive and disturbing in itself – the failure of officers in these incidents to criticise the language, raise a complaint, or signify that such language is unacceptable is indicative of the toxic culture which normalised the most extreme forms of racist language. It is powerful evidence of institutional racism which in itself is degrading.[153]

90. D643 also set out several other examples of racist language which are indicative of the institutional culture at Brook House. For example, he recalls several instances of specifically anti-black racism, with staff referring to detainees as "*the blacks*";[154] he heard an officer say *why don't these blacks go back to their country"* and that "*all the blacks are the same*".[155] This institutional culture was so pervasive that it not only affected those detained at Brook House. Staff also gave evidence of their experiences of the deep-rooted racism at Brook House, with Shayne Munroe describing her experience of multiple instances of racism from other staff,[156] and Babatunde Fagbo

[149] DL0000228_0020
[150] DL0000228_0039
[151] D643, 22 February 2022, 40/23 – 41/4
[152] TRN000085_0044.
[153] E.g Dr Paterson at 103-104, BHM000045_0023-0024 and expert report of Professor Bosworth at 8.1-8.11 – INQ000064_0039-0041
[154] DL0000228_0039
[155] DL0000228_0039-0041
[156] Shayne Munroe, 4 March 2022, 29/7-22.

also deemed Brook House institutionally racist.[157] John Connelly exhibited the same derogatory attitude to a staff member from an ethnic minority as he did to detained persons- othering and referring to both a "cunts".

91. He also recalls that certain nationalities, in particular Jamaicans, were treated differently and stereotyped.[158] For example, he described how officers were more ready to use physical force against Jamaicans.[159] This accords with the evidence of a range of other witnesses, for example Owen Syred, who explained that some staff would stereotype detainees, regarding all Somalians as pirates,[160] and D2033 who recalled staff assuming that all Afghani detainees were connected to the Taliban.[161]

92. He also describes a culture of complacency and indifference towards bullying and abuse from other detainees – how he would be subjected to homophobic and racist abuse but guards would do nothing to intervene and sometimes even join in.[162]

93. D643 refers the Chair to Annex 5 which sets out the multiple examples found in the disclosure to this Inquiry of such racist incidents and attitudes. The culture is encapsulated by the comments of former DCO Dan Small in his witness statement 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.*"[163]

94. D643 refers the Chair to Causal Factor 4 of the Group Closing Statement and in particular to the evidence of Professor Bosworth[164], Dr Paterson[165] and Emma Ginn of Medical Justice[166], which sets out in greater detail the toxic and corrupted institutional

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157 Babatunde Fagbo, 4 March 2022, 65/3-14.
158 DL0000228_0039
159 D643, 22 February 2022, 41/22-25.
160 INN000007_0028.
161 D2033, 10 December 2021, 127/1-10.
162 DL0000228_0041
163 Witness Statement of Daniel Small dated 10 February 2022, BDP000003_0008
164 INQ000064
165 BHM000045
166 BHM000041

culture of racism, dehumanisation and xenophobia, and how this contributed to the abuse and mistreatment of people held at Brook House. As set out there, D643's case requires particularly careful consideration in that he experienced overt and shocking racism.

95. Crucially, the evidence seen and heard by the Inquiry is clear that the racism experienced by detainees was not caused by a few "bad apples", but rather is a symptom of a racist institution which corrupts and debases both those held at the centre, and those who work there. Dr Paterson found the language, attitudes and behaviour of staff as *"clear evidence of a corrupted or toxic culture… 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.*[167]*"*. He emphasises that: *"The problem is not one of bad apples it is of a rotten barrel."*[168]

96. Professor Mary Bosworth in her evidence noted that "*extremely aggressive language and mannerisms*"[169] towards detainees, and explained how officers reliance on racial stereotypes was a predominant form of racism in IRCs, views which in turn prevent them from having meaningful interactions with detainees.[170] Professor Bosworth also explained that staff appeared to label young black men in particular as a potential security threat.[171] She concluded that such views are an inevitable part of an IRC, which designates people as 'foreign nationals', who society does not want – such that officers are just responding to the prompts given to them by the institution.[172]

97. D643 seeks a finding from the Chair that officer Graham Purnell, Joseph Marshall and Luke Instone Brewer did make abusive and racist comments towards him, which violated Article 3 ECHR. He also seeks a finding from the Chair that officers did regularly use inappropriate and racist language towards detainees.

98. Only Mr Purnell responded to D643's allegations and that was simply to say in a witness statement that he had no recollection of the incident and denies ever using such

[167] BHM000045_0022
[168] BHM000045_0022
[169] Prof Bosworth, 29 March 2022, 6/23-7/3.
[170] Prof Bosworth, 29 March 2022, 35/7-24.
[171] INQ000064_0040.
[172] Prof Bosworth, 29 March 2022, 36/5-19, 97/11-12.

language or behaviour.[173] He was not called for live evidence despite our request on 8 February 2022 setting out the importance of him doing so. These simple bare denials hold little evidential value when faced with the detail of D643's allegations. D643's characterisation of Mr Purnell is consistent with the evidence of Callum Tulley[174] and Owen Syred.[175]

99. D643 invites the Chair to make a finding that Brook House was institutionally racist, on the basis of the compelling and extensive evidence from him, other witnesses, Callum Tulley's undercover reporting, the documentary evidence and the expert evidence of the pervasive and unchecked racist attitudes and behaviour of a significant proportion of staff at Brook House. The fact that it was known to senior managers including the Centre Director Ben Saunders[176] but went unchallenged is indicative of its institutional nature and is not limited to a subculture as found by Stephen Shaw in his PPO investigation into Racism and Abuse at Oakington IRC (2005).

Incident on 22 December 2016

100. D643's experiences record not only the overtly racist language at Brook House, but also other manifestations of this toxic and dehumanising culture, which were not only cumulatively a violation of his Article 3 rights but in many cases standalone violations.

101. He provided an account of an unlawful, and deeply degrading, use of force on 22 December 2016 in the context of a hospital escort. He had been suffering from chest pains and was taken to A&E.[177] Officers needlessly handcuffed D643,[178] which in itself constituted an unlawful use of force in that it was disproportionate. This was just one instance of several heard throughout the Inquiry of routine disproportionate and degrading use of restraints during hospital escorts. It is indicative of the general misuse and overuse of force as a matter of course and the default position. [179]

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[173] Paragraph 5, BDP00008_0002
[174] Witness Statement of Callum Tulley – see paragraphs 63-70 and 193-196, INQ000052_0015-0016, 00049-0050
[175] Witness Statement of Owen Syred, see paragraphs 92-93, 111—12, 157, INQ000007_0022, 0027-0028, 0037
[176] See second statement of Owen Syred at paragraphs 33-35, INQ000010_0010-0011
[177] DL0000228_0031.
[178] DL0000228_0031.
[179] See, for example, the use of handcuffs for D1914 when attending a hospital appointment, or the evidence of Hindpal Singh Bhui on complaints raised to the HMIP about the failure to remove restraints during a hospital appointment – HMIP000685_0021.

102. This assault was then compounded by the officer's needless inhuman cruelty in providing a 'chain' to the cuffs, fashioning what looked like a 'leash' – in D643's words, he felt like a "*dog*".[180] This profoundly humiliating contraption meant that when D643 needed to use the toilet, the door would not close properly, to further add to the humiliation.[181] He described this as "*extremely humiliating*", and he "*cried the entire journey back to Brook House because [I] felt so humiliated and degraded*."[182]

103. This incident is indicative of the profound impact of the culture of dehumanization that prevailed in Brook House. It was also evident in the widespread use of insulting and discriminatory language which was so normalised at Brook House – the dehumanisation of those subject to such language, to the point they are literally treated like an animal. The connotation of slavery with a black person chained by and white guards cannot be underestimated and as symbolic of the subjugation of D643 by these actions. D643 invites the Chair to find that the use of handcuffs in this instance was an unlawful use of force. He also invites the Chair to find that forcing D643 to use the toilet where the door could not be closed, and where he was forced to wear a restraint which involved chaining him to a guard is indicative of the dehumanised culture and practices at Brook House and constituted a violation of his Article 3 rights.

Fire in D643's cell

104. The pervasive toxic and dehumanising culture also led to staff making clear that they did not care about the lives of detainees. D643 gave an account of a frightening and dangerous manifestation of this attitude. His cellmate had set fire to a letter he had received from the Home Office.[183] Smoke started to fill the room and D643 rang the emergency bell to call for help for five minutes, but no officers attended the scene. He had to lie on the floor and breathe through the gap in the door – he thought he was going to die.[184] Eventually, staff arrived on scene to put the fire out.[185]

105. D643 recalls complaining about this incident, but he received no response.[186]

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[180] D643, 22 February 2022, 35/10-19.
[181] DL0000228_0031.
[182] DL0000228_0031.
[183] DL0000228_0045.
[184] DL0000228_0045.
[185] DL0000228_0045.
[186] DL0000228_0045.

106. D643's experiences here are illustrative of an environment which had no regard for the life and health of him or his cellmate. The Inquiry heard of numerous other events where staff showed similar attitudes, thereby endangering the lives of those in their care– of DCM Chris Donnelly failing to remove a ligature from D865's neck for two minutes, only acting when prompted to do so by DCO Tulley;[187] of the officers who joked amongst themselves prior to a restraint of a man, D1914, with a chronic heart condition, "*if he dies, he dies*".[188]

107. D643 invites the Chair to find that the failure to attend the scene promptly was a violation of the operational requirements under Article 3 ECHR. He invites the Chair to find that, given that D643's complaint clearly raised incidents which were themselves a violation of Article 3 ECHR, the failure to conduct an effective investigation – or an investigation at all - into the same violated the investigative obligation.

Mental ill health and drug use

108. D643 also gave evidence as to how this toxic and dehumanising culture led to staff mocking detainees who were mentally unwell, standing around and laughing at them.[189] He also described how officers would laugh and mock detainees who fell ill due to spice.[190]

109. The Inquiry has heard countless examples of such behaviour which corroborate D643's account. Just a few examples from Callum Tulley's undercover footage will suffice:

i. Officers talking about a detainee with bipolar, calling him a "*bi-polar nutter*", a "*lunatic*".[191]

ii. A nurse mocking D1527 when he was acutely distressed and suicidal, laughing at him and stating he did not want to do the washing up.[192]

[187] Chris Donnelly, 23 February 2022, 123/8 – 128/16.
[188] Ben Saunders, 22 March 2022, 185/13 – 187/10.
[189] DL0000228_0045.
[190] DL0000228_0045.
[191] KENCOV1012_0044.
[192] See Dr Bingham's criticism of this incident BHM000033_0091.

iii. A nurse mocking a detainee having an adverse reaction to spice – "*Oh, like saucers, that's what we like. You've had a good old time haven't you?*"[193]

110. These comments reflect a culture which normalised and encouraged the dehumanisation of detainees, manifested here in a complete lack of care or concern for their welfare, or understanding that they deserve respect as human beings.

The impact of detention on D643

111. It was inevitable that the detention of a man like D643 for an indefinite period, day after long day, week after long week, asking for help for his mental distress and receiving none in return, would damage him – as is supported by the evidence of numerous witnesses who commented on the impact of detention of a man with his mental vulnerabilities.[194] The damage was long lasting and it continues. D643 ended his witness statement by stating that:

'When I was released from detention I was referred by my GP to receive treatment from a psychiatrist at Warneford Mental Health Hospital in [redacted]. My faith in medical professionals had been so shaken by the treatment I had received by the Brook House Healthcare that I was extremely anxious. I did not feel able to trust the psychiatrist on meeting her, it was as though I was waiting for her to disbelieve me or act in the hostile manner than I had become accustomed to at Brook House. I was unable to move past my fear that she would turn out to be like the healthcare staff and doctors at Brook House and, as a result, I did not feel able attend any further sessions with her.

Even now, almost 4 years later, I do not feel that I have fully recovered from the treatment I was subjected to at Brook House. I still suffer from flashbacks, in particular in relation to the use of force incidents outlined above and the way I was treated by the healthcare professionals, in particular Dr Chaudhary and Dr Oozeerally."

112. He explained in live evidence that his PTSD combined with his experiences at Brook House have made it very difficult for him to engage with healthcare or to trust others, and how this affected his ability on release to seek ongoing treatment for his PTSD.[195]

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[193] KENCOV1037 – please note the relevant pages are not published on the Website.
[194] E.g. Dr Hard, 28 March 2022, 141/17-25.
[195] D643, 22 February 2022, 87/24 – 88/13.

113. This Inquiry has heard evidence of men, such as D1851, who entered immigration detention with no pre-existing mental health diagnoses, but left detention with serious mental ill-health.[196] The situation was therefore even more dangerous for the large majority, who, like D643, enter detention with a background of trauma and psychiatric conditions. Witnesses, including detention staff[197] and Home Office officials[198], were well aware of the deleterious impact of detention on mental health. D643 was no exception to the rule that, whatever the state of one's mental health on entering detention, upon leaving detention, one's mental ill-health becomes much worse with his pre-existing mental illness exacerbated by the experience and inhumane conditions of detention.

Conclusions

114. The conditions of his detention, his vulnerability and the prolonged nature of that detention combine to lead to a finding of inhuman and degrading treatment in violation of Article 3 ECHR.

115. Particular causal factors in his mistreatment were:

a. The decision of the Home Office to detain him and the fact of his detention at all.

b. The absence of any effective screening mechanism to ensure that relevant factors were taken into account about his health and vulnerabilities before and during detaining him.

c. The systemic failure in detention policy and practice in particular the AAR policy and the Rule 34/35 safeguards that should have led to his prompt release.

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[196] e.g. D1851 - DL0000143_0001.

[197] "*Detainees with mental health issues should not be in detention as it is not suitable for their needs and makes them worse*" (Derek Murphy, 2 March 2022, 16/21-24);

[198] "*If you spend more than 24 hours in Brook House you're going to develop mental health issues*" (Ian Castle, 15 March 2022, 39/16-19), "*There was a general acceptance that detention had the potential to impact negatively on people, especially those with mental health conditions*") (Ian Cheeseman, 16 March 2022, 165/25-166/2)

d. The failures of the healthcare team to identify his mental health vulnerabilities and to operate as an effective safeguard and a specific dereliction of the duty of care by Dr Chaudhary and Dr Oozeerally in D643's case.

e. The routine unlawful use of removal from association by officers who neither had authority for such matters nor used it for lawful purposes.

f. The repeated unlawful use of force against him.

g. The toxic and institutionally racist culture.

h. The failure to acknowledge, take seriously, or respond to his complaints about his abuse and mistreatment.

i. The absence of any oversight, monitoring or checks and balances capable of picking up on the abuse and mistreatment exhibited in his case and generally.

116. D643's case graphically illustrates the evidence from many sources that the Inquiry has heard that the system of indefinite detention harms people. The system of detaining the mentally ill and the vulnerable harms people. It is cruel. The system brutalises those that are expected to work in it, it harms those who are detained within it and rewards the careless cruelty of those who displayed indifference to D643's suffering again and again.

117. D643 is clear that tinkering with the machinery of this cruelty will not end it, nor will increasing the numbers of officers. The answer as Stephen Shaw made clear in 2016 is in reducing the numbers of people in detention and the periods of time in detention, and not to detain those with vulnerability at or all or promptly to secure their release. Better training with only assist if its purpose is to identifying those who are unsuitable for detention or for continued detention and to ensuring that robust safeguards are in place and operated pre-emptively so as to prevent harm occurring. Nothing short of a radical change in detention policy, practice and institutional culture will ensure that what happened to D643 will not happen again.

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UNA MORRIS
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GARDEN COURT CHAMBERS

DUNCAN LEWIS SOLICITORS
9 MAY 2022

Documents to be adduced to the Inquiry

CJS0072723 – Use of Force Complaint and Brief Outcome of Case

LIB000003 - Letter from the Home Office sent to Duncan Lewis Solicitors in connection to Rule 35 FOI Data Request - (supplied by Lewis Kett - Duncan Lewis Solicitors).; letter dated 19/12/2018

CJS0073862 - Stephen Shaw, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons', dated July 2018

DL0000140_0113-0149 – Annex 10 of Nathan Ward's Witness Statement - Letter from IMB to the Minister for Immigration Compliance and the Courts, HO dated 02.10.20 and Annual Report of the IMB at Brook House IRC for reporting year 01.01-31.12.20

DL0000216 – D643 Medical Records