IN THE BROOK HOUSE INQUIRY

CLOSING STATEMENT ON BEHALF OF
THE DEIGHTON PIERCE GLYNN CORE PARTICIPANTS (D687 and GDWG)

INTRODUCTION

1. In their oral closing, the Deighton Pierce Glynn Core Participants ("DPG CPs") invited the Chair to be clear and definitive in her findings, and bold in her recommendations. The DPG CPs emphasised the history of previous inaction in the area of immigration detention, and the unique position of this Inquiry in having had the extensive oral evidence drawn out by the Counsel to the Inquiry ("CTI") team. This has meant that this Inquiry, and this Inquiry alone, has seen, often in awful, grinding, granular detail, the toxicity at the heart of immigration detention and the harm which that causes.

2. The DPG CPs maintain that call for boldness. They emphasise one point in particular from their oral closing: of course, G4S staff behaved appallingly; of course, disturbing numbers of healthcare staff did too; and the IMB and other oversight mechanisms also failed. But the real fault for all of this, and the real driver behind the toxic culture which has been on display throughout the 46 days of hearings, lies with the Home Office. The Home Office is the detainer; it is ultimately responsible. But more than that, the Home Office set the culture and it set the tone. It did that in all of its own day to day interactions with G4S, detained people and others; it did that in the way it set and enforced the contract with G4S (or did not enforce it) or set the Detention Centre Rules 2001 to one side; and it did that in the way it set the overall political rhetoric.

3. The Home Office wanted a hostile environment. In Brook House, that is exactly what it got. This Inquiry must not shy away from showing that, and saying what that means. This Inquiry

must show what a hostile environment looks like, what it does to vulnerable detained individuals, and also what it does to the staff who are expected to deliver it. The DPG CPs bring this back to the two men who brought the judicial review which produced this Inquiry, D1527 and D687. Both were now too unwell to give evidence in their own Inquiry. Look too at D643 who so visibly struggled through his evidence. Remember D1914 who wanted to give evidence and tried to do so but then could not. But remember also Michelle Brown, a senior staff member who tried to call out what she was seeing and was, in the end, also unable to give evidence for medical reasons. Remember Stacie Dean and her time off work with stress; Owen Syred and the bullying he received; and, of course, Callum Tulley himself and the footage of him uncontrollably crying in the toilet because of what he had just seen. All these people were broken by Brook House one way or the other, to greater or lesser degrees of permanence.

4. All that flows from the Home Office's hostility; its determined persistence in pushing on despite the human consequences. It represents a striking range and depth of human harm. The question is, however, what, realistically, can be done to change that?

5. The DPG CPs seriously doubt that this Inquiry can do much if anything to change Home Office attitudes. It can and should call out the hostility and its consequences, but changing them will take much longer, if it can be done at all. Political rhetoric in the area of immigration is currently getting worse not better, and at some speed. In their oral closing on 5 April 2022 the DPG CPs invited the Chair to reflect, for a moment, on what an Ascension Island detention centre might look like; what the situational psychology of such a place might be like, far removed from any sensible scrutiny. Nine days later, on 14 April, that fear had crystallised, albeit now in the form of a Kigali asylum processing centre[1]. At the time of preparing this written closing, that proposal was so controversial that some Home Office officials were reported as talking about strike action[2]. Yet the Home Office pushes on; unbowed and unashamed.

6. This is not a Home Secretary who has any serious interest in migrant welfare. This is not a Home Office rhetoric which is going to change any time soon. On 4 April 2022 Phil Riley attempted to tell the Inquiry that all had changed, and had done so in response to the Wendy

[1] Speech by the Home Secretary, Priti Patel, on 14 April 2022: https://www.gov.uk/government/speeches/home-secretarys-speech-on-uk-and-rwanda-migration-and-economic-development-partnership

[2] https://www.dailymail.co.uk/news/article-10736919/Home-Office-officials-threaten-strike-action-Priti-Patels-immoral-Rwanda-deal.html.

Williams report into the Windrush scandal which had unseated Amber Rudd[3]. But Mr Riley had not read his papers. He had not watched the unbroadcast footage[4]; he had not read all the documents[5]; he did not know what individual Home Office officials had actually done in this case (such as Vanessa Smith[6]); and it appears that before relying on Wendy Williams he had not taken the time to read her progress report. Just four days prior to Mr Riley giving evidence Ms Williams reported that only eight of her 30 recommendations had been fully acted on two years on; there was "limited evidence that a compassionate approach is being embedded consistently across the department"; and officials had "overstated the progress made" and "closed some recommendations prematurely"[7].

7. In these circumstances, the only conclusion which the Chair can reasonably draw is that the Home Office will do the least it possibly can in response to her recommendations, and that its hostility will remain. More likely, in fact, is that the hostility will increase.

8. This means there is no point in tweaking the system. That is what the Home Office wants. It seeks to confine the Inquiry to "mundane" recommendations[8]. But mundane changes, with the rhetoric, tone and Home Office culture still in place, leaves the cause of the toxicity in place and it forever free to return. And that toxicity is never far away, as can be seen in 2020 with the pressures around Dublin removals, and then again with the small boat arrivals[9]. Owen Syred warned of this creeping back like a "virus"[10], but remember also Daniel Small's evidence. He was one of the DCOs whose racism will be dealt with further below, but which

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[3] Philip Riley 4 April 2022 26/2-6: "As I have said, Mr Altman, we have done an awful lot of work over the last four years – three years, four years – in learning from the Wendy Williams report, from what has happened at Brook House, and generally about our cultural to how we treat people".

[4] "I have limited myself to the documentary, sir": Philip Riley 4 April 2022 6/12.

[5] He relied on a summary: Philip Riley 4 April 2022 8/10.

[6] Philip Riley 4 April 2022 22/25.

[7] Windrush Lessons Learned Review – Progress update, Independent Report by Wendy Williams, published 31 March 2022, at pages 8 and 49.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1065012/14.12_HO_Windrush_Lessons_Learned_Review_Accessible_6_.pdf

[8] Home Office closing, 6 April 2022 65/6, referring back to the opening (26 Nov 2022 45/1-4) which was "It's easy to place the blame on obviously political topics… none of which are within the scope of this inquiry – but the improvements that were required at Brook House are actually more mundane, principally contractual matters". The past tense also matters: not only were the required changed mundane, but the Home Office believes (or believed when the hearing started) that those changes have already been made.

[9] IMB000202_0005 Eg §3.1: "The combination of the compressed nature of the charter flight programme, with Brook House as its sole base for Dublin Convention flights, and the fundamental changes in the centre's population and nationalities, their different vulnerabilities and their needs, put the centre's systems, detainees and staff under great stress and raised some serious concerns for the Board".

[10] Owen Syred 7 December 2021 102/15-16: "It's -- if somebody is like a virus, it creeps back."

included the comments about those who had tragically died in the Grenfell Tower fire[11]. He told the Inquiry that it was inevitable that, even after this Inquiry, the environment at Brook House and types of behaviour under the spotlight of this Inquiry, will return[12]. As will be seen, all the mundane changes require energy and interest and ethics on the part of the individuals operating the system. As soon as the spotlight of the Inquiry moves away, that interest and energy will dissipate and the toxicity will be restored.

9. This is why only fundamental change will do. And there is only one change which can contain the toxicity in any meaningful way. If immigration detention is to remain at all – and there are powerful arguments why it should not – it must be heavily constrained. There must be time limits, and short ones at that. Absent that, some version of what has been seen over the course of this Inquiry will continue, driving up stress, mental illness and, often, irreversible harm.

10. The DPG CPs therefore invite the Chair to record the number of people who have advocated for time limits. That ranges from the detained people themselves including D687[13] and D1527[14], to Professor Bosworth[15], to the specialist bodies such as GDWG[16], BID[17], Detention Action[18], Medical Justice[19] and the authors of previous reports[20]. It notably extends to the UK's National Preventative Mechanism, who have repeatedly called on the government to establish a statutory time-limit on immigration detention[21]. But also included are the senior G4S people such as Jerry Petherick who have talked about the particular impact of indeterminate detention[22], and Dr Oozeerally who recommended that immigration detention

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[11] Daniel Small 28 February 2022 143/8-149/25; Callum Tulley's First Witness Statement INQ000052_0047 paras 185 – 186; Callum Tulley's Video Diary for 14 June 2017: TRN0000068_0006-0011; and Unbroadcast Footage TRN0000092_0050.

[12] Daniel Small 28 February 2022 142/13 –142/24: "You don't realise what you're saying or how it can affect someone until you're out of that environment, and even after this inquiry, it will only revert back. Whatever company takes over, whoever they take over, they will all want to make profit. The morale will always go back down and the environment will change. Q. Do you feel like these type of comments, this type of behaviour, is inevitable in a place like this? A. I believe so, yeah. I think the way that people speak to each other, detainee on detainee, officers making jokes, I think, after this inquiry, it won't solve the issue that is going on there."

[13] DPG000021_0008-0009 para 26

[14] DL0000144_0059 para 145

[15] INQ000064_0011 §2.28.

[16] GDW000012_0008 §14.

[17] DPG000038_0029 §92a.

[18] DPG000020_0030 §90a.

[19] BHM000041_0058 §160.

[20] See Annex 1 to Emma Ginn's witness statement BHM000041_0070.

[21] NPM000002_0011-0012 para 16. See also para 17 on the UK NPM's submission to the UN Committee against Torture: "The impact of open-ended and prolonged detention, particularly for those held in prison-like environments and who are subject to disproportionate security measures, may be such that it amounts to inhuman or degrading treatment for some detainees"

[22] Petherick, 21 March 2022 98/17-25.

should have a maximum time limit of one week[23]. It would be wrong not to record the range and expertise of all these very different people, all saying the same thing. It would be wrong not to adopt the recommendation which flows from it. Indeterminate detention is a particular feature of immigration detention, unlike any other form of detention[24]; it dehumanises people, it degrades them, and, so, it is a particular cause of the toxicity.

11. The DPG CPs understand that other CPs may say time limits are outside the terms of reference ("TOR") of this Inquiry. Those CPs are wrong. The DPG CPs set out why below.

12. With regard to the factual findings which the DPG CPs seek, these are set out below. In summary, however, the DPG CPs say the following has been established, and should be recorded as conclusions:

    a. That Callum Tulley is a witness of truth, that D687 is a witness of truth, and that the GDWG witnesses (Anna Pincus, James Wilson and Jamie Macpherson) all told the truth about what they saw, and the interactions they had with Home Office and G4S staff. All this material has been tested and/or interacts with other multi-sourced material which confirms its reliability.

    b. That the physical environment of Brook House was never suitable to hold people for more than short periods of time. This was because of its size, its location, next to the Gatwick runway, the restrictions which flow from that, and the lack of outside space. Cell size and design was another factor.

    c. Staffing levels were far too low, and obviously so. No or no proper thought was given to what was an appropriate staff ratio at Brook House. The contractual minimum level of staffing was inadequate to ensure the safety of individuals detained at Brook House, and even it was not being met on a regular basis. The chronic understaffing at Brook House negatively impacted upon the conditions of detention for detained people, including by restricting the activities and facilities available to detained people, and creating working conditions which contributing to the staff culture.

[23] DR0000001_0013 para 115

[24] Though a slight parallel might be drawn to sentences of imprisonment for public protection ("IPPs"), with which the Chair is likely to be familiar. The harm those brought is also know well documented.

d. Staff training was woeful. Mental health training was obviously a minimum requirement. There should also have been diversity training. There should have been training on the Detention Centre Rules and accompanying policy. There was no training, and no guidance, on the *purpose* of immigration detention, which would have informed staff identity and ethics[25]. Immigration detention is not just about removal. It is about holding people humanely[26], and in the majority of cases it ends up being about holding them pending their establishing a right to remain in the UK and ultimately, returning them to their community. Honesty and transparency about this is required. Proceeding on the basis of a fiction that all are removed and removed quickly fosters and breeds abuse.

e. As has now been accepted by the Home Office[27], the contract with G4S was also not fit for purpose. It prioritised security over welfare. It contributed to the "prisonisation" of Brook House. That focus informed the attitudes and culture, and it did so at every level. To the extent that the contract contained the means of enforcement, those means were insufficient, not least because they depended on self-reporting when there was no incentive to do so, no meaningful check, and no sanction for not self-reporting. This contractual monitoring system was inherently flawed, was facilitative of and contributed to the underreporting by staff of incidents of abuse and mistreatment of detained people at Brook House.

f. The culture at Brook House was toxic. At the lowest levels, that manifested in the level and intensity of the swearing, which regularly included racist abuse. This contributed to the institutional racism at Brook House, and this Inquiry should say so explicitly. The toxicity was also fed by internecine dysfuntionality at the senior management level, with an established grievance culture that then cascaded down, but also undermined any attempt to lead or resolve what was happening at DCO and DCM level. It made it impossible for the likes of Stacie Dean and Michelle Brown to bring about change. There was probably also institutional sexism.

g. The toxic culture at Brook House, including the institutional racism and sexism present, was propped up by and maintained through a culture of silence. The culture of silence existed at Brook House before, during and after the Relevant

[25] See eg Prof Bosworth, INQ000123_0011 at §2.64.
[26] Detention Centre Rules 2001, Rule3(1)
[27] Phil Riley 4 April 2022 5/19-21.

Period. It had a chilling effect on those who sought to raise issues within G4S and Brook House. It was directed at detained people, G4S's own staff – including Owen Syred and the female DCO described by Callum Tulley[28] – and external organisations, such as GDWG, mentioned below. It included ostracising individual staff members where they challenged unacceptable behaviour, including by labelling them a "grass" or "snitch"; not reporting wrongdoing staff committed or witnessed; and falsifying evidence when wrongdoing was reported, to protect themselves and others from being held accountable for that wrongdoing. The culture of silence is reflected in the evidence given by many witnesses to the Inquiry and their attitude towards Callum Tulley, including current and former DCOs, DCMs, members of the SMT and senior G4S corporate officials[29].

h. The Home Office both drove and reflected that toxic culture, in their day to day interactions, but also at an institutional and policy level. They did nothing about the toxicity in G4S, because they had little or no interest in doing so.

i. This toxic culture was sufficient to infect others. Healthcare staff including the GPs – particularly the GPs – reflected a culture of disbelief. Perhaps because they were faced with more unwell men than they could cope with, they responded by saying they were not unwell and that amplified and reinforced the culture yet further. Healthcare staff also failed properly to inform themselves about the requirements of safeguards such as Rule 35, for which they were responsible, and they failed properly to operate those safeguards. More generally, they operated a system of healthcare which fell below the standards which would have been applied in the community, and to which detained people were entitled. There were structural reasons for some of this, including an absence of training, but also (in the case of the GPs) a conflict of interests arising out of an interest in maintaining the contract for GP services. It is a particular concern that the current healthcare

[28] Callum Tulley First Witness Statement INQ000052_0017 para 73. See also Callum Tulley 30 November 2021 2/2 – 8/10; and 19/22-20/6. Callum Tulley gave evidence to the Inquiry about a female DCO who had concerns about the welfare of detained people. She witnessed DCM Graham Purnell stealing cash sent in by relatives for the detained people and reported this. Tulley says: "I saw an officer complained about wrongdoing which directly affected detainees and, rather than the manager in question facing disciplinary action, she was punished, she was taken away from her duties, and she was marginalise and pushed aside and people called her a grass behind her back. I was never prepared to have that happen to me. So I was never going to follow in her footsteps in terms of complaining internally."
[28] DPG000021_0062-0063 paras 171-173
[29] See for example, Peter Neden 22 March 2022 64/22-65/7

providers, PPG, seem to be trying[30], but failing, to get the GPs to understand the requirements of Rule 35 and write more reports. Dr Oozeerally in particular is not performing to the standard expected of a GP, and his maintenance of his position in the face of this Inquiry, and now PPG concern, is little short of extraordinary.

j. The toxicity was also directed at those who sought to help. GDWG were bullied by both the Home Office and G4S. The attitude and approach taken in response to the Naomi Blackwell witness statement was particularly disgraceful, and revealing, but the real impact was the sustained and long term bullying and threats to remove the drop in sessions. This had a chilling effect, impacting severely on what GDWG felt they could do in the Centre on behalf of detained people.

k. The toxic culture was so widespread, and entrenched, that it also infected the likes of the Independent Monitoring Board ("IMB"), who proved unable to resist it. Structural issues around the IMB, including but not restricted to its lack of diversity of membership, contributed to this. Matters have now changed, but it is difficult to know how reliable that change is, particularly if the personnel were to change again.

l. This culture of abuse and of disbelief increased the misuse of force. The often racist "othering" of detained people increased the frequency with which force was used, and the frequency with which it went further than was necessary, or was used without lawful authority.

m. The use of force at Brook House was not properly monitored or scrutinised.

n. The abuse, including verbal and physical abuse, extended well beyond the individuals that were shown on Panorama. Most now accept that, save for those (like Mr Brockington) who have limited their exposure to the evidence. Some of the individuals responsible for the abuse and mistreatment of detained people at Brook House during the Relevant Period are still working at Brook House today. That continued employment needs to be reviewed, in particular in the light of oral evidence some individuals have given.

[30] See eg the PPG closing at 6 April 2022 p.58 2-9

o. Drugs particularly spice were easily available at Brook House, and insufficient measures were taken to stop that. Staff brought drugs into Brook House and sold them. Luke Instone-Brewer was a drug dealer. The Inquiry should say so.

p. All this collided with a population which was vulnerable in a number of different ways: many if not most in Brook House exhibited mental ill health. suicidality and self-harm, English not as a first language, traumatic backgrounds, isolation from family, and because they were more transient, they were less able to establish other protective relationships, including with staff.

q. The indeterminate nature of immigration detention is also a particular feature which increases its adverse impact. Not knowing when or if they will be released fosters a particular kind of fear and despair in detained people that is unique to this cohort, and at a level which often drives mental ill-health. It also impacted staff who were coming into contact with detained people and their trauma on a daily basis, at Brook House[31]. This vicarious exposure to trauma is likely to be one of the causes of staff becoming desensitised, and developing a culture of disbelief[32].

r. That staff desensitisation was also driven by the "prisonisation" of Brook House. Officers' assumed criminality of detained people was another aspect of the racist "othering" that occurred in Brook House[33].

s. The complaints and whistleblowing systems theoretically available at Brook House were not capable of properly operating in a culture as toxic as this. The experiences of Stacie Dean, Michelle Brown, Owen Syred and David Waldock all show that[34]. Callum Tulley was right so to conclude, and he was right therefore to approach Panorama, and to carry out secret filming.

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[31] VER000226_0020 at 255, Ben Saunders describes staff being confronted by the desperation of detained people on a daily basis and the exposure to this being one of the most challenging jobs.

[32] To give just one example, the Inquiry heard a stark example of this from Chris Donnelly who gave evidence that there was no risk from swallowing razor blades, so the threat to do so was an empty threat from a detained person. This explained why he said to a detained person, "swallow as many as you want". He did not believe he had become desensitised: Chris Donnelly 23 February 2022 161/3-11; 161/19-21; 164/21-166/8.

[33] See eg Luke Instone-Brewer, referenced by Dominic Aitken 8 December 2021 71/16-72/7

[34] Callum Tulley also gave evidence to the Inquiry about a female DCO who suffered reprisals after reporting DCM Graham Purnell for stealing cash sent in by relatives for the detained people. See Callum Tulley First Witness Statement INQ000052_0017 para 73. See also Callum Tulley 30 November 2021 2/2 – 8/10; and 19/22-20/6.

t. The Professional Standards Unit ("PSU") took a narrow approach to the type and form of evidence that it would accept. This resulted in it excluding relevant evidence, particularly that provided by detained people, or alternatively downgrading it. This together with a failure properly to probe staff evidence meant that the PSU routinely and inappropriately resolved complaints against detained people, and this was another missed opportunity to pick up what was happening. It also made detained people even more reluctant to complain.

u. The response to Callum Tulley from senior members of G4S and others, which has included allegations of personal financial gain, and that he dubbed or otherwise edited footage and disposed of relevant documentary evidence, was both reprehensible, and very revealing about attitudes and the unwillingness to learn. This appears to have been led by Ben Saunders from the first post-Panorama briefing, establishing an early narrative that has persisted through to the Inquiry hearings (see further below).

v. Finally, much of what has been revealed at Brook House in 2017 was presaged by earlier revelations and investigations, going back to Yarl's Wood and Oakington in 2003 and 2005, but also taking in findings in civil litigation such as *HA (Nigeria)* and findings in inquests such as those for Jimmy Mubenga and Prince Fosu[35]. The kinds of problems revealed by this Inquiry are long known about, particularly by the Home Office. Brook House in 2017 was just a new manifestation, with added detail.

13. With regard to D687 specifically, this is addressed in more detail below but the Chair is invited to accept the evidence about his background and vulnerability, his mental ill health, the regular abuse, including racist abuse, which he received at Brook House, and in 2017, the rejection of his increasing cries for help (including by leaving him without appropriate medical treatment). This degraded him and was inhumane. The Chair is also invited to accept that the unplanned use of force on D687 on 13 May 2017 was unnecessary and/or went further than was necessary. All this broke D687's physical and moral resistance and amounted to treatment that was inhuman and degrading.

[35] See the statement of Deborah Coles [INQ000037].

APPROACH TO FACT-FINDING

14. The DPG CPs said in their oral closing that they would leave law to their written closing. In large part the DPG CPs agree with the approach set out by CTI in their Note dated 25 March 2022. However, there are some further points worth making, and three where it is submitted that CTI's approach is potentially problematic or incomplete.

Standard and burden of proof

15. The DPG CPs endorse the variable and flexible approach identified by CTI at §18(a)-(d) and (f) of their Note, and which was repeated in oral submissions on 5 April 2022 (Day 45, 7/16-8/9, 16-17). Such an approach is supported by the rulings in the Baha Mousa and Undercover Policing Inquiries that CTI have addressed in their Note (§§13-15). It is also the approach that has been adopted in numerous other inquiries:

    a. Shipman Inquiry First Report, §§9.43–9.48.
    b. Bloody Sunday Inquiry ruling on standard of proof, §§9–10.
    c. Azelle Rodney Inquiry Report, §1.12.
    d. Mid-Staffordshire NHS Foundation Trust Public Inquiry Report, Volume 1 Part 1, §§79-100.
    e. Alexander Litvinenko Inquiry Report, §2.20 and Appendix §§122-123.
    f. Grenfell Tower Inquiry Phase 1 Report (Sir Martin Moore-Bick), §1.17.
    g. Anthony Grainger Inquiry Report (HHJ Teague QC, the current Chief Coroner), §1.48.
    h. Manchester Arena Inquiry Volume 1 Report (Sir John Saunders), §A3.8, p.190.

16. However, the first point where it is submitted that CTI's approach is not quite right, concerns where CTI suggest that where "the Chair is "sure" (the criminal standard) that an alleged incident of mistreatment did occur, it *may* be appropriate to say so, or to use such terminology as will make the level of her satisfaction clear." (Note, §18(d); Day 45, 8/3-5, emphasis added). The DPG CPs submit that where the Chair is *sure* that Article 3 ill-treatment occurred, it *will* be appropriate to say so, and the Chair *should* do so. That is for a number of reasons:

    a. Doing so will provide the greatest possible clarity for those involved in, and affected by the Inquiry. That is particularly important for formerly detained

persons. If the Chair is sure that Article 3 ill-treatment took place, the victims are entitled to a clearly expressed finding to that effect.

b. Such clarity will also assist those subject to criticisms and recommendations in the Inquiry's report. Findings that the Chair is sure that Article 3 ill-treatment took place will emphasise the gravity of what took place and focus minds.

c. The clearest possible findings in the Inquiry's report will also foster public confidence in the Inquiry's findings.

d. Making clear findings where the Chair is sure that Article 3 ill-treatment took place is consistent with and will assist in discharging the Article 3 investigative duty. That duty requires that the Article 3 investigation should be capable of leading to the identification and punishment of those responsible and should "ensure, so far as possible, that the full facts are brought to light, so as to uncover and expose culpable and discreditable conduct to public view and allay any unjustified suspicions of wrongdoing" (*R (MA BB) v SSHD* [2019] EWHC 1523 (Admin), §§39, 42(2)). Further, the Article 3 investigative duty requires the investigator to "deliver fully reasoned, impartial and objective decisions" (*BS v Spain* (App No. 47159/08), §58 (emphasis added), citing *Nachova v Bulgaria* (2006) 42 EHRR 43 [GC], §160; see also *Balazs v Hungary* (App. No. 15529/12), §52, *Abdu v Bulgaria* (26827/08), §44, and *MC and AC v Romania* (App. No. 12060/12), §113). These Article 3 requirements favour the greatest possible clarity in the Chair's factual findings.

17. The second area where it is submitted that CTI's suggested approach is not quite right, concerns where it is said that, "To find a violation of Article 3 there must be "sufficiently strong, clear and concordant inferences or similar unrebutted presumptions of fact". The supporting evidence must be "elaborate and consistent … mentioning the specific elements … credible and reasonably detailed"." (Note, §§16-17 and 18(e); 5 April 2022, 8/10-15).

18. The DPG CPs note the authorities cited by CTI in collating that summary. However, it is submitted that that summary risks setting the bar too high. The DPG CPs invite the Chair to apply the following principles concerning the burden and standard of proof that apply to Article 3, alongside those identified by CTI:

a. Allegations of ill-treatment must be supported by appropriate evidence (*Premininy v Russia* (2016) 62 EHRR 18, §78; *Bouyid v Belgium* (2016) 62 EHRR 32 [GC], §82). A prima facie case must be set out (*Husayn v Poland* (2015) 60 EHRR 16, §395). Once this burden has been discharged, where the events in issue lie wholly or in large part within the exclusive knowledge of the authorities (which is the case in respect of a number of incidents with which this Inquiry is concerned), the burden then rests on the authorities to provide a satisfactory and convincing explanation for the ill-treatment alleged. This has been described by the Court of Appeal as a "powerful evidential burden" (*Sheppard v Secretary of State for the Home Department* [2002] EWCA Civ 1921, §13; see also *Grant v Ministry of Justice* [2011] EWHC 3379, §71).

b. The standard of proof to establish a breach of Article 3 in domestic civil and public law proceedings is the balance of probabilities (*Sheppard v Secretary of State for the Home Department* [2002] EWCA Civ 1921, §10; *Grant v Ministry of Justice* [2011] EWHC 3379, §§ 77, 78(3)). That is relevant in a statutory inquiry where the starting point for the standard of proof is, as CTI rightly state, the civil standard (Note, §18(b)).

c. The standard of proof for an Article 3 violation can be met by inferences and presumptions of fact (*Bouyid v Belgium* (2016) 62 EHRR 32 [GC], §82; *El Masri v Macedonia* (2013) 57 EHRR 25, §151; *Salman v Turkey* (2002) 34 EHRR 17, §100; *Kalashnikov v Russia* (2003) 36 EHRR 34, §100).

d. Where the State fails to provide a satisfactory and convincing explanation of how the events in question occurred, strong inferences can be drawn (*Husayn v Poland* (2015) 60 EHRR 16, §395; *Bouyid v Belgium* (2016) 62 EHRR 32 [GC], §83).

Article 3

19. With regard to Article 3 more broadly, again the DPG CPs largely endorse what is said in CTI's Note. The third and final point of possible difference concerns paragraph 5 of the Note, where it is said that the investigation of methods, policies, practices etc that caused or contributed to identifiable instances of mistreatment are only relevant if they "rendered the

detained persons vulnerable or more vulnerable to the identified abuse". The note goes on: any systems failures need to be linked to identified mistreatment or abuse.

20. It is submitted that that is not a requirement of Article 3. For the purposes of Article 3 there may be a violation of the systems duty even though no risk has been identified to a specified individual (*Savage v South Essex Partnership Trust* [2009] 1 AC 681, §31 (an Article 2 case)) and no serious harm has been suffered by a victim (*R (CSM) v SSHD* [2021] 4 WLR 110, §100). That is because the systems duty is concerned with the State's systems and their adequacy; it is not contingent on the risk posed to an individual victim and determinations of individual liability (*Cevrioglu v Turkey* (App. No. 69546/12) [2017] Inquest LR 37, §69 (an Article 2 case)).

21. Put another way, the systems aspect of Article 3 is forward as well as backwards looking. It therefore requires adequate systems to reduce the risk of future ill-treatment. It does not require such ill-treatment yet to have occurred.

22. At the same time, even when it is necessary to identify harm (for example because a court is considering whether or not damages should be awarded for a past breach), the same, lower, causation test applies here as it applies with regard to the operational duty. It is not then necessary to establish that "but for" the systems failure, the Article 3 ill-treatment would not have occurred. It is only necessary to show that had the systems duty been satisfied, that would have increased the possibility of identifying and remedying the failings which were responsible for the Article 3 ill-treatment (*Cevrioglu v Turkey* (App. No. 69546/12) [2017] Inquest LR 37, §69 (an Article 2 case)).

23. In *LW v Sodexo* [2019] 1 WLR 5654, §§49-50, it was put in this way:

> "49. …The Claimants put the matter as follows in their Skeleton Argument at [43]:
>
> > "The positive obligations inherent in Article 3 and 8 are not intended to impose an impossible or disproportionate burden on authorities. In the context of Article 3, it is not necessary for the Secretary of State to minimize the risk of a breach of Article 3 'to the greatest extent possible': cf R (FI) v SSHD [2014] EWCA Civ 1272, §42. The applicable test is whether the authorities had 'taken all steps which could have been reasonably expected of them' to prevent a violation of Article 3: see Premininy v Russia (2016) 62 EHRR 18, §84. This depends on 'all of the circumstances of the case under examination' (id). State responsibility will be engaged 'by a failure to take reasonably available measures which could have had

a real prospect of altering the outcome or mitigating the harm to the applicant' (id)."

50. The Claimants' approach is not controversial in this case."

24. The "real prospect of altering the outcome" language used here is the same language that has been used in the operational duty cases of (for example): *E v UK* (2003) 36 EHRR 31, §99; *O'Keeffe v Ireland* (2014) 59 EHRR 15, §149; *Watling v Chief Constable of Suffolk Constabulary* [2019] EWHC 2342 (QB), §§97-99. This is the language of "possibility", not "probability".

25. The DPG CPs therefore submit that in the systems context, there is nothing in Article 3 which requires a link to actual harm. However, even to the extent that that is a requirement of the TOR, it only requires such harm *possibly* to have flowed from a systems failure. That matters here, because it is very difficult to see how any of the systems which this Inquiry has examined (staffing; Rules 34 or 35; safeguarding and oversight etc) would not *possibly* have caused or contributed to harm.

26. The DPG CPs would also add some further detail about Article 3. As well as the points already made by CTI, in particular with regard to the relevance of mental health, the relevance of the duration of ill-treatment, and the particular vulnerability of those who are detained, the following may assist.

27. With regard to the operational duty:

a. *Rooman v Belgium* [2020] MHLR 1, §145, already cited by CTI, is clear that "the conditions of detention must under no circumstances arouse in the person deprived of his liberty feelings of fear, anguish and inferiority capable of humiliating and debasing him and possibly breaking his physical and moral resistance". This reflects the absolute nature of Article 3. Once at that threshold there is a breach. As set out above, this is where D687 says he was by the time he entered the disabled toilet on 13 May 2017: he had had his physical and moral resistance broken.

b. The existence of a discriminatory motive to the ill-treatment in question, and/or the use of discriminatory remarks and racist insults, increases the likelihood that treatment will be incompatible with human dignity, contrary to the minimum

severity threshold in Article 3 read with the Article 14 prohibition of discrimination (*MC and AC v Romania* (App. No. 12060/12), §§116-119). The use of discriminatory remarks and racist insults "is highly relevant to the question whether or not unlawful, hatred-induced violence has taken place" (*Balazs v Hungary* (App. No. 15529/12), §61, citing *Nachova v Bulgaria* (2006) 42 EHRR 43 [GC], §164), and will, at the least, be an aggravating factor in the Article 3 assessment (*Balazs v Hungary* (App. No. 15529/12), §49; *Moldovan v Romania (No. 2)* (App. Nos. 41138/98 and 64320/01), §111).

c. The general attitude of the authorities to a victim's plight may also contribute to mental suffering, diminishing human dignity and arousing feelings of humiliation and debasement (*Moldovan v Romania (No. 2)* (App. Nos. 41138/98 and 64320/01), §110). A lack of safeguards, or lack of interest in operating safeguards, may therefore increase the likelihood that treatment will be found to have been inhuman and/or degrading.

d. Similarly, official indifference exhibited by the authorities, *eg* in response to a legitimate complaint raised about the conduct of State agents, may give rise to a breach of Article 3: *Kurt v Turkey* (1999) 27 EHRR 373, §133-134.

e. Treatment can be degrading where there is no deliberate or malign intention (*Raninen v Finland* (1998) 26 EHRR 563, §55; *Keenan v UK* (2001) 33 EHRR 38, §109; *Ramirez Sanchez v France* (2007) 45 EHRR 49, §118; *MS v UK* (2012) 55 EHRR 23; *ZH v Commissioner of Police of the Metropolis* [2013] 1 WLR 3021, §76; *Bouyid v Belgium* (2016) 62 EHRR 32 [GC], §86).

f. There is no requirement for the victim to suffer serious or lasting physical injuries for treatment to be degrading. That is because even where a use of force does not result in such injuries, it can amount to an assault on a person's dignity and physical integrity (*Balazs v Hungary* (App. No. 15529/12), §48; *Abdu v Bulgaria* (26827/08), §37).

g. Indeed, there is no requirement for the victim to suffer any physical injury at all for treatment to violate Article 3: *Balazs v Hungary* (App. No. 15529/12), §48.

h. Where ill-treatment involves the victim being "treated as an object in the power of the authorities", that has been held to constitute "an assault on precisely that which it is one of the main purposes of Article 3 to protect, namely a person's dignity and physical integrity", particularly where it is compounded by a "whole aura of official procedure … and by the fact that those inflicting [the ill-treatment] were total strangers to the [victim]." (*Bouyid v Belgium* (2016) 62 EHRR 32 [GC], §90; *Tyrer v UK* (1979-80) 2 EHRR 1, §33 (a case concerning corporal punishment)).

i. Even limited force inflicted by State agents on persons under their control can amount to degrading treatment because of the sense of injustice and powerless that such conduct may generate: see *Bouyid v Belgium* (2016) 62 EHRR 32 [GC] at §§105-106. Indeed, the Article 3 operational duty is particularly important and exacting in respect of vulnerable individuals, who are especially entitled to State protection (*DMD v Romania* (App. No. 23022/13), §41). Groups recognised as vulnerable include those suffering from a mental disorder, young detainees and others at a heightened risk of abuse (*Dimcho Dimov v Bulgaria (No. 2)* (App. No. 77248/12), §61).

j. The ECtHR Grand Chamber has indicated that the victim's conduct in provoking the use of force is irrelevant to the Article 3 assessment (*Bouyid v Belgium* (2016) 62 EHRR 32 [GC], §108).

k. Also relevant to the assessment is the potential inability of mentally ill detainees to complain coherently or at all about their treatment (*Herczegfalvy v Austria* (1993) 15 EHRR 437, §82; *Keenan v UK* (2001) 33 EHRR 38, §110; *Musial v Poland* (App. No. 28300/06), §87).

l. Cell size and conditions may lead to a breach (*Mursic v Croatia* (2017) 65 EHRR 1, §§129-132, 138), as may noise levels (at least where the duration of detention is sufficiently lengthy: *SF v Bulgaria* (App. No. 8138/16), §83).

28. As was set out in the oral closing, D687 does not claim that his treatment amounted to torture. He does however submit that he had been degraded to the extent that he had suffered treatment amounting to inhuman or degrading treatment, *and* that he had reached that

threshold before he entered the disabled toilet on 13 May 2017. In the alternative (and/or additionally) it is submitted that D687 certainly passed that threshold once force was applied to him which was not even lawful in domestic legal terms (because it was unnecessary). This submission is developed further below.

29. With regard to the systems duty:

a. This requires not only that there be an an adequate administrative framework in place, but that that framework functions practically and effectively at ground level (*LW v Sodexo* [2019] 1 WLR 5654, §46; R *(Scarfe) v Governor of Woodhill Prison* [2017] EWHC 1194 (Admin), §54 (an Article 2 case); *Savage v South Essex Partnership Trust* [2009] 1 AC 681, §31 (an Article 2 case); *McGlinchey v UK* (2003) 37 EHRR 821 (an Article 2 case); *Cevrioglu v Turkey* (App. No. 69546/12) [2017] Inquest LR 37, §66 (an Article 2 case)). An adequate system is not effective if it is routinely not applied in practice (R *(Long) v Secretary of State for Defence* [2015] 1 WLR 5006 (an Article 2 case)).

b. The State's administrative framework must include "effective mechanisms for the detection and reporting of any ill-treatment by and to a state-controlled body, such procedures being fundamental to the enforcement of the criminal laws, to the prevention of such ill-treatment and, more generally therefore, to the fulfilment of the positive protective obligation of the state" (*O'Keeffe v Ireland* (2014) 59 EHRR 15, §162).

c. There must be sufficient staffing in place (*McGlinchey v UK* (2003) 37 EHRR 821 (an Article 2 case)).

d. There must be adequate supervision (*DSD and NBV v Commissioner of Police of the Metropolis* [2014] EWHC 436 (QB), §13).

e. Training and information to staff must be adequate and its quality and delivery should be monitored, including where the State leaves issues of training to a contractor (R *(CSM) v SSHD* [2021] 4 WLR 110, §§91, 97; *LW v Sodexo* [2019] 1 WLR 5654, §§84, 88-91, 97, 101, 105, 106, 107, 109-111; *DSD and NBV v*

Commissioner of Police of the Metropolis [2014] EWHC 436 (QB), §13). This may require the State to require a contractor, in its tender application, to provide details on how this aspect of the systems duty will be met (*LW v Sodexo*, §114).

f. Training must be properly applied by those at ground level. If it is not, that may indicate an inadequate system (*R (CSM) v SSHD* [2021] 4 WLR 110, §§90-91).

g. There must be adequate resourcing to ensure that Article 3 ill-treatment is prevented (*DSD and NBV v Commissioner of Police of the Metropolis* [2014] EWHC 436 (QB), §13; R *(Humberstone) v Legal Services Commission* [2011] 1 WLR 1460, §§69-70 (an Article 2 case)).

h. The authorities must respond to individual instances of Article 3 ill-treatment with systematic measures capable of preventing recurrence, including appropriate monitoring mechanisms, adequate policy decisions and comprehensive protective measures designed to combat the underlying problem giving rise to the risk of further Article 3 ill-treatment (*Dordevic v Croatia* [2013] MHLR 89, §§146-149, 153).

30. The DPG CPs would also make some points about what the Article 3 investigative duty requires:

a. An Article 3 investigation should be capable of leading to the identification and punishment of those responsible (R *(MA, BB) v SSHD* [2019] EWHC 1523 (Admin), §39). That finding of responsibility should also be made publicly. That is necessary to comply with the other aspects of the investigative duty, including public establishment of the facts, the allaying of suspicion, vindication and lesson learning (*MA BB*, §§40-42, applying the purposes of an Article 2 investigation set out in R *(Amin) v Secretary of State for the Home Department* [2004] 1 AC 653, §31, to the Article 3 context).

b. An Article 3 investigation should "ensure, so far as possible, that the full facts are brought to light, so as to uncover and expose culpable and discreditable conduct to public view and allay any unjustified suspicions of wrongdoing" (*MA BB*, §42(2)). It is submitted that the best way of ensuring such exposure, to the fullest

extent possible, and of allaying (or indeed confirming) suspicion, is to make full factual findings in the Inquiry's report. It follows (in case others suggest otherwise) that is not sufficient that the Inquiry has aired evidence.

c. Similarly, Article 3 requires that the investigation should "discover and rectify processes which have caused or contributed to Article 3 breaches (if established), in order that … lessons may be learned, the better to minimise the risk of recurrence." (*MA BB*, §42(4)-(5)). It is submitted that it also requires full factual findings, because the foundation for the rectification work must be set out.

d. The investigative duty requires that "where the State authorities investigate violent incidents, they have an additional obligation to take all reasonable measures to identify whether there were racist motives and to *establish* whether or not ethnic hatred or prejudice may have played a role in the events". This includes an obligation to "deliver *fully reasoned*, impartial and objective *decisions*, without omitting suspicious facts that may be indicative of racially induced violence" (*BS v Spain* (App No. 47159/08), §58 (emphasis added), citing *Nachova v Bulgaria* (2006) 42 EHRR 43 [GC], §160; see also *Balazs v Hungary* (App. No. 15529/12), §52, *Abdu v Bulgaria* (26827/08), §44, and *MC and AC v Romania* (App. No. 12060/12), §113).

e. This obligation arises under both Article 3 and Article 14: "the authorities' duty to investigate the existence of a possible link between racist attitudes and an act of violence is an aspect of their procedural obligations arising under Article 3 of the Convention, but may also be seen as implicit in their responsibilities under Article 14 of the Convention to secure respect without discrimination for the fundamental value enshrined in Article 3" (*BS*, §59, citing *Nachova*, §161; see also *Balazs*, §54, *Abdu*, §46, and *MC*, §105).

31. For this Inquiry to fulfil its Article 3 obligation, therefore, specific and public findings must be made, particularly where racist attitudes or violence is involved, and particularly in order to found full and proper recommendations. The need for recommendations is addressed further below.

Permissible findings

32. Here, it is also convenient to address briefly, section 2 of the Inquiries Act 2005, and again, just in case others address it. For the avoidance of doubt, there is no prohibition on the Chair making findings that, *inter alia*, treatment, conduct, omissions and/or conditions at Brook House were "contrary to Article 3" (a phrase used more than once in the TOR that were set by the SSHD), or "amounted" to Article 3 inhuman or degrading treatment or punishment. That is consistent with CTI's Note, in particular, §§5, 8, 9, 18(e), 18(h) and 24(k)(i).

33. Section 2 does not prohibit such findings because they do not "determine any person's civil or criminal liability" (s.2(1)). At most, such findings amount to factual findings from which liability may be inferred. Of course, s.2(2) expressly permits such findings.

34. This analysis is supported by the Inquiry's TOR, previous inquiry practice, and analogous case law in the coronial context:

    a. The sorts of findings identified above are required in order to discharge the Inquiry's TOR. That is because the TOR require the Chair, "To reach conclusions with regard to the treatment of detainees where there is credible evidence of mistreatment contrary to Article 3 ECHR" in circumstances where the TOR expressly define the "mistreatment" about which conclusions are required as "treatment that is contrary to Article 3 ECHR." Were the Chair to avoid conclusions as to whether treatment was "contrary to Article 3" or "amounted" to Article 3 ill-treatment, that would fail to discharge the Inquiry's TOR.

    b. The Anthony Grainger Inquiry, which considered the fatal police shooting of Anthony Grainger by Greater Manchester Police firearms officers, makes clear that statutory inquiries can lawfully reach conclusions that relevant conduct was contrary to, in that case, the standards set under Article 2. HHJ Teague QC, the Chair of the Grainger Inquiry and now the Chief Coroner, concluded that, "Overall, Mr Grainger died because GMP failed to authorise, plan or conduct the MASTS operation on 3 March in such a way as to minimise, to the greatest extent possible, recourse to the use of lethal force." (§§1.75 and 12.11). That form of wording is drawn directly from the requirement under the relevant Article 2 substantive duty. There was no criticism of that approach.

c. Statutory inquiries are permitted to make findings that amount to the constituent elements of civil wrongs and criminal acts, provided that they do not purport to determine the liability of a person. That has been done in numerous recent inquiries without adverse comment, see *eg* the Report of the Azelle Rodney Inquiry, Chaired by Sir Christopher Holland, which identified the unreasonable and therefore unlawful use of fatal force on the deceased (§§1.6.2, 19.1-19.11 and 21.13), and the Report of the Alexander Litvinenko Inquiry, Chaired by Sir Robert Owen, which found to the criminal standard various matters of unlawful killing (§§9.201-9.215 and 10.14-10.16).

d. This approach is also supported by analogous case law from the coronial context: see R *(Pounder) v HM Coroner for North and South Districts of Durham and Darlington* [2009] EWHC 76 (Admin), §§62, 70, 72, 73, 78, and R *(Pounder) v HM Coroner for North and South Districts of Durham and Darlington* [2010] EWHC 328 (Admin), §§3, 6, 15, 53. In particular, §73 of the 2009 judgment made clear that it was permissible for the inquest into the death of Adam Rickwood, a child in a secure training centre run by Serco who hanged himself shortly after being subjected to restraint, to consider whether conduct towards Adam was in accordance with law: "a proper inquiry into factors that might have contributed to Adam's death and formed a material circumstance as to how he came by his death, *required consideration of whether the force used on Adam was legitimate*, and whether the staff of the STC *were operating in accordance with law in their use of force* on the children assigned to their care." (emphasis added).

Time limits and the TOR

35. A further possible point of law arises. It is understood that other CPs may say that matters such as time limits for immigration detention fall outside the TOR. The DPG CPs say that is wrong. This is because:

a. As already set out, the TOR are broad: "*reach conclusions*… where there is credible evidence of mistreatment" and then "*in particular* the inquiry will investigate" (meaning the list which follows is non-exhaustive). Number (ii) in the following list is then "methods, policies, practices and management arrangements (both of

the Home Office and its contractors) caused or contributed". That too is broad. It is submitted that terms such as "methods", "practices" and "arrangements" are all amply wide enough to embrace detaining for indeterminate periods.

b. At the same time, there is extensive evidence that the indeterminate nature of immigration detention *is* a contributing factor to ill treatment. That is because it renders detained people more stressed, more mentally ill, and more vulnerable. It also makes it harder for staff to respond to them (by offering meaningful help: staff cannot help with the key thing detained people are finding difficult). It is submitted that this evidence is so important that it is must be recorded. A "conclusion" on it should also follow because there is no evidence the other way: no-one suggests that the indeterminate nature of the detention is *not* a significant factor, contributing to stress and mental ill health.

c. Further, and now touching on recommendations as well as conclusions, the Chair has already made clear, as she must, that there are "no constraints at all as to the conclusions that I may reach or the recommendations that I may make": see §24 of the scope decision dated 6 January 2021. However, even were that wrong, the evidence concerning the impact of indeterminate detention is evidence which has grown throughout the Inquiry, and the scope decision also made clear that the Chair would be flexible and go where the evidence led: see *eg* §§8 and 30.

36. It follows that the Inquiry can and should record the evidence, and reach conclusions, concerning the effect of indeterminate detention. That is amply within the scope of the TOR, and is also required by Article 3 if, as it is submitted, it is a factor relevant to whether Article 3 ill treatment has occurred because, for example, it rendered a detained person more vulnerable. With regard to making recommendations, there is nothing at all confining the Chair in this respect.

37. The DPG CPs would also add this: it would be highly unsatisfactory if this Inquiry could not comment on, and address, an aspect of immigration detention which has featured so prominently in the evidence. Were the Chair to agree with the witnesses, and several Core Participants (including it may be noticed the IMB[36]), who said that a time limit was the only

[36] IMB closing, 6 April 2022 52/16-17.

answer to what has been seen, it would be extraordinary if she were unable to say so. Were that the case it is submitted it would also be a breach of the Article 3 investigative duty, because it would be an arbitrary constraint rendering the investigation ineffective because it was unable to rectify the problems which it had uncovered: see *eg MA BB* at §42 etc and more generally, the sections above.

RECOMMENDATIONS

38. Finally, it is necessary to address recommendations directly. As already said, in her scope determination the Chair confirmed that she is unconstrained in her recommendations, and that is right. The DPG CPs also submit, in addition, that it is vital for there to be effective, directed and far-reaching recommendations. That is in part because of the facts and circumstances of this particular Inquiry. In particular:

    a. There is an obvious risk of further Article 3 ill-treatment. Only strong recommendations (and perhaps one urgent recommendation: see further below) will be able to avoid that.

    b. The history of investigations in this area, and the reluctance and defensiveness (addressed elsewhere in this closing) that the Home Office and G4S have shown in accepting the seriousness of what occurred, its extent, and the need for fundamental change. Put simply, the Home Office and G4S cannot be trusted to make the necessary changes themselves. They will need strong recommendations (and it is submitted, further monitoring: below) if real change is to be achieved.

    c. Far-reaching recommendations are vital for ensuring public confidence.

    d. Proper recommendations are also required in order to discharge the Article 3 investigative duty: see again the rectification/preventing recurrence requirements of that duty, and again May J's judgment in *MA & BB*. The purpose of an Article 3 inquiry is to rectify dangerous practices and procedures, learn lessons to ensure future prevention, and "discover and rectify processes which have caused or contributed to Article 3 breaches (if established), in order that lessons may be learned, the better to minimise the risk of recurrence." As May J observed, "The 'learning lessons' element of an Article 2/3 investigation is critical, as the purpose

of the investigation is to buttress the substantive prohibition for the future. The best way to ensure future compliance is to learn lessons from the past." (*R (MA BB) v SSHD* [2019] EWHC 1523 (Admin), §§40, 42-43).

39. The DPG CPs also make now the submission that it will not be sufficient, given the particular context and history of this Inquiry, for the Chair to make recommendations without also putting in place an effective mechanism for ensuring that those recommendations are monitored and implemented effectively. It is submitted that without such a mechanism, there is a significant risk that the Chair's recommendations will not result in the vital, practical change that is needed to prevent future ill-treatment and abuse.

40. In recent years, a number of academic and policy reports have expressed concern about the inability of inquiries to bring about effective change through recommendations. For example:

    a. The House of Lords Select Committee on the Inquiries Act 2005, "The Inquiries Act 2005: post-legislative scrutiny" (HL Paper 143) (11 March 2014). In particular, see pp.83-85.

    b. The Centre for Effective Dispute Resolution (CEDR), "Setting up and running a Public Inquiry: Guidance for Chairs and Commissioning Bodies" (January 2015). In particular, see pp.61-64.

    c. The Institute for Government, "How public inquiries can lead to change" (December 2017). In particular, see the summary at pp.3-5, drawing on pp.25-33 of the main report.

    d. National Audit Office "Investigation into government-funded inquiries" (23 May 2018). In particular, see p.10/§§11-12 and pp.29-31/§§3.15-3.20.

    e. Article by Nicholas Timmins (Senior Fellow at the King's Fund), entitled "Seven things to consider before setting up a public inquiry" (23 August 2019). See in particular points 5 and 6.

    f. JUSTICE, "When Things Go Wrong: The response of the justice system" (July 2020). Sir Robert Owen, the Chairman of the Litvinenko Inquiry, chaired the

Committee that drafted the report. In particular, see §§1.15-1.18 and chapter 6/p.86ff.

41. One of the central reasons that inquiries have struggled to bring about effective change has been the lack of ongoing monitoring, follow up and the provision of support to ensure the effective implementation of inquiry recommendations. That concern is particularly acute where, as is the case here, an inquiry's recommendations are issued to the very organisations who are also being criticised. The risk that such organisations will – once the spotlight is off – simply consign the inquiry's recommendations to a filing cabinet is obvious. That risk is significantly heightened where, again as here, there is ongoing and deeply entrenched cultural resistance and political rhetoric in the way of real change.

42. The concern that inquiries are not able to bring about effective change through the implementation of their recommendations has been recognised and reflected in inquiry practice:

    a. In the Independent Inquiry into Child Sexual Abuse (IICSA), the Chair has published a "Process for monitoring responses to Inquiry recommendations".[37] Essentially, it involves an expectation that institutions will act upon the recommendations the inquiry makes, will publish the steps they will take in response to recommendations and will publish their timetable for doing so. IICSA expects institutions to identify their intended response within six months. The IICSA process involves staged correspondence through which the inquiry invites institutions to set out publicly what they will be doing in response to the inquiry's recommendations, eventually culminating in a request under Rule 9 and a s.21 notice in cases of non-compliance. This is an effective approach where, as in the case of IICSA, recommendations have been issued throughout the ongoing life of the inquiry. In such circumstances, the inquiry can actively monitor the implementation of recommendations during the lifetime of the inquiry.

    b. A similar approach has recently been adopted in the Manchester Arena Inquiry. The Chair's Volume 1 report identified a range of "monitored recommendations", the report identified a process for overseeing the implementation of those

[37] https://www.iicsa.org.uk/reports/process-monitoring-responses-inquiry-recommendations

recommendations[38], and the Chair has subsequently required the production of further evidence from CPs addressing the Inquiry's recommendations and oral evidence hearings have been convened specifically in order to assess the progress of implementation.[39] The Chair's clear intention was summarised in the Volume 1 report: "I intend to scrutinise what has been done in response and use all the powers available to me, if required, to achieve transparency and accountability" (§8.125, p.168). That is an approach which the DPG CPs commend.

c. Previous inquiries have issued recommendations that the inquiry should be subject to a mandatory follow up by a Parliamentary Select Committee. This was done in the Mid Staffordshire Inquiry, the Chilcott Inquiry and in the Macpherson Inquiry.

d. The Bichard Inquiry – a non-statutory inquiry which considered issues arising from the Soham murders – reconvened six months after its conclusion in order to ensure implementation of its recommendations. In proposing this approach, Sir Michael Bichard, wrote to the Home Secretary as follows:

> "As you know, I aim to reconvene my Inquiry in six months' time to assess progress on those recommendations which the Government chooses to accept. I am confident, as I acknowledge in my report, of the spirit in which my recommendations will be received and taken forward."[40]

Following the reconvening of the inquiry, Sir Michael published a further 32-page report entitled "The Bichard Inquiry Final Report: Report by Sir Michael's reconvened Inquiry to establish progress on delivering the recommendations made in his original report published on 22 June 2004".[41] The Report includes a covering letter to the Home Secretary summarising the progress that had been made in response to the recommendations in his June 2004 report and where there was still work to do.[42] Sir Michael explained his motivation in adopting this approach during evidence to the Public Administration Select Committee in December 2004:

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38 https://files.manchesterarenainquiry.org.uk/live/uploads/2021/06/17164904/CCS0321126370-002_MAI-Report-Volume-ONE_WebAccessible.pdf, Part 8, p.149ff; see in particular §§8.1-8.5 (p.149) and §§8.122-8.125 (p.168).

39 https://manchesterarenainquiry.org.uk/evidence/volume-is-monitored-recommendations-10-and-11-january-2022/.

40 https://dera.ioe.ac.uk/6394/1/report.pdf, p.4

41 http://image.guardian.co.uk/sys-files/Society/documents/2005/03/15/Bichardfinalreport.pdf

42 Ibid, pp.5-7

> "I have seen too many inquiries with excellent recommendations not followed up, and I did not want that to happen. These are serious matters. I have given up six months of my life; lots of other people have given up a lot of their time. It just seemed to me it was important that we reviewed it. The feedback I am getting from senior civil servants is that this has focused people, and that probably more has happened than would otherwise have been the case."

43. Again, in the particular circumstances of this Inquiry, and for the reasons already given, it is submitted there is a particularly pronounced need for *post hoc* monitoring.

44. There are a number of ways in which this Inquiry can ensure its recommendations are monitored and implemented effectively. They include the following.

45. First, the Inquiry could issue recommendations, establish a monitoring and oversight process, decline to end the Inquiry under s.14(1)(a), require relevant CPs to address (including through evidence) their responses to the Inquiry's recommendations, and ensure that the Inquiry's recommendations were being effectively implemented prior to notifying the Minister of the end of the Inquiry under s.14(1)(a).

46. This approach contains significant advantages: it would focus minds, avoid inertia and generate action.

47. This approach is permissible: s.14(1)(a) expressly permits the Chair to notify the Minister of an end date to the Inquiry that is *later* than the delivery of the report, in order to permit the Inquiry to fulfil its TOR. Monitoring the Inquiry's recommendations clearly falls within and will assist in the fulfilment of the TOR, including because it will enable the Chair to refine those recommendations, or make further recommendations, in light of evidence given in relation to the implementation of those recommendations. This approach is therefore consistent with the Inquiry's TOR.

48. Such a process need not be unduly onerous, time-consuming or costly: it will involve only limited additional work from the Inquiry Team and CPs, whose benefit far outweighs the costs of such work.

49. The DPG CPs would also add this: were the Home Office and G4S to object to this lawful and beneficial course of action, that would itself raise concerns. Not only because in doing so they would be seeking to frustrate scrutiny of their own conduct, but also because the Home Office is the Inquiry's sponsoring department. The conflict of interest would be obvious.

50. Second, and alternatively, if the Chair were not to adopt the approach summarised above, she could still formally recommend and make arrangements for the Inquiry to reconvene within a reasonable period after the s.14(1) end date. Such an approach was taken in the Bichard Inquiry with very good effect. It would confer all the benefits of the approach set out above, in particular, focusing minds and monitoring implementation to ensure that changes are made. The Chair would not have the powers conferred by the 2005 Act and the 2006 Rules, which is why the approach above should be preferred. But the absence of powers under the 2005 Act and the 2006 Rules should not be a reason to ignore this option if it is required; the absence of such powers was not an issue in the Bichard Inquiry.

51. Third, and as a further alternative, or in addition to the approaches set out above, the Inquiry could issue express recommendations that the monitoring and implementation of its recommendations should be subject to mandatory, ongoing and independent oversight, with set timeframes identified. This could be done in a number of ways: through a monitoring board established for the purpose and independent from the Home Office; through the Cabinet Office; or through Parliament, *eg* by recommending that the Home Affairs Select Committee be given responsibility for mandatory monitoring, oversight and implementation.

52. There are therefore a range of options available. In choosing the most appropriate, the focus should be on ensuring effective implementation through an independent oversight mechanism so that the work of this Inquiry is not lost.

53. Finally, with regard to recommendations, it is respectfully submitted that the Chair should also consider urgent recommendations. A possible urgent recommendation is highlighted in the concluding recommendations section, below. So far as the law is concerned, however, there is ample precedent for issuing urgent recommendations prior to an inquiry's final report: see *eg* the interim reports into the Hillsborough Stadium Disaster and the Manchester Arena attack. There is also nothing in the TOR to prevent such an approach, and s.24(3) of the 2005 Act expressly envisages an interim report (including interim recommendations).

BROOK HOUSE

54. Turning now to the detailed findings which the DPG CPs say the Inquiry should reach, and starting with Brook House itself, the key points about Brook House's physical environment and regime are already clear: originally built for short detentions only (there is an issue about

whether this was the case – see the evidence of Mr Riley[43] – but it is telling that that was the understanding of those who were operating it, including Mr Petherick[44]); to prison Category B standards; close to the Gatwick runway with little access to outside space[45]. Many witnesses refer also to the internal noise, with banging heavy doors putting people on edge[46], and echoes. Much of that was clearly audible on Panorama itself. All this goes to the creation of an overall oppressive atmosphere – for many, the sense of deep fear - and the "prisonisation" of detention at Brook House. It also further informs the culture. The fact that Brook House looked and felt like a prison is one that was unanimously accepted by witnesses irrespective of their organisational allegiances.[47] It is submitted all this should be recorded.

55. Whilst relevant to culture, the physical environment and conditions of detention are also vital to the TOR for a more direct reason: an individual can suffer mistreatment contrary to Article 3 solely as a result of inadequate conditions of detention. Where those conditions are not themselves, in isolation, enough to amount to mistreatment contrary to Article 3, they are nevertheless relevant to "all the circumstances" which must be considered in an Article 3 assessment. In some of the instances this Inquiry has looked at, they may be the final cause or contributing factor which tips over treatment which would otherwise only be subject to criticism, into mistreatment of an individual contrary to Article 3.

56. Other points about the environment and related arrangements include the following:

    a. Cell size, features and sharing arrangements, in particular around what that meant for privacy and smells when toileting[48], but also generally with the lack of ventilation or fresh air making some feel there was not enough oxygen to breathe properly.[49] Relatedly, the general uncleanliness is also relevant. Callum Tulley described how G4S explicitly told staff in training to refer to the cells as rooms.

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[43] Philip Riley 4 April 2022 45/22-46/12.
[44] Irrespective of whether this was in fact the case, the bids made by GSL and G4S were premised on it being used for short-term detention. When GSL's bid was accepted on those terms, GSL and later G4S were contractually obligated to provide services put forward for a short term holding centre, but in a long term detention centre.
[45] Note also the impact on detained people of hearing the flights because they represent removal. See Owen Syred 7 December 2021 p.58/15-34: "You're in a detention centre right next to a runway… It's almost like 'it's my turn next'. That's how I'd feel"".
[46] D687 statement [DPG000021_0011 §36].
[47] Witness statement of D1618 INQ000055_2 para 8; Steve Skitt VER000248_0018 para 192; Ian Castle INQ000056_0010 para 45; Dr Hindpal Singh Bhui 24 March 2022 154/2-7; Clayton Fraser 28 February 2022 13/20; VER000257_0005 para 32; Theresa Schleicher BHM000031_0003 para 5(b). See also John Connolly 2 March 2022 204/1-23.
[48] D687 statement [DPG000021_0011 §37].
[49] D1618 statement [INQ000055_0003, para 12]

He considered that doing so marked the reality of the conditions in which detained people are kept in Brook House[50], which is supported by the contemporaneous view set out in the petition from multiple detained people about human rights breaches they were said to be suffering at Brook House during the Relevant Period[51], owing to the conditions of their detention.

b. The inadequacies of mobile phone coverage, how that combined with an IT suite which rarely worked properly, and how that meant that access was limited and controlled, including by staff such as Luke Instone-Brewer who abused access to that critical resource[52]. This limited the ability of detained people to stay in contact with their family, friends and legal representatives – particularly where contacts are abroad and so prohibitively expensive to contact other than by using the internet. Staff knew of the problems with the IT suite but did nothing to resolve the issues.

c. The extent to which the limited outside space limited the activities that could be made available. The Inquiry has heard about activities being limited by staff shortages, but the physical environment also imposed limits. Additionally, owing to its prison specification, Brook House was surrounded by tall razor wire fencing[53]. This is another relevant feature of the physical environment which emphasised its secure prison-like nature.

d. The arrangements around E wing, and how that located apparently refractory detained people alongside those with significant mental health and other vulnerabilities[54].

e. Restricted access for those who might have improved or softened things. GDWG had very restricted access, never accessing beyond the visits room or the legal visits corridor, neither of which was within the main communal area[55]. That reflected the lack of "trust" (as it was put) in them, limited their effectiveness, and removed an

[50] Callum Tulley – First Witness Statement INQ000052_0005 para 18.
[51] CJS001397_0001. See CJS001397_0006-0009 for response by Steve Skitt.
[52] D687 statement [DPG000021_0031] §93.
[53] Callum Tulley – First Witness Statement INQ000052_0036 para 143.
[54] Owen Syred 7 December 2021 59/19-24:
Q. Do you think that rule 42 was used by staff in order to manage people with mental health problems –
A. Yes.
Q. -- because it was difficult to -- those people were inherently difficult to manage?
A. It was, yes.
[55] Anna Pincus [DPG000002_0012 §30].

opportunity for scrutiny and so a relevant safeguard. The Home Office and G4S sought control. This was also seen in referral arrangements such as that which prevented direct referrals from GDWG to the Forward Trust[56].

f. The lock in regime, including the needless but routine confrontation it created between staff and detained people each day. The Inquiry has seen the evidence that this resulted in the use of force on detained people on multiple occasions[57]. This regime also, however, impacted on individuals' mental health including behaviour of their previous experiences of torture[58], or because of the practice of removing detained people from their cells in the middle of the night, either to take them to E Wing or directly to the airport, for attempted removal[59].

57. All this marches together: the Home Office wanted a hostile environment, and Brook House was the physical manifestation of that policy objective. Everything in its physicality, and its surrounding arrangements, revealed and fostered the lack of concern for detained people's welfare. It was instead about hide them away; move them on as fast as possible; do not get too close (stay in your office as Mr Gasson was said to do[60]); push their management down to the lowest staffing level; cut or restrict contact with those who might empathise or help because that might obstruct removal. The attitude was therefore one about isolating and removal and trying to ignore the anguish and mental ill health[61], and the physical environment served and amplified this objective.

58. The DPG CPs endorse Professor Bosworth's conclusion contained within her First Report, that the design of Brook House is inappropriate for its purpose[62]. They also emphasise that the physical environment and conditions of detention experienced at Brook House would have a detrimental impact on anyone, never mind the individuals detained there who have multifactorial vulnerabilities. This is a point the Home Office DES Area Manager Ian Castle

[56] Bole, 8 December 2021 168/24-25: Mr Bole was given to understand, he thinks by Mr Skitt, that there was something like an intelligence reason GDWG could not refer direct to the Forward Trust.
[57] Callum Tulley 29 November 2021 85/8 – 92/5; DPG000021_0067 paras 186-194.
[58] E.g. DL0000231_0007 para 32
[59] See *eg* D1618's statement: INQ000055_0002-0006 §§ 20-24 ("lock-ins were the hardest time of each day…").
[60] "Paul wouldn't go out and Paul wouldn't talk to the detainees": Saunders, VER000226_0040 at §570.
[61] As Nathan Ward reported Deborah Western saying: "It's a game of Home Office and detainee, whoever breaks first": DL0000141_0064 at §181.
[62] INQ000064_0043 para 9.8

appears to accept, as he also told the Inquiry, "I think, if you spend more than 24 hours in Brook House, you're going to develop mental health issues. It's not a nice place to be".[63]

STAFFING AND TRAINING

59. The Inquiry also has the key points about staffing and training. The DPG CPs can therefore take these points relatively lightly:

a. Working in a detention environment is ripe for abuse. Peter Neden told the Inquiry, "I was conscious of the risk of abuse in all of the custodial facilities. I think it's well understood that people in positions of dominance -- some people -- may have a tendency to become abusive. I think that's widely understood and, yes, I had that understanding."[64] There is, however, little evidence as to the steps taken by G4S to identify this characteristic and protect against it, including at the recruitment stage. Instead, staffing was driven by local employment market needs, heavily impacted by the proximity of the airport. It appears that Brook House took what they could get.

b. The problems (which were legion) associated with staffing a wing with just two officers should, and must have been obvious. They had persisted for a long time; the problem was not new. That strongly suggests a lack of interest from the Home Office and G4S in staffing wings properly. There were also, of course, financial benefits to G4S in leaving staff vacancies open[65]. There did need to be proper focused consideration of was an appropriate staff/detained person ratio and there is no evidence that consideration was ever given. Instead, staffing levels seem to have been pushed down to the lowest possible level, with consequential impacts on things like activities.

c. The need for mental health awareness training for detention staff must have been equally obvious. It had also featured in previous reports[66]. This is an environment where mental ill health, including severe ill health, is common. Staff who do not understand mental health will not be able properly to respond to it, and may also

[63] Ian Castle 15 March 2022 38/16-18
[64] Peter Neden 22 March 2022 6/4-13
[65] Saunders interview, VER000226_0009 §112.
[66] See generally Emma Ginn, at [BHM000041], eg §36.

engage in inappropriate responses such as treating mental health symptoms as being deliberate misbehaviour. The same is true of the responses to suicide/self-harm: lack of training and awareness drives the culture of disbelief. However, none of this is or was new; it is well understood in the detention environment and has been for many years. The lack of training in these areas was therefore very significant, and very obvious.

d. The absence of training in Rules 35(1) and (2) was stark. There is force in what G4S said in its closing about the Home Office not having equipped anyone to discharge their functions under these Rules, and pointing out that the training and guidance which did exist was confined to Rule 35(3)[67]. This is not a complete answer, particularly for healthcare, because Rules 35(1) and (2) are clearly drafted and not difficult to understand. Staff could and should therefore have read them for themselves, and healthcare staff in particular were required by their professional codes to inform themselves of the requirements of their practising environment and should have done so[68].

e. There were and are also very obvious other training needs, including around what is the proper purpose of an IS91 Part C (and what it can and cannot do), and around the immigration process[69]. Professor Bosworth's evidence will be recalled: if staff do not know how to help detained people, then they can withdraw into dysfunctional responses such as beliefs that detained people are not worthy of help. The purpose has to be clear[70]. Confusion about the staff roles fosters or contributes to abuse.

f. There should have been training for DCMs. There was none[71].

g. There is also a very pronounced need for diversity training. There appears to have been none.

[67] G4S closing, 6 April 2022 85/14-87/20.
[68] It appears that Dr Chaudhary thought it was enough to be just a GP: Dr Chaudhary 11 March 2022 183/21-184/3. Dr Oozeerally accepted he had to familiarise himself with the rules: Dr Oozeerally 11 March 2022 7/1-6.
[69] Syred interview, VER000252_0003 §22.
[70] INQ000123_0011 at §2.64.
[71] See *eg* Nathan Ring 25 February 2022 32/14-21.

h. Staff also require support to deal with the sometimes traumatic matters with which they are faced. There was a Staff Care Team, but Joe Marshall described it as "not fit for purpose"[72].

THE CONTRACT

60. The Home Office accepted that the contract with G4S was not fit for purpose. Mr Riley told the Inquiry that it "wasn't suitable for what we were asking the centre to deliver"[73] and that it inappropriately directed attention away from welfare. This was put in strong terms, although Mr Riley also seemed to focus on matters of presentation: "I agree, the optics were terrible under the old contract…"[74].

61. The clear unsuitability also reflected what the National Audit Office was told in July 2019. See [INQ000011_17 §1.4]: "The Home Office told us that, in retrospect, it now believes the Brook House contract was not set up to achieve the outcomes it wants to see".

62. Again, however, this is hardly surprising. The focus of the contract simply reflects the priorities of the Home Office, and its lack of interest in welfare. But is another area where the gaps should have been obvious. It is particularly notable that Schedule G of the contract contained no key performance indicator ("KPI") concerning the misuse of force on detained people. That was undoubtedly a contributing cause of the lack of focus on use of force, including the complete absence of a scrutiny committee until after Panorama. As Mr Collier said several times, the reason reviews and debriefs and subsequent scrutiny generally is so important is to learn lessons[75]. If that is not done, or is not done properly, then there will be no learning and use of force will not be carried out correctly. Yet this gap remained for years. It was so fundamental that it is difficult to see how it could be mere oversight.

63. Another obvious problem was the reliance on self-reporting. That was particularly clear in the absence of any KPI on self-harm despite 60 incidents during the period. But the reason was clear: a KPI on self-harm requires a report on the incident; the author of the monthly report to assess it for any failures of procedures; and/or for the Home Office to check that. Ian

[72] VER000254_0019 paras 362-367
[73] Riley 4 April 2022 44/18.
[74] *Op cit* 174/22.
[75] Collier 30 March 2022 175/21-176/20; 106/4.

Castle said that if there was a process he did not know what it was[76], and Paul Gasson said he did not remember ever carrying it out[77]. That shows there was no such contractual process, which means there was no relevant contractual safeguard operating.

64. Moreover, the problems associated with self-reporting appears to remain. The KPI on self-harm still requires it. But how does such a failure end up being reported? Who decides that there has been a failure of procedures? In his oral evidence Mr Hewer said that every injury or incident is now discussed[78] with a view to assessing whether there has been a KPI breach but it was not possible fully to probe that answer. This requires post Inquiry monitoring. A relevant recommendation is set out below.

65. The real problem here is that the enforcement mechanisms such as these depend on the interest and energy of individual members of staff, which in turn depends on their capacity, their understanding, and their professional ethics. That raises the question of professional culture, which is perhaps the most important issue for this Inquiry, as well as the most difficult to change.

CULTURE

66. It is now obvious that the professional culture at Brook House in 2017 was deeply toxic. At its most basic level, the level and intensity of the swearing, between staff and between staff and detained people, suffices to make that point. It is not necessary to repeat it or set it all out again. However, the racist content of the language must be emphasised, whether that is direct (such as Mr Connolly[79]) or indirect via (for example) the regularly reported "why don't you f***off home" references.[80]

67. Some further points about this language should be made. Of course it matters, specifically for the purposes of Article 3. But the reason for that is that the Strasbourg court understands the

[76] HOM0332049_0005 at §16.
[77] Paul Gasson 15 March 2022 161/21-162/10: "I don't know, to be honest with you. I don't know if we did. I don't remember doing that… I didn't go back and check".
[78] Steve Hewer 1 April 2022 19/12 - 20/7.
[79] The exchange between Mr Altman and Mr Connolly about this is set out at John Connolly 2 March 2022 at 188/4 - 190/5 and is worth reading again in full, to see how bad it is, and how hard Mr Connolly had to be pushed to accept it.
[80] Dan Small, see: TRN0000092_0050 1614-1619; D687's First Statement DPG00021_0019 para 61; _0022 para 66; _0023 para 73; _0067 para 186; _0069 para 194; D180's First Statement DPG000040_0014-0015 paras 62-64; D790's First Statement DPG000022_0009 para 35; D643's First Statement DL0000228_0008 para 35.

impact of this kind of language. Racist language, or similar discriminatory language, matters because it degrades by allowing those using it to "other" their victims, making them worth less, making them seem less than human (remember the frequent "they treated us like animals" in the evidence of detained people), and that in turn makes it easier to mete out other forms of abuse including physical abuse. This language drives the situational psychology, particularly in a detention environment. That was understood by those in power in Germany in the 1930s. It was understood by those who made the radio broadcasts that preceded the 1994 Rwandan genocide, with their reference to "cockroaches" amongst other things[81].

68. Such language is therefore completely unacceptable, and completely unjustifiable. D687, of course, experienced it throughout his time at Brook House[82]. He experienced sustained racist abuse over a year and a half (the length of time D687 spent at Brook House). That is bound to degrade.

69. This language, and the attitudes which it betrays, were audible and visible throughout Brook House. This Inquiry should so find. That is what the detained people say. That is what Callum Tulley says. It can be heard on the footage, both broadcast and unbroadcast, but it can also be seen in other things: the "nigger lover" and "grass" post-it notes left on Owen Syred's desk[83]; it is consistent with the scrawling on whistleblowing posters (left in place for months)[84]; and it is consistent with Juls Williams (a member of the SMT) and his behaviour surrounding a gay member of staff and a banana[85].

70. This was not just unprofessional; it was toxic. It is unnecessary to imagine what detention in such an environment must have been like, particularly for the vulnerable, because it can be seen and the detained people have described it and its effect on them. The result is unavoidable: this was a toxic environment; but it was also institutionally racist. It will be

[81] This has not been adduced (though could be) but for wider reading see Zambrano, *The Lucifer Effect: How good people turn evil* (2007) and its analysis of the Stanford prison experiment referenced in the Jill Dando Institute documents. See in particular p.307, *Dehumanization and moral disengagement*: "dehumanization is a central process in prejudice, racism, and discrimination. Dehumanization stigmatizes others, attributing to them a 'spoiled identity'… Under such conditions, it becomes possible for normal, morally upright, and even usually idealistic people to perform acts of destructive cruelty". The Jill Dando Institute ref is [CJS0073865_0012].

[82] D687 Rule 9 witness statement [DPG000021_0019 §61]: "On an almost daily basis…". See also §§61-72.

[83] INN000007_0031 §127.

[84] INQ000052_0013 §58.

[85] Still not quite accepted by him, it seems: "I was mucking about with a banana. One of the members of staff was a lesbian in there *and, for some strange reason*, a couple of days later… it was suggested that I'd been homophobic". [Juls Williams 16 March 2022 67/23-25].

remembered that the definition of institutional racism, which comes from the Macpherson report into the death of Stephen Lawrence, is:

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

71. It is submitted that definition is easily satisfied here.

72. There has been much talk of the cause of this toxicity, and much of that has been about behavioural modelling. Much of what has been said about that, including by the Verita report, has been accepted[86]: the SMT was dysfunctional, focused on matters such as historic disputes between Ben Saunders and Duncan Partridge and the ongoing consequences of that, and it was operating by way of formal grievance instead of informal guidance. All that cascaded down, and left DCOs without leadership[87]. Ben Saunders accepted the criticism that his focus on concerns of those outside the organisation had been at the expense of more active and visible management in Brook House.[88]

73. There are however two critical points that have not yet been accepted. The first is that this culture flows, ultimately, from the Home Office; and the second is that it is very deeply entrenched. As to the first point, all this was set out in the oral closing, but bears repeating:

    a. The Home Office attitudes may be less visible because there were fewer of them, they were not on the wings, and they were not therefore on the secret camera footage. Where they are seen, however, the attitudes are clear, and consistent. See *eg* the Vanessa Smith/Hibiscus incident where not only does she exhibit the language and attitude herself, she also fails to report the language and attitudes used by others. It is submitted that this is very telling, especially given that it was five months after Panorama so presumably when the corrective spotlight was still on. Mr Riley accepted this was not what he would have expected of a Home Office

[86] The Inquiry invited to reject Mr Brockington's regrettable attempts to row back on what had been previously accepted: see his exchange with Mr Altman at Gordon Brockington 31 March 2022 5/6 onwards to 12/1-12 ("broadly accepted" etc) and the challenges to his position

[87] Callum Tulley First Witness Statement INQ000052_0047 Para 187; Dominic Aitken 8 December 2021 110/23 – 111/9.

[88] Ben Saunders 22 March 2022 84/21-85/9.

official. He hoped it was a "one off"[89]. However he had no basis for knowing whether it was a one off or not because he had not explored it. In his witness statement he optimistically maintained that Home Office staff *would* have reported such things[90], but he was unaware of the Vanessa Smith episode until Mr Altman put it to him[91].

b. Similar things may be said of Mr Gasson. Mr Saunders described how Mr Gasson "wouldn't go out much and Paul wouldn't talk to the detainees"[92] (hence the point about maintaining a distance). Also, "the Home Office didn't really care about the people we locked up"[93]. The same may be seen in Mr Hanford's evidence about the Home Office actively criticising G4S staff for showing too much empathy[94]. Mr Ward said Mr Gasson "came across as particularly emotionless and detached towards detainees… did not show any sign of compassion"[95] which chimes with both Mr Saunders' and Mr Hanford's accounts. Most directly of all, of course, is the evidence of James Wilson and how he was treated by Mr Gasson, in the key meeting on 18 August 2017[96], but read with the evidence of Mr Haughton that the steer with regard to GDWG came from the Home Office (i.e. Mr Gasson) and Mr Saunders[97]. This is important evidence: it shows the Home Office leading and setting the tone, and it shows what that tone was: hostile, bullying, anti-migrant welfare, and highly defensive.

c. See also the casual remark of Karen Churcher, all the more persuasive because of its throwaway nature: "A lot of mental health was not taken seriously; by the HO I think"[98].

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[89] Philip Riley 4 April 2022 25/21.
[90] Statement at §16 [HOM0332005_0006]
[91] Philip Riley 4 April 2022 22/25.
[92] VER000226_0040 §570.
[93] VER000226_0020 §249.
[94] VER000266 at §§113, 139 and 288.
[95] DL0000141_0064 para 181.
[96] Where Mr Wilson sets out in detail, supported by his contemporaneous e-mail (see Anna Pincus statement [DPG000002_57 §162], that he was bullied at that meeting: see James Wilson 10 December 2021 60/8-21 ("they were toying with me… I was really shaken by the meeting"). When that was put to Mr Gasson (as it was also to Mr Skitt) he could only retreat into "If that was the case and he felt that way, of course I can only apologise that I made him feel that way…" Paul Gasson 15 March 2022 217/3-9.
[97] See Mr Haughton's statement [SER000453_0056 at §§250 and SER000453_0047 at 217(a)].
[98] Karen Churcher 10 March 2022 22/8-12.

d. As already said, the Home Office attitudes may also be seen in its design of the contract, in the physical space, and in its enforcement priorities. All this marches together. See again Mr Saunders: "Their primary focus was all about the removal process. Absolutely right."[99] The interview with Mr Kempster was to the same effect[100].

e. As also already said, however, this is hardly surprising. It simply reflects Home Office political rhetoric and agenda. Again, the Home Office wanted a hostile agenda and they got one. That is despite Windrush and what Mr Riley says about the lesson learned there: see what Wendy Williams herself says about that (above). See also the current moves towards offshore processing of asylum claims. Again, none of this shows compassion, or a serious interest in migrant welfare (para 6 above).

74. With regard to the second point; the level of entrenchment and inertia matters because it goes to what would be required to change things. The entrenchment may be seen in the following:

a. The resistance seen from the perpetrators portrayed on Panorama might be unsurprising, though it is still remarkable that it remained in place as long as it did even, in most cases, through the oral evidence. Mr Connolly eventually abandoned the wholly implausible suggestion that footage had been dubbed, but it took considerable pressure of questioning for him to do so (above, para 66 and accompanying footnote). By contrast, the shameless Mr Paschali used his oral evidence as an opportunity to introduce a new allegation, that Callum Tulley had removed a use of force document that he had properly completed. A full list of these childish attempts to avoid responsibility was set out in the BBC's closing submissions on 6 April 2022[101] and it is unnecessary to repeat them.

b. More worrying was the higher level G4S attitudes, first to reports of mistreatment and drug dealing; and then to Panorama itself. This Inquiry should find that G4S was put on notice of serious misbehaviour by its staff. Stacie Dean, Michelle Brown, Nathan Ward, David Waldock and Owen Syred all raised concerns. The

[99] VER000226_0011 at §129
[100] VER000271_0016 at §208
[101] 6 April 2022 3/19-10/8.

failure properly to respond to Stacie Dean in January 2017, when she raised issues directly with Jerry Petherick, and sent a follow up e-mail about the drug dealing by Instone-Brewer[102], and when G4S should have been on high alert for such problems following Medway and then the Birmingham prison riots in late 2016, was particularly reprehensible.

c. This also goes to the response of the likes of Mr Saunders, who even as recently as his second statement (on 1 March 2022) was still speculating (as he had in the first debrief to staff[103]) that Mr Tulley might have acted out of financial gain[104]. That is a hopeless suggestion, born out of desperation not to take full responsibility.

d. Even Mr Neden, who despite all he knew and certainly now knows, joined with Mr Saunders to persist in claims that Mr Tulley should have reported what he saw and filmed, failed in his duty by not doing so, and that people may have been harmed by that inaction. Mr Neden maintained that in his oral evidence[105]. That suggestion needs to be put alongside the attempts others made to whistleblow, such as Mr Waldock. Mr Neden knew about those (not least because the Waldock complaint was sent to him and he was responsible for the monitoring the whistleblowing service[106]). Again as recently as his statement of 1 March 2022 Mr Saunders was maintaining that Mr Tulley had failed in his duties; that he was in breach of the rules; and that had he gone through "proper processes and procedure, as he should have done, many of the behaviours witnessed in the documentary could have been prevented. He chose not do so and instead, he placed the safety and welfare of detained persons at risk"[107]. He said the same in his oral evidence[108].

e. It is of note that the date of these statements means they were made once disclosure had been made, and with the benefit of legal advice. Yet they are completely and obviously hopeless. That is very revealing. Again they betray a

[102] See [CJS0073633 – Grievance meeting Jerry Petherick and Stacie Dean]; [CJS0073679 – email from Stacie Dean].
[103] See Mr Syred's statement at INN000007_0032 §130.
[104] KEN000003_12 §65.
[105] 22 March 2022 65/1-4: "I include Callum Tulley in that. He had an obligation to report that, and he didn't, and it would have prevented further harm if he had".
[106] Statement: INQ000119_0022 §99.
[107] KEN000003_0012 at §64.
[108] Ben Saunders 22 March 2022 136/16 onwards.

determination to avoid full responsibility, and a deeply entrenched resistance to learning.

f. Even when G4S purports to take responsibility, expressing disgust for what happened and apologising, it later attempts to row back from that. Mr Brockington did that in his witness statement[109], and when challenged on it by CTI tried to suggest he had not[110]. At least as bad was the fact that Mr Brockington clearly came to the Inquiry anxious to maintain the "few bad apples" trope, but had not troubled to read or watch key bits of the evidence. He had not read Professor Bosworth's report[111]. He had seen only snippets of the unbroadcast snippets and the footage which G4S itself provided[112]. That was an unpromising start for trying to persuade the Inquiry that it was only concerned with a "small minority" of employees[113], but that is what Mr Brockington tried to do. None of this shows any genuine interest in learning or change; it shows instead ongoing, determined and often arrogant minimisation. This is highly relevant in the context of the DPG CPs' submissions about the strong recommendations now required, and how they should be monitored (see above). It seems G4S cannot be trusted to stick to it previous concessions, even when the hearings are ongoing. That does not bode well for what will happen now they are over.

g. The same resistance to change may be seen in healthcare staff, and particularly with the GPs. A single example suffices: the near total absence of Rule 35(1) and (2) reports is obviously a matter of very serious concern. Yet not only has Dr Oozeerally never completed one[114], it appears there may still be none (or very few) being completed, despite the pressures of the Inquiry and despite that being communicated to the GPs by PPG. Sandra Calver's evidence to the Inquiry was, in effect, that she was trying: "I think it's the GPs are thinking – I can't answer for the GPs, to be fair, but the GPs haven't done them… I've gone through the Rule 35s again with them"[115]. In its oral closing PPG confirmed that it had tried again,

[109] CJS0074041 See eg §§62, 98-99, 103 and 132:.
[110] See again Mr Brockington's exchange with Mr Altman at Gordon Brockington 31 March 2022 5/6 onwards to 12/1-12 ("broadly accepted" etc) and the challenges to his position.
[111] Gordon Brockington 31 March 2022 24/17.
[112] Gordon Brockington 31 March 2022 28/13-29/3.
[113] See his statement CJS0074041 at §§34, 59 and 137.
[114] Dr Oozeerally 11 March 2022 53/14.
[115] Dr Oozeerally 1 March 2022 235/23-236/25.

even after the joint NHS England/Home Office letter, and an *instruction* had been given with regard to those on constant observations[116]. None of this should be necessary. It betrays not just deep inertia but arrogance on the part of the GPs, who appear to think they know better. The Chair is respectfully invited to reflect, for a moment, on what it must be like for detained people faced with this level of intransigence. If a public inquiry, CTI and the head of healthcare cannot extract proper thought and assessment from a doctor, then what chance does a detained person stand? D687, in fact, provides some of that insight. He told the Inquiry what it was like: he explained how Dr Oozeerally "didn't believe me or take me seriously" when he showed fresh self-harming scars. D687 said that Dr Oozeerally "already knew what he was going to write". Then in conclusion:

> "As the appointment went on, I couldn't wait for it to end. I remember leaving it feeling worse than when I went in. I also felt a strong sense of regret. Like I shouldn't have said anything. I was naïve to think otherwise."[117]

h. In other words, when confronted with Dr Oozeerally's arrogant disinterest, D687 gave up. This matters because it is precisely the kind of breaking of physical and moral resistance which Article 3 speaks about. The Inquiry should find that the GPs exhibited this culture, and that it degraded or contributed to the degradation of those subject to it, including D687.

i. The same dogged inertia spread to the IMB. The IMB now recognises that in its approach to GDWG it was too affected by "managers criticisms". However that came too late, from Mary Molyneux only[118], and it betrays a malaise much wider than the approach to GDWG: the IMB was too close to G4S and the Home Office and it was therefore too willing to accept what they were being told. This rendered them too gullible and too susceptible to the same toxic culture, which can be seen in their own casual use of language about detained people[119]; their instinctive response when Panorama was shown[120]; and matters such as their writing to HMIP

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[116] Closing statement 6 April 2022 58/18-19.
[117] [DPG000021_0055 §153].
[118] IMB000203_0044 §126. This statement was given on 13 February 2022, so after Phase 1, which seems to have opened the IMB's eyes. At §124: "until hearing Mr Wilson's evidence to the Inquiry I did not realise just how bad the relationship between GDWG, G4S, and the Home Office was and I was shocked by the bullying he describes".
[119] The "hissy fit" remark: IMB000013_0001 and oral evidence Jackie Colbran 25 March 2022 86/7-14.
[120] Only now regretted: Colbran statement at IMB000204_0053 §155.

to secure a more favourable inspection report from them[121]. It appears the IMB has now moved on with regard to all these things (see further below), but it has taken four and a half years and the pressure of an Inquiry for it to do so. Again, that speaks volumes about the engrained nature of the culture, and what it takes to bring about open reflection and sustainable change.

j. The nature and depth of the attitude may also be seen directly in the detail of the interactions with GDWG. The Naomi Blackwell statement[122] has been referenced many times, but that is because it is so revealing: an obviously properly made witness statement, in sober and restrained support of a man who was later found to lack mental capacity, to be unlawfully detained, and to have been detained in breach of Article 3[123]. Yet neither the Home Office nor G4S seem to have stopped to ask how they missed all this. Instead they used the fact of the statement (which Mr Gasson did not bother to read despite his concern being about its content[124]) as a justification for bullying GDWG and threatening to reduce or close their sessions. Also, this went on for years: the Blackwell statement was made in October 2015. This shows the "us and them" culture, to which Mr Tulley referred and Prof Bosworth endorsed[125], with GDWG very much as a "them". The reference to "the problem for HO/G4S is one of trust" in the IMB discussion about GDWG[126] shows the defensiveness, and engrained culture. All this evidence is multi-sourced, and points in the same direction.

75. The long history obviously shows the same. Emma Ginn's statement on behalf of Medical Justice shows the long history of official inaction in the face of previous investigation reports, stretching back to Yarl's Wood in 2003[127]. The history of how this Inquiry came about, with the Home Office resisting it right up to seeking permission to appeal from the Court of Appeal, all points in the same direction: the Home Office does not want to know. It wants to do the least it can, and then look away. It asks the Inquiry to focus on the mundane, and

[121] Now accepted as having been inappropriate: oral evidence, Mary Molyneux 25 March 2022 106/17-25. Note, however, that Ms Colbran was more defensive about this e-mail: Jackie Colbran 25 March 2022 32/23 - 33/12. For her it was just "an interesting question why we saw it as better than they did".
[122] See BHM000038.
[123] See BHM000040_0012 at §45.
[124] Mr Gasson was concerned about its "level of detail": Paul Gasson 15 March 2022 210/23.
[125] INQ000123_0033 §8.34.
[126] IMB000003_0004.
[127] BHM000041_0004 §14 onwards.

indeed mundane things that have already been done[128]. Mr Riley was anxious to sound like he was learning, but he had to be forced to move too: he had to moderate what he had said about confidence in Home Office officials reporting things when he learned of the Vanessa Smith case; he should also moderate what he said about learning from Windrush in the light of the Wendy Williams progress report (above). It took the pressure of giving evidence to make Mr Riley read relevant evidence, and even then he only got to it over the weekend before and his reading was incomplete[129]. None of this suggests any proactive interest in change, still less a wholesale reversal in Home Office culture. Nor, to repeat, would such a change be consistent with the overarching political rhetoric.

76. This Inquiry does not want to involve itself in politics. It can and should, however, record that all this – from the granular detail up to the overarching rhetoric – points in the same direction. The culture of Brook House reflected the hostile environment sought by the Home Office. It is deep and it is long and it is very long standing. All those involved, but particularly those at the top, have been resistant to changing it. There is considerable evidence that there is no real interest in changing it. All that is relevant to the recommendations which the Inquiry should make, and how they should be made and monitored.

HEALTHCARE

77. The DPG CPs endorse and adopt the submissions, and proposed findings, advanced on behalf of Medical Justice. The following is by way of addition and emphasis only:

    a. The points already made, above, concerning the culture of healthcare and, how it ingrained it is. The GPs and, in particular Dr Oozeerally, are the obvious manifestation of that, but it obviously goes much further. The evidence of Nurse Buss, and her late and desperate attempt to go behind the Nursing and Midwifery Council finding and find a new explanation for her behaviour in not acting or reporting on D1527 was one of the most startling pieces of oral evidence in the Inquiry (and there were several of those). Reference has already been made to what seem to be the efforts of PPG and Sandra Calver to get the GPs to complete the Rule 35 reports that are clearly required (particularly Rule 35(2) reports in constant

[128] Oral opening, 26 Nov 2021 45/1-4.
[129] "I spent the weekend reading Mr Altman, but there was a limit to my capacity to read documents…": Philip Riley 4 April 2022 10/21-22.

watch cases; although note, such reports are obviously also required for those with much lower or more variable suicide/self-harm risks. Constant watch means the suicidality is very acute indeed). The Inquiry should find that the only explanation for this resistance - this determined maintenance of a position that is obviously wrong - is once again the deep and widespread toxic culture, even among those who are well educated and well trained and whose job it is to focus on patient welfare.

b. That touches on another important point, which is professional ethics. Both the nursing staff and the doctors have clear professional codes requiring them to act independently and in the best interests of patients; make and keep proper records; inform themselves of the requirements of their particular setting, and so on. There were substantial failures in respect of all of that, but the fact that these professional codes were overcome is important in its own right. It is one thing for DCOs to act in the way they did. They have to operate without much in the way of professional training; without clear leadership; and without any professional code telling them where their priorities should lie. It is quite another for healthcare staff to so easily put their codes to one side. That says something about the power of the toxic culture operating in Brook House.

c. It should also be noted: precisely the same thing happened in inquests such as that concerning the death of Prince Fosu[130]. In that case four GPs and a number of nurses all failed to engage; failed to spot a man who was obviously mentally ill and dying (naked on the floor, not eating, sleeping, or taking fluids, over six days); and walked away from his door. The facts of the Fosu case were brutal. None of those staff had the wherewithal and presence of mind to step in and be the one to act. Again, this suggests there is something particularly toxic, and irresistably toxic (save for Callum Tulley alone) about immigration detention generally (Prince Fosu died in Harmondsworth) and Brook House in particular. Even where there are clear professional codes; they are too easily overwhelmed.

[130] See the statement of Deborah Coles [INQ000037] at §§19 and 21-26; also Emma Ginn at [BHM000041] §78 onwards. Note also the reference back to the Dalrymple inquest at §19 of Deborah Coles [INQ000037], showing how long standing are these issues.

d. The DPG CPs submit, as they did in their opening, that a contributing problem, so far as the GPs are concerned, is their financial interest in the maintenance of the contract. Dr Oozeerally refused to reveal its value[131]. It was about £200,000 per year in Fosu. It is obviously unwise, it is submitted, to have those who need to determine potentially balanced matters of judgment such as whether someone is fit to be removed, or fit to remain in detention, financially dependant (and over the long term) on those who want to remove someone or keep them in detention. Further, when the Inquiry sees a witness as determined to maintain a position, in the face of contrary evidence and the efforts of PPG, as it is submitted it saw with Dr Oozeerally, then the Inquiry is entitled to ask why. One explanation, or contributing explanation, is that Dr Oozeerally was acting in conflict. Dr Oozeerally was unable to tell the Inquiry that he had taken any steps to safeguard the effects of this conflict. For him, it was enough that he was a doctor: "that, alone, is enough of an incentive"[132]. Regrettably, it appears it is not.

e. A real problem with healthcare in immigration detention is of course that there are just too many men there who should not be, because they are too unwell. The Home Office does not want to accept that, because then it would have to release them. That message, that tone, then cascades down. It becomes one of disbelief, and many have spoken of that negative culture, including Dr Hard[133]. Instead the medical reports that the Adults at Risk policy requires are attacked. Further, staff report that they cannot complete proper Rule 34 assessments, or timely Rule 35 assessments, because they do not have the resources[134]. The only answer to this is that these men should be released, or better still, not detained in the first place.

f. The Inquiry should also find that even the proper observance of Rule 34 is not a complete answer to the discovery of ill-health in detention. Particularly where mental ill health is concerned, immigration detention produces it. Men who are

[131] "The value is substantial, is it? Again, I'm not sure I really want to answer that question": Dr Oozeerally 11 March 2022 27/10-14.
[132] Dr Oozeerally 11 March 2022 27/24.
[133] Jake Hard INQ000075_204 §6.4.8: "In my opinion, during the period in question there appears to have been a mixture of inadequately trained healthcare and custodial staff who were tasked with dealing with a number of considerably complex detained persons which lead to a prevailing negative culture in Brook House". See also Emma Ginn BHM000041 at §§33, 94, 200 and elsewhere, and Anna Pincus DPG000002_76 at §218.
[134] Dr Hard touched on this in his evidence: Jake Hard 28 March 2022 20/2-5. See also Dr Oozeerally and what he says about Rule 35 assessment requiring 45 minutes: Dr Oozeerally 11 March 2022 204/4-9; also 224/21-225/8 ("you know, I want to tell the truth and the honesty of it…").

well on arrival may become unwell over time. Men who are already unwell get worse, particularly when they have a history of trauma, and particularly in segregation. The medical evidence is unequivocal: Dr Hard agreed with Dr Bingham[135]. This means that intensive monitoring and assessment is required. Better still – because the required intensity is not possible – these men will not enter detention, or will not remain there very long. A time limit would, of course, go some way towards achieving that.

g. The healthcare staff were not, therefore, able to meet the needs of this particularly vulnerable cohort. They did not therefore meet those needs. Instead they engaged in fire-fighting, or dismissing serious complaints with paracetamol. Worse, they justified what they had to do with an attitude and culture which reflected what was coming from the Home Office and G4S, and then amplified it before reflecting it back. In this way the toxicity widened and deepened.

78. Of course better or different training might help and should be attempted. Again, however, there are fundamental problems here concerning the nature of immigration detention and the culture which it generates. As Sarah Bromley put it in her oral evidence, when being asked about the efforts being taken to improve GP reports:

> "Well, it is, but I think the evidence that has been given and the conversations and reports that have been written have pretty much explained to Dr Oozeerally and Dr Chaudhary that the expectation is around that, so I don't know I am going to add an awful lot to that."[136]

79. In other words, if the Inquiry, with its independent experts and CTI's questioning, cannot move the GPs, then PPG is unlikely to be able to do so either. The DPG CPs submit that DrPA Ltd has now proved itself unsuitable to retain the contract for services at Brook House. There are however wider questions about how matters became so bad, and what that meant for the detained people who did not have their needs met. The DPG CPs submit that it is obvious that these vulnerable men were degraded, each time they were misunderstood and dismissed and had their needs branded as trivial or non-existent.

[135] See eg Jake Hard 28 March 2022 64/18.
[136] Sarah Bromley 1 April 2022 183/17-21.

OVERSIGHT

80. Some aspects of oversight have already been touched upon, but it is necessary to make other points about the IMB, and to address HMIP and the Professional Standards Unit ("PSU").

IMB

81. With regard to the IMB, for the reasons already given, and also found by Verita and now partially accepted by the IMB itself, the Inquiry is invited to find that the Brook House IMB got too close to the Home Office and G4S, and assimilated part of the toxic culture. That is shown, in particular, by the approach taken to GDWG including:

    a. The willingness to limit the way GDWG could or could not refer matters: see the Jackie Colbran e-mail of 5 August 2017 ("This is beginning to step outside our remit and I don't think it is appropriate that we should follow your request up. As independent monitors we are looking to see that the system is working well and picking up problems… In this case there is no indication that the correct procedures are being followed")[137]. The IMB is of course not confined to systemic matters and no-one now suggests otherwise.

    b. Lending itself to the action against GDWG by the Home Office and G4S, at the IMB meeting on 16 August 2017: "the problem [with GDWG] for HO/G4S is one of trust…"[138] That became the meeting with James Wilson on 18 August 2017 where he was bullied and threatened with the loss of drop in sessions. It is submitted this should never have been an action point for the IMB which, if anything, should have been probing and reining in the Home Office and G4S.

    c. The casual and dismissive language, adopted and not corrected, concerning a detained person's "hissy fit"[139]. A concern here is that if that can be recorded in a formal document, and is left uncorrected at a formal minuted meeting, what is being expressed privately, and not being recorded?

[137] GDW000003_0038.
[138] IMB000003_0004.
[139] IMB000013_0001 and for the oral evidence see Jackie Colbran 25 March 2022 86/2-14.

d. The e-mail to Mr Bhui, questioning the HMIP report and rating. That amounted to advocating for the Centre, so on behalf of the Home Office and G4S. As Ms Molyneux accepted in her oral evidence, that was wholly inappropriate[140].

82. See also Prof Bosworth, referring to the IMB's public expression of horror about what Panorama had shown but then saying:

> "While the sentiment of this statement is welcome and important, it does not address the lingering questions about why and how the committee were unaware of the issues occurring in the centre they visited so regularly. Unfortunately, the documents submitted to the Inquiry do point to a shared culture with officers among the committee at the time. The lack of trust of the detained men, the concerns about the work of GDWG, and the use of prison terminology all paint an organisation that was not fully independent and thus was not performing adequately as a safeguard for human rights."[141]

83. The Brook House IMB has clearly moved on since 2017, particularly under the national stewardship of Dame Anne Owers. Its reports have become much stronger and much more effective. The IMB also had to do a significant amount of soul-searching in the light of the Prince Fosu inquest, heard in early 2020. Dame Anne deals with that at some length in her second statement[142]. IMB members were among those who walked away from Mr Fosu's door, despite his obviously very serious presentation, and struggled to explain why. However, it is probably true that the IMB has done significantly more to reflect on those actions than any of the other organisations who did the same.

84. However:

a. It has taken these two significant very recent events – the Prince Fosu inquest and now this Inquiry – to produce this reflection. It has also taken Dame Anne being appointed National Chair (she took up her post in November 2017).

b. The reflection on the individual failures in this case still took a long time to come. The recognition that the response to Panorama was inappropriate (Ms Colbran's "fluff" remark) did not come until her witness statement. The recognition that the e-mail to HMIP was inappropriate did not come until the oral evidence. The acknowledgement concerning the approach to GDWG also came late. Put shortly,

[140] Mary Molyneux 25 March 2022 106/23.
[141] INQ000064_52 §10.33.
[142] IMB000221.

the IMB has had to be pushed, and pushed hard, to recognise the inappropriateness of some of its actions. That raises a concern about the sustainability and reliability of the change, particularly in an area where so much (as already said) depends on the interest and energy of individuals.

c. This is also, of course, all the more true when the fundamental toxicity, and certainly the causes of it, remain in place. The Inquiry has seen how hard it is for so many to resist the toxicity which flows, fundamentally, from the Home Office. Almost all succumbed to it in one way or another, or left.

d. It is also a concern that many of the IMB structural problems remain. It does not appear that any precise figures on the diversity of the IMB's membership are available. Impressionistically, the membership appears to be overwhelmingly white professional retirees (although there appears to have been some recent progress on this at Brook House, in particular with regard to recruiting younger members). That has a real impact in cultural terms, and in lived experience and matters such as subconscious bias. The DPG CPs also submit that payment has more of an impact than Dame Anne thinks it does (paragraph 30 of her second statement). School governorship raises similar issues: voluntary work only attracts the wealthy. Prof Bosworth appears to agree:

> "My suggestion for the IMB would be to recruit more widely, including from the population of those who have been previously detained. I recommend also that they offer remuneration to their members to allow a more diverse group to take up the position."[143]

e. It is also a real concern that Dame Anne still has to express her "disappointment" (second statement, §33) about government action on the Rules, and that action with regard to securing a proper statutory footing also remains outstanding. As she said in her first statement (§17), the need for this has been raised on many occasions. It is understood that part of the need for this goes to independence. The DPG CPs remain very concerned that IMBs are still clerked by Home Office employees, which appears to mean Home Office officials in Brook House[144]. That is another factor in eroding independence, and bringing about assimilation. The government should be acting more quickly than it seems to be.

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[143] INQ000064_19 §10.34.

[144] This certainly used to be the position: see Jackie Colbran statement [IMB000204_16] at §44.

85. Again, therefore, the IMB and Dame Anne have done a lot of work. They are to be commended for that. This is however in the particular context of a new National Chair, and two key and very troubling events which have forced that focus. Sustained and reliable change is required in order to maintain that focus when the spotlight moves away.

86. The DPG CPs would also echo and endorse what the IMB said in its oral closing concerning the Home Office and G4S's reliance on IMB findings as "cover": "You may wonder how it is that a company the size of G4S, employing as many people as it did, operating a contract valued in the millions, say they came to rely quite so heavily on occasional HMIP visits and the nine unpaid members of the IMB"[145]. That is obviously wholly inappropriate, but it underlines the limits of what the IMB can do.

87. It is also of note that the IMB specifically supports calls for a time limit[146].

88. The Inquiry is however invited to find that the IMB was not, at least in 2017, an effective safeguard against the abuse and mistreatment that occurred in Brook House.

HMIP

89. There is no dispute but that there are limits to what HMIP can do. Mr Singh Bhui said in his oral evidence that "it is not news that we look at the general rather than the specific"[147]. Even keeping that in mind, however, the reality is that HMIP did not uncover anything like the nature and scale of abuse shown in Panorama and now examined in careful detail throughout the course of this inquiry. For an inspectorate body, that has to be a failure.

90. It is no answer to that to suggest (as Mr Singh Bhui did once or twice in his evidence) that matters may have changed between HMIP's inspection and Callum Tulley starting filming. The clear evidence from Mr Tulley was that that which he filmed was present before (and Mr Tulley expressly disputed the HMIP finding). The point that CTI picked up with Mr Singh Bhui concerning the failure to spot the gaps in the review of use of force also applies[148]: Mr Singh Bhui suggested, again, that the periods might be different, but there is nothing in the

[145] 6 April 2022 45/13-17.
[146] 6 April 2022 52/16-17.
[147] Singh Bhui 24 March 2022 193/23-25.
[148] Singh Bhui 24 March 2022 135-136.

evidence to suggest that Steve Webb (the use of force reviewer) changed his practice between the inspection and the relevant period.

91. During his oral evidence, Mr Singh Bhui was asked about "The Right to Community Equivalent Healthcare in Immigration Removal Centres: A Public Law Analysis of Systemic Issues in the Inspection Regime" report[149] and its criticism of the triangulation methodology, which is that the evidence of detained people is treated as one source of evidence, while three out of the five sources are institutional sources, which has the characteristics of an underlying systemic unfairness. The report recommends that the triangulation methodology should be removed, and Mr Singh Bhui was also asked about that. Rather than deal with the critical issue of systemic unfairness, however, Mr Singh Bhui instead focused on what he said was a misunderstanding of the triangulation methodology and defending the approach as "useful"[150]. It is submitted that more is required.

92. The DPG CPs resist the HMIP proposal that recommendations be replaced with "key concerns". The apparent intention behind this, as stated by Mr Singh Bhui in oral evidence, is to "increase the level of focus" and "really focus minds on key concerns and get managers to spend their time looking at those rather than…doing an action plan and then producing figures which show that 50 per cent of recommendations have been met"[151]. It is submitted that those figures are vital, as they show what the identified issues were and where there have been failures to take any action at all. Diluting and reducing HMIP recommendations must be resisted.

93. Finally, Mr Singh Bhui described GDWG's suggestion for a free phone line or online service as "a reasonable suggestion"[152].

PSU

94. It is hoped, and anticipated, that this Inquiry will uphold – where relevant to its Article 3 investigation – many of the complaints that the PSU dismissed. D687 is a particularly vivid example of that. The Inquiry has been asked to find that D687 is a witness of truth. The PSU, by contrast, dismissed all but one of his complaints (the fifth was referred to the NHS, who never determined it).

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[149] GDW000011
[150] Singh Bhui 24 March 2022 168-9.
[151] Singh Bhui 24 March 2022 205-7.
[152] Singh Bhui 24 March 2022 190-191.

95. This requires serious soul-searching by the PSU, and there is scant evidence that that has taken place, despite the pleas of Mr Khan at the end of his evidence that the PSU "uncover" and "get to the bottom" of the "type of wrongdoing" shown on Panorama[153]. The result is that the PSU continues to be an inadequate and ineffective safeguard against Article 3 ill treatment, which is why detained people hardly ever use it. The explanations for the PSU's failure include the following:

a. It is not and can never be independent. Although Mr Khan stated in oral evidence that it is important to have separation between PSU and Detention and Escorting Services, he was bound to accept that both are part of the Home Office. That conflict of interest is real. Mr Khan's attempts to downplay it[154] were far too optimistic. The PSU is infected by the same toxic culture of the department of which it is a part.

b. As has been seen throughout the evidence, it would take considerable training and individual professional confidence and stoicism to stand in the face of that culture. Both things are lacking, and were seen to be lacking in Ms Wilkinson, who had only a "baseline accreditation…a BTEC 7" to do her role as an investigator[155], followed by training on witness interviewing techniques (but not on interviewing vulnerable people[156]), statement taking and courses from ACAS. Ms Wilkinson also accepted, in answer to questions from the Chair, that the PSU did not have specific training on the types of complaints likely coming from people in immigration removal centres and that they had "general interview techniques training", which "wasn't specific to dealing with vulnerable people"[157].

c. A linked and profound problem is the absurd narrowness of Ms Wilkinson's approach, and what she is prepared to accept as evidence. This must reflect her training and so can be assumed to represent the approach of the PSU more generally. Instead of accepting that all relevant evidence is admissible and the issue is just one of weight, Mr Wilkinson persisted in answers concerning what she

[153] Mohammed Khan 24 March 2022 52.
[154] Mohammed Khan 24 March 2022 2-3.
[155] Helen Wilkinson 24 March 2022 49-50.
[156] Helen Wilkinson 24 March 2022 92.
[157] Helen Wilkinson 24 March 2022 106.

described as "the information was in front of [her]"[158], dismissing complaints save where there was direct evidence, and detailed evidence, including of matters such as where someone was when something was said, together with dates and times.

d. This sets the threshold far too high, particularly for men who are unwell, for whom English may not be the first language, and who may have limited literacy skills. However Ms Wilkinson's approach also reveals the wider cultural problem: how can it be that D687's complaint about racist abuse could so easily be put to one side, when Panorama was shot through with racist abuse? Ignoring that evidence looks like more than just a mistake about admissible evidence. It is so stark that it suggests a determination to dismiss D687's complaint, and those of complainants like him, which is redolent of toxic culture and institutional racism which has been seen throughout Brook House and the Home Office. Ms Wilkinson was asked about D687. She said it was "in the balance" and that he was recorded as being abusive to officers, when considering his allegations of racist and verbal abuse. When asked why that was relevant at all, she said that "was just the documentary evidence that [she] had available to [her]"[159]. All this shows, as above, and contrary to the evidence of Mr Khan, that the PSU is far from being an ineffective and independent monitor of its own parent department.

96. The reality is that the PSU only upheld complaints when there was direct evidence in support of them, more often than not camera footage (and even then, the footage was not always sufficient for a complaint to be upheld). That is what Ms Wilkinson appears to need when she says she can "only go off what the information was in front of [her]"[160]. That is hopeless, and this Inquiry should so find. It should also find that training and culture caused and contributed to that outcome.

E WING/R40/42

97. The DPG CPs have little to say on the subject of E wing, and the use of Rule 40 and Rule 42. D687 describes three occasions in which he was placed in segregation on E Wing as a means of punishment[161]. One of those occasions followed a peaceful protest on 23 May 2016, during

[158] Helen Wilkinson 24 March 2022 81.
[159] Helen Wilkinson 24 March 2022 89.
[160] Helen Wilkinson 24 March 2022 81.
[161] DPG000021_0015-0017 47-51 and DPG000021_0038-0039 paras 112-114.

which detained people were protesting about the conditions of detention and consistent abuse they experienced from staff at Brook House, amongst other things. D687 describes how the records relating to him being placed in segregation inaccurately record the issues being protested, downplaying their significance as only "various immigration issues". He also gives evidence about suffering reprisals from staff following these protests, including an increase in verbal abuse. He says, "Staff used their power to exert control over us so we would stay quiet and not complain". This is demonstrative of how staff would use segregation, together with other abusive tactics, to enforce their culture of silence upon detained people as well as fellow staff.

98. There are obviously real issues about the overuse of this regime, its monitoring, and its authorisation; all of which are demonstrative of the punitive use of Rule 40/42, consistent with D687's evidence mentioned above. There is also the issue of apparent quasi-segregation on E Wing under what is described in G4S's policy as a "restricted regime", but which is not under Rules 40 or 42 and therefore does not require Home Office authorisation, nor other safeguards such as daily visits by a medical practitioner under Rule 40(9)[162]. The Duncan Lewis CPs are addressing those points.

GDWG

99. Some of the points concerning GDWG have already been touched on above. For completeness, the Inquiry is invited to find:

    a. That as described by many witnesses[163], GDWG is an excellent organisation, doing good and valuable work on behalf of detained people, providing support including social and practical support, as well as referrals onwards where appropriate.

[162] G4S E Wing Policy, amended November 2016: CJS000697. Section 3 provides a list of circumstances under which someone may be moved to E Wing. Sections 16 and 18 suggest that anyone on E Wing who wants to see Healthcare or IMB must make a request, in contrast with the automatic occurrence under Rule 40.

[163] D668 in oral evidence: "Gatwick Detainee is very useful for a detention centre 18 and I hope they continue to do that job." [D668 22 February 2022 68/14]; D393 in his statement: "If I had needs they could not help with, they would refer me on to someone else who could. I found their support very useful, especially given I was not receiving any other welfare support." [DPG000023_0010 para 37]; D180 in his statement: "It was only because Mary Lewis at GDWG stepped in that the second operation went ahead when it did." [DPG000040_0010 para 43]; Anton Bole in oral evidence: "I was always keen to have their adverts and their presence because I think they're doing a good job, and I've seen from feedbacks from our clients, but I didn't see -- didn't hear any complaint. So in that situation, the stressful situation, to have such an organisation on the site, we can take advice, help with money, clothes, I think it's very good. It reduces stress and it's actually helping, as well, officers on the wing. They don't need to deal with such stuff." [8 December 2021 160/1-10]; Jackie Colbran of IMB interview with Verita, "We have, I would say, a high esteem for Gatwick Detainees Welfare Group" [VER000229_0010 para 131]; Steve Skitt witness statement "The service of the GDWG is invaluable in my opinion." [SER000455_0022 para 60]. He confirmed his view in oral

b. That GWDG well understands the relevant restrictions, and does not carry out legal advice or representation work. There is no evidence that it does, and its witnesses have been clear on the point.

c. Concerns about other aspects of GDWG, including its campaign work, have not been supported by evidence. Those concerns are not therefore well founded. There is nothing to suggest that GDWG's campaigning work, its referral work, or its occasional provision of witness evidence on behalf of detained people, made it appropriate to limit, or threaten to limit, GDWG's work for detained people in the centre.

d. The Inquiry is expressly invited to find that the concern directed at GDWG as a result of Naomi Blackwell's statement was particularly regrettable. That statement was properly provided. The fact that this statement was provided in support of what became a successful claim for false imprisonment and breach of Article 3 rights makes the Home Office and G4S response to it of particular concern. Particularly in that anxious context the Home Office and G4S should understand the importance of access to justice. That is a right which the Home Office and G4S are required to secure for those whom they detain.

e. The response to the Blackwell statement is particularly revealing of the culture and attitudes of the Home Office and G4S, but the real impact on GDWG flowed from what came next. GDWG was bullied and threatened by senior representatives of the Home Office and G4S. This was sustained over a long period: see James Wilson's statement from the judicial review concerning the meetings on 25 July 2016, 17 August 2016, 9 March 2017, 6 June 2017 and 18 August 2017[164]. See also his account of the responses they were getting to e-mails throughout this time. This sustained threat that GDWG might lose their drop in sessions had a real impact on what GDWG could do at Brook House, and how effective they could be. Note that even when Mr Wilson came to give his evidence

evidence [Steve Skitt 17 March 2021 109/20-24]; Dan Haughton witness statement "In my opinion, GDWD offer an invaluable service to residents." [SER000453_0057 para 253]; Paul Gasson First witness statement "It was widely acknowledged that GDWG provided a valuable service to those at Brook House." [HOM0332004_0013 para 36].

[164] [GDW000001] at §§25 onwards through to 44.

in support of the *MA and BB* judicial review, he was still fearful of what might happen as a result. At paragraph 7 of the same statement:

> "I would also like to say this. I am concerned that in giving this statement Brook House managers will take me as unfriendly, and a critic, and as somehow 'on the other side', and that GDWG's role in supporting detainees at Brook House and Tinsley House may be affected. I hope this will not happen. I make this statement because BB's solicitors have asked me to, because – as I understand it – they think the experiences of GDWG may assist the court, and any wider investigation of the causes and contributors to what happened at Brook House. Whether that is so is of course a matter for the court. I do think there is learning to be done, and my only interest is in contributing to that learning."

f. The Inquiry is invited to accept this evidence, and to reflect on what it meant. If the director of GDWG felt this way – inhibited by what he could say even in an important judicial review with the support of lawyers and other parties – then that provides another real insight into the level of toxicity, and its power.

g. The "us and them" culture, which this evidence illuminates, was defensive, at time aggressive, and inconsistent with the reflection and learning that was to be expected of the Home Office and G4S.

h. This attitude to GDWG, which came from the Home Office and G4S (as Mr Haughton put it, the "steer", which was a "shame", came from Mr Saunders and Mr Gasson[165]) also infected others including the IMB. It was inappropriate for the IMB to be part of an action against GDWG, as they were in August 2017. It was also inappropriate for the IMB to seek to prevent or restrict GDWG from referring matters direct to them[166].

i. The apparent assimilation of the IMB into a position of "distrust" of GDWG[167] was regrettable.

100. GDWG recognises, and wishes to acknowledge, that there have been significant improvements since 2017. It has however taken the Inquiry to produce that. GDWG has a better relationship with Mr Haughton, and Serco, than it did previously. There have been moves, albeit recent, to open up access for GDWG. Between January and March 2022

[165] See eg §217(a) of the statement at SER000453_47.
[166] See the Jackie Colbran "beginning to step outside our remit" e-mail of 5 August 2017: GDW000003_38.
[167] See the IMB minutes for 16 August 2017: IMB000003_4.

GDWG was able to attend Safer Community meetings. Serco has commented on the benefit of GDWG's contribution to those meetings[168]. That has however now ceased, apparently because of concerns of the Home Office, and the latest draft of the Memorandum of Understanding (being worked on to replace that which G4S and the Home Office attempted to impose in 2016 and 2016) has that provision removed[169].

101. There was also discussion about GDWG attending Vulnerable Residents meetings but that too appears to have run into problems. It follows that although there have been improvements, those improvements are far from complete, or reliable.

102. The same may be said of the IMB. As already seen, the IMB has clearly shifted position since Panorama (and since the inquest into the death of Prince Fosu in early 2020). Its later reports have been much more effective, and in some respects excellent. Its relationship with GDWG, under the stewardship of first Mary Molyneux and now Neil Beer has also improved. GDWG welcomes all that and the IMB including Dame Anne is to be commended for the work they have put in. However the concerns remain about whether this will continue once the spotlight of the Inquiry moves away, or were personnel to change again. As already said, there are real issues about the IMB structure, and the diversity of its membership. Much of its effectiveness, as with many other safeguards in this area, depend on the particular energy and interest of individuals. That is relatively high at the moment, but sustaining it remains an unknown.

D687

103. There is no dispute about D687's background, and about his mental health diagnosis, and the Inquiry is asked to accept all of it. It is all relevant to the Article 3 assessment which the Inquiry has to conduct:

    a. D687 has a diagnosis of recurrent depressive disorder and PTSD (see Dr Galappathie's report dated 22 September 2021[170]). He is also suspected of having Bipolar Affective Disorder and he may have ADHD.

[168] See statement of Daniel Haughton "There is now a more open approach with Serco and we are actively trying to get GDWG into the centre. They attend my monthly safer community meetings and make a valuable contribution to this." SER000453_0057 para 253.
[169] Fifth statement of Anna Pincus [DPG000042_0002-0005].
[170] DPG000006_0040-0045

b. D687 has a history of childhood trauma and serious abuse including childhood sexual abuse.

c. D687 has a history of being a child in care. It appears to be that this is why he never secured British citizenship. It is common for social services departments to fail to make such applications on behalf of those who whom they are responsible, and this is what seems to have happened to D687[171]. One of the tragedies of this case is that if that application had been made, at the right time, D687 would never have been the subject of deportation action. This also goes to the way in which when D687 was being told to "fuck off home" he experienced that as an attack on his identity. Like the rest of his family, he felt British.

d. It is also clear that D687 exhibited long standing, and serious, suicide/self harm ("S/SH") ideation and action at all material times.

104. The cumulative effect of the abuse and mistreatment of D687 should be considered against D687's background and heightened vulnerability.

105. First, the length of time D687 was detained indeterminately pervades all of his experiences of detention. By May 2017, he had been held using immigration powers for two years and three months, and about a year and a half of that had been in Brook House. To put that in context, D687 would have had to have received a prison sentence of four and a half years to have remained deprived of his liberty for that long. But his detention was administrative, despite being in prison-like conditions. This was also his second period of immigration detention. He could see no material progress in his position. D687 was of course anxious to oppose removal. This was unsurprising given that he had arrived in the UK aged 10 and was by now nearly 33.

106. The duration of D687's detention has a number of important consequences:

a. It means that he was subjected to the Brook House abuse and mistreatment for a very long time. This also includes the general conditions of detention there.

[171] Statement, DPG000021_3 §11.

b. He shows, very vividly, what indeterminate detention looks like. To those subject to it, it seems to extend indefinitely. D687, like most witnesses, have spoken about the effect of that, but in his case the impact was obviously very profound indeed because his detention was so long. This of itself degraded him. D687 speaks of this explicitly in terms of it making him feel like an animal, and being robbed of respect and dignity[172].

c. The length of D687's detention was also such that he suffered two close bereavements whilst in detention: his grandmother, and his brother. He was refused permission by the Home Office to attend the funerals. He has spoken about the impact of this, and it is recorded in contemporaneous records because he was speaking about it[173]. The impact was profound. It robbed D687 of an aspect of his identity and his dignity, because it prevented him from being able to grieve.

107. Second, throughout his detention D687 suffered the daily degradations of which this Inquiry has heard so much. The Inquiry is asked to accept that D687 is a witness of truth. It is obvious that he suffered what he said he suffered in terms of verbal racist abuse not least because it can be seen that he was regularly encountering the likes of Luke Instone-Brewer. D687 knew him to be a serious drug-dealer[174], and the Inquiry is invited to find that. D687's evidence chimes with the other evidence, from Stacie Dean and Michelle Brown, about Mr Instone-Brewer.

108. It is easy to imagine what regular interaction of this kind did to D687, particularly over an extended time. D687 was abused by Instone-Brewer and by others, and he knew, absolutely, that that this was not a man who was going to help him. D687 also suffered goading and provocation, at Mr Instone-Brewer's hand, including through the denial of access to the IT facilities[175]. D687 also suffered the denial of access to the cultural kitchen on a false, humiliating and very damaging basis (that he was a sex offender)[176], and which resulted in him being physically assaulted by another detained person[177]. He describes the dismissive attitude that Ms Patel took to that on behalf of the Home Office.

[172] Statement, DPG000021_008, §26. At §38 he compared it with prison.
[173] GDW000006_0016. See also Callum Tulley video diary: TRN0000047.
[174] DPG000021_0027 §§84-98.
[175] DPG000021_0032 at §95.
[176] DPG000021_0040 §§118-127.
[177] DPG000021_0040-0041 paras 119-120

109. D687 also describes a further incident of being assaulted by a staff member in late 2016, when he was pushed back into his cell[178]. Notably, one of the officers he identified as being present was Graham Purnell. Callum Tulley describes Purnell as having been involved in a similar but separate incident[179]. The DPG CPs submit that this, along with the overwhelming evidence of misconduct by Graham Purnell at Brook House, corroborates D687's evidence of that incident. All these experiences and the others described by D687 in his witness statement[180] are illustrations of the abuse and mistreatment by staff, which led to D687 experiencing feeling of fear, anguish and inferiority.

110. Third, D687's needs were also dismissed by healthcare staff. This was a particular issue in the last few months at Brook House, when D687 was visibly deteriorating. He was referred to mental health on 17 February 2017[181], but then missed appointments on 25 February, or 1 March. Those should have been followed up. D687 then attended on 7 March 2017 and made the important disclosure which is recorded in his clinical notes. This should have prompted a Rule 35(3) report as the very least, but the nurse failed to make the required referral to the GP. D687 went on to self-harm on 13 April 2017, demonstrating his further deterioration. He then disclosed again to Dr Oozeerally on 15 April, but as already said, that left him feeling worse[182]. Dr Oozeerally prepared no Rule 35(1) or (2) report which enabled the Home Office to dismiss the Rule 35(3) on the basis that there was no evidence about deterioration[183]. Dr Hard was clear Dr Oozeerrally should have completed both reports – on 15 April and 10 May[184]. He considered the failure to do so were significant failures in the safeguards.[185] Dr Galappathie was clear that Dr Oozeerally should also have prescribed anti-depressants[186]. Dr Hard thought it might have been less straightforward – that antidepressants would not necessarily have prevented the deterioration – but noted the "interesting phrasing" which suggested Dr Oozeerally had not even considered the question. For Dr Hard, the main thing was to communicate to the Home Office that D687's mental health was deteriorating and that was not done[187]. It was of course the responsibility of healthcare and, in particular, Dr Oozeerally, to do that.

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[178] DPG000021_0067-0069 paras 186-194
[179] Callum Tulley 29 November 2021 85/8 – 92/5
[180] DPG000021
[181] CJS007109/1; DPG000021_52 para 146.
[182] DPG000021_55 §153.
[183] Dr James Hard 28 March 2022 101/18-24
[184] Dr James Hard 28 March 2022 102/10-11.
[185] Dr James Hard 28 March 2022 105/6-12
[186] DPG000006 _0040-0042 para193
[187] Dr James Hard 28 March 2022 105/1-5; 106/2-4; 108/24-110/3.

111. Fourth, in addition to healthcare staff, D687 was also dismissed by G4S and Home Office staff, all of whom failed in their safeguarding duties towards him. D687 self-harmed on 13 April. He disclosed his suicidal ideation in a group therapy session on 24 April but, despite a referral to Oscar 1 by the therapist, D687 was not put on an ACDT. The following day he had an interaction with Chis Donnelly[188] in which he told him he would leave Brook House in a "bodybag". He was clearly very distressed and an ACDT should have been opened. It was not. Chris Donnelly's desensitisation and attitude towards detained people is dealt with elsewhere, but this is another example. D687 then told Vanessa Smith of his intentions on 27 April – even that he was writing a suicide note[189] – but none of this was taken seriously, or sufficiently seriously. She too failed to open an ACDT. Ms Smith told the Inquiry it was because "he didn't say he was going to do it immediately" but she has had training since[190]. D687 describes her attitude towards him as dismissive[191]. All this shows regular and callous dismissals of a vulnerable man, consistent with a wider culture which was not confined to one organisation. All this contributed to D687's mistreatment contrary to Article 3.

112. D687 was therefore long term detained, with no hope or prospect of release, marooned in the toxic environment of Brook House, being regularly abused including in a racist way and being dismissed by all including healthcare staff who should have been identifying his mental health needs and meeting them.

113. This was the point at which D687 gave up. By 13 May 2017, he wanted to die and this was foreseeable.[192] When the officers came to remove him, he gave up. His physical and moral resistance had been broken. As he put it repeatedly on the footage[193]: "I have had enough, bruv". It is submitted that this footage shows, very clearly, what Brook House does: it shows a man who has been broken. He had been degraded and dehumanised. His mental health had been made worse and then not treated. For these reasons D687 was by this point detained in breach of his Article 3 rights.

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[188] Chris Donnelly knew of D687's suicidal ideation on 13 May 2017, as D687 had told him about it on 25 April 2017.
[189] HOM000115_0007
[190] Vanessa Smith 15 March 2022 249/10- 250/23.
[191] DPG000021_0062-0063 para 172
[192] Callum Tulley 2 December 2022 D687 17/15-25: Q. Can you say whether they did, or any of them did? I mean, did people talk about 687 and say, "This man is going to kill himself sooner or later"? A. They didn't say those words exactly, sir, but they would talk about him in particular because he had been there for so long. I mean, he was one of the longest serving, as far as I remember, and we were all aware that the longer people were in Brook House, the more likely they were to hurt themselves. Q. Well, he certainly made no secret of it. A. Indeed, sir.
[193] E.g. TRN0000095_0033 at 1065, 1071, 1074, 1075, 1077, 1078

114. At that moment, however, it got worse: D687 suffered an unnecessary and disproportionate use of force. Again, in the lead up to the use of force, D687 was on ACDT as a result of his deteriorating mental health and was expressing suicidal ideation. This had now been recorded in a number of places; accessible to all. He was awaiting a further appointment with Dr Oozeerally to discuss antidepressant medication. However, and without him having had that appointment, a decision was taken to transfer D687 to The Verne. Dr Hard told the Inquiry that should not have happened and that the decision to transfer him should not have been made, prior to the Home Office having been provided with details of D687's deteriorating health.[194] That is particularly when it is for administrative convenience[195] rather than for reasons of (for example) best interests.

115. On 13 May officers including duty manager Dan Haughton responded to D687 in a shambolic and unplanned way. This meant that healthcare were not present. There was no proper or complete engagement with D687. No-one switched on their cameras, despite Mr Haughton being senior and despite, it seems, being the "guru" on BWC[196]. There was degrading language from Mr Donnelly suggesting D687 should get on with hanging himself, as he would let him hang until he passed out before cutting him down[197]. This added to D687's feeling of worthlessness[198]. Chris Donnelly was in fact threatening to do to D687 what he did do to D865 on 4 July 2017[199]. The Inquiry should so find.

116. At this moment, Mr Haughton decided to try his trick with the lighter; no other officer knew what was happening; and D687 ended up on the ground, with officers on top of him, a pain-inducing reverse grip unnecessarily imposed after he had been handcuffed and subdued, and bruising that was sufficiently significant he had to go to hospital in Dorset later that night. Mr Haughton told the Inquiry that he had not intended to initiate force[200], meaning there was no justification for it. However, he did initiate the force against D687 and this prompted the other officers to join in on the unjustified use of force.

117. Mr Collier told the Inquiry that the force used was unnecessary. That means it was unlawful in domestic legal terms. Fundamentally the problem was that Dan Haughton moved in too

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[194] Dr James Hard 28 March 2022 106/14-20
[195] Dr James Hard 28 March 2022 105/20-106/1
[196] See Michelle Brown VER000221_0007/A69.
[197] BBC000654 [0:18]. See also TRN0000095_0033 at 1061-1068
[198] DPG000021_0073 para 209
[199] Callum Tulley 2 December 2022 D687 24/24 - 25/8
[200] Daniel Haughton 16 March 2022 110/2-11.

fast without properly engaging, without planning and without giving instructions. As Mr Collier put it:

> "The actions, I felt, of the deputy director was something that – rather than engage with someone and trying to get a peaceful resolution, it almost seemed that he was intent on just turning up and ending the situation, because in all of my experience, I've never known a senior manager to take somebody's fish knife, rescue knife, off a colleague in order to carry out an action. For me, I just got the impression that he was intent on getting the incident done and dusted, for want of a better term."[201]

118. Mr Collier said there should have been more engagement; that might have rendered the force unnecessary; and healthcare not being present (in a S/SH case) was a "massive failing"[202]. "It could all have been avoidable"[203]. Mr Collier was also clear that the inverted wrist hold was unnecessary[204]. The protocols had not been followed[205]. Finally, Mr Collier agreed that D687's chest contusions required explanation given that it appeared to have been an easy restraint[206].

119. It is submitted that if D687 was not the victim of inhuman or degrading treatment until that point, this unlawful use of force certainly took him to that threshold. The Inquiry is invited so to find.

120. Also relevant is the ineffectiveness of what happened next. There was no proper review by the nurse. There was no KPI on the S/SH incident; it was not even explored (as occurred generally). The PSU dismissed nearly all of D687's complaints whilst attacking his credibility in a way which further degraded him. But for Callum Tulley's undercover footage of the incident (which has only come to light by way of this Inquiry; it was not broadcast), the truth would never have become known. Again, the culture of silence, falsification of records and cover up nearly prevailed at Brook House.

121. There was therefore indifference to a potential Article 3 breach from both the Home Office and G4S. Safeguards failed. There was also a failure properly to review the incident (the review was on 31 July 2017 so more than two and a half months later, and it was then just a tick-box). All this weighs in support of there having been a breach. The Inquiry is invited so to find.

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[201] John Collier 30 March 2022 94/12-21.
[202] John Collier 30 March 2022 96/15-19.
[203] John Collier 30 March 2022 97/1.
[204] John Collier 30 March 2022 99/6-13.
[205] John Collier 30 March 2022 100/19-22.
[206] John Collier 30 March 2022 101/4-17.

RECOMMENDATIONS

122. As well as reaching the above findings, including the finding that D687 suffered inhuman or degrading treatment, the Chair is also invited to make recommendations. As already said, the particular context of this Inquiry, and the long history of failures to make meaningful change, means strong recommendations are required.

123. The DPG CPs primary call is for a time limit on immigration detention. If there has to be immigration detention then it must be firmly time limited. Nothing else will do.

124. Beyond that, the DPG CPs invite the Chair to recommend as follows. Nothing in this detailed list should dilute the primary call for a time limit. These recommendations should be made even with a time limit. The following represents a distilled version of recommendations already made by GDWG, BID, INQUEST, and Detention Action. The Chair is however respectfully invited to read all those individual recommendation in full[207].

Improved safeguards to prevent the detention of vulnerable people

125. Safeguards to prevent the detention of the most vulnerable must be made sufficiently robust that vulnerable people are identified before detention decisions are made. The DPG CPs adopt the specific recommendations made on behalf of Medical Justice as regard improved safeguards and make the following general points.

126. Reforms should include a return to the category-based approach to the identification of vulnerabilities as recommended by Mr Shaw in his first report, where vulnerable people are treated as unsuitable for detention save in "very exceptional circumstances". The categories of vulnerabilities should include all groups now identified in the Adults at Risk ("AAR") Policy. There should be no requirement for additional or specific evidence of risk of harm. There should be a system for independent and robust oversight of detention decisions to ensure that all relevant evidence of vulnerability has been obtained and considered.

127. The failings of the current Rules 34 and 35 processes must be replaced by a reliable clinical screening process to identify vulnerability upon detention and thereafter where vulnerability

[207] They may be found at GDW000012_0007_paras_11-92; DPG000038_0028; INQ000037_0027; and DPG000020_0030 respectively.

develops during detention. Additionally, it is recommended that mental and physical health assessments of suitability to be detained should be offered at monthly intervals.

128. Adequate training, and refresher training, for all those responsible for implementing pre- and post-detention screening safeguards, is essential and should include the views of detained or formerly detained people.

129. As a matter of urgency, there needs to be effective training of medical staff in the making of Rule 34 and 35 reports and Home Office staff in responding to those reports. An urgent recommendation ought to be issued with respect to ensuring a proper review of the current detained person population at Brook House, and who among them requires Rules 35(1) and (2) reports.

Culture

130. A lack of respect for detained people, and a culture in which those who are detained are disbelieved, lie at the heart of the dehumanisation and mistreatment of detained people at Brook House.

131. Improved recruitment, training, supervision and management of detention, healthcare and Home Office staff, on issues of race and other cultural matters, including measures to promote respect for detained people and to combat the existing culture of disbelief in the accounts of detained persons, will provide better protection against abuse occurring and improve levels of trust by detained people in staff. Training should be produced in collaboration with detained or formerly detained people and should include independent external assessment of participants' progress. Training on anti-racism should be designed and delivered in collaboration with a reputable independent organisation specialising in such training.

132. Strategies for preventing, recording, investigating, and responding to racist incidents should be designed with, and monitored by, an independent body.

The contract

133. The new contract between the Home Office and Serco still depends heavily on self-reporting. That requires careful monitoring, including by way of independent oversight of how the use

of force and suicide/self-harm and issues are being reported. Intensive dip-sampling might work. Such oversight should have available the means of issuing sanctions for under reporting.

Architecture and Facilities

134. Brook House, built to Category B prison specification and apparently intended for detention of no more than 72 hours, is unsuitable as a place of immigration detention for more than that period. People should not be held at Brook House for longer than 72 hours.

135. Immigration detention is not to be used to punish people or coerce them into agreeing to removal from the UK. It should be humane and as far as possible resemble life in the community by allowing unimpeded communication with friends and family, suitable and private facilities for sleeping, washing and toileting, opportunities for entertainment, education, socialisation and activity, including religious observance, and adequate outside space.

136. Insofar as the interior and exterior of Brook House can be re-designed to reduce the prison-like appearance and feel of the place, it should be re-configured, in consultation with detained and formerly detained people. Obvious steps would be to increase the size of rooms and provide properly separated toilet and washing facilities. Fittings and furnishings should be replaced with more attractive and comfortable items.

137. Detained people should be given the option to have a room to themselves and no more than 2 people should be accommodated in the same room.

138. Detained people should be allowed possession of their own devices such as laptops and smart phones, with access to the internet, email and social media. Such devices should be issued to those who do not have one.

139. There should be improved communal IT facilities, mobile telephone signal and Wi-fi access, and websites should not be blocked unless they contain illegal material, with a review mechanism available to challenge decisions to block websites.

140. High quality independent interpretation services should be made available as a matter of course for healthcare appointments and offered for general interactions with detention staff.

Reliance should not be placed by detention and healthcare staff on other detained people or staff to interpret.

141. Whilst strongly maintaining that people should not be detained at Brook House for more than 72 hours, if detention occurs for longer a full programme of activities and educational opportunity should be provided, developed in consultation with detained and formerly detained people.

142. Detained people should not be locked-in their rooms. The lock-in regime is demeaning and inconsistent with the principle that detention is not for punishment or coercion. It has an adverse effect on mental health. It is unnecessary and encourages detention and healthcare staff to view detained people as criminals and less than human.

Healthcare; management of self-harm and suicide; mental incapacity

143. The DPG CPs adopt the recommendations made on behalf of Medical Justice.

144. In addition, they adopt the recommendations made in the Report of the Strategic Public Law Clinic[208].

Use of Force and Segregation

145. The DPG CPs adopt the submissions on use of force and segregation made on behalf of the Duncan Lewis CPs.

146. At an operational level, it is recommended that training for staff should include mental health training and greater emphasis on improving listening and discussion skills; more time should be allowed for seeking to resolve disputes by alternatives to the use of force and segregation and mediation, including the use of external mediators, should be employed.

147. Where force and/or segregation is used written reasons should be provided in the detained person's preferred language.

148. NGOs should be permitted to visit detained people in the room where they are held in segregation.

[208] GDW000012_0005 and GDW000011_0008.

Legal Services

149. It is recommended that an independent review is undertaken into how to improve access by people detained at Brook House to legal advice and how to improve the quality of that advice, including advice given under the Legal Aid Agency's Detention Duty Advice Scheme. The review should include consultation with detained people about their difficulties accessing good quality legal services.

Home Office

150. It is recommended that detained people are given the opportunity to regularly meet in person the Home Office caseworker making decisions about their case. Home Office staff in Brook House should have dedicated time to walk through the centre to speak with detained people.

151. Home Office documents should only be served on detained people during usual office working hours when they can access advice from legal representatives and support from organisations such as GDWG. All correspondence and documents from the Home Office, those running Brook House and Healthcare to detained people should be provided in both English and any other preferred language of the detained person.

152. The Home Office should engage meaningfully with NGO stakeholders, valuing and making use of the expertise these organisations offer.

153. The Home Office should seek to learn lessons from court decisions and reports from PPO investigations and inquests into deaths in IRCs in order to improve the quality of their decision-making and the policies, practices and systems of detention practiced by the Home Office and those running IRCs. They should establish processes, and allocate time and resources of specific experienced people, to anaylse, understand and acknowledge the mistakes made and the failure of safeguards and determine what can be done to strengthen the protections. Arrangements should be established for lesson learning to be cascaded within the Home Office and to those running IRCs so that systemic problems are rectified, mistakes are not repeated, and change is implemented.

Complaints

154. An overhaul of complaints mechanisms is required and should be undertaken by an independent organisation in consultation with detained people. Complaints should be accepted by text and in any language and written translation and telephone line interpreter services should be made available.

155. The DPG CPs endorse the recommendations of Liberty in relation to complaints set out at Annex D to the ICIBI report of July 2020[209] which include shorter timeframes for investigating and responding to complaints and the appointment of an independent complaints officer at each IRC to facilitate complaints, ensure lessons are learnt and change is implemented.

156. The complaint system should be widely advertised in different locations in the centre and explained in numerous different ways, formats and languages. It should be explained fully during the induction process and again at regular information sessions on the wings.

157. A Suggestions and Feedback mechanism should be created in addition to the complaints mechanisms.

Oversight - IMB, HMIP, CQC and the National Prevent Mechanism

158. There needs to be statutory underpinning of the national IMB. This should include reference to IMB membership of the UK National Prevent Mechanism (NPM) and their OPCAT responsibilities and the Detention Centre Rules should be amended to update the responsibilities of IMBs in line with current and best practice, including specifically to their NPM duties[210].

159. Funding of local IMBs must be provided such that they can provide their own secretariat – the use of Home Office secretariat undermines the actual and perceived independence of the IMB.

[209] GDW000012_0019 para 62.
[210] As recommended by Dame Ann Owers in her written evidence to the Inquiry IMB000199_0006 para 17 and IMB000221_0009 para 32-33.

160. The IMB at national and local level should take steps to achieve a more diverse membership of the Brook House IMB, such as the introduction of paid positions and recruitment drives, including drives to encourage formerly detained people to apply.

161. Induction and training of IMB members should specifically refer to the key facts found by this Inquiry, as well as the death of Prince Fosu, and the lessons for the IMB from both. The induction and training should include significant input from detained and formerly detained people.

162. The Brook House IMB should seek to entrench in their training, supervision, processes, procedures and meetings the need to strive for and maintain formal and practical independence from the Home Office and Brook House to safeguard their independence, effectiveness and credibility[211].

163. The Brook House IMB should do more to increase their visibility and publicise their role to detained people, particularly their role as an NPM member in preventing ill- treatment in detention, and to demonstrate to detained people their independence from those running the IRC and the Home Office.

164. HMIP should invite, via their website and a free phone line, the reporting of issues as part of their ongoing information gathering between inspections. They should seek out the information and views held by GDWG, Medical Justice and other NGOs as a valuable source of evidence which can inform their reports.

165. IMB, HMIP and CQC should each adopt more consultative relationships with the relevant NGOs working in the detention sector, and this should continue beyond the spotlight of the Inquiry. The quarterly meetings between GDWG and the Brook House IMB should continue.

166. Overall, there needs to be a much more proactive role on the part of IMB, HMIP and CQC to ensure that their oversight is thorough and robust and that changes they recommend are implemented. They should have a more "preventive" and human rights-based focus[212].

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[211] This is also a recommendation of the UK NPM – see John Wadham's first statement NPM000001_20 para 23c.
[212] As recommended by the United Nations Subcommittee on the Prevention of Torture (SPT) and by the Chair of the UK NPM, John Wadham in his first statement NPM000001_20 para 23a, and referenced in the First Statement of Deborah Coles INQ000037_0023 paras 75-78.

167. In line with the recommendations of the United Nations Subcommittee on the Prevention of Torture (SPT), the UK NPM should be put on a statutory footing[213] and the OPCAT responsibilities of individual NPM members (including the IMBs, HMIP and CQC) should be placed on a statutory basis with new powers, increased or specific budgets for NPM work and specific requirements placed on them as a result of the designation as NPM members[214].

Relationship between Serco, Home Office, Healthcare and GDWG

168. The Home Office and those running Brook House (currently Serco) should acquire a good understanding of the important role that GDWG play in befriending and advocating for detained people and view the work of GDWG as being in the interest of the safety and well-being of detained people. They should facilitate rather than hinder the work of GDWG through prompt response to emails, holding quarterly meetings with GDWG and inviting GDWG to the Safer Community and Vulnerable Residents meetings for Brook House.

169. Those running Brook House should ensure that detained people have greater access to information about the support and assistance that GDWG can provide. Measures to achieve this would include inviting GDWG to take part in the induction process, including GDWG material in an induction pack and encouraging liaison between wing officers and GDWG. Detention staff (not only staff who work in the Welfare Office) and healthcare staff should be encouraged by managers to refer detained people to GDWG.

170. GDWG should be allowed to hold "drop-in" advice sessions (i.e. sessions which detained people may attend without a prior appointment) in a central location in Brook House which is accessible to detained people, such as the library or Welfare Office, in addition to the advice sessions held in the Legal Visits Corridor, which are by prior appointment. GDWG should be permitted to carry out as many advice sessions as GDWG deem are necessary to meet the needs of each detained person and access to interpreting services should be provided and paid for by those running the IRC.

Visits by family, friends and GDWG

171. Visits by friends and family and by GDWG visitors are very important in helping a detained person to maintain their sense of self and dignity. There should be consultation by those

[213] First Statement John Wadham NPM000001_20 para 24.
[214] First Statement John Wadham NPM00001_19 para 20 and First Statement of Deborah Coles INQ000037_0023 paras 74 & 79.

running Brook House with detained people to find out how the visits process and the Visits Room could be improved.

172. Private visits rooms, such as the current legal visit rooms, should be made available for visits in particular circumstances. Closed visits should be used sparingly or not at all and never for punitive purposes.

173. Frequent visitor passes should be made available for GDWG volunteer visitors. GDWG volunteer visitors should be permitted to visit as many detained people as necessary across multiple slots in a single day. Wifi should be made available in the Visits Room and GDWG visitors should be allowed to bring in devices to allow for access to interpreters and/or they should have access to interpreters for visits. GDWG volunteer visitors should continue to be permitted to take a pen and notebook into the visits hall, as well as relevant information to be provided to the detained person, such as leaflets from other relevant support organisations.

FINALLY

174. The DPG CPs thank the Chair, STI and CTI teams and the Inquiry Secretariat for their time. It is hoped these written submissions assist.

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