

BROOK HOUSE INQUIRY

CLOSING STATEMENT ON BEHALF OF THE HOME OFFICE

I. INTRODUCTION

1. This written closing statement is filed on behalf of the Home Office on the conclusion of the hearings in the Brook House Inquiry. The Home Office wishes to thank the Chair for undertaking the significant task of investigating the treatment of those who were detained at Brook House during the period 1 April 2017 to 31 August 2017 (the “**Relevant Period**”). The Inquiry has been carrying out its investigation in a statutory form since 5 November 2019 and has now heard a great deal of compelling and informative evidence with the assistance of a wide range of Core Participants and witnesses.
2. The Home Office has made clear from the outset that the treatment shown in the *Panorama* Broadcast was completely unacceptable, and that remains its position¹. Indeed, Mr Riley took the opportunity at the very beginning of his evidence² to “apologise to the people at Brook House in 2017 who suffered the distressing incidents we saw in *Panorama*”. He explained: “I have reflected over the period and, you know, the failures in the contract, in the level of Home Office supervision, you know, are deeply distressing for everybody and I would like to open today just to apologise for that”.
3. The Home Office does not shy away from the fact that there was undoubtedly inappropriate use of force and mistreatment by G4S officers during the Relevant Period. In terms of the former, the Home Office does not seek to go behind the findings of the Inquiry’s expert, Jon Collier. In terms of the latter, the Home Office will await the findings of this inquisitorial process. Whilst the Home Office does not seek to make submissions in respect of individual allegations of mistreatment, it agrees with the observation of Callum Tulley that the incident involving D1527 which was captured on

¹ [HOM0332005_002](#) para 5

² Phil Riley [4 April 2022 1/17](#)

camera was a “*high point*”³ in the identified mistreatment during the Relevant Period and treatment of that scale was “*rare*”. It is however concerned more broadly with incidents of physical and verbal abuse that have been brought to light and other failings, particularly in the field of healthcare at that time.

4. Unfortunately, the reality was that the abuse that was demonstrated in the Panorama documentary or that has been highlighted to this Inquiry did not reach the Home Office. As Callum Tulley himself observed, he was not aware of “*any abusive language*”⁴ being demonstrated in front of, for example, the IMB and even though he had concerns he didn’t feel that he could say to the IMB or HMIP that he witnessed mocking or humiliation of a detainee because “*I had no evidence of the abuse...how could I prove any of this?*”⁵. Conversations in front of third parties, such as the researcher Dr Dominic Aitkin who had full access to Brook House were “*civil and respectful*”⁶. In all the time that the Forward Trust’s Anton Bole worked with those suffering with substance misuse, no detained person mentioned that they had been mistreated by an officer or staff⁷. Even Jamie MacPherson of GDWG, who had regular contact with those who were detained was not aware, observing that “*it never occurred to me that physical mistreatment of detained persons at the hands of Brook House staff could be taking place*”⁸ and “*I was unaware of the kind of physical and verbal abuse that was shown on the Panorama programme*”⁹.
5. The fact that the Home Office was not aware of the kind of abuse that has now been shown to have taken place does not, of course, absolve it of any blame. It has been open and honest about the need to improve. It has accepted that there were clearly organisational failings, mostly in areas of performance management and assurance. Steps were taken some time ago to begin to address the identified problems. A new contract was developed, with a greater focus on the safety and welfare of those detained, with new performance measures and monitoring. The contractor was replaced. The numbers of Home Office staff were increased, including the introduction of the Detention Engagement Teams (known as the Pre-Departure Teams at the time). A wide range of further changes have occurred throughout the estate and in policies and

³ Callum Tulley [30 November 2021 52/2-25](#)

⁴ Callum Tulley [29 November 2021 106/12](#)

⁵ Callum Tulley [30 November 2021 104/6-25](#)

⁶ Dr Dominic Aitkin [8 December 2021 80/18](#)

⁷ Anton Bole [8 December 2021 175/1 and 180/21](#)

⁸ [INQ000027_0014](#) at para 58

⁹ Jamie Macpherson [8 December 2021 222/17](#)

procedures – as set out in the witness statements of Mr Riley¹⁰ and Frances Hardy¹¹ which the Inquiry is asked to consider in full.

6. That learning has not stopped or even been paused awaiting the results of this Inquiry. Indeed, as recently as 1 April 2022 the Home Office and NHS England wrote to healthcare commissioners and providers¹² in respect of Rules 34 and 35 of the Detention Centre Rules 2001 in light of failures that were identified in evidence heard by the Inquiry. The Home Office looks forward in due course to receiving the Inquiry's report and recommendations so that further improvements can be made to how the rules are operated which will help to ensure the welfare of those in immigration detention.
7. The structure of this Closing Statement is as follows:

<u>Topic</u>	<u>Paragraphs</u>
II. ISSUES OF LAW	11 - 83
The Role of Article 3 ECHR	11 - 44
Distinguishing factual findings from legal determinations	45 - 56
Interpreting Article 3 ECHR	57 - 63
The standard of proof and role of oral evidence	64 - 81
Other matters of evidence	82 - 83
III. KEY ISSUES IN DISPUTE	84 - 198
Home Office and Institutional Culture	85 - 94
The Contract	95 - 112
Staffing levels at the Centre	113 - 117
Rules 34 and 35, ACDT and Adults at Risk	118 - 146
Rules 40 and 42	147 - 152
The issue of Race	153 - 159
The physical structure of the building	160 - 169
Hygiene	170 - 172
Drugs	173 - 177
The Professional Standards Unit	178 - 191
The IMB and HMIP	192 - 198
IV. OTHER MATTERS OF CLARIFICATION	199 - 217

¹⁰ [HOM0332005](#) and [HOM0332051](#)

¹¹ [HOM0332138](#)

¹² [HOM0332160](#)

Internet availability	200
Learning from caselaw	201
No notice removals	202 - 211
Allegations against Home Office civil servants	212 - 217
V. CONCLUSION	218

8. In addition to this written Closing Statement, the Home Office asks that all the witness evidence from Home Office witnesses is considered, including:

Statements of Phil Riley and his oral evidence¹³
Statement of Ian Castle and his oral evidence¹⁴
Statement of Michelle Smith and her oral evidence¹⁵
Statements of Paul Gasson and his oral evidence¹⁶
Statement of Philip Shoenenberger and his oral evidence¹⁷
Statement of Ian Cheeseman and his oral evidence¹⁸
Statement of Vanessa Smith and her oral evidence¹⁹
Statement of Mohammed Khan and his oral evidence²⁰
Statement of Helen Wilkinson and her oral evidence²¹
Statement of Hugh Ind²²
Statement of Alan Gibson²³
Statements of Clare Checksfield²⁴
Statement of Frances Hardy²⁵
Statement of Debra Weston²⁶
Statement of Julie Galvin²⁷

¹³ [HOM0332005](#), [HOM0332051](#), Phil Riley [4 April 2022](#)
¹⁴ [HOM0332049](#), Ian Castle [15 March 2022](#)
¹⁵ [HOM0332121](#), Michelle Smith [23 March 2022](#)
¹⁶ [HOM0332004](#), [HOM0332152](#), Paul Gasson [15 March 2022](#)
¹⁷ [HOM0332132](#), Philip Shoenenberger [23 March 2022](#)
¹⁸ [HOM0332154](#), Ian Cheeseman [16 March 2022](#)
¹⁹ [HOM0332141](#), Vanessa Smith [15 March 2022](#)
²⁰ [HOM0332155](#), Mohammed Khan [24 March 2022](#)
²¹ [HOM0332047](#), Helen Wilkinson [24 March 2022](#)
²² [HOM0332153](#)
²³ [HOM0331980](#), [HOM0332133](#)
²⁴ [HOM0331981](#), [HOM0332139](#)
²⁵ [HOM0332138](#)
²⁶ [HOM0332003](#)
²⁷ [HOM0332030](#)

Statement of Anthony Lennon²⁸

Statement of Simon Murrell²⁹

Statement of Mark Hartley-King³⁰

Statement of Rukshana Rafique³¹

Statement of Shane Byrne³²

Statement of Andy Kupoluyi³³

Statement of Paul Benson³⁴

9. In addition to the above, Stephen Kershaw CBE (Senior Director for Strategy and Transformation at the Home Office) has been asked by the Inquiry to produce a statement and this will be provided in due course.
10. It is clear from the above list that there are many witnesses from the Home Office, including those who were deeply involved in matters relating to Brook House during the relevant period, who have not given oral evidence but who have important evidence for the Inquiry to consider. They tell the story from a first hand perspective whereas this Closing Statement can only identify some key pieces of evidence, in the absence of any competing pleaded case or comprehensive list of allegations.

II. ISSUES OF LAW

(i) THE ROLE OF ARTICLE 3 ECHR

Summary of the position

11. On 25 March 2022, a note was circulated to Core Participants by Counsel to the Inquiry ("the CTI Note"). The CTI Note stated that its intention was to inform Core Participants about the approach Counsel to the Inquiry suggests the Chair should take in relation to the making of findings of fact. The CTI Note also appears to suggest that the Chair should make findings as to whether article 3 of the European Convention on Human

²⁸ HOM0332031

²⁹ [HOM0332006](#)

³⁰ [HOM0331946](#)

³¹ HOM0332123

³² [HOM0332131](#)

³³ [HOM0332157](#)

³⁴ [HOM0332158](#)

Rights (“**the Convention**”) was “*violated*” at Brook House and refers in several places to the Chair identifying “*Article 3 violations*”. Similar oral submissions were made by CTI at the hearing on 5 April 2022 and by several Core Participants in their own closing statements.

12. No ruling on this matter has yet been made and Counsel for the Home Office made clear in his oral closing statement that the Home Office does not agree with this analysis. It appears that there is a narrow, but fundamental, disagreement on this matter which would best be determined in a ruling well in advance of the final report in light of the significant impact that it will have on the content of that report.
13. In summary, the Home Office’s position is as follows:
 - (1) The question of whether article 3 has been violated is not a question of fact. It is a question of law. A determination that a public authority violated an individual’s rights under article 3 would be a determination as to that public authority’s civil liability. The Inquiry is prevented from making any such determination by section 2 of the Inquiries Act 2005 (“**the 2005 Act**”). Any purported attempt to do so would be *ultra vires* and would be liable to be quashed in judicial review proceedings. Whilst it may be possible to infer a breach of article 3, or other forms of civil or criminal liability, from the Chair’s findings of fact, the Inquiry must stop short of drawing any such conclusion itself.
 - (2) The Inquiry should take significant care in the language it uses to avoid giving the misleading impression that it is making decisions on questions of law. Guidance as to the line between permissible fact-finding and impermissible legal findings may be found by analogy in the case law and guidance relating to inquests. It is clearly appropriate for the Chair to use judgemental language that she considers to be warranted. However, words such as ‘unlawful’ or any language that is indicative of a breach of any *legal* duty would fall foul of section 2(1) of the 2005 Act.

The Human Rights Act 1998 (“HRA”)

14. Article 2 of the Convention begins: “*Everyone’s right to life shall be protected by law.*”

15. Article 3 of the Convention provides that: “No one shall be subjected to torture or to inhuman or degrading treatment or punishment”.
16. Articles 2 and 3 have been interpreted by the European Court of Human Rights to include an obligation on the state to conduct an effective official investigation where an individual raises an arguable claim their substantive rights under the relevant article have been violated: see, for example, *Assenov v Bulgaria* (1999) 28 EHRR 652, §102; *R (AM) v Secretary of State for the Home Department* [2009] UKHRR 973, §§3-4.
17. The Convention rights listed in Schedule 1 of the HRA, including articles 2 and 3, are given effect in domestic law by virtue of the HRA. The relevant provisions of the HRA include the following:
 - (1) Section 2 requires any domestic court or tribunal to take account of decisions of European Court when determining question which has arisen in connection with a Convention right.
 - (2) Section 6(1) makes it unlawful for a public authority to act in a way which is incompatible with a Convention right.
 - (3) Section 7(1) provides that a person who claims that a public authority has acted (or proposes to act) in a way which is made unlawful by section 6(1) may bring proceedings against the authority under the HRA or rely on the Convention right(s) concerned in any legal proceedings.
 - (4) Section 8 allows a court which finds a public authority to have acted incompatibly with a Convention right to grant such relief or remedy, or make such order, within its powers as it considers just and appropriate. This may include an award of damages.

The Inquiries Act 2005 (“the 2005 Act”)

18. Section 1 of the 2005 Act gives a Minister the power to cause a public inquiry to be held in relation to a case in relation to which it appears that there is or may be public concern.

19. Section 2 of the 2005 Act provides that: (1) an inquiry panel is not to rule on, and has no power to determine, any person's civil or criminal liability; but (2) an inquiry panel is not to be inhibited in the discharge of its functions by any likelihood of liability being inferred from the facts it determines or recommendations that it makes.
20. Section 5 of the 2005 Act requires the Minister responsible for an inquiry to set out the inquiry's terms of reference. By section 5(5), the functions conferred by the 2005 Act on an inquiry panel or a member of an inquiry panel are exercisable only within the terms of reference.

The Coroners and Justice Act 2009 ("the 2009 Act")

21. By sections 1 and 6 of the 2009 Act, a senior coroner is required to conduct an inquest into a death within their area if the coroner has reason to suspect that: (a) the deceased died a violent or unnatural death; (b) the cause of death is unknown; or (c) the deceased died while in custody or otherwise in state detention.
22. Section 10(1)(a) of the 2009 Act requires the senior coroner or jury at an inquest to make a determination on who the deceased was; and how, when and where the deceased came by his or her death. Section 10(2) of the 2009 provides that a determination under section 10(1)(a) may not be framed in such a way as to appear to determine any question of: (a) criminal liability on the part of a named person; or (b) civil liability.

No power to making findings on whether article 3 was violated

23. The purpose of a statutory inquiry is to make *factual* findings and recommendations. This can be seen from section 24(1) of the 2005 Act which requires the Inquiry's report to set out "the facts determined by the inquiry panel" along with any recommendations. It can also be seen from §8 of the Explanatory Notes to the 2005 Act which states that the aim of a public inquiry "*is to help to restore public confidence in systems or services by investigating the facts and making recommendations to prevent recurrence, not to establish liability or to punish anyone*". The Terms of Reference of this particular Inquiry ask the Chair to "*reach conclusions*" and these must be factual conclusions rather than legal determinations.

24. The suggestion that the Chair's report should include conclusions as to whether, for example, there were investigative failures under article 3 of the Convention or whether there has been "*a violation of Article 3 ECHR*" (§18e of the CTI Note) are questions of *law* which the Inquiry should not purport to rule on. This is for the following general reasons:
25. **First**, section 2 of the 2005 Act prohibits the Inquiry from making any ruling or determination on any person's civil liability. This is reflected in the Terms of Reference which state that "*It is not part of the Inquiry's function to determine civil or criminal liability of named individuals or organisations*". The powers of the Inquiry are exercisable only within the Terms of Reference by virtue of section 5(5) of the 2005 Act.
26. The effect of the HRA is that Convention rights are 'civil rights' as a matter of domestic law. This is supported by a number of cases relating to article 6(1) of the Convention (the right to a fair trial). For example, in *In re S (Minors) (Care Order: Implementation of Care Plan)* [2002] 2 AC 291, Lord Nicholls said at §71:
- "Although a right guaranteed by article 8 is not in itself a civil right within the meaning of article 6(1), the Human Rights Act 1998 has now transformed the position in this country. By virtue of the Human Rights Act article 8 rights are now part of the civil rights of parents and children for the purposes of article 6(1). This is because, now, under section 6 of the Act, it is unlawful for a public authority to act inconsistently with article 8."*³⁵
27. In light of this, a determination that a public authority has acted contrary to or violated article 3 of the Convention would be a determination of the civil liability of that public authority. Specifically, it would be a finding that the public authority had committed a statutory tort by breaching section 6(1) of the HRA. Such a finding could only properly be determined in court proceedings under section 7 of the HRA. Any such determination made by the Inquiry would be *ultra vires* the Inquiry's powers by virtue of sections 2(1) and 5(5) of the 2005 Act.
28. **Second**, this limit on the Inquiry's powers is consistent with state's investigatory duty under article 3 of the Convention. As was recognised in the case of *R (MA) v Secretary of*

³⁵ See also the judgments of Collins J in *Home Secretary v BC* [2010] 1 WLR 1542 at §31 and Farbey J in *QX v Home Secretary* [2021] QB 315 at §42.

State for the Home Department [2019] EHC 1523 (Admin) at §38, the Home Office has always accepted that the allegations of mistreatment of detainees at Brook House *prima facie* engage an obligation under article 3 to investigate. However, it does not follow that the investigation must involve a determination of whether article 3 was violated.

29. The purpose of an article 3 investigation is to establish the facts in relation to the alleged mistreatment, not to reach conclusions as to whether the established facts amount to a violation of article 3 as a matter of law. For example, in *Banks v United Kingdom* (2007) 45 EHRR SE2 the European Court said that “*the procedural element contained in Art.3 of the Convention imposes the minimum requirement that where a state or its agents potentially bear responsibility for serious ill-treatment the events in question should be subject to an effective investigation or scrutiny which enables the facts to become known*”.
30. This analysis is supported by the case law relating to inquests and the investigative duty under article 2 of the Convention. In *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182, Lord Bingham said at §20:

“The European Court has repeatedly recognised that there are many different ways in which a state may discharge its procedural obligation to investigate under article 2. In England and Wales an inquest is the means by which the state ordinarily discharges that obligation, save where a criminal prosecution intervenes or a public inquiry is ordered into a major accident, usually involving multiple fatalities. To meet the procedural requirement of article 2 an inquest ought ordinarily to culminate in an expression, however brief, of the jury’s conclusion on the disputed factual issues at the heart of the case.”

31. Although an inquest is the means by which the article 2 investigative duty is ordinarily discharged, inquests do not reach any conclusion as to the death involved a substantive violation of article 2. They are prevented from doing so by section 10(2) of the 2009 Act which prohibits inquests from determining civil or criminal liability. This was made clear by the Court of Appeal in *R (Maguire) v Blackpool and Fylde Senior Coroner* [2021] QB 409 in the following terms at §17:

“Section 10 preserved the prohibitions of the earlier statutory scheme against appearing to determine criminal liability of a named person and civil liability. It remains no part of the function of an inquest to determine civil liability, including whether there has been a breach of a substantive duty imposed by article 2, or to appear to do so.”

32. It is clear from *Maguire* that the Court of Appeal considered that a finding that article 2 had been breached would be a finding of “civil liability” and would therefore fall foul of section 10(2) of the 2009 Act. A finding by the Inquiry that article 3 had been breached would be directly analogous. Accordingly, it would be inconsistent with the equivalent prohibition in section 2(1) of the 2005 Act. Further, the judgment demonstrates that the procedural obligation under article 2 may be satisfied by a process which does not result in a determination of whether there has been a breach of the substantive duty under article 2. This should also apply equally to article 3 cases. As such, an inquiry which is prohibited by section 2(1) of the 2005 Act from determining whether article 3 was violated will nonetheless discharge the state’s procedural obligation under article 3.
33. **Third**, there is a clear rationale for these limitations on the Inquiry’s powers. The fact that inquiries do not determine questions of liability explains why many of the safeguards to which parties are entitled in legal proceedings, such as the right to cross-examine witnesses, are not afforded to core participants in the Inquiry; and why inquiries are not required to be, and this Inquiry is not, chaired by a judge or lawyer. If legal proceedings were conducted in a forum with these features, they would arguably be contrary to the principles of natural justice, procedural fairness and, where applicable, article 6(1) of the Convention (the right to a fair trial).
34. The inappropriateness of the Inquiry as a forum for determining whether article 3 was breached at Brook House is apparent from the oral submissions that were made to the Inquiry on behalf of certain participants on 5 April 2022. For example, in response to the CTI Note, Stephanie Harrison QC³⁶ made submissions as to why she says that article 3 applies differently in the context of an immigration removal centre as compared to the cases cited in the CTI Note, which related to prisons. She argued that “*the minimum threshold of severity under article 3 is different where the detention arose from a discretionary power and where its exercise is unlawful because it is in breach of policy and safeguards*”³⁷.
35. In light of this submission, in order to rule on whether article 3 was violated in relation to any given allegation of mistreatment, the Chair would be required to:

³⁶ On behalf of D1527, D523, D2077, D1538, D313, D1914 and Reverend Nathan Ward.

³⁷ Stephanie Harrison QC [5 April 2021 28/16-21](#).

- (1) First, determine whether Ms Harrison's submission as to the proper approach to article 3 is correct. That would involve the interpretation of complex and contested caselaw, including from the European Court of Human Rights.
 - (2) Second, if the Chair accepts that Ms Harrison's submission is correct, it would appear to be necessary for the Chair to determine whether the detention of each relevant detainee was lawful and in accordance with the policies in place at the relevant time before deciding whether the minimum level of severity was reached. This is likely to involve complex questions of domestic law as can be seen, for example, from the judgment in *R (MA (Sudan)) v Secretary of State for the Home Department* [2015] EWHC 1354 (Admin).
36. These are matters which only a court could determine following detailed argument on the law from counsel. They clearly demonstrate why the Inquiry is an inappropriate forum for determining whether article 3 was violated.
37. There are additional reasons why, in the particular circumstances of the present Inquiry (over and above the compelling more general factors already outlined), the Inquiry should not make such a determination:
38. **First**, the Inquiry has made very clear to the principal public authority core participant (the Home Office) and, it is understood, to G4S that cross examination of those who have made complaints of mistreatment is not permitted and the asking of any Rule 10 questions has been heavily restricted. By way of examples only:
- (1) In respect of D668, all 49 Rule 10 questions were rejected and the Home Office was told that, in respect of most of these questions the issues "*will be covered by CTI in questioning generally*" or that a question would not be asked but the witness would merely "*be asked to comment, if he wishes to do so*" in general terms³⁸
 - (2) In respect of D1851, the witness had submitted a witness statement in civil proceedings where he had said "*They used so much force at one stage I thought they had broken my hand. I was in a lot of pain and I was screaming for them to just release the pressure, but they ignored me*"³⁹. The Home Office proposed a question that

³⁸ Response by the Inquiry of 05/12/21

³⁹ DL0000086_0021 para 63

challenged the witness on the inconsistency of that with his evidence to the Inquiry (his statement made no mention of physical injury⁴⁰ and his ultimate oral evidence made very clear that he did not sustain any such injury⁴¹). This question was rejected on the following basis: *"The Chair does not consider that these questions should be put to this witness. The extent of the witnesses statement is not relevant to the Inquiry's terms of reference"*⁴².

- (3) In respect of D191, the Home Office sought to ask a series of questions of Mr Macpherson concerning the dental treatment that D191 had received (requesting at the same time that relevant entries which were redacted as "Sensitive/Irrelevant" were unredacted as rebuttal evidence to §65 of Mr Macpherson's witness statement⁴³). These were rejected and the Home Office were told *"CTI will ask open questions about how the witness came to know that D191's dental treatment was delayed"*⁴⁴, thereby removing any testing of the evidence.

39. The rejection of cross examination and probing questions to those who have made accusations of mistreatment is a matter for the Chair. As Sir Thomas Bingham MR observed in *Crampton and others v Secretary of State for Health* (1993) (unrep.) *"It does not follow that the procedures suitable for inter-partes litigation or criminal prosecution are by any means necessarily appropriate for a fact finding exercise intended to result in management recommendations, a task quite unlike that which is entrusted to a court of law"*. However, conducting the Inquiry in this way means that the usual safeguards are not present which are vital in adversarial proceedings of the kind where civil liability is determined following contested factual accounts. This is a fundamental matter of fairness in any such proceedings⁴⁵.

⁴⁰ [DL0000143](#)

⁴¹ D1851 [3 December 2021 92/4-8](#)

⁴² Response by the Inquiry of 03/12/21

⁴³ [INQ000027_0016](#) para 65

⁴⁴ Response by the Inquiry of 08/12/21

⁴⁵ It is assumed that Counsel to the Inquiry (i.e. those barristers who asked questions of witnesses) will play no part in the actual drafting of the Inquiry Report. Plainly any involvement of counsel in respect of the Report would be a significant further reason to justify the Home Office's position in respect of Article 3 ECHR and any such involvement would need to be disclosed as a matter of candour.

40. **Second**, set against the inability to cross examine complainants was the robust cross examination of Home Office and other ‘accused’ witnesses, often as the default form of questioning.
41. **Third**, a great deal of evidence has been adduced on behalf of those who were detained in the form of written statements or summaries which have not been tested. In some cases the evidence of a formerly detained person’s solicitor has simply been read rather than obtaining a statement from the individual themselves. In ordinary proceedings these individuals would have to satisfy the court that the witnesses were not competent to give evidence (and there would be no question of a solicitor or other representative being able to provide evidence *on behalf of* their client in the way that has been permitted in this Inquiry). Similarly, medical reports have been accepted into evidence without any testing whatsoever, whereas there may well be competing (or at least jointly instructed) expert evidence in a contested trial⁴⁶.
42. **Fourth**, the Inquiry has not established sufficient evidence on which to form conclusions in respect of matters that would be highly relevant to legal determinations. By way of an example, in order to establish whether the failure to complete a Rule 35 report (or an alleged mishandling of such a report) should have led to the release of an individual (which appears to form part of the article 3 arguments of some Core Participants, albeit decision to detain are outside the TORs) there would have to be careful scrutiny of matters such as the offending history of the individual to identify the level of risk of harm to the public posed by release.
43. The Home Office set out its position in this respect clearly in correspondence with the Inquiry on 22 February 2022 (on receipt of two detailed witness statements of some 90 pages in length from D643 and D1914 both of whom had significant relevant criminal convictions), namely: *“Prior convictions can be relevant to both decisions to detain/continue detention and the perception of detention officers of threats posed. In any case, where the Inquiry has redacted that offending history, the Chair will not be able to fairly reach any conclusions as to the appropriateness of responses to Rule 35 reports and, where the reasonableness of resort*

⁴⁶ It is understood, for example, that in respect of D1851 there is a second psychiatric report which has been filed by the Home Office in civil proceedings which has a significantly different conclusion to the report that was prepared for his representatives. Whilst the Home Office confirmed to the solicitors representing D1851 that it had no objection to their disclosing the documents from the civil proceedings to the Inquiry, this second psychiatric report does not appear to have been uploaded onto the Inquiry’s document management system and has not been adduced in evidence (assuming it was disclosed).

to/use of force is raised by a custody officer, more finely balanced uses of force. If the Chair is not intending to reach these kinds of conclusions, then so be it, but it behoves the Home Office to draw this to the Chair's attention at this stage rather than waiting until the evidence has concluded".

44. In highlighting these features of the Inquiry, the Home Office does not suggest that the Inquiry is unable to fairly make conclusions but the above factors emphasise why such conclusions cannot and should not be framed in a way that is suggestive of a legal determination.

(ii) DISTINGUISHING FACTUAL FINDINGS FROM LEGAL DETERMINATIONS

45. As set out above, nothing in the foregoing is intended to suggest that the Inquiry is not entitled to make detailed factual findings, and express factual judgements, in relation to all allegations of serious mistreatment at Brook House. The Home Office accepts that this is the proper role of the Inquiry, and further accepts that the factors listed in paragraph 24(a)-(j) of the CTI Note are appropriate questions to which the Chair may properly have regard when reaching her factual conclusions.
46. These factual findings may be highly relevant to the legal question of whether article 3 was violated, and the Chair is not restricted from finding facts from which liability may be *inferred* as is made clear by section 2(2) of the 2005 Act. However, contrary to the suggestion in the CTI Note (see, for example, paragraphs 8 and 24(k)), the Inquiry must stop short of reaching any conclusions on that legal question itself.
47. There has been fairly limited judicial consideration of exactly what section 2 of the 2005 Act does and does not prevent the Inquiry from concluding. However, section 2 was the subject of a judicial review permission decision in a case relating to the terms of reference in the Billy Wright Inquiry.
48. The terms of reference of the Billy Wright Inquiry provided that the inquiry would determine "*whether any wrongful act or omission... facilitated [Billy Wright's] death*" and "*whether any such act or omission was intentional or negligent*". The claimants argued that the terms of reference fell foul of section 2(1) because they necessarily required the inquiry to make findings on civil and/or criminal liability. However, during the pre-

action stage the Inquiry confirmed that it would not and could not make such a determination.

49. This concession made by the chairman was reflected in the report of the Billy Wright Inquiry in the following terms⁴⁷:

"The Terms of Reference do, of course, use the word 'negligent' and other terms such as 'wrongful act or omission' and 'facilitated'. However, in view of what has been said previously, and given the terms of section 2 of the 2005 Act, the Inquiry has considered these expressions and indeed all of the words used in the Terms of Reference in a non-technical and non-legal sense only.

... In considering whether an act or omission is wrongful, as indicated above, the Inquiry has considered that term in a non-technical and non-legal way and taken it to mean unjustified, inappropriate, erroneous or simply wrong."

50. It goes without saying that it would not be conceptually possible to make a finding as to whether article 3 was violated at Brook House in anything other than a technical and legal sense. A finding in terms that article 3 had been violated would straightforwardly be *ultra vires* the Inquiry's powers for the reasons given above.
51. However, the *Billy Wright* case also supports a further proposition. That is that significant care should be taken by the Inquiry if it intends to use the language of article 3 – in particular, the words "inhuman", "degrading" or "torture". If these words were to be used by the Inquiry it should at the very least be made clear that they are being used in a non-technical and non-legal sense. The detailed references to the jurisprudence of the European Court of Human Rights in the CTI Note indicate a clear intention to interpret these terms in a "legal" sense. In that context, it appears likely that any use of the language of article 3 would run a significant risk of giving the misleading impression that the role of the Inquiry is to adjudicate on whether article 3 was breached.
52. That the Chair should avoid using the language of article 3 in her report is further supported by the case law and guidance relating to inquests and the analogous prohibition on making determinations of liability in section 10(2) of the 2009 Act. This provision, and its predecessor in rule 42 of the Coroners Rules 1984, have received greater judicial consideration than section 2 of the 2005 Act.

⁴⁷ [Billy Wright Inquiry Report](#) at 1.29.

53. In *R (Jamieson) v North Humberside Coroner* [1995] QB 1, Sir Thomas Bingham MR noted that inquest verdicts which attribute a death to a “lack of care” led to “an almost inevitable confusion between this expression and the lack of care which is the foundation for a successful claim in common law negligence” (p.25). To avoid this confusion, he said that “[i]t is to be hoped that in future the expression “lack of care” may for practical purposes be deleted from the lexicon of inquests and replaced by “neglect””.
54. Section 10(2) was considered recently by the Divisional Court in *R (GS) v Wiltshire and Swindon Senior Coroner* [2020] 1 WLR 4889. It held that the following directions given by Sir John Goldring to the jury in the inquest into the Hillsborough Stadium disaster were “plainly correct as a statement of what section 10(2) does and does not prohibit” (§81):
- “(f) You should not say anything to the effect that a crime or a breach of civil law duty of any kind has been committed. Note that this rule does not affect your answer to question 6 [whether those who died in the disaster were unlawfully killed]. Because of this rule, when writing any explanations, you should avoid using words and phrases such as ‘crime/criminal’, ‘illegal/unlawful’, ‘negligence/negligent’, ‘breach of duty’, ‘duty of care’, ‘careless’, ‘reckless’, ‘liability’, ‘guilt/guilty’.
- (g) However, you may use ordinary and non-technical words which express factual judgments. So, you may say that errors or mistakes were made and you may use words such as ‘failure’, ‘inappropriate’, ‘inadequate’, ‘unsuitable’, ‘unsatisfactory’, ‘insufficient’, ‘omit/omission’, ‘unacceptable’ or ‘lacking’. Equally, you may indicate in your answer if you consider that particular errors or mistakes were not made. You may add adjectives, such as ‘serious’ or ‘important’, to indicate the strength of your findings.”
55. Sir John Goldring’s directions are also consistent with the Chief Coroner’s guidance on “Conclusions: Short-form and narrative” (14 January 2016), the most relevant parts of which read as follows:
- “52. Permitted judgmental words include ‘inadequate’, ‘inappropriate’, ‘insufficient’, ‘lacking’, ‘unsuitable’, ‘unsatisfactory’, and ‘failure’. It is unlawful to direct a jury in an Article 2 case in such a way that they were prevented from entering ‘a judgmental conclusion of a factual nature’. Wording denoting causation such as ‘because’ and ‘contributed to’ are permissible.
53. On the other hand words which suggest civil liability such as ‘negligence’, ‘breach of duty’, breach of Article 2 and ‘careless’ are not permitted as they may breach Section 10(2), 2009 Act.”

56. It is respectfully submitted that this is useful guidance in the present Inquiry. The Chair can undoubtedly use judgmental language. However, it would be outside of the powers of the Inquiry to go further than this and use language which indicates not merely a factual finding but also the determination of a question of law or liability and a clear statement to the effect that terminology is being used in a “*non-technical and non-legal sense*” would help to avoid any breach of section 2 of the 2005 Act.

(iii) INTERPRETING ARTICLE 3 ECHR

57. Without prejudice to the Home Office’s position on the Inquiry’s role outlined above, for completeness, the Home Office makes the following observations on the proper approach to interpreting article 3.
58. The approach outlined in §§20-21 and 24(k) of the CTI Note suggests that the starting point is to consider whether treatment attained a minimum level of severity to amount to torture, and then consider “*further or alternatively*” whether the treatment was inhuman or degrading. This is contrary to the approach of the ECtHR, which considers first whether the threshold of inhuman or degrading treatment or punishment is met and then, only if it is, does it go on to consider whether that treatment should be classed as torture: see, for example, *Selmouni v France* (2000) 29 EHRR 403, §§99-105.
59. The first question, therefore, is whether the punishment or treatment attains a “*minimum level of severity*” to amount to inhuman or degrading treatment. This has to be assessed in the light of all the circumstances of the case. The relevant circumstances may include: the duration of the treatment; its physical or mental effects; the sex, age and state of health of the victim; the purpose for which the treatment was inflicted and the intention or motivation behind it; and the context in which it occurred (e.g. an atmosphere of heightened tension and emotion): *Gäfgen v Germany* (2011) 52 EHRR 1, §88; *R (AB) Justice Secretary* [2021] 3 WLR 494, §40.
60. Paragraph 22 of the CTI Note states that treatment or punishment is inhuman “*if it causes intense physical or mental suffering*” and treatment is degrading if it “*arouses feelings of fear, anguish and inferiority capable of humiliating and debasing*”. This represents only part of the definitions found in the judgments of the ECtHR. The complete language consistently

used by the European Court can be seen, for example, in *Hajrulahu v Macedonia* (2018) 67 EHRR 23 at §97:

*"Treatment has been held by the Court to be "inhuman" because, inter alia, it was premeditated, was applied for hours at a stretch and caused either actual bodily injury or intense physical and mental suffering. Treatment has been considered "degrading" when it was such as to arouse in its victims feelings of fear, anguish and inferiority capable of humiliating and debasing them and possibly breaking their physical or moral resistance."*⁴⁸

61. In order to be inhuman or degrading the relevant suffering or humiliation must go beyond that which is inevitable with a given form of legitimate treatment or punishment: *Hajrulahu*, §98. Measures depriving a person of their liberty may often involve such an inevitable element and this will not, on its own, amount to a violation of article 3: *Kudla v Poland* (2002) 35 EHRR 11, §93.
62. Further, the fact that an individual has been treated badly does not necessarily mean that their rights under article 3 have been violated. The ECtHR has regularly reiterated that it is *"attentive to the seriousness that attaches to a ruling that a Contracting State has violated fundamental rights"*: see, for example, *Nachova v Bulgaria* (2006) 42 EHRR 43, §147. Treatment may be condemned on moral grounds, and under the domestic law of contracting states, without attaining the minimum level of severity required to constitute a violation of the fundamental right protected by article 3: *Ireland v UK* (1979-80) 2 EHRR 25, §167.
63. Accordingly, the *"minimum level of severity"* required to amount to inhuman or degrading treatment or punishment sets a high bar. Further, it is only if it is concluded that this already high bar has been reached, and therefore article 3 has been violated, that it becomes necessary to consider the further question of whether that treatment amounts to torture. The ECtHR has consistently held that when determining whether a particular form of ill-treatment should qualify as torture, consideration must be given to the distinction that the Convention draws between torture and other forms of inhuman or degrading treatment. It has held that torture attracts *"special stigma"* and has described it as the deliberate inhuman treatment which causes very serious and cruel suffering: *Selmouni v France* (2000) 29 EHRR 403, §96, 100.

⁴⁸ See also, for example, *Gäfgen v Germany* (2011) 52 EHRR 1, §89; *Yagiz v Turkey* (2014) 59 EHRR 4, §36.

(iv) THE STANDARD OF PROOF AND ROLE OF ORAL EVIDENCE

64. The CTI Note states that its intention is to “*inform Core Participants about Counsel to the Inquiry’s suggested approach to the making of findings of fact*” (§1). It outlines the “*variable and flexible approach to the standard of proof*” favoured by Sir Christopher Pitchford in the Undercover Policing Inquiry and Sir William Gage in the Baha Mousa Inquiry when making their factual findings (§§10-15) and suggests that the Chair should adopt the same approach (§§18(a)-(c)).
65. The Home Office has no objection to the approach outlined in the CTI Note as to the standard of proof to be applied when making findings of fact. The 2005 Act does not prescribe any particular standard of proof to be adopted by the Inquiry. The suggested approach appears reasonable and in-keeping with the approach taken in other recent public inquiries. Indeed, one of the very reasons why the standard of proof is not narrowly proscribed is because the Inquiry is not making legal determinations and is not, for example, finding whether ECHR rights have been “*violated*” or “*breached*”.
66. However, the Home Office wishes draw the attention of the Chair to the following additional considerations which should guide the Chair’s determinations:
67. **First**, there is the often repeated caution against undue reliance on witness evidence. In the case of *Gestmin SGPS SA v Credit Suisse (UK) Ltd & Anor* [2013] EWHC 3560 (Comm), Mr Justice Leggatt observed (at §§15 to 22) that witness evidence, based on recalled events that occurred several years in the past (or longer), is limited by the “*unreliability of human memory*”. It is helpful to quote from this judgment at some length:

“While everyone knows that memory is fallible, I do not believe that the legal system has sufficiently absorbed the lessons of a century of psychological research into the nature of memory and the unreliability of eyewitness testimony. One of the most important lessons of such research is that in everyday life we are not aware of the extent to which our own and other people’s memories are unreliable and believe our memories to be more faithful than they are. Two common (and related) errors are to suppose: (1) that the stronger and more vivid is our feeling or experience of recollection, the more likely the recollection is to be accurate; and (2) that the more confident another person is in their recollection, the more likely their recollection is to be accurate.

Underlying both these errors is a faulty model of memory as a mental record which is fixed at the time of experience of an event and then fades (more or less slowly) over time. In fact, psychological research has demonstrated that memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is true even of so-called 'flashbulb' memories, that is memories of experiencing or learning of a particularly shocking or traumatic event ... External information can intrude into a witness's memory, as can his or her own thoughts and beliefs, and both can cause dramatic changes in recollection. Events can come to be recalled as memories which did not happen at all or which happened to someone else ...

Memory is especially unreliable when it comes to recalling past beliefs. Our memories of past beliefs are revised to make them more consistent with our present beliefs. Studies have also shown that memory is particularly vulnerable to interference and alteration when a person is presented with new information or suggestions about an event in circumstances where his or her memory of it is already weak due to the passage of time.

A witness is asked to make a statement, often (as in the present case) when a long time has already elapsed since the relevant events ... The statement is made after the witness's memory has been "refreshed" by reading documents. The documents considered often include statements of case and other argumentative material as well as documents which the witness did not see at the time or which came into existence after the events which he or she is being asked to recall ... The effect of this process is to establish in the mind of the witness the matters recorded in his or her own statement and other written material, whether they be true or false, and to cause the witness's memory of events to be based increasingly on this material and later interpretations of it rather than on the original experience of the events.

... This does not mean that oral testimony serves no useful purpose – though its utility is often disproportionate to its length. But its value lies largely, as I see it, in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth'."

68. This caution has been repeated in a wide range of legal contexts. For example in the divorce case of *Lachaux v Lachaux* [2017] EWHC 385 (Fam) Mostyn J cited extensively from *Gestmin* and further approved of the following (at §36):

"Witnesses, especially those who are emotional, who think that they are morally in the right, tend very easily and unconsciously to conjure up a legal right that did not exist. It is a truism, often used in accident cases, that with every day that passes the memory becomes fainter and the imagination becomes more active. For that reason, a witness, however honest, rarely persuades a judge that his present recollection is preferable to that which was taken down in writing immediately after the accident occurred. Therefore, contemporary documents are always of the utmost importance. And lastly, although the honest witness believes he heard or

saw this or that, is it so improbable that it is on balance more likely that he was mistaken? On this point it is essential that the balance of probability is put correctly into the scales in weighing the credibility of a witness."

69. An uncontentious example of this (the Chair will no doubt determine for herself the more contentious examples which concern allegations of actual mistreatment) may be the evidence of D668 in respect of the audio recording of his PSU interview. D668's evidence was as follows:

"Q. Was it audio recorded?

A. Yes, audio recorded. We agree about that. Surprisingly, from that day until now, I didn't receive anything.

Q. So you've never heard the recording?

A. Nothing."

70. The evidence that D668 had not received the audio recording (which was fundamental to several assertions that the transcript of interview was inaccurate) was stated with the same confidence as the rest of his evidence and the witness may well have had an honest belief in its truth. However, the audio recording was provided by the PSU, as shown in clear and unchallenged evidence⁴⁹.

71. It goes without saying that it is the contemporaneous evidence, such as the undercover footage, body-worn camera and other footage, minutes and CID entries that will play a significant role in the factual findings in the present case. The above passages from *Gestmin* and similar cases will be relevant to the Chair's consideration of all witness evidence, in particular evidence based on witness statements which were drafted several years after the underlying incidents. As Leggatt J cautioned: *"A witness is asked to make a statement, often (as in the present case) when a long time has already elapsed since the relevant events. The statement is usually drafted for the witness by a lawyer who is inevitably conscious of the significance for the issues in the case of what the witness does nor does not say."* There are many examples of witness statements which have plainly had significant involvement of legal representatives.

⁴⁹ Evidence of Helen Wilkinson [HOM0332047_0012](#) para 42. This was also pointed out in correspondence with Duncan Lewis, copied to the Inquiry in order to ensure an opportunity for rebuttal.

72. **Second, where there is to be reliance on witness evidence**, there is the general rule that oral evidence given under cross-examination is the gold standard because it reflects the long-established common law consensus that the best way of assessing reliability of evidence is by confronting the witness. The vulnerability of a witness – absent clear evidence that they lack capacity – is not a good reason not to call that witness to give oral evidence, even if special measures need to be put in place to make that possible.
73. In *Carmarthenshire CC v Y* [2017] 4 WLR 136, for example, the complainant in care proceedings was detained in a psychiatric hospital and there was compelling, unchallenged medical evidence that it would be very harmful for her to give oral evidence in court. The court held that in the absence of oral evidence, in particular the lack of opportunity for the parents to confront her with her manifold inconsistencies, the court could not be satisfied that it was more likely than not that the father abused his daughter in the manner alleged. The following passages from that judgment are particularly relevant (at §§8-9 and 14-16):

“It is because it reflects the long-established common-law consensus that the best way of assessing the reliability of evidence is by confronting the witness. In Crawford v Washington (2004) 124 S Ct 1354, para 62 Scalia J, when discussing the explicit command to afford cross-examination of witnesses in criminal cases contained within the Sixth Amendment to the US Constitution, stated:

“To be sure, the clause's ultimate goal is to ensure reliability of evidence, but it is a procedural rather than a substantive guarantee. It commands, not that evidence be reliable, but that reliability be assessed in a particular manner: by testing in the crucible of cross-examination. The clause thus reflects a judgment, not only about the desirability of reliable evidence (a point on which there could be little dissent), but about how reliability can best be determined. Cf 3 Blackstone, Commentaries, at 373 (“This open examination of witnesses ... is much more conducive to the clearing up of truth”); M Hale, History and Analysis of the Common Law of England 258 (1713) (adversarial testing ‘beats and bolts out the truth much better’).”

It should not be thought that this consensus or viewpoint is confined to criminal causes. Thus, in Goldberg v Kelly (1970) 397 US 254, a case about the entitlement to receive certain federal welfare benefits, Brennan J stated, at p 269: “In almost every setting where important decisions turn on questions of fact, due process requires an opportunity to confront and cross-examine adverse witnesses.

...

Of course, in some circumstances cross-examination will be impossible. For example, the complainant may be dead, or a child. In care proceedings, it is rare to allow any children to give

oral evidence under cross-examination, in sharp contrast to criminal proceedings...In such circumstances the court must do the best it can with hearsay evidence from the complainant, although the reliability of that evidence will, for the reasons given above, be markedly inferior to properly tested testimony.

*But the reasons given by Baroness Hale JSC for confining the cross-examination of children do not apply to capacitous adults, even if they are vulnerable, as the decision in *In re J* demonstrates. In that case there was an earlier excursion to the Supreme Court – see *In re A (A Child)* (Family Proceedings: Disclosure of Information) [2012] UKSC 60; [2013] 2 AC 66. At para 36, Baroness Hale JSC stated:*

*“If any party wishes to call X to give oral evidence, up to date medical evidence can be obtained to discover whether she is fit to do so. There are many ways in which her evidence could be received without recourse to the normal method of courtroom confrontation. Family proceedings have long been more flexible than other proceedings in this respect. The court has power to receive and act upon hearsay evidence. It is commonplace for children to give their accounts in videotaped conversations *5 with specially trained police officers or social workers. Such arrangements might be extended to other vulnerable witnesses such as X. These could include the facility to have specific questions put to the witness at the request of the parties. If she is too unwell to cope with oral questioning, the court may have to do its best with her recorded allegations, perhaps supplemented with written questions put to her in circumstances approved by Dr W. On the other hand, oral questioning could be arranged in ways which did not involve face to face confrontation. It is not a requirement that the father be able to see her face. It is, to say the least, unlikely that the court would ever allow direct questioning by the father, should he still (other than in this court) be acting in person. The court's only concern in family proceedings is to get at the truth. The object of the procedure is to enable witnesses to give their evidence in the way which best enables the court to assess its reliability. It is certainly not to compound any abuse which may have been suffered.”*

It is implicit in this passage that the reliability of evidence is best assessed by direct oral questioning, and this, of course, reflects the age-old consensus to which I have referred.”

74. In the present Inquiry, not only has cross-examination of those who were detained been prohibited, but a vast amount of evidence has been read into the record without those individuals even being called to give oral evidence.
75. The Home Office accepts that in some cases the giving of oral evidence can be extremely difficult, but there is a significant difference between that and lacking the capacity to do so. By way of example, D687 attended many hearings sitting in the public gallery whilst relying on a statement that has been prepared by his solicitors⁵⁰. It must be stressed that

⁵⁰ [DPG000021_001](#) para 3.

the Home Office is not seeking to undermine the medical report that has been provided on his behalf in respect of his ability to give evidence, but even that report recorded that the witness had capacity to give oral evidence⁵¹ and the Inquiry will therefore have to bear in mind the repeated caution expressed by the Courts with regard to reliance on untested written evidence.

76. **Third**, there is the “*inherent improbability concept*”. Sir William Gage’s Ruling on the Standard of Proof in the Baha Mousa Inquiry stated as follows (at §20):

“I recognise that in relation to some issues in this Inquiry, the more serious the allegation the more cogent must be the evidence to support a finding of wrongdoing... I think that the usual starting point will be to apply the civil standard but taking account of the ‘inherent improbability’ concept where it properly applies.”

77. By the “*inherent improbability*” concept, Sir William was referring to a well-established principle that applies when the courts are making findings on the balance of probabilities. It was expressed by Lord Nicholls in the case of *Re H* [1996] AC 563 in the following terms (at p.586):

“The balance of probability standard means that a court is satisfied an event occurred if the court considers that, on the evidence, the occurrence of the event was more likely than not. When assessing the probabilities the court will have in mind as a factor, to whatever extent is appropriate in the particular case, that the more serious the allegation is the less likely it is that the event occurred and, hence, the stronger should be the evidence before the court concludes that the allegation is established on the balance of probability. Fraud is usually less likely than negligence. Deliberate physical injury is usually less likely than accidental physical injury. A step-father is usually less likely to have repeatedly raped and had non-consensual oral sex with his under age stepdaughter than on some occasion to have lost his temper and slapped her. Built into the preponderance of probability standard is a generous degree of flexibility in respect of the seriousness of the allegation.

Although the result is much the same, this does not mean that where a serious allegation is in issue the standard of proof required is higher. It means only that the inherent probability or improbability of an event is itself a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred. The more improbable the event, the stronger must be the evidence that it did occur before, on the balance of probability, its occurrence will be established.”

⁵¹ DPG000006_0047 para 211

78. In *In re S-B (Children)* [2010] 1 AC 678, Baroness Hale described the principle in the following terms at §11:

"If an event is inherently improbable, it may take better evidence to persuade the judge that it has happened than would be required if the event were commonplace."

79. It is suggested that consistent with the approach taken in the Baha Mousa Inquiry, the Chair should take account of the *"inherent improbability"* concept when making her findings in accordance with the variable and flexible approach to the standard of proof. Allegations of deliberate mistreatment, in particular deliberate physical injury, undoubtedly call for such an approach.
80. An example that can be used to draw all three of these points together is the case of D1851. In civil proceedings that have been instigated by this individual, D1851 relied upon a written statement of another detained person, D390 which stated that *"the guards proceeded to hit me with their batons and shields"*. In the same proceedings D1851 filed his own statement, referred to above, in which he had said *"They used so much force at one stage I thought they had broken my hand. I was in a lot of pain and I was screaming for them to just release the pressure, but they ignored me"*⁵². Had that untested written evidence been accepted in this Inquiry, the Chair would have been significantly misled as to the level of force used both on D390 and D1851. Applying the above principles:

- (1) **Caution against undue reliance on witness evidence** – the contemporaneous video footage that was shown during the Inquiry clearly established that D390 had not been hit by batons, indeed that there were no batons at all. The contemporary evidence was more reliable than the witness's recollection.
- (2) **Oral evidence given under cross-examination is the gold standard** – whilst D1851 was not 'cross-examined', even gentle examination of this witness identified that, contrary to the earlier written statement which suggested significant force and injury, in fact he did not sustain any injury⁵³.
- (3) **The inherent improbability concept** – quite rightly, given how these two allegations were undermined, this is a good lesson in why a finding of deliberate

⁵² DL0000086_0021 para 63

⁵³ D1851 [3 December 2021 92/4-8](#)

physical injury would require strong evidence before the Inquiry concludes that an allegation is established on the balance of probability.

81. As an investigative and inquisitorial Inquiry, and in circumstances where the actions are those of officers employed by a contractor, the Home Office does not seek to play the role of defence to the allegations that are made in the present case. However, the Home Office does ask that the Chair adopts the above approach in her careful scrutiny of the evidence.

(v) OTHER MATTERS OF EVIDENCE

82. The Inquiry has received some evidence in the form of anonymous case studies. This includes case studies carried out by Freedom from Torture and also by GDWG. It is important to note that whilst the Inquiry can take into account anonymous case-studies as part of a wider tapestry, it should not make specific findings based on the individual anonymised cases: see *R (Associated Newspapers Ltd) v The Rt Hon Lord Justice Leveson (As Chairman of the Leveson Inquiry)* [2012] EWHC 57 (Admin) at §56.
83. Further, where the Inquiry is seeking to place any reliance on such studies it should, of course, also take into account that the Home Office is unable to test these cases without knowledge of the identities of the individuals, so the evidential weight must be limited.

III. KEY ISSUES IN DISPUTE

84. It is impossible, without producing a closing statement that is unmanageably long, to address each and every issue which has been identified during the Inquiry. The Home Office has attempted to address some of the key issues below and, should the Chair require assistance with or identification of the Home Office's position on further issues, the Home Office is happy to produce further targeted submissions⁵⁴.

⁵⁴ There are, of course, also matters that the Inquiry has confirmed are **outside** the scope of its investigation. This includes, for example, "*immigration decisions and applications for asylum and/or immigration*" (05/12/21 response by the Inquiry to the Home Office's Rule 10 application) and treatment by Tascor officers (02/12/21 response by the Inquiry to the Home Office's Rule 10 application).

(i) HOME OFFICE AND INSTITUTIONAL CULTURE

85. Whilst no Home Office civil servant is accused of physical or verbal abuse of those who were detained, there is a broader suggestion that the Home Office were somehow part of an overall culture which contributed to mistreatment. The Home Office does not accept this suggestion and asks the Chair to take into account the range of evidence which suggest that the Home Office acted with compassion in respect of those detained at Brook House; had a good reputation insofar as other detention facilities was concerned; and operated with a culture that invited scrutiny.
86. Owen Syred's evidence in this respect is important as he was plainly an individual who cares a great deal for the welfare of those who are detained. He explained⁵⁵:

"I had a unique insight into Home Office colleagues because of my secondment. I got on well with Home Office staff and they always behaved professionally. The relationship between Home Office staff and detainees improved while I was at Brook House. At first, Home Office staff didn't like to attend the Wings because they felt intimidated. Home Office staff would meet detainees to inform them that their claim to remain in the UK had been refused, and this would often result in the detainee kicking off. However, as part of the returns pilot I was able to act in a liaison capacity and to explain the Home Office processes and their decisions to detainees on the Wing on behalf of the Home Office and this took a lot of pressure off Home Office colleagues. Debbie Smith, the Home Office manager with responsibility for Brook House, commented that there was a need for this role in every detention centre. Through better collaboration between the Home Office, G4S staff, and the detainees, for example at the weekly focus groups which all three groups attended, Home Office staff started to feel more at ease in the centre and this improved relations between the Home Office and detainees.

The Home Office had a difficult job to do but they behaved with compassion. I can recall an Eritrean national, who had fled Eritrea because of the civil war in which his family had been killed, who had also been subject to abuse while in transit to the UK. I assisted this detainee to complete the form to claim asylum and personally delivered it to the Home Office. The claim for asylum was granted and the Home Office officer who administered the claim, commented that it was cases like this that made the job worthwhile"

87. He referred to helpful meetings of the Welfare Teams, observing⁵⁶:

"The Home Office Manager, Debbie Weston, organised quarterly meetings between different IRC Welfare Teams. I can recall attending these meetings at Harmondsworth, Morton Hall,

⁵⁵ [INN000007_0023](#) paras 97 and 98.

⁵⁶ [INN000010_0003](#) para 8

and, I think, The Verne. Welfare representatives from Brook House, Tinsley House, Colnbrook, The Verne, Morton Hall, Yarl's Wood, and Dungavel House would attend these meetings. We would discuss the subjects of the voluntary returns pilot, and any changes to Home Office procedures. We also shared statistics and good practice, and it was helpful to build relationships with colleagues who were performing the same role."

88. Many witnesses spoke positively about the other facilities which were ultimately run by the same teams at the Home Office. Mr Syred observed that the welfare facilities at Harmondsworth were impressive⁵⁷ and he said that *"Tinsley Staff were very different. They obviously were working with a different type of detainee and they almost, like, had a better team going there"*⁵⁸. Callum Tulley similarly saw a difference with Tinsley House staff, observing *"Tinsley House was a much more humane and appropriate environment"*⁵⁹. Jamie Mcpherson of GDWG commented⁶⁰:

"I have been to Tinsley House on a number of occasions. Yes, it was like chalk and cheese. They were totally different. The situation at Tinsley House was much more relaxed. There was – for instance, going in as a visitor, there was one locked door to go through rather than four. The staff in the visits hall at Tinsley House didn't patrol around the room; they just sat behind the desk. Generally, the staff were friendly, helpful, they would come up and ask if they could assist with anything if there were any issues."

89. The messaging during training courses also focused on the wellbeing of those who were detained. As Callum Tulley observed⁶¹:

"The messaging on the training course was that a detainee should be treated with respect. We were told to use force only when necessary and so on...the DCO's I'd met on my training course, many of them seemed like good people. The ACO's I'd worked with didn't seem capable of such behaviour".

90. When one looks at the culture in the Home Office it is important to bear in mind that Brook House was just one facility and one which, on the evidence that the Inquiry has heard, stood apart from the rest.

⁵⁷ Owen Syred [7 December 2021 31/17](#)

⁵⁸ Owen Syred [7 December 2021 103/17](#)

⁵⁹ Callum Tulley [30 November 2021 91/2-15](#)

⁶⁰ Jamie Mcpherson [8 December 2021 232/8](#)

⁶¹ Callum Tulley [29 November 2021 84/10-22](#)

91. It is also important to bear in mind that the treatment shown on the Panorama broadcast, and in some of the cases which have been identified by the Inquiry, were not experiences shared by everyone. As Owen Syred said⁶²:

"A Home Office manager got in touch with me following the documentary because I had experience of Home Office focus groups. The Home Office set up some focus groups with detainees, and I attended together with colleagues from religious affairs and the chaplaincy team. The purpose was to provide information to detainees about the action that would be taken in response to the issues identified in the documentary. An investigation was promised, and it was explained that rogue officers were the cause. Many detainees commented in the focus groups that the incidents shown in the documentary were not typical of their experience, and that in general they had been treated fairly, and that staff were helpful and polite. I took part in two or three focus groups (7 or 8 detainees in each group). I was also asked by the Home Office to engage with detainees on an individual basis to obtain feedback, and this was generally the same, namely that the documentary was not representative of their experience."

92. Even amongst the officers at Brook House, there was undoubtedly a range. Owen Syred explained: *"Some staff had massive compassion and some staff had absolutely none."*⁶³ Callum Tulley's evidence was that *"the majority of DCO's weren't abusive. Many of them were hardworking decent people"*⁶⁴ and that the majority of DCOs *"were good people"*⁶⁵. He acknowledged that the same was true for some of the DCMs and highlighted the good, indeed *"inspiring"*, practice of DCM Stuart Povey-Meier. Whilst Mr Tulley was undoubtedly critical of the culture and environment at Brook House he did acknowledge that *"there were so many staff members that were able to remain professional in the environment that they found themselves in"*⁶⁶. Anton Bole of the Forward Trust had never received a report of mistreatment and considered *"I don't think it was like, majority of officers involved in that"*⁶⁷ and *"it seems to me there was a clique of officers"*⁶⁸.
93. Owen Syred was of course himself based at Brook House and the welfare officers were observed by Callum Tulley as being *"helpful officers, kind and compassionate, willing to help"*⁶⁹ albeit there were undoubtedly too few of them. There was an obviously highly

⁶² [INN000007_0052](#) para 212

⁶³ Owen Syred [7 December 2021 92/8](#)

⁶⁴ [INQ000052_0017](#) para 73

⁶⁵ Callum Tulley [30 November 2021 156/15](#)

⁶⁶ Callum Tulley [30 November 2021 169/1](#)

⁶⁷ Anton Bole [8 December 2021 181/1](#)

⁶⁸ Anton Bole [8 December 2021 182/24](#)

⁶⁹ Callum Tulley [30 November 2021 145/13](#)

problematic and influential clique at Brook House during the relevant period but the Home Office asks the Chair to bear in mind this, and similar observations from witnesses.

94. Another matter that is relevant in assessing the institutional culture is how open the Home Office is to scrutiny. The Chair will recall the evidence of Dr Dominic Aitken who carried out his research at Brook House unrestricted. He said that he “*was allowed to go pretty much everywhere*” and “*was free to go around and go wherever I wanted to go*”⁷⁰. The criticisms that the Inquiry has heard from the IMB and HMIP are examples of the Home Office inviting scrutiny, as part of a wider network – including reviews carried out by Mary Bosworth, Stephen Shaw and others, to help improve the wellbeing of those who are detained.

(ii) THE CONTRACT

95. The Home Office has accepted that there were failures in that the contract did not appropriately cover the issues that arose in this case, and in the supervision of G4S’s performance of the contract⁷¹. The principal failing of the contract was that it did not allow the Home Office to categorise the abuse perpetrated by G4S staff in Panorama as a contract failure. Further, there was insufficient escalation of minor infringements of the contract, and It focused on outputs rather than the impact of the contract on residents⁷². There may have been an insufficient focus on detainee welfare⁷³. The Home Office has accepted the NAO’s observations and findings.

Contract design and procurement

96. The Inquiry has, understandably in light of contemporaneous documentation, explored in detail the way in which the original bids were assessed, and whether flaws were built into the contract at the bid stage due to the way in which bids were assessed. The Home Office has accepted that the bids at the time appeared to have done all they could to

⁷⁰ Dr Dominic Aitken [8 December 2021 56/21 to 57/23](#)

⁷¹ [HOM0332005_0006](#) para 17; Phil Riley [4 April 2022 5/19](#)

⁷² Phil Riley [4 April 2022 30/10](#)

⁷³ [HOM0332005_0008](#) para 24

reduce costs against the required specification⁷⁴, and that by 2017 the staffing levels provided for in the contract were inadequate⁷⁵.

97. As Mr Gibson explained, the contract was likely designed in 2004 or 2005⁷⁶ - some 17 years ago - and was awarded in 2008. There would have been a 'senior responsible officer' for the project, and the award of the contract would have been subject to internal approvals within the Home Office, and external approvals within the Cabinet Office and HM Treasury⁷⁷.
98. Much has changed in the intervening years since its design, not just in immigration and detention policy but in the government rules and guidance which apply to procurement of such contracts. One of the most significant changes has been to the Cabinet Office 'play book' which all central departments are expected to follow⁷⁸. Other applicable guidance includes HM Treasury's Green Book and 'Managing Public Money'⁷⁹.
99. The Home Office is rightly expected to adhere not only to the complex requirements of procurement law but also to current Cabinet Office and HM Treasury guidance when procuring a major contract⁸⁰ - there is a demanding fiduciary duty to use public money responsibly. It is government policy to award contracts on the basis of value for money. Value for money is defined as securing the best mix of quality and effectiveness for the least outlay over the period of the contract - not minimising up-front costs. The Government recognises the risk of low cost bias, even if evaluation criteria are designed to balance quality and cost. Departments are directed by the Sourcing Playbook to refer abnormally low bids to the Commercial Continuous Improvement team (see also regulation 69 of the Public Contracts Regulations 2015). Guidance on potential approaches to evaluating price warns caution in using relative price scoring rather than scoring such as 'price per quality point' which sets an absolute standard against which

⁷⁴ Phil Riley [4 April 2022 49/19](#)

⁷⁵ Phil Riley [4 April 2022 51/1](#)

⁷⁶ Phil Riley [4 April 2022 34/24](#)

⁷⁷ Phil Riley [4 April 2022 52/21 to 53/3](#)

⁷⁸ [The Sourcing and Consultancy Playbooks](#)

⁷⁹ [Managing Public Money](#)

⁸⁰ Phil Riley [4 April 2022 34/10 and 44/2-24](#)

bids are evaluated⁸¹. Bids are also evaluated on social value, which is generally allocated at least 10% weighting⁸².

100. The Inquiry has heard from the Home Office that for the “*new generation of contracts [...]* costs are only 35 per cent of the assessment process, and quality and social and value are the other 65 per cent”⁸³. The new contracts have greater scope for amendment during their lifetime⁸⁴. The new contract includes the Model Services Contract ‘Change Control Procedure’ Schedule which allows for contractual changes during the contract term, with mechanisms that allows the Authority the right to amend, remove, replace or add KPIs (in accordance with Clause 7.7 of the Agreement (Changes to Performance Indicators and Service Credits)).
101. It was suggested to Mr Riley in questioning that after the award of the contract for Brook House IRC to GSL, G4S came in and took GSL ‘out of the market’⁸⁵. It would be more accurate to say that G4S acquired GSL by acquiring the entire issued share capital through a holding company. G4S therefore acquired the contract that had been awarded to GSL – it did not alter the terms agreed between the Home Office and GSL, nor did it substitute them with G4S’s failed bid.
102. The Inquiry has heard evidence about the improvements made in the current contract⁸⁶, which takes forward the response to the findings of Stephen Shaw’s two reviews of welfare in detention, and the lessons learned following the Panorama broadcast. These include, in summary: a new staffing model with more staff supporting detainees; major improvements in the professional skills of staff; a two hour reduction in the time individuals are locked in their rooms overnight; more welfare staff, making more systematic assessments of detained individuals on arrival; educational and recreational activities seven days a week; increased assurance; a clearer and firmer approach to sanctions for poor performance; and requirements for the reduction of violence, substance misuse and drug supply. Overall, the new contract has been designed to have a much greater focus on the safety and welfare of those detained.

⁸¹ [Bid Evaluation Guidance Note](#)

⁸² [Procurement Policy Note](#)

⁸³ Phil Riley [4 April 2022 35/17](#)

⁸⁴ Phil Riley [4 April 2022 34/25](#)

⁸⁵ Phil Riley [4 April 2022 38/18](#)

⁸⁶ [HOM0332005 0007-8](#)

Contract monitoring

103. The Home Office has accepted⁸⁷ that, with hindsight, there were insufficient staff resources dedicated to monitoring contract compliance, with the single onsite Home Office team also having to deal with time critical operational work (such as serving papers). In addition to monitoring contract performance, the (conceptually distinct) task of monitoring the welfare of detainees in the centre, including the impact of how the contract was designed and delivered on their day to day lives, received insufficient attention.
104. During the Relevant Period, the single onsite team consisted of one Immigration Manager/Contract Monitor, two Deputy Immigration Manager/Contract Monitors, and seven to eight Contact Managers⁸⁸. The team was then split into two, with detainee engagement in one team and contract monitoring in the other, from October 2017⁸⁹. The current Gatwick team is now split into three: operations, performance (i.e. contract compliance) and assurance (third party recommendations, audits)⁹⁰.
105. The Inquiry has heard⁹¹ about the design of the contract: Schedule D of the contract dealt with "Operational Specifications" (e.g. "Maintenance of Security and Safety", "Healthcare", "Catering", and "Welfare and Regime"), with measurable out-put based requirements. Schedule G Performance Evaluation prescribed a points value which was awarded for each relevant failure. When the relevant conversion rate was applied to the points awarded in a given month, the total would be subtracted from the monthly payment to G4S. In that way Schedule G provided a financial incentive to meet the operational requirements in Schedule D.
106. The Inquiry has heard how compliance with the G4S contract was monitored during the Relevant Period⁹²: in quarterly, monthly, and weekly meetings; weekly and monthly supplier self declaration; reviewing data such as raw staffing level data, and complaints

⁸⁷ [HOM0332005_0006](#) para 15; [Phil Riley 4 April 2022 57/13 and 72/9](#)

⁸⁸ [HOM0332004_0002](#) para 5

⁸⁹ Michelle Smith [23 March 2022](#) 108 to 111

⁹⁰ Michelle Smith [23 March 2022](#) 105/17

⁹¹ E.g. [HOM0332004_0005-7](#) paras 10 to 17

⁹² E.g. [HOM0332004_0006](#) paras 14 to 17 and [HOM0332152_0003](#) at paras 12 to 25; Michelle Smith [23 March 2022](#) 114/21 to 133/6, 143

data; thematic reviews; talking to staff and walking round the centre; attending detainee engagement forums; daily Rule 40 and 42 visits; reviewing use of force reviews, Rule 40 and 42 documents, and ACDT forms; dip sampling complaint responses; sources of information such as IMB reports, the Safer Community reports, security reports, surveys; and audits of maintenance and cleaning by a Ministry of Justice subject matter expert.

107. In late 2017/early 2018⁹³, staff monitoring contract compliance were given specific areas to monitor including the reception/induction process, detainee welfare, and catering/cleaning; with meetings on a monthly basis to discuss issues, particularly those that were not being addressed. Home Office staff attended weekly detainee welfare forums. The Inquiry also has written evidence from the Compliance Manager for January 2018 – November 2019 and November 2020 – June 2021, and current Area Manager (who was not asked to give oral evidence)⁹⁴. His evidence and his Verita interview⁹⁵ explain how contract compliance was monitored during that period.
108. The significant improvements in contract monitoring under the new contract have been highlighted by Mr Riley in his written evidence⁹⁶.
109. The contractual relationship, as with any contractual relationship, did depend in part on trust. It is clear that not all failings were self-reported by G4S, and the Home Office looks forward to the Inquiry's findings as to why this was⁹⁷.
110. The Inquiry has investigated an apparent discrepancy between CJS004581 page 2 which records that there were no "Self harm resulting in injury" events during July, and IMB000047, a Combined Report to the Independent Monitoring Board regarding Brook House July 2017, completed by the Home Office and G4S, which records at page 2 that there were 14 acts of self-harm during July 2017, by 11 individuals. The Inquiry has heard⁹⁸ that in fact the two statistics were not comparable: the former was not referring to instances of a performance KPI where the self-harm results from a failure of the supplier to follow laid down procedures for the safety of Detainees, as set out in

⁹³ [INQ000056_0004](#) para 16

⁹⁴ [HOM0332006](#)

⁹⁵ VER000242

⁹⁶ See, for example [HOM0332051](#) at §§26 to 30.

⁹⁷ [HOM0332005_0008](#) para 22

⁹⁸ [HOM0332152_0006](#) para 26 and Michelle Smith [23 March 2022](#) 143-146

Schedule D. The latter sets out all instances of self-harm. However, it does, of course, highlight the problem with the KPI which set too high a test for failure.

111. Monthly multi-disciplinary Safer Community meetings attended by healthcare, the supplier, the Home Office team, the Samaritans/Forward Trust, and the IMB review self-harm incidents and analysed trends (many self-harm incidents or attempts were first occurrences for the individual) – these meetings along with supplier self-reporting should pick up instances where self-harm resulted from a relevant supplier failure, but the Home Office has accepted that it may be that there can be improvements in the questions that these meetings consider⁹⁹.
112. The Inquiry has explored the qualifications of those monitoring the delivery of the contract during the Relevant Period¹⁰⁰. It has heard that, for example, from the former Detention and Escorting Services (DES) Area Manager for the Gatwick IRCs, who did not have specific contract monitoring or management training¹⁰¹. Since the Relevant Period, the Government has introduced contract management professional standards¹⁰², and in 2019 launched a Contract Management Capability Programme, a bespoke training programme that will train and accredit contract managers¹⁰³. The Standards form the basis of learning and accreditation across three levels; Foundation, Practitioner and Expert; and were developed in collaboration with professional bodies and the Chartered Institute for Procurement and Supply. They introduce a minimum standard of knowledge across IRC Home Office Managers.

(iii) STAFFING LEVELS OF THE CENTRE

113. The Home Office recognises that the number of Home Office staff deployed to Brook House during the Relevant Period was insufficient to manage the competing demands of oversight of resident welfare, supporting the removals process and ensuring that G4S met contract obligations¹⁰⁴.

⁹⁹ Michelle Smith [23 March 2022](#) 140/22 - 146/18

¹⁰⁰ E.g. [Ian Castle 15 March 2022 pp3-4](#)

¹⁰¹ [INQ000056_0002](#) para 35

¹⁰² [Contract Management](#) and [Helping you with managing suppliers and contracts](#)

¹⁰³ [Contract Management Capability](#)

¹⁰⁴ [HOM0332005_0006](#) para 15 and Phil Riley [4 April 2022 70/24](#)

114. Staffing levels are important to the safe and decent running of IRCs¹⁰⁵. The level of staffing provided for by the contract with G4S was, with hindsight, insufficient. The contract was designed within Cabinet Office rules in force at the time (the 'play book' now sets out a different process for procurement of contracts of this type)¹⁰⁶, and to the specification set by the Home Office. The Home Office accepts that the contract mandated the number of staff in the centre, and it was up to the supplier to decide where to deploy those staff¹⁰⁷. Now, the new contract mandates the staffing levels in certain areas of the IRC and in certain facilities.
115. In early 2017 G4S staffing levels were not always meeting the required contracted hours¹⁰⁸, and at one point a failure to update the contract meant that it was not operating to set the minimum expected¹⁰⁹. The Home Office's monitoring of staffing levels principally relied on daily self-reporting by G4S of its staffing levels (as mandated by the contract), based on a system which tracked the time spent on site¹¹⁰.
116. Staffing levels became an issue when Tinsley House re-opened¹¹¹. Insufficient staffing levels were raised with G4S's Managing Director of Immigration Services, and in both June 2017 and July 2017, the Home Office Commercial directorate penalised G4S for failing to meet contractual minimum staffing levels¹¹². The Home Office had understood that there were staffing concerns at Brook House, but not the extent of the impact on daily activities later reported¹¹³. G4S did have a recruitment plan in place to improve staffing levels, which appeared to be on track, although recruitment to immigration removal centres was difficult near Gatwick and Heathrow, because of the local labour market¹¹⁴ and attrition¹¹⁵.
117. Staffing levels were increased in response to Panorama¹¹⁶. The current contract at Brook House includes an entirely new staffing model, developed in partnership with the

¹⁰⁵ [HOM0331981_0017](#) para 65

¹⁰⁶ Phil Riley [4 April 2022 35/22 - 36/23](#)

¹⁰⁷ Phil Riley [4 April 2022 51/8](#)

¹⁰⁸ [HOM0331981_0018](#) para 66 and [HOM0332139_0015](#) para 55

¹⁰⁹ Michelle Smith [23 March 2022 136/5](#)

¹¹⁰ Michelle Smith [23 March 2022 114/21](#)

¹¹¹ Michelle Smith [23 March 2022 135/22](#)

¹¹² [HOM0332005_0010](#) para 29

¹¹³ [HOM0331981_0018](#) para 68

¹¹⁴ [HOM0331981_0011](#) para 41 and [HOM0331981_0018](#) para 66

¹¹⁵ Michelle Smith [23 March 2022 139/19](#)

¹¹⁶ [HOM0331981_0023](#) para 83

Prison Service, focussing on the safety and security of the centre¹¹⁷. The size of the Home Office presence at Brook House is also now significantly greater, with clearer roles for teams.

(iv) RULES 34 AND 35, ACDT AND ADULTS AT RISK

Rule 34 of the Detention Centre Rules 2001

118. There has been some criticism from witnesses during this Inquiry that the Rule 34 physical and mental examination is too brief to allow for serious needs to be identified and that those who are detained are not sufficiently informed of the purpose of such examination. The Home Office agrees that there is undoubtedly room for improvement in this area, but also asks the Chair to take into account the wider purposes of this rule.

119. Rule 34 provides as follows:

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

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

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

120. The process that is followed in IRCs is that every detained individual receives an initial nurse-led healthcare screening within 2 hours of their arrival and, in line with Rule 34, should be given a physical and mental examination by a medical practitioner within 24 hours of their initial admission, provided they consent to this. Some IRCs will make an automatic appointment that is then cancelled if they do not consent, others will simply ask the individuals whether they would like a GP appointment. There is no power to examine a person under Rule 34 if consent is withheld, however, the person can change their mind and has the right to request an examination at any subsequent time (Rule 34(3)).

¹¹⁷ [HOM0332005_0011](#) para 31

121. The primary purpose of Rule 34 is to ensure that the physical and mental health of detained individuals is assessed shortly after their arrival at the centre, ensuring that any immediate health needs can be identified and managed appropriately.
122. As Ian Cheeseman noted¹¹⁸, the purpose of Rule 34 is broader than just to address Rule 35 and, from his experience *“was also partly about identifying whether an individual had particular needs in detention”*. There is a danger in simply equating the Rule 34 process with an appointment for the purpose of Rule 35. However, the Home Office accepts that the identification of concerns that would justify a Rule 35 report is one important purpose of this examination and it is vital to properly inform those who are detained of its purpose. As Mr Riley explained in his evidence, the Home Office and NHS England have recently written to healthcare commissioners and providers to emphasise the importance of properly informing those who are detained about the Rule 34 appointment¹¹⁹.
123. The Home Office also accepts that witnesses were critical of the time that is allocated to these appointments. It does note however that Sandra Calver and Dr Oozerally explained that although these were allocated for 5 minutes each, this was for scheduling purposes and more time would be taken if necessary¹²⁰, or a follow-up appointment could be booked. Many people failed to attend at all. Some individuals would need or want less time. Further, these appointments are now for 10 minutes in length rather than 5. As Dr Sarah Bromley recognised in her evidence: *“GP appointments in the community are all ten minutes long so it would stand to reason that that is...translated into the environment as standard”*¹²¹
124. However, both the Home Office and the new healthcare providers have heard and taken into account the issues raised in respect of Rule 34 appointments. PPG is developing new training¹²² and there is a full review of the operation of the relevant DSOs. Work to review the Detention Centre Rules 2001 has also recently started.

¹¹⁸ Ian Cheeseman [16 March 2022 193/25](#)

¹¹⁹ [HOM0332160](#)

¹²⁰ Dr Oozerally [11 March 2022 8/20 to 9/8](#)

¹²¹ Dr Sarah Bromley [1 April 2022 165/2](#)

¹²² [PPG000172_007](#) para 38.

Rule 35 of the Detention Centre Rules 2001

125. There has been a great deal of criticism from witnesses during this Inquiry that the healthcare teams have given insufficient regard to referrals under rules 35(1) and 35(2) and are more broadly reluctant to examine for and produce Rule 35 reports. The Home Office acknowledges these issues, has been concerned by some of the evidence given in this regard and is working to improve this process. However, the Home Office does ask the Inquiry to bear in mind that the completion of a Rule 35 report does not equate with release and nor does a failure to complete a form necessarily mean that an individual's detention was not reviewed.

126. Rule 35 provides as follows:

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

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

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

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

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

(6) [since July 2018] For the purposes of paragraph (3), "torture" means any act by which a perpetrator intentionally inflicts severe pain or suffering on a victim in a situation in which –

(a) the perpetrator has control (whether mental or physical) over the victim, and

(b) as a result of that control, the victim is powerless to resist."

127. The requirements of Rule 35(1), (2) and (3) are clearly defined in those rules. Such concerns may arise or become more significant at any point during a person's detention, although it is most likely that they will first be identified at the initial health screening or at the Rule 34 appointment.

128. The Home Office wishes to make clear that it does not agree with, and was concerned by, the evidence of Sandra Calver, which appeared to put a gloss on the clear words on the Rules¹²³.

129. The process is set out clearly in DSO 09/2016¹²⁴, namely:

“Where an immigration removal centre (IRC) doctor considers that one or more of the criteria in rule 35 of the Detention Centre Rules 2001 (DC), as amended by the Detention Centre (Amendment) Rules 2018, are met they must complete a clear and legible report using the relevant template, either:

- *Annex A: Rule 35(1)/Rule 32(1) report template*
- *Annex B: Rule 35(2)/Rule 32(2) report template*
- *Annex C: Rule 35(3)/Rule 32(3) report template*

There are separate templates for each of the reporting categories. The templates guide doctors through the information that is required in a completed report. In any case where a detainee falls into more than one of the reporting categories, a separate report must be made in respect of the individual categories concerned. The completed report must be submitted without delay to the local detention engagement team (DET) manager copied to the Removal Centre manager. A copy must also be placed on the detainee’s medical record, and provided to the detainee free of charge.”

130. The Home Office recognises that there were only eight Rule 35(1) reports and no Rule 35(2) reports in 2017. This does give cause for concern and the evidence that was heard by the Inquiry led to urgent clarification from the Home Office and NHS England to healthcare commissioners and providers¹²⁵.

131. However, the Home Office does wish to draw to the Chair’s attention that, whilst not ideal, there is evidence that (i) information relevant to Rules 35(1) and (2) would be included in Rule 35(3) forms by some practitioners and (ii) concerns would also be raised in Form IS91RA Part C. Notification via these routes may well lead to a review of detention under Detention: General Instructions which states as follows:

¹²³ Sandra Calver [1 March 2022 216/10 to 219/22](#)

¹²⁴ [HOM002591_0008](#)

¹²⁵ [HOM0332160](#)

"If there is a significant and/or material change in circumstances in between reviews during the initial stages of detention, an inspector or SEO must conduct a review. Where there is a significant or material change in circumstances during later stages of detention, a review must be conducted by the relevant grade for the review period at the point of the change."

132. Whilst it has been suggested to witnesses that Part C doesn't trigger a review of detention¹²⁶, it should trigger a review if there is a "significant and/or material change in circumstances" albeit the Home Office recognises the limitations of undue reliance on the Part C process. As Paul Gasson observed¹²⁷: "A Part C was a change in that person's risk. So if it came from healthcare, or a GP, depending on what the information said on the Part C – all Part Cs would go to the caseworker and they should react to the information on the Part C".
133. The same is the case for Rule 35(3) reports. As Ian Cheeseman told the Inquiry¹²⁸, the vast majority of people who were identified as engaging Rule 35 were also claiming to have been tortured and therefore Rule 35(3) reports were being completed and "if the doctor further considered that the individual's health was likely to suffer in detention, some would complete a separate rule 35(1) report, whereas others would complete – would add that information on to the rule 35(3) report." He explained that "the important thing for me was that the information was received by the Home Office" and where a doctor had reported that the individual's health was likely to suffer the expectation was that they would be placed at level 3 of the Adults at Risk policy. However, once again, the Home Office has recently reiterated to healthcare providers the importance of completing the relevant forms.
134. Further, and as will be explained in relation to the Adults and Risk Policy, the completion of a Rule 35 Report is not to be equated with release.

ACDT

135. ACDT is a vulnerability notification process. Concerns that have been raised by some witnesses that the ACDT and Rule 35 processes exist in isolation and further that the ACDT process is used as a risk management tool rather than leading to any therapeutic intervention.

¹²⁶ For example Sandra Calver [1 March 2022 195/25](#)

¹²⁷ Paul Gasson [15 March 2022 180/7](#)

¹²⁸ Ian Cheeseman [16 March 2022 198/12 to 199/15](#)

136. The evidence before the Inquiry was that there was no inherent problem with the completion or instigation of the ACDT process. The Chair will no doubt note the evidence of Callum Tulley that DCOs were taught to fill in an ACDT and an incident report form in respect of self-harm and that he knew what he was doing in this regard¹²⁹. Mr Tulley acknowledged that anyone could open an ACDT, that in the DCM's Oscar One office there was a noticeboard with a list of every individual who was on an ACDT and that a member of the Senior Management Team would also be informed.
137. Owen Syred also confirmed¹³⁰ that the ACDT training improved vastly over time and by 2017 "*it has been highlighted more as a very important part of what a DCO does, or a DCM*". He also confirmed that, at least after the relevant period, an automatic review by the healthcare team would take place once an ACDT was opened¹³¹ and, around about the relevant period, those on constant supervision were no longer confined to their room¹³².
138. However, one concern, closely linked to Rule 35(2), is the imbalance in ACDT reports and Rule 35(2) Reports. As the Home Office has acknowledged above, the failure to complete individual Rule 35(2) reports goes some way to explain this (and has been addressed in the recent correspondence from the Home Office and NHS England). However, it is also worth bearing in mind that an ACDT will not necessarily justify a Rule 35(2) Report. DSO 09/2016 provides as follows¹³³:

"Where the rule 32 report is completed in accordance with rule 32(2) the healthcare professional must refer without delay to Detention services order (DSO) 06/2008 - Assessment care in detention and teamwork (ACDT) and follow the procedures for managing the detainee in accordance with ACDT policies. However, given that an individual may be subject to ACDT for a number of reasons, being subject to ACDT does not equate automatically to a need to raise a rule 32(2) report

A medical practitioner must, however, issue a Rule 35(2) report when they have concerns about suicidal intent, whether those concerns are based on first hand examination or are based on what they know from current management of the detainee under the ACDT process".

¹²⁹ See Callum Tulley [29 November 2021 52/2-24](#) and [1 December 2021 5/9 to 10/25](#)

¹³⁰ Owen Syred [7 December 2021 77/21 to 80/24](#).

¹³¹ Owen Syred [7 December 2021 84/25 to 86/9](#) and [INN000007 0043](#) at para 174

¹³² Owen Syred [7 December 2021 93/22 to 94/16](#)

¹³³ [HOM002591 0009](#) (2016 version), [FFT000002 0012](#) (2019 version)

139. In respect of therapeutic intervention, the Inquiry will no doubt take into account that Stephen Shaw's 2016 Report which said¹³⁴:

"9.21 There are clearly individuals for whom talking therapies in an IRC environment are not appropriate. A detainee who has been diagnosed with PTSD after suffering torture, for example, will not find the level of support they need within an IRC. However, I believe there are those who would benefit from talking therapies to create resilience and to help deal with symptoms of anxiety.

9.22 The Health and Wellbeing Needs Assessment Programme National Summary Report recommended that: "NHS England may want to establish a minimum service specification for mental health support services in IRCs and STHFs including the provision of culturally sensitive and appropriate counselling." If the Home Office is to avoid creating a system whereby an individual's mental health has to deteriorate in order to warrant treatment, then talking therapies become an important part of the bigger picture.

Recommendation 57: I recommend that talking therapies become an intrinsic part of healthcare provision in immigration detention."

140. As made clear during the Inquiry, talking therapies, as recommended by Stephen Shaw, are available¹³⁵ and the healthcare facilities for those suffering from mental health issues has undoubtedly improved since the Relevant Period, with on site psychologists and an expansion of the mental health team¹³⁶.

Adults at Risk

141. The AAR policy reinforces the presumption against detention for those considered vulnerable. Those identified as vulnerable under the specified AAR policy are assigned a 'level', which relates to the nature of the evidence in relation to the relevant conditions, e.g. self-reporting by the detained individual, advice from the responsible clinicians or an external expert report from a non-treating clinician instructed by the detained person and so on. The AAR policy level determines the approach that then should be taken to the case.

¹³⁴ [INQ000060_0183](#)

¹³⁵ Sandra Calver [1 March 2022 176/24](#)

¹³⁶ Sandra Calver [1 March 2022 192/19](#)

142. As stated in relation to Rule 35, the level of evidence of vulnerability that applies in an individual's case is balanced against the immigration control considerations that apply in their case (for example, public protection, compliance with immigration law, and prospective removal date). When immigration considerations outweigh evidence of vulnerability, the individual's continued detention may be justified.
143. The policy is not designed to ensure that adults at risk are never detained, but is instead a tool to ensure that adults at risk are only detained where the immigration control considerations are such that continued detention is considered necessary notwithstanding the individual's vulnerability.
144. By way of example, Andy Kupoluyi, a Home Office Caseworker has described the exercise which was required¹³⁷. In that specific case, D1275 was assessed to be an adult at risk, level 2, according to the policy. However, he had what is described in the statement as an "*extensive history of offending*" (the detail of which has been redacted by the Inquiry but was no doubt relevant to the underlying assessment), which together with other factors that were taken into account meant that "*his risk of causing harm to others was high*". As Mr Kupoluyi explained in his statement¹³⁸:
- "D1275 presented a high risk to the public due to the risks of him re-offending, and his patterns of offending behaviour, as well as behaviours which were observed in detention. Additionally, it was extremely challenging to source appropriate bail accommodation for him, due to his own behaviours and offending history. It is worth noting that many of the same behaviours which led to him being categorised as an Adult at Risk Level 2 were the same behaviours which made it very difficult to safely release him, and there was no evidence available at the time which demonstrated that D1275's health could not be appropriately managed in detention."*
145. During oral evidence it was repeatedly suggested that certain detained individuals would have been released but for the lack of a Rule 35 report. However, those suggestions failed to mention the countervailing factors which may have justified continued detention of vulnerable people notwithstanding their vulnerabilities. The Home Office has a duty to consider whether releasing someone with a vulnerability factor may then put others at risk. These are difficult decisions for the Home Office to balance.

¹³⁷ [HOM0332157](#)

¹³⁸ [HOM0332157_0011](#) para 39

146. The Home Office does not in this Closing Statement seek to address the Rule 35 and AAR process for each and every individual mentioned during the course of the Inquiry but wishes the Inquiry to take into account that it may not have before it sufficient information to properly weigh up the competing immigration control considerations. Further the Inquiry should not make any determinations in respect of anonymous case study evidence produced by, for example, Freedom from Torture both because it does not have the full detail of the cases before it and because it is legally prohibited from making such conclusions in respect of anonymous cases (as set out in the legal analysis section of this statement).

(v) RULES 40 AND 42 OF THE DETENTION CENTRE RULES 2001

147. During the course of the Inquiry two criticisms of the use of these rules emerged in evidence. First, that the rules were used in some cases “*in order to maintain order and discipline*” rather than the narrow purposes set out in the rules. Second, there was an overuse of these procedures and improper authorisation. The Home Office agrees, and has made clear, that the only justification for use of these procedures is those narrow purposes set out in the rules and that any such use must be properly authorised.

148. Rules 40 and 42 provide as follows:

“40 (1) Where it appears necessary in the interests of security or safety that a detained person should not associate with other detained persons, either generally or for particular purposes, the Secretary of State (in the case of a contracted-out detention centre) or the manager (in the case of a directly managed detention centre) may arrange for the detained person’s removal from association accordingly.

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

(3) A detained person shall not be removed under this rule for a period of more than 24 hours without the authority of the Secretary of State...

...

42 (1) The Secretary of State (in the case of a contracted out detention centre) or the manager (in the case of a directly managed detention centre) may order a refractory or violent detained person to be confined temporarily in special accommodation, but a detained person shall not be so confined as a punishment, or after he (she) has ceased to be refractory or violent

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

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

149. Rule 40 deals with the removal from association of a detained person where it is necessary in the interests of security or safety that a detained person should not associate with others. Rule 42 deals with the temporary confinement of a refractory or violent detained person to be confined temporarily in special accommodation (but not as a punishment, and not after they have ceased to be refractory or violent).

150. The guidance surrounding the use of Rules 40 and 42 are found in DSO 02/2017. The Home Office accepts the delicate balance to be struck between the need to keep the centre safe, and the need to protect individuals from the risks occasioned by segregation. Whilst it is important to have such tools as Rules 40 and 42 available, the Home Office is absolutely clear that (as the DSO states in terms), these mechanisms are not to be used as a punishment or behaviour management tool, but only to ensure the security and safety of the centre, centre staff, and the detained population.

151. As far as the Home Office is concerned the position regarding who may authorise the powers is also set out clearly in Detention Services Order 02/2017, namely:

"In cases of urgency, and if the circumstances are such that it is impracticable to seek the authority required in paragraph 40 in advance, the centre/duty manager (in a contracted out or HMPPS run centre) can make the emergency authorisation so that the authority is considered to begin at that point. In such circumstances, the DES manager (or the DES on-call manager if out of hours) must be notified immediately."

152. The Home Office expects this DSO to be followed. The Inquiry has very properly brought this issue to the attention of the Home Office and its contractors and efforts will be made to ensure strict compliance.

(vi) THE ISSUE OF RACE

153. The Home Office deplores and condemns the racist language that has been identified during the course of this Inquiry. Comments made by, for example, Jon Connolly in the back corridor at Brook House or comments made by Dan Small to other G4S officers about London and the Grenfell Tower or the comments Sam Gurney made to Owen Syred are indefensible. Further, the Home Office is concerned by reports of a lack of support provided by G4S management to those who reported such comments.
154. It is, however, important to note that not a single witness has made an allegation of racism against a Home Office civil servant. It is also important not to confuse allegations that the Home Office was pre-occupied with removal or wider immigration policy objectives with racism and, in particular in support of an allegation of ‘institutional racism’.
155. A finding of racism is one of the utmost gravity in respect of an individual (and it would likely be tied to individuals even if that were not done expressly) and the severity is multiplied when applied to a wider organisation over an extended period of time (which would include individuals who had nothing whatsoever to do with Brook House and would even tarnish those who have joined the Home Office subsequent to the Relevant Period).
156. Importantly, the extreme seriousness of such an allegation is a matter of profound importance when determining what fairness requires in this context. In the Stephen Lawrence Inquiry, for example, Sir William Macpherson clearly and explicitly treated allegations of institutional racism as so serious as to warrant extensive procedural safeguards akin to an adversarial trial. His report noted¹³⁹:

“3.14 It has also always been known that Mr & Mrs Lawrence's allegations included suggestions that the investigation had been flawed by racism and collusion. Hence full representation, and a procedure which was in the result adversarial rather than inquisitorial.

...

3.20...Since the conduct of the Inquiry was largely adversarial the Report is in this case in the nature of a judgement. It is thus markedly different from other inquiries which are wholly inquisitorial in nature and in conduct.”

¹³⁹ [The Stephen Lawrence Report](#)

157. As the Home Office has already noted, this was not the process that has been adopted in the present Inquiry and any such serious allegation against the Home Office would have to be properly tested by an adversarial process given that it is an extremely severe adverse finding against a whole organisation. Indeed, no question was even put to a Home Office witness concerning an allegation of racism *at the Home Office*.
158. There are additional reasons why a finding of institutional racism would be wholly inappropriate as against the Home Office. **First**, the term must be subject to very careful definition, as set out at 6.34 of the Lawrence Inquiry Report, which requires far more comprehensive findings than incidents of racism by particular staff members (e.g. the “*collective failure of an organisation*” and a failure to provide a professional service “*because of*” their colour, culture, or ethnic origin). **Second**, there is an additional layer of complexity in respect of the Home Office because the nature of certain of the Home Office’s functions depend on the ability to distinguish on grounds of nationality or national origin, or residence. This need is recognised in statutory form in, for example, the exceptions to the Equality Act 2010 in Schedule 18, Schedule 3 paragraph 17 and Schedule 23.
159. For all of these reasons, it is respectfully submitted that there is no evidential support for such a finding against the Home Office, nor has the procedure, depth of investigation and legal analysis been sufficient to justify such a conclusion.

(vii) THE PHYSICAL STRUCTURE OF THE BUILDING

160. A number of witnesses referred to Brook House as being a Category B prison and have also suggested that it was designed to hold detained persons for only 72 hours. Whilst the Inquiry is entitled to make findings in respect of the culture and any overlap in that respect, the Home Office does wish to make clear that these two assertions are not correct and that there was good reason for Brook House to be built in the way that it was. Separately, the Home Office accepts that the increase in capacity of 60 additional beds should, in retrospect, have been subjected to greater scrutiny.

161. **First**, whilst Brook House was designed to meet Category B safety standards, the physical structure is not the same as a Category B prison. For example, as Owen Syred rightly observed¹⁴⁰, the size of the rooms are not the same:

Q. What was Brook House designed to be?

A. It was a cat B prison. So it was designed as a cat B prison. However, you know, I've actually been in some prisons, like, in a prison cell, obviously a lot smaller, but in the rooms in Brook House quite a bit bigger, so that was the sort of difference really"

162. Phil Riley's evidence was as follows:

"I don't agree that it is designed as a category B prison. You know, I note the evidence from Dr Bosworth, Mary, on that. The living accommodation is built to a standard that is category B, category C secure, there is very little difference, in practice. But the regime there, and the culture is anything but prison-like, it is designed on purpose to differentiate between an immigration removal centre and a prison. So, you know, the staff carry different PPE, they don't carry batons or PAVA spray, residents have free movement, they have mobile phones. The regime itself is set up differently, there is no enforced work as there would be in a category B prison. There is no adjudication, so there is no additional days given by a visiting judge, there is no incentive for privileges where negative behaviour can have you on a basic level of regime. So, you know, yes, the rooms themselves are built to category B/C standard, but I don't believe it is a category B prison environment myself."

163. **Second**, it is not correct to say that Brook House was designed to only hold people for 72 hours. Whilst Rev Nathan Ward believed that this was the case and believed that the contract "points to a short-term holding centre"¹⁴¹, that is not correct. As Phil Riley stated emphatically¹⁴²:

A. Yes, I am -- there is a question that seems to keep reappearing here about what Brook House was designed for and the length of stay that -- I have not, myself, been able to nail down this view that it was only ever designed for a 72-hour stay, which is patently incorrect and that IRCs have always had people for longer than that. Mr Tulley, I think, mentioned it during the Panorama documentary and I don't understand where this has sprung from, but, you know, it is incorrect and, you know, I would like to put that on the record.

¹⁴⁰ Owen Syred [7 December 2021 24/1-5](#)

¹⁴¹ Nathan Ward [7 December 2021 135/2-19](#)

¹⁴² Phil Riley [4 April 2022 45/12 to 46/12 and 59/22 to 60/5](#)

164. With the exception of a passing mention in an HMIP report of 2010, there does not appear to be any evidence, and certainly nothing from the Home Office, which would substantiate the suggestion that Brook House was designed as a 72 hour holding facility.
165. **Third**, when considering whether the design of Brook House was necessary, it is important to understand the reasons why it was built to a specification of heightened security. The Home Office evidence on this was as follows¹⁴³:

“the decision to build Brook House and Colnbrook to Prison Service Category B standards came after serious fires at Harmondsworth and Yarl’s Wood, and the discovery in 2006 that many time served foreign national prisoners had not been deported.”

166. This was also addressed by Phil Riley in his oral evidence¹⁴⁴:

“When you look at, you know, when Brook House was built for example, it was built on the back of what was happening at Yarl’s Wood in 2002. We attempted there to build a centre with a different environment, with a different physical structure, that wasn’t a cat B or cat C-type, prison built environment and, within three months of it opening, it had burnt down. The Home Office’s favourite independent observed, Stephen Shaw, came in and completed the review of the Yarl’s Wood fire and his view was clearly that, if you are going to detain people, you need a physical infrastructure that is capable of doing so. So there is a balance to be struck between listening to what Mary says and taking her views on board and making sure that we have an environment that is as soft as possible but, at the same time, having somewhere that is safe for residents and staff and secure, if there is concerned action”.

167. **Finally**, the Inquiry has heard evidence concerning the addition of 60 beds in 2017. The Home Office does not seek to defend this temporary measure, but does draw to the Inquiry’s attention the evidence from the Home Office’s witness in this regard¹⁴⁵. Importantly it was not simply an attempt to “squeeze value” out of Brook House, but was part of a wider planned rearrangement of the detention estate that was planned from 2014 onwards. Whilst G4S were understood to have carried out a proper risk assessment, with the benefit of hindsight “there should have been an independent operational review of the 60-bed expansion at Brook House during 2016, because of the length of time from the start of the proposal to its implementation”.

¹⁴³ [HOM0332139_0013](#) para 47

¹⁴⁴ Phil Riley [4 April 2022 65/23](#)

¹⁴⁵ [HOM0332139_0013](#)

168. Therefore, it is important to bear in mind that this was part of a larger programme and was not simply for the purpose of increasing capacity in Brook House in isolation. Whilst Rev Nathan Ward was no doubt passionate in his beliefs, he was of course not privy to wider policy considerations or the overarching changes in the detention estate. His assertion, for example, that the increase was not necessary because the number of successful removals was around 50%¹⁴⁶ superficially sounds attractive but he was in no position to weigh up the wider policy and resourcing implications to make an informed decision¹⁴⁷.

169. In any event, as Mr Riley identified, in light of Stephen Shaw's second review, in 2018, the Home Office ultimately made a number of changes¹⁴⁸: *"We took the third beds out of the centres, Gatwick and Heathrow, we closed Campsfield House because the rooms there were crowded and I wasn't happy with them, and we put an operating cap of 80 percent occupancy on a centre, except in exceptional circumstances"*.

(viii) HYGIENE

170. The Inquiry has heard evidence about the cleanliness and hygiene within Brook House during the Relevant Period. The evidence of former detainees and others has referred to poor conditions in rooms, the cleaning of which was left to detainees, with insufficient cleaning products made available to them. The Home Office is clear that the standards of cleanliness which prevailed during the Relevant Period, and which have been described in the evidence to this Inquiry, were not acceptable. Indeed, this has already been the subject of extensive work following both HMIP and Verita recommendations.

¹⁴⁶ Nathan Ward [7 December 2021 147/7-13](#)

¹⁴⁷ The Home Office makes a broader observation about the evidence of Rev Ward. Whilst this witness is well placed to talk about his own experiences within Brook House (albeit not within the Relevant Period), the Inquiry must be careful not to treat his evidence as expert evidence or give it any special weight. Further, where Rev Ward refers to there being "no legal basis" for certain actions or certain treatment being "unlawful" the Inquiry must bear in mind that this is the evidence of a lay witness rather than based on any formal legal determination.

¹⁴⁸ Phil Riley [4 April 2022 68/17](#)

171. The 2016 HMIP inspection led to a recommendation¹⁴⁹ that *“Concerted action should be taken to soften the prison-like living conditions. Showers and toilets should be adequately screened, and toilets deep cleaned. Units should be well ventilated and detainees should have more control over access to fresh air”*. The Service improvement Plan records that the recommendation was partially accepted (the building management system which managed the temperature and ventilation throughout the Centre did not allow individual control over fresh air access in bedrooms), and sets out that a *“comprehensive action plan has been implemented and work commenced to clean all detainee rooms and toilet areas which is being tracked and is part of a continuous programme of cleaning”*, that *“All showers are individual and are located in communal areas. They are each screened with a curtain and a door”*, and that a *“review of the effectiveness of ventilation system has been commissioned”*.
172. Further improvements made since the Relevant Period are set out in the witness statement of Phil Riley¹⁵⁰, including an enhanced cleaning and maintenance programme, and an environment plan, which uses detained individual focus groups to identify options to change activities, and improve the environment. Refurbishments and redecorations commenced in October 2017 and were remarked upon by the Inspectorate in its follow-up report (published in 2019) as had improvements to toilet and shower screening. The most recent HMIP report has described the standards of cleanliness as high¹⁵¹ and the Home Office is glad to note that its efforts in this regard since the Relevant Period have been acknowledged.

(ix) DRUGS

173. As highlighted by Counsel to the Inquiry, *“during the relevant period in Brook House, there was what has been referred to by some as a spice outbreak. There was prolific use of spice among detained persons at this time and there was a significant number of incidents involving drugs”*¹⁵². This was an issue that was undoubtedly worrying centre managers at the time¹⁵³.

¹⁴⁹ HMIP000613_0051 para 5.2

¹⁵⁰ [HOM0332005_0018](#)-19.

¹⁵¹ [HMIP000674_0016](#) at S20

¹⁵² [23 November 2021](#) 54/19

¹⁵³ [HOM0331981_0011](#) para 41

174. However, it is important to bear in mind that this was not just a Brook House or an immigration removal centre issue: Ian Castle, a former Home Office employee, referred to a number of major prison disturbances in late 2016 as a consequence of spice¹⁵⁴. Dr Mary Bosworth explained that *"There was a fundamental problem around the presence of spice that was smuggled into the centre, and that – I mean, that was a factor that was apparent in other sites of custody at the time, so prisons in England and Wales had a big problem with spice at the time"*¹⁵⁵. Stephen Shaw's January 2016 Report noted it as a new issue at paragraph 3.129¹⁵⁶.
175. Spice was a direct factor in a number of the incidents in the Inquiry's schedule¹⁵⁷. Sandra Calver, Head of Healthcare during the Relevant Period, gave evidence that spice *"certainly"* affected detainees' mental health, and that those with mental health issues may be more likely to take it¹⁵⁸. Anton Bole of the Forward Trust explained that during the Relevant Period it was not possible to detect spice entering the centre – it could be sprayed onto paper and sent in the post – and that the chemical formulation constantly changed so that the effects were not predictable from batch to batch¹⁵⁹.
176. He also gave evidence that post-Panorama, security significantly improved, saying that Michelle Brown *"really increased security activities, staff and resident searches, including dog-led searches"* and that fewer drugs were coming in¹⁶⁰. Mr Bole explained that his organisation is now in a more central position¹⁶¹, security measures have increased¹⁶² and there are drug awareness courses for staff focusing on spice¹⁶³.
177. HMIP's 2019 inspection of Brook House found real improvements¹⁶⁴. A new multidisciplinary drug and alcohol strategy and action plan had been introduced (paragraph 1.53). There had been intelligence led disruption of the supply of liquid psychoactive substances by photocopying all mail over a designated period (paragraph

¹⁵⁴ Ian Castle [15 March 2022 78/2](#)

¹⁵⁵ Dr Mary Bosworth [29 March 2022 156/7](#)

¹⁵⁶ [INQ000060_0061](#)

¹⁵⁷ On 27.04.17, 13.05.17, 09.06.17, 14.06.17, 15.06.17.

¹⁵⁸ Sandra Calver [1 March 2022 183/7](#)

¹⁵⁹ Anton Bole [8 December 2021 128/18 and 130/11](#).

¹⁶⁰ Anton Bole [8 December 2021 152/12](#)

¹⁶¹ Anton Bole [8 December 2021 125/1](#)

¹⁶² Anton Bole [8 December 2021 151/5 to 152/20](#) and FWT000001 para 97

¹⁶³ Anton Bole [8 December 2021 156/4 to 158/20](#)

¹⁶⁴ HMIP000674

1.48), there “*had been some very good corruption prevention work*” (1.52), “*good work had been done to interrupt the supply of drugs into the centre*” including ‘contact mapping’ and liaison with the police leading to arrests (1.54). The evidence was of “*limited drug availability*” (1.53) and a “*small amount of illicit drug use in the centre*” (2.84).

(x) PROFESSIONAL STANDARDS UNIT

178. Whilst the Home Office is content to address issues relating to the PSU in this Closing Statement, it is vital to note that the PSU is independent from Immigration Enforcement. Mr Khan explained that he had no doubt as to the PSU’s independence and impartiality. He had never experienced or been told of any pressure for the PSU to reach a particular conclusion¹⁶⁵. Mr Riley was clear that the PSU “*has to be absolutely independent*”¹⁶⁶. Therefore, whilst the PSU has shared representation with Immigration Enforcement it respectfully wishes to emphasise that this shared representation was simply in order to best assist the Inquiry in the most cost and time effective way.
179. By way of background, the ‘corporate’ evidence from the PSU has been given in a detailed statement from Mark Hartley King¹⁶⁷, who also addresses the cases of D87, D191, D377, D642, D668, D687, D234, D1527, D1538, D1738, D1747, D1798, D2054, D2953, D3545, D326 and D3548. Helen Wilkinson’s statement and oral evidence¹⁶⁸ address the cases of D668, D687 and D2054. Rukshana Rafique¹⁶⁹ addresses the case of D2953. Finally, Mohammed Khan provided a witness statement adopting the evidence of Mr Hartley King and further oral evidence¹⁷⁰.
180. The Inquiry will also be assisted by a detailed explanation of 24 July 2020¹⁷¹, which sets out the role of the Home Office in dealing with any complaints to it made by G4S, G4S Health Services, Home Office or other Brook House staff complaints, including whistleblowing allegations; an explanation of the work of the Security and Use of Force Team with regard to Brook House during 2017; an explanation of the relationship between the Home Office, G4S and G4S Health Services regarding dealing with and

¹⁶⁵ Mohammed Khan [24 March 2022 5/16](#)

¹⁶⁶ Phil Riley [4 April 2022 160/24](#)

¹⁶⁷ [HOM0331946](#)

¹⁶⁸ [HOM0332047](#), Helen Wilkinson [24 March 2022](#)

¹⁶⁹ [HOM0332123](#)

¹⁷⁰ [HOM0332155](#), Mohammed Khan [24 March 2022](#)

¹⁷¹ [HOM0331998](#)

responding to detainee complaints; and an explanation of the respective complaints handling roles of the DES complaints team and the PSU. The Chair is asked to consider this document in full.

181. The Inquiry has scrutinised 21 PSU investigations closely, and in a small number of cases has found instances where practice could have been better. However, the overall picture remains that of a thorough and impartial investigator. The high standards to which the PSU holds itself were exemplified by the evidence of Mr Khan and the Inquiry will no doubt take into account his closing words:

*"My parents were immigrants as well and, looking at that, I just imagine my father being in that situation, and one of the people actually does remind me as well. And the idea of him being treated like that is absolutely — is just really upsetting. So — and I think I just want to underline the fact that that's what PSU's role is. We basically — we undertake and uncover and get to that type of wrongdoing and we get to the bottom of it. And, really, anything that the inquiry can come up with, in terms of any recommendations that I would absolutely warmly take on board and, really, anything that can help us do our work better and more efficiently, I welcome."*¹⁷².

182. Indeed, the detailed reports which were produced by the PSU following *Panorama* substantiated a wide range of allegations which are consistent with the Inquiry's own investigations. The reports were critical of the actions of a number of named custody officers and nursing staff including DCO Kelvin Sanders, DCM Nathan Ring, DCO Yan Pascali, DCO Clayton Fraser and Nurse Jo Buss. Even in those cases where the PSU did not substantiate individual allegations it was critical of identified organisational deficiencies and made important recommendations.
183. Of course, the PSU cannot be blamed for a failure or a delay in the referral of complaints to the PSU. As counsel to the Inquiry highlighted during the questioning of Mr Khan, there is a contemporaneous email from Mark Hartley King which appeared to be critical of the failure to refer cases that were proper for referral in a timely way¹⁷³.
184. The PSU would like to respond to the most significant features of the evidence in this Closing Statement but a full response can be found in the written and oral evidence of the relevant PSU witnesses – **First**, it appears that there may be an instance where G4S

¹⁷² Mohammed Khan [24 March 2022 52/11](#)

¹⁷³ [HOM005049_0001](#) and Mohammed Khan [24 March 2022 26/24](#)

officers took statements from witnesses who were detained¹⁷⁴ rather than the PSU taking the statement themselves. The PSU does not consider that to have been appropriate, as it stands, but notes that it appears to have been a one off error rather than something that was commonplace. Indeed, since the Investigating Officer has not been called to give evidence and is no longer with the PSU, the reason for this approach will never be known. As Mr Khan emphasised, he *"would not be happy for a contractor to be taking statements on behalf of the PSU"*¹⁷⁵ and the Inquiry does not have any further examples.

185. **Second**, it appears that in the particular circumstances of a tranche of investigations which followed the Panorama broadcast and were commissioned by Detention & Escorting Services following wide ranging complaints from solicitors (including complaints outside of the PSU's remit), the letter communicating the decision was sent by Detention & Escorting Services rather than the PSU. As Mr Khan explained, that was different to what would normally have been the case¹⁷⁶. This would not, of course, alter the PSU's independent determination, which would have been completed by the time that the letter was written. However, the PSU accepts that the way that these letters were provided – in the particular and unusual circumstances of those investigations – may have given the wrong appearance that Detention & Escorting Services were involved in the investigatory process. The entire reason for this, however, was to ensure that matters outside of the PSU's remit were simultaneously addressed alongside other concerns. That included matters relating to immigration status, health and other matters which needed to be addressed outside the PSU.
186. **Third**, and closely related to this, is the letter from Helen Wilkinson in relation to the investigation of D668¹⁷⁷ which tails off at the end. It is important to note that although it was suggested in questioning that this letter was signed by Helen Wilkinson, in fact it was not signed and is clearly not a final version and is both unsigned and undated. As Ms Wilkinson identified *"the letters I prepared went up to a senior officer and then they were all sent over to GLD or detention services"* and that the passages which were removed were not part of her investigation but were merely *"a prompt"* in respect of the separate organisational-wide reviews. Whilst the PSU accepts that the impression given in the disclosure of this draft is unhelpful, it must be seen both in that context and in the

¹⁷⁴ [HOM002419](#)

¹⁷⁵ Mohammed Khan [24 March 2022 45/16](#)

¹⁷⁶ Mohammed Khan [24 March 2022 16/17](#)

¹⁷⁷ [HOM002747](#)

unusual circumstances of these particular commissions. There were other allegations which were put to Ms Wilkinson about D668¹⁷⁸ and other investigations for which she has provided comprehensive explanations in her written and oral evidence.

187. **Fourth**, there was a suggestion put to Mr Khan that Rukshana Rafique's email to Ian Castle of 15 February 2018 was inappropriate¹⁷⁹. Rukshana Rafique was not called to give evidence on this matter and cannot therefore be criticised for her actions. However, Mr Khan noted that her email stated that an advanced copy of the investigation report was being provided for *"information only...so you can make any necessary handling considerations at your end"* and a later email in the chain refers to *"necessary contingency arrangements"*. That this may have been (one can only speculate) *"simply because they could perhaps manage what the recommendations are going to be. If for example, the recommendation was the immediate – something that impacted on operations of Brook House"*¹⁸⁰ What is clear from that email exchange is that there was strong push back from the Home Office at the suggestion that G4S be given an opportunity to influence the report, with Anthony Lennon stating: *"The purpose of giving the heads up to the Delivery Managers in Detention is so that they are aware PSU have substantiated or partially substantiated a complaint and not for the report to be going backwards and forwards and certainly not for a supplier to challenge the findings of the investigation"*¹⁸¹. Mr Khan's oral evidence responded to the further criticisms of the email exchange, stating definitively that the PSU are not accountable to Detention & Escorting Services¹⁸².
188. **Fifth**, it was suggested that it would be helpful for there to be a straightforward means by which the PSU could identify whether there had been previous complaints against particular officers, to assist them in assessing the officer's credibility and propensity. Mr Khan accepted that there may be merit in the idea, but explained that potential policy implications would need to be considered¹⁸³. The Inquiry will understand that such a policy change would need to be carefully considered to ensure both substantive and procedural fairness for those investigated (and the PSU is not itself responsible for the overall complaints system). A pattern of complaints should be investigated: as explained by Phil Riley, Detention & Escorting Services themselves *"keep a very clear log*

¹⁷⁸ [HOM0332047](#) at §§40 to 50

¹⁷⁹ [HOM005200_003](#)

¹⁸⁰ Mohammed Khan [24 March 2022 20/8](#)

¹⁸¹ [HOM005200_001](#)

¹⁸² Mohammed Khan [24 March 2022 23/12](#)

¹⁸³ Mohammed Khan [24 March 2022 8/11](#)

that is discussed monthly about patterns of complaints against DCOs, so if there are patterns of behaviour, that would actually prompt a referral to PSU”¹⁸⁴.

189. Whether at the level of an individual PSU investigation previous unsubstantiated allegations made against an individual ought to be placed before the investigator raises more difficult questions of fairness. Indeed, there are complex rules for relying on ‘bad character’ evidence in criminal proceedings. What use the investigator ought to make of that material would need to be the subject of careful guidance. The PSU would also need to be alive to the possibility that an individual may have been a target of untrue complaints, and that individuals might be the target of more untrue complaints due to a protected characteristic such as sex or ethnicity.
190. **Sixth**, the Inquiry has also explored with witnesses whether the PSU ought to always invite those who are subject to allegations of mistreatment and who have left their employment to an interview¹⁸⁵. Mr Khan explained that he would expect the subject of an allegation to be invited to interview unless the police advised otherwise or they were physically unable (e.g. ill)¹⁸⁶. Those who are still employed are required to attend, those who are not cannot be compelled¹⁸⁷. Mr Khan agreed that in some instances it would be helpful to invite a complainant to comment on e.g. CCTV footage, but it would not be the case across the board¹⁸⁸. Having handled a large amount of undercover footage, BWC and CCTV footage, the Inquiry will be well aware of the difficulties in handling such material and sharing it. Mr Khan agreed that the PSU could handle ‘broader systemic issues’, and the PSU does already look at matters such as the culture of a specific team or organisation¹⁸⁹, but ultimately the PSU has to be commissioned to undertake such work.
191. **Finally**, and of particular importance to this inquiry, it was suggested to Mr Khan at the beginning of his evidence that an old 2011 Detention Services Order¹⁹⁰ states that the PSU’s procedures do not comply with Article 3 ECHR. This was a misreading of the

¹⁸⁴ Phil Riley [4 April 2022 157/10](#)

¹⁸⁵ Phil Riley [4 April 2022 159/20](#)

¹⁸⁶ Mohammed Khan [24 March 2022 10/19](#)

¹⁸⁷ Mohammed Khan [24 March 2022 38/7](#)

¹⁸⁸ Mohammed Khan [24 March 2022 12/14](#)

¹⁸⁹ Mohammed Khan [24 March 2022 13/10](#)

¹⁹⁰ [VER000031](#)

2011 DSO. The passage that was cited was in reference only to management reviews. The investigations in issue in the present case are not management reviews, as Mr Khan clarified at the end of his evidence¹⁹¹. In any event the relevant DSO for the purpose of the Inquiry is DSO 03/2015¹⁹². The ability for a PSU investigation to help meet the investigative requirements of Article 3 ECHR (together with the availability of an appeal to the PPO), is well recognised by the courts – see e.g. *R(MM and AO) v SSHD* [2012] EWCA Civ 668 at §§54-57 - and is simply irrefutable.

(xi) THE IMB AND HMIP

192. Brook House, other IRCs and the wider detention estate are the subject of significant oversight by bodies such as HMIP and the IMB. These bodies have varying roles, from formal inspection to volunteers monitoring day-to-day life in the centre. The Home Office welcomes all of their insights and recommendations but is clear that it cannot rely on external oversight alone to ensure standards – it is one part of the picture. As recognised by HMIP, there “*will always be particular challenges in identifying concealed practices*”¹⁹³. The view of Mr Riley, and of the Home Office, is that “*the more people who are in there and seeing what is going on and are contributing, the better, but at the end of the day the Home Office is ultimately responsible*” for Brook House and other IRCs¹⁹⁴. Once the Home Office has fully considered the recommendations, they are tracked and, in the case of HMIP recommendations, a response is published. Oversight also comes from ICIBI, NAO, and specific reports such as those by Stephen Shaw.

193. Once a recommendation has been accepted, a first-line assurance team look at the implementation of recommendations in centres (which may include recommendations being implemented by the supplier). A second-line assurance undertakes thematic reviews and dip samples the performance locally. An audit and assurance team within the relevant returns command looks at returns-focused recommendations, and a security audit and assurance team looks at security and use of force recommendations. A corporate oversight team coordinates the assurance work¹⁹⁵.

¹⁹¹ Mohammed Khan [24 March 2022 48/1](#)

¹⁹² CJS000727

¹⁹³ HMIP Oral Opening Statement [26 November 2021 54/18](#)

¹⁹⁴ Phil Riley [4 April 2022 181/13](#)

¹⁹⁵ Phil Riley [4 April 2022 88/3](#)

194. The Inquiry has heard the reflections of those at HMIP and the IMB as to how it was that they, also, did not find the abuse that was uncovered by Panorama, and the changes that they have made since, such as the implementation of enhanced methodology in all IRC inspections by HMIP. The Home Office accepts that in the past, it did not have sufficient dedicated resource in IRCs to make sure that recommendations were being delivered¹⁹⁶. Now, the teams at the IRCs are split to ensure better oversight, and there are also a number of cross Directorate second-line assurance teams.
195. The new contract also requires suppliers to implement recommendations. Serco has explained that they *"have a performance improvement plan, we look at all third party recommendations, and HMIP recommendations, and we will action and go through those and discuss and sit down with the Home Office"*¹⁹⁷. Their view is that HMIP, for example, *"are there to advise, support and look at the decency agenda, et cetera, so we would take the appropriate action to address any concerns that HMIP had within Brook House"*¹⁹⁸.
196. Immigration enforcement, including immigration detention and the running of IRCs, is a complex and difficult area of policy, operations, and law¹⁹⁹. It is a *"difficult operating environment"*, in addition to which *"the debate on migration and enforcement is polarised and entrenched"*²⁰⁰. Underestimating this complexity and difficulty can, from the outside, lead to a view that the Home Office is slow or reluctant to take on board recommendations and effect change. This is not the case.
197. The view of HMIP is that *"we should be clear that the fact that we can't enforce recommendations doesn't mean they're not taken seriously. [...] we think that recommendations which we make and the findings which we come up with are taken pretty seriously, I think, by the Home Office. Their implementation may not be effective all the time, and some parts of the Home Office haven't done well enough, but I think that certainly in immigration enforcement, I think the attitude has changed. This was from a time when I think the attitude was very defensive, and I think, over the years, that's softened and has become more constructive"*²⁰¹.

¹⁹⁶ Phil Riley [4 April 2022 98/10](#)

¹⁹⁷ Steven Hower [1 April 2022 8/3](#)

¹⁹⁸ Steven Hower [1 April 151/16](#)

¹⁹⁹ Phil Riley [4 April 2022 104/23 to 105/17](#)

²⁰⁰ Phil Riley [4 April 2022 128/1](#)

²⁰¹ Singh Bhui [24 March 2022 185/2](#)

198. The Home Office accepts that there is still room for improvement – “*we are working hard to do better. [...] it is not ideal and there are delays at times but it is a work in progress and I think we are improving*”²⁰². The Home Office accepts that “*there are things we haven't got right and we continue not to get right and I accept that, at times, we need to move faster on recommendations. We are doing our best on that and it is a work in progress, but we are keen to learn*”²⁰³.

IV. OTHER MATTERS OF CLARIFICATION

199. There are further issues which, although unlikely to be the focus of the Inquiry's report, nevertheless warrant clarification by the Home Office.

(i) INTERNET AVAILABILITY

200. Whilst some witnesses speculated that there was a pattern to when the internet was not available, this is simply not correct. Owen Syred confirmed that “*there wasn't a pattern*”²⁰⁴ and Phil Riley made clear that he has no knowledge whatsoever of how that would even be possible²⁰⁵. It may well be that when there were charter flights there was greater demand for the internet (and therefore problems with connectivity were only identified at that time) but that, or any other explanation, is pure speculation.

(ii) LEARNING LESSONS FROM CASELAW

201. It may be suggested that there was not a process for learning lessons from caselaw and other legal developments in the Home Office. It may be that Core Participants rely heavily on the comments of Phil Shoenenberger in this respect (whose memory of the processes during the Relevant Period was imperfect). However, it is not the case that lessons from litigation are not passed to the relevant individuals. See for example, the evidence of Mr Cheeseman which was as follows²⁰⁶:

²⁰² Phil Riley [4 April 2022 106/9](#)

²⁰³ Phil Riley [4 April 2022 128/8](#)

²⁰⁴ Owen Syred [7 December 2021 127/13](#)

²⁰⁵ Phil Riley [4 April 2022 86/18](#)

²⁰⁶ Ian Cheeseman [16 March 2022 173/9 to 176/14](#)

Q. I'm also asking about cases that have been through the courts, where a decision has been made, a judgment has been issued, which either has criticised an individual decision maker, or the decisions being made, or found a policy implementation to have been unlawful. How would you become aware of case law litigation through the courts of that nature?

A. In the Home Office, there was a team, or a whole area, which -- whose responsibility was to keep an eye on litigation, and they --

Q. How did that feed into policy in relation to the detention of vulnerable people which you were responsible for?

A. Because any litigation that related to my area of responsibility would be raised with me by the team that kept a weather eye on ongoing litigation.

...

Q. Was there any process to inform and feed back court rulings to the people on the ground, whether that was G4S management or healthcare management, at all?

A. If a judgment required us to change policy in any way, then we would have amended the policy documents and the Detention Services Orders if necessary, and they would have been usually disseminated to the healthcare staff and operational staff at immigration removal centres through Detention Services, which is part of Immigration Removal Service.

(iii) NO NOTICE REMOVALS

202. This policy has been referred to a number of times during the evidence to the Inquiry, and it has been suggested that it increased stress on certain detainees, and contributed to uses of force. Often referred to by core participants to this Inquiry as “*no notice removals*”, the policy was to provide notice of a window of time during which a person may be removed without *further* notice. It was not in fact the case that detainees received no notice of their removal whatsoever. The minimum ‘notice period’ in detained cases between the notice and the opening of the removal window was 72 hours (including at least 2 working days).

203. It was the product of a long history of interaction between the Secretary of State, the Administrative Court, and immigration practitioners concerning the balance between effective removals and access to justice. As set out in the judgment of Silber J in *R (Medical Justice) v Secretary of State for the Home Department* [2010] EWHC 1925 (Admin) at paras 5–30, from 1999 following discussion with the Administrative Court the

Secretary of State put in place a policy designed to clarify arrangements for responding to late challenges to removal (at that time notice of removal directions set out details of the removal flight such as date, time, exit airport and route as part of the single decision letter process).

204. By 2005, there were concerns that the judicial review process was being abused to frustrate removal – in a significant number of cases threats of judicial review did not lead to proceeding actually being pursued, or permission was refused or cases failed at the substantive hearing. Following discussion with the Administrative Court, a policy was introduced whereby in most cases a person would be given at least 48 hours' notice (including at least one working day) between the time at which they were notified of removal directions and the time when they were carried out, to allow legal advice and an Administrative Court Office reference number obtained if required. The policy was changed again in 2006, so that removal would only be deferred upon receipt of an Administrative Court Office reference number and of the grounds of claim – not merely on the threat of a judicial review. The notice period was extended to a minimum of 72 hours including two working days.
205. A revised policy was then set out in Chapter 44 of the Operational Enforcement Manual published on 1 March 2007, and took effect from 12 March 2007. A minimum of 72 hours (including at least 2 working days) had to be allowed between notification of removal direction to the person being removed and the actual removal, with the last 24 hours including a working day. There were specified exceptions to the minimum period. A further revised policy was set out on 11 January 2010.
206. From 2015, a new policy was set out in Chapter 60 of the Home Office Immigration Returns, Enforcement and Detention: General Instructions, “Judicial reviews and injunctions”. It was later versions of this policy which were considered in *FB* and in *Medical Justice*.
207. Both the Upper Tribunal, in *FB v Secretary of State for the Home Department* [2018] UKUT 428 (IAC) - 31 October 2018, and the High Court, in *R. (on the application of Medical Justice) v Secretary of State for the Home Department* [2019] EWHC 2391 (Admin), found the policy to be lawful. However, in its 21 October 2020 judgment in *R (FB (Afghanistan)) v Secretary*

of State for Home Department [2020] EWCA Civ 1338, [2022] QB 185, the Court of Appeal reversed both decisions and found that the policy was unlawful.

208. The Court of Appeal sets out at §39 the three types of notice that could be issued. In relation to one, notice of a removal window, the policy provided that a person who was liable to removal under section 10 of the Immigration and Asylum Act 1999 (as amended) could be served with a notice which confirmed liability for removal and the country or area to which removal was to be effected and set a short period during which there would be no risk of removal, followed by a “removal window” during which he or she might be removed without service of removal directions or any further notice. A notice of removal window could not be used in family cases, where the person had no leave but had made an asylum or humanitarian protection or human rights claim or had an appeal pending, or in respect of an adult at risk (§41).
209. The Court of Appeal was *not* persuaded that notice of a removal window, without notice of removal directions, was inherently unlawful (§§74, 79-87). The Court found that “is not unlawful for the Secretary of State to effect removal of an irregular migrant where that migrant has been given notice of removal in the form of a notice of a window of time during which it is intended to remove him or her, even if no notice of the exact intended date and time of removal, in the form of removal directions, is given” (§87).
210. However, the Court of Appeal found that the policy *did* pose an “unacceptable risk of interference with the right of access to court” (§147), because “almost all decisions material to removal which are made in respect of applications and representations made following service of the notice of the removal window are made within the window period itself” and “those involved are at risk of removal without any opportunity to challenge the relevant decision in a court or tribunal, ie they are at real risk of effectively being prevented from having access to justice.” (§126).
211. The Home Office draws the above to the Inquiry’s attention as a matter of clarification and to provide a proper context to the statement that the “*no notice removals*” policy was found to be unlawful.

(iv) ALLEGATIONS AGAINST HOME OFFICE CIVIL SERVANTS

212. Finally, there are three allegations against Home Office witnesses which require a response.

213. **First**, there is a serious allegation that has been made by James Wilson of GDWG that Paul Gasson, amongst others, was shouting at him in a meeting in August 2017, that the meeting was “*highly combative*”²⁰⁷ and that there was a dynamic “*tantamount to bullying*”²⁰⁸. It is respectfully submitted that the Inquiry should not make any findings in this regard. An allegation of bullying is a grave allegation that can have profound reputational and personal consequences and one that does not need to be determined for the Inquiry to fulfil its Terms of Reference. There is undoubtedly a difference of opinion between Mr Wilson and Mr Gasson on this matter which does not take the Inquiry any further in reaching conclusions regarding the treatment of detainees.

214. However, if the Chair does wish to consider this matter any further:

- (1) The Home Office position is that this criticism is not borne out by the contemporaneous documents. By way of examples, an earlier meeting that took place in March 2017 was followed by an email on 13 March 2017²⁰⁹ thanking Mr Gasson for the meeting and referring to the conversation as “*honest and positive*” and referring to “*our good working relationship*”. Another on 29 March 2017 thanked Mr Gasson for the meeting and for his time. A subsequent email of 12 June 2017²¹⁰ began “*many thanks again for the meeting last week. I really appreciated the opportunity to talk through the proposed MOU and current work*” and ended “*Thank you very much again for your ongoing support*”. In line with this regular positive correspondence, on 18 August 2017 - shortly after the meeting in question – Mr Wilson wrote again to say²¹¹: “*Thank you for the useful meeting this afternoon. I very much appreciate your raising concerns directly and us having the chance to discuss them*”. Whilst Mr Wilson suggests that he was simply being diplomatic in correspondence, even his email to colleagues of the same day did not mention shouting or bullying and whilst it referred to a “*gruelling meeting*” it was accompanied

²⁰⁷ [DPG000003_003](#) para 8

²⁰⁸ James Wilson [10 December 53/25](#)

²⁰⁹ [GDW000003_0011](#)

²¹⁰ [GDW000003_0029](#)

²¹¹ [GDW000003_0040](#)

by a light-hearted video of a baby monkey riding backwards on a pig rather than any matters of serious complaint²¹².

(2) Further, the evidence from Mr Wilson in respect of the discussions that took place with the Home Office on this issue has been marked by some confusion and, disappointingly, allegations against the Home Office that have been shown to have been untrue. It is clear, for example, that GDWG had agreed an MOU in 2016 (as shown by contemporaneous emails²¹³), but Mr Wilson wrongly stated with confidence in his oral evidence that the MOU “*had never been finalised*”²¹⁴ and alleged that the Home Office deliberately suggested that it had agreed in order to obtain an advantage in their discussions²¹⁵. Whilst GDWG have confirmed in evidence served after the conclusion of the Inquiry that this was due to an internal miscommunication at GDWG in the handover to Mr Wilson, it serves to demonstrate – at the very least – that the meeting itself was likely to have been marked by similar confusion and miscommunication on the part of Mr Wilson.

(3) Mr Gasson has made clear his recollection. At paragraph 103 of his witness statement, he stated²¹⁶:

“There was no sense from his emails at the time that he felt under undue pressure or treated unfairly. The requests for clarification of what GDWG did in the surgeries had not been forthcoming and this had been asked for on at least two occasions. This was a reasonable request, given the concerns that had been raised by both G4S and the IMB. I do not think that asking for clarification of the role of a visitor group who had private one-to-one meetings with detained individuals who were in the care of G4S was unreasonable or tantamount to bullying. I can now see from the evidence that at least in hindsight there has obviously been a difference of opinion as to the conduct and outcomes of the meetings. I did not understand that I was being (or would be perceived as being), hostile, and certainly would not intentionally act in that way.”

This is consistent with his oral evidence, where he stated:

Q. He said, in hindsight, the approach from you on behalf of the Home Office and G4S was tantamount to bullying. Do you accept that?

²¹² [GDW000008](#)

²¹³ [HOM0332156](#)

²¹⁴ James Wilson [10 December 2021 20/14](#)

²¹⁵ James Wilson [10 December 2021 21/23](#)

²¹⁶ [HOM0332152_0027](#) para 103

A. Absolutely not. We were simply asking him to clarify his vision for the surgeries and the role of the company that -- his charity that he was the director for. At times, I think from memory, certainly in the first two or three meetings, which might have been all of them, he didn't really seem to know what the people were doing who were coming in and we did ask for clarification and I think that did finally come through about five or six weeks after this August the 18th. He wrote it -- I never received it. I have only seen it as part of this inquiry. I seem to be cc'd onto a letter so I'm not sure how G4S received that or how it was sent, was it sent through the post, because it looked like it was a letter, or if they received it by email, but I have checked my inbox and I can't find anything on that date that clarified the drop-in surgeries or what he wanted.

Q. Looking back, Mr Gasson, do you consider your approach to James Wilson and GDWG during the relevant period was a reasonable one?

A. I do consider it was reasonable. I mean, they were fairly short meetings. There was about four of them over the period of a number of months. You know, with all due respect to James and the GDWG, you know, they didn't feature that prominently on my radar. I was aware that they came in and they did a very valuable service to the people who were detained. I think that's referenced in one of the emails. I think he actually quotes one of us saying it, how valuable the service is, and it really was. There was no issue with them coming in on social visits. We just wanted clarification around the drop-in surgeries and what they actually did in there. Because we'd made some good progress -- or G4S had made some good progress with GDWG in the run-up to 2015. The person in place at the time, a guy called Chris -- because, from the email, I remember -- he had offered to walk around -- Nick and his colleagues around Brook House, an offer which he took up. They took a tour around Brook House. But James Wilson talks about building a relationship and that, which is fine, as far as I was aware, looking at the emails, there was nothing in his emails, in any of his emails, to show that, in any way, shape or form, he felt anything that he says in his verbal and witness evidence. If that was the case and he felt that way, of course I can only apologise that I made him feel that way, but I cannot think of anything that myself or even Steve or Dan said in that meeting that may have made him think that way. We were just simply asking for clarification and he didn't seem to be able to tell us that -- what that was."

215. **Second**, there is an allegation against Vanessa Smith in respect of a training session on 22 February 2018. The first thing to note is that this incident occurred outside the Relevant Period and does not need to be determined by the Inquiry. It also does not involve any interaction whatsoever with a detained person and relates only to

comments made when presented with a hypothetical situation in a training exercise. Ms Smith has addressed this in her statement²¹⁷ and in her oral evidence²¹⁸. She has apologised for saying that a hypothetical individual in a case study “*had it coming*”, said it was a “*poor choice of words*” and was appropriately disciplined. An allegation that she made a further comment that she would “*go to town*” on a hypothetical individual referred to in the case study is denied and was not proven after investigation at a disciplinary hearing where Ms Smith was able to give her own account²¹⁹ (at the earlier G4S investigation it appears that she had not been asked to provide an account²²⁰). The Inquiry has not called the other witnesses to give evidence and has nothing more to go on than a summary contained in a G4S investigation.

216. It is respectfully submitted that reliance on an allegation following an unrelated grievance complaint from DCO David Waldoock, who did not give oral evidence to the Inquiry, that amongst other things Ms Smith was “*talking in her native tongue*”²²¹ to another DCO says a lot more about Mr Waldoock than it does about Ms Smith and would be a totally inappropriate basis on which to make any negative finding against Ms Smith.

217. **Finally**, there is a negative comment that was made by Nathan Ward alleging that Debra Weston said “*It’s all down to who breaks first: the Home Office or the detainee*”²²². Again, the Home Office do not consider this is a point that needs to be determined for the Inquiry to fulfil its Terms of Reference. The assertion was also never put to Ms Weston who provided a detailed witness statement to the Inquiry covering a large number of topics²²³ but who was never called to give evidence.

²¹⁷ [HOM0332141_009](#)

²¹⁸ Vanessa Smith [15 March 2022 230/2](#)

²¹⁹ [HOM005909_002](#)

²²⁰ [HOM005901_0004](#)

²²¹ [VER000061_0004](#)

²²² Rev Nathan Ward [7 Dec 2021 139/21](#)

²²³ [HOM0332003](#)

V. CONCLUSION

218. As Counsel for the Home Office said in his closing speech, the Home Office has full confidence that the Chair will approach what is a very difficult task with the careful, thoughtful and sensitive manner she has personally shown to witnesses throughout this inquiry. The Home Office looks forward to receiving the Chair's factual findings and recommendations in due course.

**JULIAN BLAKE
EMILY WILSDON
REBECCA HANDCOCK**

29 April 2022