

<p>1 Thursday, 25 November 2021</p> <p>2 (10.00 am)</p> <p>3 MS SIMCOCK: Chair, today you will hear opening statements</p> <p>4 from core participants. Ms Harrison will go first.</p> <p>5 (Audio problems)</p> <p>6 MS SIMCOCK: Chair, perhaps if we rise for five minutes.</p> <p>7 THE CHAIR: I'm afraid we may need to. My apologies.</p> <p>8 (10.09 am)</p> <p>9 (A short break)</p> <p>10 (10.26 am)</p> <p>11 THE CHAIR: Thank you, again. Ms Harrison, thank you.</p> <p>12 Opening statement by MS HARRISON</p> <p>13 MS HARRISON: Chair, the inquiry counsel indicated to you on</p> <p>14 the first day of the hearing that I represent a number</p> <p>15 of core participants, instructed by the firm of</p> <p>16 solicitors Duncan Lewis. Those core participants are</p> <p>17 D1527, D1851, D1914, D2077 and D1538. The latter is</p> <p>18 a core participant who was only added this week, and so</p> <p>19 I will leave his case to the second phase.</p> <p>20 You are going to hear submissions from me in opening</p> <p>21 of a generic nature, from Mr Goodman on behalf of D1527</p> <p>22 and from Ms Morris in respect of Nathan Ward. But my</p> <p>23 focus is very much on the generic.</p> <p>24 I am going to start with what we have heard on</p> <p>25 a number of occasions said: this is an inquiry into</p> <p style="text-align: center;">Page 1</p>	<p>1 rights becomes acclimatised, as surely it was in</p> <p>2 Brook House, not just during the period of this</p> <p>3 investigation, but probably for many months, if not</p> <p>4 years, before, it further hardens and brutalises all</p> <p>5 those who have become accustomed to it and it corrupts</p> <p>6 the whole. That's why we are here concerned not with</p> <p>7 the aberrant acts of a few isolated individuals, but</p> <p>8 with an entire institutional culture and practice that</p> <p>9 was engrained, well known and allowed to continue with</p> <p>10 impunity until the good fortune of the courage of</p> <p>11 Mr Tulley to use his camera to bring into the light the</p> <p>12 darkness that was Brook House.</p> <p>13 In looking at the importance of the protection</p> <p>14 against treatment which is torture, inhuman or</p> <p>15 degrading, we can go back in this country to 1689.</p> <p>16 That's the first time that legally sanctioned</p> <p>17 ill-treatment was prohibited by law. It was at a time</p> <p>18 when Parliament recognised that, in circumstances where</p> <p>19 you have extraordinary powers being exercised by the</p> <p>20 executive -- at that time, it was the King -- that's</p> <p>21 incompatible with the liberty of the subject. We say,</p> <p>22 although this inquiry is not directly concerned with the</p> <p>23 wider questions of immigration detention, it is</p> <p>24 important to recognise that we start off here with an</p> <p>25 extraordinary draconian power: that of executive</p> <p style="text-align: center;">Page 3</p>
<p>1 article 3 mistreatment, the prohibition on torture,</p> <p>2 inhuman or degrading treatment. Whilst this inquiry</p> <p>3 will understand that that critical phrase comes from the</p> <p>4 European Convention on Human Rights, it should be</p> <p>5 understood not just here, but beyond, that it is a key</p> <p>6 common law protection well entrenched in English law</p> <p>7 that any form of torture or other cruel or inhuman</p> <p>8 treatment is utterly repugnant and contrary to</p> <p>9 fundamental principles of English law. It is repugnant</p> <p>10 also to reason, justice and humanity.</p> <p>11 Yet we have seen already, if only in snapshot form,</p> <p>12 from the Panorama footage, that that form of abhorrent</p> <p>13 and repugnant treatment was taking place in a removal</p> <p>14 centre not more than ten miles from this place.</p> <p>15 Such cruelty, as we have graphically seen, serves</p> <p>16 only to destroy the moral and physical integrity of</p> <p>17 the victim, subjecting them to pain, severe mental</p> <p>18 anguish and stripping them of their human dignity.</p> <p>19 We can also see that it serves to degrade those who</p> <p>20 engaged in the practice, as well as those who</p> <p>21 instigated, encouraged, colluded or acquiesced in it.</p> <p>22 It's in all those forms of responsibility that this</p> <p>23 inquiry must address its mind.</p> <p>24 What we say the inquiry will find is that, once</p> <p>25 mistreatment, abuse and fundamental disrespect for human</p> <p style="text-align: center;">Page 2</p>	<p>1 administrative detention, normally only used in times of</p> <p>2 war or public emergency, but here used on a mundane and</p> <p>3 regular basis, with individuals held for indeterminate</p> <p>4 periods without charge or trial.</p> <p>5 This inquiry cannot ignore or disregard that that's</p> <p>6 the starting point for understanding the rest. That's</p> <p>7 because, when you come to see, as we say the evidence</p> <p>8 will show, the profound weaknesses in the legal</p> <p>9 protections and the safeguards for detainees'</p> <p>10 fundamental rights, and indeed in the attitudes of those</p> <p>11 who had responsibility for detaining them and looking</p> <p>12 after them on the ground in Brook House, it is that</p> <p>13 fundamental lack of a robust legal protection that</p> <p>14 explains some of the consequences that we are now</p> <p>15 investigating.</p> <p>16 It is also important because you will have seen</p> <p>17 already from some of the extracts of the evidence that</p> <p>18 being detained indeterminately or indefinitely impacts</p> <p>19 on the detainee's own experience.</p> <p>20 You will also know that, based on</p> <p>21 Professor Bosworth's study for the first Shaw review,</p> <p>22 detention which is indeterminate has a negative impact</p> <p>23 on a detainee's mental health, and that impact increases</p> <p>24 the longer the person is in detention. It was also</p> <p>25 established by Professor Bosworth's first study that it</p> <p style="text-align: center;">Page 4</p>

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<p>1 is not just the length of detention that impacts 2 negatively on mental health, it is also in circumstances 3 where that individual has pre-existing trauma, such as 4 torture or other forms of ill-treatment, and where they 5 already have pre-existing mental illness. However, you 6 will also hear from detainees, former detainees, who had 7 no mental illness when they went into detention, but 8 nevertheless, as a result of relatively short periods of 9 detention, their mental health was damaged irredeemably 10 and broken. That will be the case of D1851, which 11 I will come to shortly.</p> <p>12 What is significant, then, about this context is 13 that, when you're viewing the evidence and when you're 14 asking yourself how this happened and why it happened, 15 you have to start from the proposition that what was 16 necessary here was rigorous, robust enforcement of 17 safeguards in policy and practice, as well as the 18 highest standards of governance, oversight, management 19 and vigilance in ensuring compliance. The evidence, 20 however, points exactly and incontrovertibly 21 categorically to the opposite at all levels within both 22 the Home Office and G4S, and it is important to 23 recognise that, whilst we will focus in this phase on 24 finding the facts on the acts of those in the detention 25 centre, this inquiry must look further, it must look</p> <p style="text-align: center;">Page 5</p>	<p>1 that those protections were fundamentally failing. They 2 had been failing for over 15 years. So it will be an 3 important and critical part of the inquiry's analysis to 4 understand why that was and, in that regard, primary 5 responsibility is going to be held by the Home Office.</p> <p>6 It is not just an operational failure, because what 7 you will also hear is that it was a deliberate decision 8 taken by the Home Office when it introduced the Adults 9 at Risk policy to rebalance the policy away from release 10 and in favour of immigration factors. You wouldn't have 11 picked that up from what ministers said. They agreed 12 with Mr Shaw that it was necessary to reduce the 13 numbers -- to improve the safeguards and reduce the 14 numbers of mentally ill people in detention, but instead 15 they adopted a policy that had precisely the opposite 16 consequence. That's important and resonates for 17 a number of reasons.</p> <p>18 Firstly, because article 3 of the European 19 Convention on Human Rights sets stringent standards. As 20 well as being absolute and non-derogable, they are also 21 non-delegable. These are not duties that can be 22 subcontracted out. They will always remain with the 23 Home Office when there is failure, and that's because 24 article 3 requires not only prohibition and punishment 25 of ill-treatment, it must also forestall its occurrence.</p> <p style="text-align: center;">Page 7</p>
<p>1 higher and it must look to the top, within director 2 level and at senior management level, and it must also 3 consider political responsibility for the oversight of 4 a system that was so fundamentally flawed and so 5 damaging to those it was supposed to protect.</p> <p>6 It is for this reason why we say at the outset it is 7 critically important for your task, chair, to understand 8 the role that the safeguards play. You have heard about 9 rule 34 and rule 35 of the Detention Centre Rules and 10 the Adults at Risk policy. It is those frameworks that 11 fill the huge gap that there is when one has 12 administrative detention. They were intended to ensure 13 that within 24 hours of entry into an immigration 14 removal centre, a doctor had assessed you, examined your 15 mental and physical health and had made a report of any 16 evidence that raised a concern that continued detention 17 would cause injury, where there was suicidal ideation or 18 a history of torture. It wasn't supposed to happen many 19 weeks later, it was supposed to happen within 24 hours 20 of arriving in the detention centre. That is because it 21 is well recognised that, in all those three categories, 22 continued detention is likely, as Professor Bosworth 23 identified, to cause relatively rapid, significant 24 deterioration in your mental health.</p> <p>25 We have already heard from counsel to the inquiry</p> <p style="text-align: center;">Page 6</p>	<p>1 It is not acceptable to intervene only after 2 infliction when moral and physical integrity has been 3 irredeemably harmed. States are bound to put in place 4 measures that pre-empt perpetration of ill-treatment. 5 Therefore, states must take steps to prevent actual 6 breaches and potential breaches of the prohibition 7 against torture, inhuman and degrading treatment. Those 8 negative and positive duties are critically important 9 when one is concerned with a cohort of especially 10 vulnerable people, those held in detention and, in 11 particular, those with mental health.</p> <p>12 The state's obligation is to take preventative 13 measures to preserve human dignity and those fundamental 14 failures of the policy and the rules are those measures 15 that this state takes to give effect to those positive 16 obligations and, when they fail, it has serious 17 consequences. It, in itself, is a breach of article 3 18 of the European Convention on Human Rights and it has 19 catastrophic, as we have seen, consequences for many of 20 those that are held within that framework.</p> <p>21 We do say that the inquiry needs to look carefully 22 at the forms of ill-treatment that are covered by 23 article 3. The chair to the inquiry opened on inhuman 24 and degrading treatment, but we do say that, in the 25 context of the case of D1527, this inquiry must look</p> <p style="text-align: center;">Page 8</p>

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<p>1 very closely at whether what, in fact, he was subjected 2 to was torture.</p> <p>3 Torture is deliberate inhuman treatment causing very 4 serious and cruel suffering. It must be inflicted for 5 a purpose -- for example, punishment, intimidation or 6 discrimination. It need not be physical. It can be 7 psychological. A single incident can amount to torture 8 if it is serious and cruel enough. The threat of 9 physical torture, the threat to kill, that we saw so 10 horrifically on the footage yesterday, can amount to 11 mental torture depending on the severity of the pressure 12 exerted and the intention of the mental suffering 13 caused.</p> <p>14 By contrast, inhuman treatment does not need to be 15 deliberate or intended to cause suffering and there is 16 no requirement that suffering be inflicted for 17 a purpose. When one looks at the single incident on 18 25 April concerning D1527, we say that it clearly does 19 have the hallmarks of torture -- deliberate, intentional 20 throttling or strangulation, application of extreme 21 pressure -- and done so in a way that was potentially 22 life threatening, in the context of a menace of a threat 23 to kill, surrounded by verbal abuse and mocking.</p> <p>24 It seems evident to us that there is a strong case 25 for this being motivated certainly by the fact that this</p> <p style="text-align: center;">Page 9</p>	<p>1 the incidents that are the subject of inquiry here.</p> <p>2 One has to ask the question: is it suffering and 3 humiliation beyond that element of suffering or 4 humiliation connected with a given form of legitimate 5 treatment or punishment? We say that, in each and every 6 respect, the critical incidents here were very much well 7 beyond any element of suffering or humiliation integral 8 to detention.</p> <p>9 When one is concerned with mentally ill detainees 10 and the standards that they are entitled to expect and 11 the state must ensure to avoid inhuman or degrading 12 treatment, the Grand Chamber of the European Court of 13 Human Rights in the case of Rooman v Belgium has given 14 authoritative guidance. It tells us, and this inquiry 15 must look at it, that suffering which flows from 16 naturally occurring illness, whether physical or mental, 17 may be covered by article 3 if it risks being 18 exacerbated by conditions of detention for which the 19 authorities can be held responsible. In assessing that 20 question, one will have to ask whether or not there was 21 appropriate treatment for the physical and medical 22 conditions.</p> <p>23 One will have to look at the conditions and whether 24 or not those conditions created feelings of fear, 25 anguish and inferiority capable of humiliating and</p> <p style="text-align: center;">Page 11</p>
<p>1 man had mental illness and experienced a disability. We 2 also say, from the surrounding evidence, that it may 3 well be motivated by discrimination on the grounds of 4 race or religion or indeed his immigration status.</p> <p>5 It certainly had as its purpose intimidation.</p> <p>6 Nobody can be in doubt that the impact on D1527 was 7 cruelty. It caused him the most profound mental 8 suffering. We saw before our eyes what it means when we 9 say to break someone's moral and physical integrity.</p> <p>10 That howling was the howling of a man whose basic 11 humanity had been stripped from him, and we say this 12 inquiry must give very careful consideration and come to 13 the conclusion that he was subjected not just to inhuman 14 treatment, but also to torture.</p> <p>15 We say that it is also, in that regard, significant 16 that it wasn't a one-off, isolated incident -- although 17 that would be enough; it was part of a targeted pattern 18 of physical mistreatment, abuse and humiliation, taking 19 place between April and June 2017.</p> <p>20 The inquiry must also be mindful of the full scope 21 of what constitutes inhuman and degrading treatment.</p> <p>22 The key case is the Kudla case and the threshold is 23 whether or not the treatment caused either actual bodily 24 injury or intense physical or mental suffering. Intense 25 mental suffering, we say, is at the heart of many of</p> <p style="text-align: center;">Page 10</p>	<p>1 debasing the person. One will have to look at the 2 medical assistance and whether there was a lack of 3 appropriate medical care for persons in custody, because 4 that is capable of engaging the responsibility of 5 the state under article 3, and it won't be enough simply 6 to have proper treatment, diagnosis by qualified staff.</p> <p>7 There will need to be a comprehensive record, diagnosis 8 and care which is prompt and accurate. It will require 9 a comprehensive, therapeutic strategy to deal with the 10 illness. And it will need to ensure that the person's 11 health problems are not aggravated.</p> <p>12 All of those matters are important elements of this 13 inquiry, and, in each respect, when one has a core 14 participant or other with a significant mental or 15 physical illness, there is clear evidence already 16 flagged up that these obligations under article 3 have 17 not been met. Whilst, of course, it is always fact 18 sensitive, this inquiry does have the benefit of six 19 decided cases, domestic cases, in which immigration 20 detention without physical, deliberate ill-treatment 21 have held to cross the line for an article 3 breach.</p> <p>22 Those cases are explored in detail in Mr Shaw's report. 23 I won't repeat them now. But there were six, there 24 since has been added a seventh, a man, VC, who was held 25 in Brook House in 2015 for a number of months, the</p> <p style="text-align: center;">Page 12</p>

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<p>1 Home Office recently conceding that he, too, was subject 2 to an article 3 breach, and this is on the basis of 3 these characteristics: a serious mental illness 4 exacerbated by detention, absence of effective medical 5 treatment; inappropriate management through segregation 6 and use of force; self-neglect; and compromised 7 interpersonal relations causing humiliation in the eyes 8 of the individual or third parties.</p> <p>9 We emphasise on behalf of the core participants whom 10 Duncan Lewis represents that, whilst, of course, D1527 11 was subject to, at the very least, inhuman and degrading 12 treatment, each of the CPs in their own right equally 13 were too. I will give some limited reference to why, 14 firstly dealing with D1851.</p> <p>15 In his entire three-month period of detention, as 16 you heard from counsel to the inquiry, he was detained 17 unlawfully. He was subject to an assault. Any touching 18 of that man would have been an unlawful trespass to his 19 person. He experienced humiliation, degradation and it 20 had a profound psychological impact upon him, such that 21 it caused him to suffer mental illness in circumstances 22 where he had no pre-existing mental illness. He 23 experienced demeaning language, witnessed disturbed 24 people and disturbing incidents of violence, drug use, 25 distress and chaos. All of this eroded his mental</p> <p style="text-align: center;">Page 13</p>	<p>1 fact that that alone could have caused him to lose his 2 life. You heard the reference to the disregard with 3 which his medical conditions were treated: "If he dies, 4 he dies".</p> <p>5 He was subject to segregation and constant watch for 6 repeated periods of time. Those factors -- segregation, 7 use of force -- on a severely mentally ill man, who also 8 had a serious heart condition, we say readily crosses 9 the threshold for inhuman or degrading treatment.</p> <p>10 Those are the snapshots. In themselves, they are 11 harrowing. They make the task of this inquiry so 12 critically important. We know that its primary task in 13 this phase is to find the full facts, to identify the 14 culpable and the discredited conduct, and of course it 15 is to ensure that dangerous practices and procedures, of 16 which we can see already there are very many here, are 17 rectified. The lessons learned function is critical.</p> <p>18 It is also important, as Mrs Justice May identified, 19 that this inquiry provides an opportunity for those who 20 have been subject to abuse to challenge and confront 21 those responsible, to put them on an equal footing, to 22 restore dignity in doing so. We are therefore concerned 23 that the inquiry, as we anticipated, has not had full 24 co-operation, and we do urge, where appropriate, for 25 this chair to use its statutory powers of compulsion so</p> <p style="text-align: center;">Page 15</p>
<p>1 well-being. It denied his human dignity and undermined 2 his self-confidence, his sense of worth. It changed him 3 and it broke his moral integrity.</p> <p>4 D2077 is an Iranian Christian. He is now 5 a recognised refugee who fled Iran after torture on 6 multiple occasions owing to his faith. He was detained 7 in Brook House for a short period, in April 2017, but he 8 had been previously detained and been released following 9 a rule 35 report that confirmed that he was a victim of 10 torture. Nevertheless, he found himself again detained, 11 this time in Brook House, despite suffering a major 12 depressive disorder and PTSD.</p> <p>13 His despair and distress at being back in detention 14 and in reaction to the conditions at Brook House caused 15 him to stitch his lips together in protest, and he went 16 on hunger strike.</p> <p>17 D1914. We heard about him from counsel to the 18 inquiry. We saw his rule 35 report that documented 19 a serious heart complaint. That alone would have been 20 of concern, that, despite the rule 35(1), he was 21 detained. But, in addition to that, there is compelling 22 evidence relating to his experience of severe mental 23 illness that caused him to subject himself to the most 24 horrific self-harm. In that context, he was subject to 25 control and restraint to effect his removal, despite the</p> <p style="text-align: center;">Page 14</p>	<p>1 that those who are culpable and need to answer for their 2 actions do so.</p> <p>3 We also ask that the inquiry consider ensuring that 4 it has witnesses from the Home Office who were present 5 and responsible during the period of time that this 6 inquiry covers. At the moment, we have seen nobody who 7 held responsibility being requested to give evidence. 8 That may change, and we may not know the full picture, 9 but, at the very least, we asked the inquiry many months 10 ago to consider requesting evidence from Hugh Ind, who 11 was the director of Detention Services, and his 12 assistant, Mr Schoenenberger, who have been in the 13 Home Office for many years and were responsible for key 14 policies. Just like Mr Ian Cheeseman and 15 Mr Simon Barrett, responsible for over a decade for the 16 rule 34 and 35 policy. We say that these individuals 17 must be called to give account of how this came to 18 happen.</p> <p>19 Similarly, Home Office officials on the ground in 20 the detention centre, like Mr Gasson, who was the 21 manager at Brook House, need to be questioned about 22 their responsibility and what they knew. These are all 23 critical parts of the restorative function that this 24 inquiry has to fulfil.</p> <p>25 It is, in many respects, an historic opportunity for</p> <p style="text-align: center;">Page 16</p>

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<p>1 dysfunction that has been present in this system for 2 many years first and foremost to be explained and 3 exposed, but, critically, to ensure that it comes to an 4 end. This inquiry isn't the first. You will be aware 5 that Mr Shaw conducted a report into racism and abuse in 6 2004, where he found that it was a small number of 7 individuals. In 2005, his second investigation into 8 Oakington identified what he called a "subculture" of 9 individuals who subjected detainees to abuse and to 10 racism. But, since then, we have also had the coroner's 11 report into the death of Mr Mubenga that exposed racism 12 as a potential pervasive aspect of the treatment of 13 detainees facing removal in 2015 and, most recently, the 14 Windrush investigation reporting in 2020 and exposing 15 institutional failure and, at the very least, 16 dehumanisation, in respect of British citizens of black 17 or Asian origin.</p> <p>18 Those are all important building blocks and starting 19 points for this inquiry when one comes to identify why 20 and the causes and, therefore, the resolutions.</p> <p>21 Mr Shaw said that he was tired of conducting such 22 investigations, and he's recognised that those inquiries 23 did not solve the problem. That means that this inquiry 24 must do something different to the ones that have gone 25 before. We say, when one looks at the evidence that has</p> <p style="text-align: center;">Page 17</p>	<p>1 taking stock and looking at the whole, to adopt the 2 approach that Professor Bosworth proposes, which is to 3 consider now whether or not actually the only answer, 4 the inevitable answer from all the information that you 5 are going to read, is not pages and pages of 6 recommendation, but saying clearly that this form of 7 power should be reviewed and it should be very 8 substantially curtailed.</p> <p>9 That can be done through time limits. It can also 10 be done by restricting groups to very limited periods of 11 time in which this power can be exercised. You will 12 hear, no doubt in much greater detail, in the second 13 phase what those time limits should be, but the critical 14 task for the inquiry is, really, to address the bold 15 but, we say, inevitable proposals that were made by 16 Professor Bosworth of actually bringing this power to an 17 end or very severely curtailing it.</p> <p>18 We know from counsel to the inquiry that you will 19 also build on the Lampard investigation. We emphasise 20 what she said about the culture of menace towards 21 detainees and a conspiracy of silence and 22 misrepresentation concerning incidents of violence or 23 neglect and the turning of a blind eye. We also point 24 you to the fact that Kate Lampard said that detention at 25 Brook House should be limited to no more than a few</p> <p style="text-align: center;">Page 19</p>
<p>1 so far been provided by the Home Office from Mr Riley, 2 that certainly one can see that the Home Office hasn't 3 begun to understand either the gravity of the abuse that 4 was taking place or, more particularly, its 5 responsibility for it.</p> <p>6 When one reads that witness statement, we 7 respectfully suggest it is little more than a press 8 release. It is a whitewash. Its value is only in 9 revealing incontrovertibly that the Home Office does not 10 and has not yet begun to seriously engage in either the 11 evidence or to reflect upon what lessons need to be 12 learnt.</p> <p>13 You are presented with two alternatives. If you go 14 with the analysis of the Home Office, it was a small, 15 aberrant group of individuals who were allowed to 16 conduct this kind of abuse because of poor performance 17 management. However, if you look at the reality of 18 the material and take on board the evidence of Reverend 19 Nathan Ward, backed by Professor Bosworth, there is only 20 one answer here. There are fundamental, institutional, 21 widespread problems. They have been given a name, as 22 based on dehumanisation, discrimination, racism and 23 xenophobia, and they do infuse the system failure that 24 is exposed by the evidence.</p> <p>25 It is in that context that we do ask the inquiry, in</p> <p style="text-align: center;">Page 18</p>	<p>1 weeks, and we remind you that the Home Affairs Select 2 Committee, again in many respects, found the Home Office 3 culpable for the abuse at Brook House and identified 4 widespread and serious failures in leadership, 5 management and organisational culture. It concluded 6 serious systemic failure.</p> <p>7 We also say, because, four years later, we have to 8 look at what the position is now, that this inquiry 9 should look very carefully and urgently at the most 10 recent IMB report into Brook House because, on 11 2 October 2020, it, as I understand it, for the first 12 time issued a notice to the immigration minister under 13 rules 6(1), (3) and (5) of the Detention Centre Rules 14 because it was concerned and had come to the conclusion 15 that the regime operated during the removal on charter 16 flights in October 2020 had created a situation 17 collectively and cumulatively whereby those impacts 18 constituted inhumane treatment in the entire centre.</p> <p>19 In its subsequent report, issued in May 2021, it set 20 out in frightening detail what it was that had led it to 21 conclude that Brook House was, once again, operating 22 systemically in an inhumane way, and it is frighteningly 23 consistent with what the evidence shows about 2017: high 24 numbers of highly vulnerable people self-harming, 25 suicidal, being subjected to force to manage their</p> <p style="text-align: center;">Page 20</p>

<p>1 mental health and to remove them from the 2 United Kingdom.</p> <p>3 It is a chilling aspect of that report that the IMB 4 identified that the prevalence of the use of force had 5 doubled between 2019 and 2018. It was increasingly 6 concerned about the prevalence of the use of force.</p> <p>7 That will obviously be something this inquiry will 8 have to consider in detail when it comes to lessons 9 learned, but we say that its need to identify lessons 10 learned is as critical and as urgent as it was on 11 5 September 2017.</p> <p>12 We offer, then, for the inquiry's consideration, on 13 the basis of the individual cases and the analysis of 14 the material that we have seen, explanation for why this 15 occurred. We say that it is a combination of factors. 16 They are multiple and they intersect. But they do 17 start, and this inquiry cannot ignore, from the 18 demonising political rhetoric concerning immigration, 19 political asylum and foreign criminals which, as Nathan 20 Ward explains, infused the attitudes of the staff on the 21 ground.</p> <p>22 The policies of hostility are incompatible with 23 humanity. Stephen Shaw himself recognised that, in 24 2005, in his report into mistreatment and racism at 25 Oakington. He said this, the combination of coercive</p> <p style="text-align: center;">Page 21</p>	<p>1 to look at the design and the contract. The building 2 was designed to be prison-like, and its regime that was 3 operated was one that was prison-like. It was focused 4 on high security, irrespective of the nature of 5 the individuals who were detained within it. And its 6 systems of control and restraint were focused on 7 refractory detainees with a history of criminal 8 conviction or experience in the prison but, 9 nevertheless, the same techniques and methods were used 10 to the non-refractory, the compliant and indeed the 11 highly vulnerable.</p> <p>12 We don't adopt the suggestion that housing those 13 with a criminal history and others is the problem. We 14 say that, within the cohort of those who have committed 15 criminal offences are sometimes some of the most 16 vulnerable. It is notable that four of the seven ECHR 17 cases were people with criminal convictions. But it is 18 a critical part of the problems that arose that this was 19 a regime and an environment that was designed to be for 20 those who present challenges and disruption, and it was 21 used pervasively and arbitrarily on anyone and in many 22 other situations where it was unnecessary.</p> <p>23 It is also important to look at the contract because 24 the material that we have provided to the inquiry 25 annexed to the witness statement of Mr Ward makes clear</p> <p style="text-align: center;">Page 23</p>
<p>1 powers over foreigners involved in immigration 2 enforcement "with the attitude towards asylum-seekers 3 and other would-be immigrants of some sections of 4 the media, can become a breeding ground for racist and 5 abusive word and deed."</p> <p>6 That, too, was echoed by Lincoln Crawford OBE who 7 gave a commentary to Mr Shaw's report and he referred as 8 significant the current climate is one of intolerance.</p> <p>9 We know and we cannot ignore that that climate of 10 intolerance is not generated just by sections of 11 the media or the population, but is led front and centre 12 by the government. Those words and deeds of those in 13 high office impact upon, in critical ways, the context 14 and the attitudes of those at the sharp end in detention 15 centres.</p> <p>16 We say it is an important factor that Brook House 17 was the centre, as it still is, for charter flights and 18 the focal point for effecting removals. It is that that 19 put huge pressure on the IRC. Mr Ward explains how the 20 then director emphasised the high-profile and high-cost 21 operations for the Home Office of charter flights, and 22 we will see and hear evidence of how that target-driven, 23 removal-focused culture drove many of the practices that 24 exposed individuals to the treatment that is of concern.</p> <p>25 Like counsel to the inquiry, we say that you do have</p> <p style="text-align: center;">Page 22</p>	<p>1 that this was always a contract that was based on 2 removals and enforcement priorities at the expense of 3 welfare. It was a contract agreed by the Home Office 4 with G4S that came in 35 per cent under budget, but it 5 did so because it provided harsh, prison-like lockdown 6 regimes, inadequate activities and, critically, low 7 staff numbers.</p> <p>8 Senior Home Office officials described it as 9 a desperate attempt to reduce costs at the expense of 10 welfare and an ethos of cutting corners and failing to 11 meet basic standards. Nevertheless, it was awarded to 12 G4S, hard wiring in many of the problems that we see. 13 It is the context in which the culture of dehumanisation 14 occurred. The existence within the detention centre of 15 high levels of mental distress and illness is a critical 16 component of the failure to -- of abuse. It has 17 a number of effects. It is key to understanding 18 dehumanisation and the "us and them" mentality.</p> <p>19 Individuals ill-equipped to deal with such complex 20 needs are being asked to care for them and their 21 response is simply to withdraw and instead to treat the 22 individual and their mental health problems as occasion 23 for the use of force and refraction.</p> <p>24 We have seen already how abusive and degrading 25 language was pervasive, and we have also seen material</p> <p style="text-align: center;">Page 24</p>

<p>1 that indicates that institutional racism is a real 2 question here. You were referred to the footage of 3 Mr Connolly advising Callum Tulley and using the racist 4 expletive "nigger". He was a man in a leadership 5 position who was described as an expert, and it is 6 clear, we suggest, that there is a wider culture of 7 racism and xenophobia.</p> <p>8 Sir William Macpherson identified key aspects of 9 institutional racism in his report into the death of 10 Stephen Lawrence. He described it as the collective 11 failure of an organisation to provide an appropriate and 12 professional service to people because of their colour, 13 culture or ethnic origin. It can be seen or detected in 14 processes, attitudes and behaviour which amount to 15 discrimination through unwitting prejudice, ignorance, 16 thoughtlessness and racist stereotyping, which 17 disadvantages minority ethnic people. The factors that 18 were identified by the Lawrence Inquiry as giving rise 19 to institutional racism were: the lack of urgency in 20 investigating the incident and failing to see the 21 relationship with race; evidence of negative 22 stereotyping of racial groups by staff, fostered through 23 workplace culture; under-reporting to the organisation 24 by black and ethnic minority individuals due to a 25 perception that their cases would not be taken</p> <p style="text-align: center;">Page 25</p>	<p>1 particularly on the prison-like environment, the 2 excessive lockdowns, the unacceptable conditions and the 3 lack of privacy in the arrangements in the cells, was 4 consistently ignored and rejected by the Home Office. 5 If the HMI is going to have a better role at regulating 6 and monitoring these facilities, there needs to be some 7 mandatory requirement in the Home Office accepting its 8 recommendations.</p> <p>9 That culture of impunity is also illustrated by the 10 fact that, whilst this is one of the most heavily 11 litigated areas, there are frequent findings by 12 High Court judges and others that the Home Office has 13 unlawfully detained individuals, that the policy is 14 operated systemically unlawfully, as well as in 15 individual cases, but, nevertheless, it does not lead to 16 remedial action. It does not lead, as far as we are 17 aware, to any consequential disciplinary action or being 18 held to account for the official responsible, either at 19 an operation or policy level, despite the most serious 20 and significant findings that have frequently been made 21 by the court.</p> <p>22 This is a grievance that D1851 has and it is 23 a reason for why he wished to give evidence to the 24 inquiry. Whatever those mechanisms are, however, this 25 inquiry would need to be satisfied that that entrenched</p> <p style="text-align: center;">Page 27</p>
<p>1 seriously; the lack of training, and the failure of 2 the organisation to unequivocally recognise, acknowledge 3 and accept the problem; the use of racially insensitive 4 language and terms by officers or staff without 5 understanding as to how such language would be 6 offensive. We say that each one of those factors, 7 although they are not a checklist, and more can be 8 added, are in place, and, in this regard, the evidence 9 of Mr Riley will be critical.</p> <p>10 That culture of dehumanisation and racism is 11 compounded by what we say the evidence shows of 12 a culture of impunity, and it is in that context, we 13 say, that responsibility falls with senior directors and 14 Home Office officials at the highest level, and it is 15 why, when one has a culture of impunity, that oversight 16 mechanisms, important though they are, are simply not 17 going to be enough.</p> <p>18 There is evidence that the IMB itself became 19 compromised by the "us and them" culture, and it came 20 down in favour of the "us" rather than the 21 individuals its role was intended to protect. Whilst, 22 of course, the HMI has an independent and effective 23 track record of identifying issues, it failed to do so. 24 We point to the fact that one of the consistent 25 responses of the Home Office to the HMI recommendations,</p> <p style="text-align: center;">Page 26</p>	<p>1 culture of impunity has been addressed because, without 2 it, whatever form scrutiny takes, whether legal or 3 monitoring or overview, will not, as we have seen, 4 address the underlying problems.</p> <p>5 That then brings me to what actions have been taken, 6 and, again, this is going to be critically important for 7 the second phase, but we should make it clear now that, 8 on the evidence that we have seen, there is no clear 9 evidence at all that steps have been taken that even 10 begin to understand and identify what went wrong here. 11 It is notable that the Home Office did not end, as 12 promptly and as quickly as it could, the G4S contract, 13 but, instead, let it run and even extended it. G4S were 14 in charge of healthcare in Brook House until August 15 2020. We have not seen any changes of management 16 structures within the Home Office and, similarly, within 17 G4S. Critically, there has been no improvement or 18 change to the rule 34 and 35 process and there has been 19 no reform, although it's regularly called for, of 20 the Adults at Risk policy.</p> <p>21 Whilst DSOs have been issued, the ACDT practices and 22 segregation practices and the use of force within the 23 detention facilities continue as they always have done. 24 Use of force continues to be made and modelled on 25 a prison model. It is inappropriate for the immigration</p> <p style="text-align: center;">Page 28</p>

<p>1 detention context, and it is particularly inappropriate</p> <p>2 for those who are vulnerable by reason of mental</p> <p>3 illness. It requires fundamental and radical review.</p> <p>4 None of that has taken place. It is business as usual</p> <p>5 since 2017.</p> <p>6 It is why we say that all those factors,</p> <p>7 institutional and widespread, have yet even begun to be</p> <p>8 seriously considered or addressed by those responsible</p> <p>9 for doing so. It will be the litmus test of this</p> <p>10 inquiry what recommendations it makes. We do propose</p> <p>11 what, on one hand, is the simpler proposition. It is to</p> <p>12 adopt what Professor Bosworth has said in her report to</p> <p>13 the inquiry at paragraph 2.28 and seriously now give</p> <p>14 consideration to alternatives to detention.</p> <p>15 It is only that, we say, that will meet the</p> <p>16 challenge of ensuring that what happened at Brook House</p> <p>17 in 2017 isn't happening now and doesn't happen again in</p> <p>18 the future.</p> <p>19 This inquiry must say in particular that, for those</p> <p>20 with vulnerability, detention should not occur. At the</p> <p>21 very least, Brook House should be operated as it was</p> <p>22 contractually intended to, for keeping those in</p> <p>23 detention for no longer than 72 hours, at least in that</p> <p>24 facility.</p> <p>25 Only strict time limits and restrictions on this</p> <p style="text-align: center;">Page 29</p>	<p>1 treatment that was inhuman and he was subjected to</p> <p>2 torture. That mistreatment must be investigated because</p> <p>3 even one case of such behaviour is contrary to the most</p> <p>4 fundamental norms of a democratic society, but all the</p> <p>5 more it must be investigated because his experience was</p> <p>6 not an isolated one.</p> <p>7 The second reason D1527 and all of us here are here</p> <p>8 today is courage. D1527 has had the courage to stay</p> <p>9 with legal processes of forcing the state to investigate</p> <p>10 and to hold to account those who are responsible for his</p> <p>11 mistreatment for well over four years. That has</p> <p>12 involved a judicial review to compel his release from</p> <p>13 detention, a two-year judicial review to compel this</p> <p>14 inquiry to be held, a judicial review to compel the</p> <p>15 Home Office to give him leave to remain, a civil claim</p> <p>16 for damages stayed behind this inquiry, a judicial</p> <p>17 review of the composition of the inquiry team,</p> <p>18 a complaint to the Professional Standards Unit and the</p> <p>19 Prisons and Probation Ombudsman, a police investigation,</p> <p>20 a threat and judicial review of the Crown Prosecution</p> <p>21 Service failure to prosecute the perpetrators of his</p> <p>22 abuse. He has borne with these processes in formidably</p> <p>23 difficult personal circumstances.</p> <p>24 The inquiry should be in no doubt as to how hard it</p> <p>25 has been for D1527. We applaud his fortitude. We</p> <p style="text-align: center;">Page 31</p>
<p>1 draconian power can ensure that dignity and humanity are</p> <p>2 protected. We say that should be the outcome and the</p> <p>3 conclusions of this inquiry, and will provide in this</p> <p>4 and in its second phase evidence to support that</p> <p>5 conclusion. That is a convenient time for the break.</p> <p>6 THE CHAIR: That's fine. Thank you, Ms Harrison. We will</p> <p>7 reconvene at, let's say, 11.30, 15 minutes.</p> <p>8 (11.18 am)</p> <p>9 (A short break)</p> <p>10 (11.40 am)</p> <p>11 Opening statement by MR GOODMAN</p> <p>12 MR GOODMAN: Chair, D1527 has been watching this inquiry on</p> <p>13 YouTube, and I hope he will be listening to this</p> <p>14 introductory part of the opening, but I understand he</p> <p>15 may wish to turn off when it comes to details of his</p> <p>16 case, and I will give a warning when he get there. For</p> <p>17 those less acquainted with the ciphers, we have already</p> <p>18 seen some of the footage related to D1527. He is the</p> <p>19 person whose case in the High Court compelled this</p> <p>20 inquiry to take place.</p> <p>21 There are three basic reasons why D1527, and indeed</p> <p>22 all of us, are in this inquiry today. The first is</p> <p>23 a tragic one. It is that, while D1527 was detained in</p> <p>24 Brook House between 4 April 2017 and 15 June 2017, he</p> <p>25 was subjected to treatment that was degrading, to</p> <p style="text-align: center;">Page 30</p>	<p>1 express in turn D1527's hope that this inquiry will be</p> <p>2 courageous and take what Professor Bosworth described at</p> <p>3 paragraph 2.27 of her report as this opportunity for</p> <p>4 a bold response. We also commend the bravery of</p> <p>5 Callum Tulley and the personal risks he took to bring to</p> <p>6 light some of the darkest corners of our society.</p> <p>7 The third reason we are here is a hopeful one. It</p> <p>8 is because our law says that no-one shall be subjected</p> <p>9 to inhuman or degrading treatment or punishment or,</p> <p>10 indeed, to torture, and that, where such mistreatment</p> <p>11 does occur, it must be investigated, the full facts must</p> <p>12 be brought to light and lessons must be learned so that</p> <p>13 it never happens again.</p> <p>14 While the law and this inquiry cannot undo what went</p> <p>15 wrong, they can restore some of the dignity that was</p> <p>16 lost, they can ensure that those who wronged D1527 are</p> <p>17 confronted and they can ensure that the mistreatment of</p> <p>18 D1527 is examined, its causes diagnosed and its cures</p> <p>19 are prescribed.</p> <p>20 So I am going to take the inquiry very summarily</p> <p>21 through some of the horrors that [D1527] endured in</p> <p>22 detention. There are four points to emphasise at the</p> <p>23 outset. The first is that almost all of what happened</p> <p>24 to D1527 could, and would, have been avoided if the</p> <p>25 legal requirements of the Detention Centre Rules 2001,</p> <p style="text-align: center;">Page 32</p>

<p>1 particularly rule 34, and the Adults at Risk policy, had 2 been observed. If the Home Office had operated the 3 immigration detention system as it is legally required 4 to do, then D1527 would have been medically examined and 5 a report identifying him as a suicide risk and torture 6 victim would have made its way to the Secretary of State 7 within a day of him being detained and the 8 Secretary of State, if she had properly applied her 9 policies, would have released him. It is the outlawry 10 of the Home Office and its contractors which has allowed 11 the events with which we are concerned to happen.</p> <p>12 Second and related, the Home Office had every chance 13 to avoid what happened to D1527. There were literally 14 dozens of occasions when the failures of the Home Office 15 to comply with the law, particularly rules 34 and 35 of 16 the Detention Centre Rules and article 3 of the European 17 Convention had been emphasised by the courts, both in 18 individual cases and on a systemic level. A chronology 19 of these events will be submitted shortly to the 20 inquiry.</p> <p>21 Third, it must be emphasised that the inquiry's 22 article 3 investigative duty must extend to 23 consideration of the cumulative effect on D1527 of 24 the whole of what happened to him. Even leaving aside 25 the incidents of physical abuse and mistreatment,</p> <p style="text-align: center;">Page 33</p>	<p>1 a very difficult experience for him. The National 2 Offender Management Service had undertaken an assessment 3 which recognised him as a vulnerable young man. At the 4 time, he was 17 years old, by his account, though he was 5 deemed to be 19 by the Home Office.</p> <p>6 NOMS assessed the likelihood of his reoffending as 7 low. When the charges came to trial, he was advised to 8 plead guilty to two minor offences because his lawyers 9 foresaw he would not receive a custodial assistance. He 10 duly pleaded as advised and, on 9 March 2017, was 11 sentenced to a community punishment and he believed he 12 would be released from HMP Belmarsh at that moment. 13 However, instead, the Secretary of State directed he 14 should remain in prison, detained indefinitely under 15 immigration powers. D1527 fell into despair. He found 16 the experience very difficult to deal with and his 17 solicitors advocated to the Secretary of State that he 18 should be transferred from prison to what should have 19 been the more relaxed regime of an immigration removal 20 centre.</p> <p>21 After four weeks in Belmarsh, he was transferred to 22 Brook House, it would appear, late at night on 4 April, 23 treated as the 5th in some of the documentation.</p> <p>24 Now at this point, rules 33, 34 and 35 of 25 the Detention Centre Rules came into play. We have</p> <p style="text-align: center;">Page 35</p>
<p>1 D1527's treatment as a whole throughout detention was 2 inhuman and degrading. That is obvious, having regard 3 to the six cases in the High Court and Court of Appeal 4 between 2014 and 2016, in which it was found the 5 Home Office's practices in immigration detention 6 breached article 3. They had all been about the way in 7 which mentally ill detainees are treated.</p> <p>8 Fourth, the inquiry is invited to find that the 9 incident which we saw on video on 25 April constituted 10 not just inhuman and degrading treatment, but torture.</p> <p>11 I turn then to an outline of what happened. At this 12 point, if my client doesn't wish to hear this recounted, 13 he may wish to turn off.</p> <p>14 D1527 suffered many horrors, including torture in 15 his country of origin, as a child and yet more horrors 16 and abuse as he made his way to this country across the 17 Mediterranean as an unaccompanied child. The details 18 are set out in the accounts given to the doctors, 19 Dr Thomas, <HOM002997> and Dr Basu, <CPS000011> at 20 paragraph 5.1.2.</p> <p>21 Before he was detained in Brook House, D1527 had 22 a history of mental health problems, including having 23 been hospitalised after a suicide attempt. Immediately 24 before he was detained by the Secretary of State, he had 25 been held on remand in HMP Belmarsh, which was also</p> <p style="text-align: center;">Page 34</p>	<p>1 already heard a lot about rule 35(3) of the Detention 2 Centre Rules, the duty to report on victims of torture, 3 and we have seen Dr Hard's report referred to which goes 4 into more detail. Here I want to emphasise rule 34 of 5 the Detention Centre Rules and some of the other 6 subparagraphs of the rule 35, 35(2) and 35(4), and 7 shortly after I will talk about rule 45 as well. I have 8 sent in a summary of the rules. They are appended to 9 the hard copies of the opening statement. If we could 10 bring those rules up on the screen.</p> <p>11 Rule 34(1) required that, upon D1527 entering 12 Brook House, within 24 hours he should have been 13 examined by a medical practitioner, which means, in 14 relation to IRCs, a person who is vocationally trained 15 as a general practitioner and fully registered within 16 the meaning of the Medical Act 1983.</p> <p>17 THE CHAIR: Mr Goodman, sorry to interrupt you, did you want 18 to try to get the document onto the screen?</p> <p>19 MR GOODMAN: If it could be done, that would be helpful, to 20 get the Detention Centre Rules up. They are appended at 21 the back of the hard copy, chair, if it is easier to 22 look there while we get that up.</p> <p>23 THE CHAIR: We may not be able to do that if it is not 24 uploaded with the document handler.</p> <p>25 MR GOODMAN: It has been sent through to the document</p> <p style="text-align: center;">Page 36</p>

<p>1 handler. If it can't be found, we will crack on. 2 THE CHAIR: Do you want to continue -- 3 MR GOODMAN: I will crack on. Hopefully we will get it up 4 as I'm talking. The important point is rule 34(1), 5 chair, and that required that, within 24 hours of 6 admission to Brook House, he should have been examined 7 by a general practitioner. Given that upon transfer to 8 Brook House D1527 was already on ACCT, suicide watch, 9 from Belmarsh -- you can see the references here, 10 <CJS001073>, <CJS001035> and <SXP000125> -- what should, 11 according to the law, have happened then was as follows. 12 One, a physical and mental examination within 13 24 hours -- that's rule 34(1). 14 Two, a report by a general practitioner to the 15 manager on D1527's suicidality -- that's rule 35(2). In 16 fact, had an examination been undertaken, a report would 17 also have been required under rule 35(3) in his case, 18 because he is a torture victim. 19 Three, a report by the manager to the 20 Secretary of State -- rule 35(4). 21 And, four, consideration by the Secretary of State 22 applying the criterion in the Adults at Risk policy of 23 whether to maintain detention in light of the GP's 24 assessment of his suicide risk, his history of torture, 25 the likely duration of detention and all other factors.</p> <p style="text-align: center;">Page 37</p>	<p>1 D1527's solicitors on 5 April turning down the entreaty 2 to conduct a medical examination -- <HOM000101_002>, and 3 telling them that the onus was on the client to raise 4 any concerns he had with staff at the detention centre. 5 That notion seems to have been an enduring one 6 because it was an argument made by the Home Office in 7 the 2006 case before Mr Justice Davis of (HK Turkey) 8 [2006] EWHC 980 (Admin) at paragraph 53 and rejected 9 there. 10 The very next day, 6 April, the solicitors wrote 11 again -- <HOM000345> -- pointing out to the 12 Secretary of State her obligations under the Adults at 13 Risk policy and enclosing a report from 14 a psychotherapist, who had previously treated D1527 in 15 the community, and which explained that D1527 was a very 16 vulnerable young man, immensely troubled by mental 17 health issues. The reference is <HOM000345_006> and 18 <HOM000345_007>. His solicitors again requested that 19 a medical assessment be undertaken of D1527's 20 vulnerability, still no examination was undertaken, and 21 on that day, 6 April, the Secretary of State reviewed 22 the detention of D1527, and it is reference <HOM000572>, 23 and it was decided to maintain detention. In taking 24 that decision, no proper consideration was given to the 25 evidence of his vulnerability, his mental health issues,</p> <p style="text-align: center;">Page 39</p>
<p>1 That legal requirement, that there be a physical and 2 mental examination within 24 hours, has applied to the 3 detention of every detainee in detention centres over 4 the past 20 years. An examination of the litigation 5 history and of the various independent reports of 6 people, such as Stephen Shaw, will show the inquiry that 7 the Home Office has repeatedly failed to enforce it and 8 that its contractors have more often than not been blind 9 to its existence. 10 Although a physical and medical examination by a GP 11 should have been automatic on admission, aware that the 12 Home Office has never regarded that law as a priority, 13 D1527's solicitors wrote to the Secretary of State on 14 5 April, the day D1527 was admitted to Brook House, 15 requesting there be such a medical examination under the 16 Detention Centre Rules -- <HOM000101_005> yet despite 17 the rule 34 obligation, despite the correspondence from 18 D1527's solicitors and despite, even more alarmingly, 19 the fact that, when D1527 arrived in detention, he was 20 on suicide and self-harm watch -- see <CJS000961>, an 21 inquiry document -- despite all of that, D1527's 22 physical and mental health was not examined by a medical 23 practitioner within 24 hours or at all. 24 On the contrary, the Secretary of State, apparently 25 in complete ignorance of her legal duties, wrote back to</p> <p style="text-align: center;">Page 38</p>	<p>1 his suicidality or his history of torture. 2 The legal safeguards under rules 33 to 35 of 3 the Detention Centre Rules were designed to ensure that 4 the suicidal, the mentally ill and the victims of 5 torture should not ordinarily be detained. They were 6 ignored. There is no suggestion in the files that their 7 full effect was even understood by the medical staff or 8 the Secretary of State. Thereafter, in the three months 9 that D1527 was detained, and despite multiple suicide 10 attempts and many periods on suicide watch, the rule 11 35(2) and 35(4) process was never fulfilled. 12 In fact, we know that in 2017 as a whole there were 13 only ten reports pursuant to rule 35(2) across the whole 14 detention state, see IS Bangladesh at paragraph 194, and 15 the Freedom of Information Requests referred to therein. 16 Furthermore, there was not a single rule 35(2) report at 17 Brook House in 2017 and, indeed, right up to 2021. 18 See annex 12 to Nathan Ward's witness statement, 19 starts at <DL000140_0156> and specifically up to 2021 at 20 pages _0175 to _0180 of that document. 21 Because there was never a GP's report, the manager 22 never wrote to the Secretary of State. The 23 Secretary of State never took any such report into 24 account in deciding to maintain detention and, even when 25 D1527's solicitors engaged an expert to produce</p> <p style="text-align: center;">Page 40</p>

<p>1 a detailed psychiatric report, that was not considered 2 in connection with authorising detention either. 3 I have taken time to spell this out because, if the 4 Detention Centre Rules had been observed, along with the 5 requirements of the operating standards and the Adults 6 at Risk policy, then the likelihood is that, considering 7 D1527's detention against the Adults at Risk policy, it 8 would have been apparent to the Secretary of State he 9 met the definition of an adult at risk under that 10 statutory guidance, he would not have been detained 11 beyond an initial 48-hour period -- 24 hours to examine 12 him and 24 hours to ascertain that he was suicidal and 13 credibly a torture victim. The Secretary of State would 14 have taken that into account and, in all likelihood, 15 applying their policies properly, would have released 16 him. 17 So there is a simple point that, if the system had 18 operated in the first 48 hours as Parliament intended, 19 when it established the Detention Centre Rules, we would 20 not be here today. However, it may also be said that, 21 if, at any point during the detention, the system had 22 operated as it should, the safeguard of the Adults at 23 Risk policy and the Detention Centre Rules should have 24 ensured D1527's prompt release. 25 What ensued instead of the release of D1527 is</p> <p style="text-align: center;">Page 41</p>	<p>1 torture, inhuman and degrading treatment was unrelated 2 to a credible attempt to enforce immigration control. 3 As the inquiry will be aware, although the statutory 4 function of detention is to facilitate removal, that is 5 not how it is used in most cases. A significant 6 majority of people who are detained are subsequently 7 released rather than removed. 8 What happened next? D1527's history is set out more 9 fully in his witness statement, his rule 9 response and 10 in the medical reports on his behalf. There is time 11 only for some highlights of the themes, and that will 12 have to suffice. But a forensic analysis of his case is 13 commended to the inquiry. 14 Medication. First, D1527's psychiatric medication 15 was not brought with him on transfer and he didn't 16 receive it for six days. Self-harm. In the meantime, 17 having arrived at Brook House, he began to self-harm, 18 the first incident on 9 April, and the references are 19 <CJS001146> and <CJS000611>. He was treated for a cut 20 wrist. See also <HOM000547> and <CJS001049>. 21 His self-harm and suicide attempts persisted 22 throughout the detention, Dr Thomas reporting that, by 23 the end of May, there were near daily attempts, 24 including banging his head against walls, cutting 25 himself repeatedly, tearing bedding and clothes to make</p> <p style="text-align: center;">Page 43</p>
<p>1 a lesson in why those safeguards, particularly 2 rule 34(1), were prescribed by parliament. It is also 3 a lesson in how egregious it is that the Home Office, by 4 2017, had still not secured compliance with the 5 Detention Centre Rules. The Home Office failure to 6 abide by the law has been well known to those working in 7 this field since at least (HK Turkey) in 2006 well 8 before D1527 was detained. Stephen Shaw's report in his 9 2016 report looked at the rule 34 and 35 procedures and 10 noted they were intended to be a key safeguard in 11 ensuring that vulnerabilities were identified in 12 detainees. It was abundantly clear that rule 35 was not 13 fit for purpose and was failing to protect vulnerable 14 people who found themselves in detention, in large part 15 because the Home Office did not have sufficient faith in 16 its own system. 17 One of the 64 recommendations Mr Shaw made to the 18 Secretary of State to improve the protection of 19 vulnerable detainees was to immediately consider 20 replacing the rule 35 mechanism and to consider the use 21 of independent doctors in the IRCs. 22 As an aside, it may be observed that the defendant 23 never progressed to a point anywhere near obtaining 24 a travel document to remove D1527, even well after he 25 was released. The whole experience of detention,</p> <p style="text-align: center;">Page 42</p>	<p>1 ligatures around his neck. Dr Basu reports in his 2 report there was no engagement at Brook House about the 3 reasons for self-harm. They simply tried to manage by 4 removing the mechanisms or means available to him for 5 achieving it. 6 Food and fluid refusal. In total, at one point, on 7 33 days out of 38, he refused food. 8 Physical and verbal abuse and victimisation. It is 9 also clear that self-harm was the occasion for abuse by 10 staff, which in turn was the occasion for further 11 self-harm. When Detention Custody Officer 12 Calvin Sanders was on observations and suicide watch and 13 boasted to other officers that he had bent back the 14 fingers of D1527 and banged his head up and down on the 15 bounce, he says it was funny, he says, "You're an 16 attention seeker, you prick". That was while he was on 17 self-harm/suicide watch. 18 The strangulation incident on 25 April that we saw 19 yesterday in the hands of DCO Paschali similarly was 20 occasioned by attempts to self-harm with a ligature and 21 to swallow a battery -- see the video at V2017042500021. 22 Similarly, in the incident on 4 May 2017, where 23 D1527 found himself on the netting -- see KENCOV1012 and 24 V2017042500022. He had been refusing food for five 25 straight days beforehand and over most of the time since</p> <p style="text-align: center;">Page 44</p>

<p>1 19 April. He says he felt there was no point in eating 2 because there was no hope left for him. The 4 May 2017 3 incident was ultimately de-escalated successfully, only 4 for a full team of DCOs to raid the cell in which he was 5 recovering and drag him forcefully back to E wing. We 6 have not been shown the CCTV footage of that incident 7 yet, but we can see that the incident involves the 8 deliberate infliction of pain by officers on D1527 see 9 <CJS005530></p> <p>10 According to Dr Basu, in each case these incidents 11 exacerbated his suicidality, self-harm and mental health 12 problems. Other features of his detention included 13 double binds. On 21 April, nurse Karen Churcher told 14 him, entirely incorrectly, that because he was 15 self-harming, he would stay in Brook House for longer. 16 This is what psychiatrists used to call a double bind. 17 He describes in his evidence that that made him feel 18 there was no way out. He had no hope. Later that day, 19 he tried to kill himself.</p> <p>20 Suicidality. Dr Thomas's report, reference 21 <HOM002997> describes how, by the time of her visit, an 22 assessment on 20 May, his suicidality was severe and 23 acute. She advised in her report that, in her view, the 24 likelihood of a successful attempt in the following 25 three months was high to very high. Her opinion was</p> <p style="text-align: center;">Page 45</p>	<p>1 purpose of the system designed to safeguard torture 2 victims. They are recognised as intrinsically 3 vulnerable to retraumatisation. That should be the 4 principle underpinning the Secretary of State's 5 statutory Adults at Risk guidance but is certainly not 6 applied in that way.</p> <p>7 Racism and dehumanisation. We have heard evidence 8 about how he was denigrated, denied his rights to visit 9 a mosque. When D1527 was subjected to dehumanising 10 insults and treatment, he was sworn at, he was called 11 derogatory names. We have seen references made to him 12 acting like a baby or sucking on a dummy. We witnessed 13 yesterday that, after being threatened that he would be 14 put to sleep and throttled by DCO Paschali, he was then 15 demeaned as he fell into a state of terror and panic, 16 being called "You fucking piece of shit" and, when he 17 does not stop gasping, he is asked "Are you a man or 18 a mouse?". We have heard how the detainee said he was 19 treated like an animal.</p> <p>20 In his own evidence, he says he wasn't believed as 21 to his self-harm. He said it made him feel that no-one 22 would take him seriously. They didn't care whether he 23 lived or died. "I felt like animals at a zoo were 24 treated better than I was". 25 D1527's description resonates with D1713's</p> <p style="text-align: center;">Page 47</p>
<p>1 that there was a real possibility of a psychotic 2 breakdown, as indeed D1527 had predicted himself. The 3 report was sent to the Secretary of State on 31 May who 4 paid no heed to it.</p> <p>5 Detention of torture victims. Following persistence 6 by his solicitors, a rule 35 report was prepared by 7 Dr Oozeerally on 13 April under 35(3). He noted that 8 D1527 had tried to kill himself a few weeks prior. He 9 did not regret it. He repeated his intention to kill 10 himself to mental health nurses and was again on suicide 11 watch. There was still no rule 35(2) report on his 12 suicidality to the manager and no rule 35(4) report to 13 the Secretary of State. Nonetheless, the 35(3) report 14 did accept that he gave a credible account of torture 15 and that he had scarring consistent with his account. 16 The report was sent to the Secretary of State. The 17 Secretary of State looked at it and concluded that 18 D1527's needs could be managed effectively by the 19 healthcare team in detention.</p> <p>20 That conclusion was based on no clinical assessment. 21 See <HOM000644>. There was no psychiatric advice that 22 D1527 was being managed in detention. Quite the 23 contrary.</p> <p>24 The Secretary of State's assumption that his fragile 25 psychology could be managed was at odds with the whole</p> <p style="text-align: center;">Page 46</p>	<p>1 description of how he was told by a female officer that 2 she would never lock up her dog but she would lock him 3 up. Some of what we have already seen is redolent of 4 a human zoo. We have seen in the clip where D1527 is 5 self-harming just before he's strangled and demeaned, 6 that officers are taking turns to peer in at him through 7 the window to the cell and joke about his predicament 8 with "Duracell bunny" jibes. We have heard how, on the 9 arrival at Brook House, DCO Tulley witnessed a bizarre 10 humiliation ritual where a detainee was standing naked 11 as officers and managers stood around laughing. We have 12 seen that, when D1527 was on the suicide netting on 13 4 May in the video yesterday, a large part of 14 the population of the detention centre, staff and 15 detainees alike, stood around watching him undergo 16 a psychotic episode.</p> <p>17 For many, this was entertainment and they taunt him, 18 one detainee relentlessly singing, "I believe I can 19 fly", perhaps goading him to jump. Officers are 20 dismissive, laughing at him, too, for expressing his 21 feelings. We hear DCO Clayton Fraser laughs that the 22 best way to deal with him is "What Yan did", in 23 reference to Paschali's strangulation. This is not so 24 much redolent of a zoo as the Bethlem lunatic asylum in 25 the 17th century.</p> <p style="text-align: center;">Page 48</p>

12 (Pages 45 to 48)

<p>1 Removal from association. D1527 says he hated 2 E wing. He was frightened of the isolation, the 3 screaming of other detainees and particularly because it 4 left him more vulnerable to abuse by other officers. 5 Denial of his dignity and religious rights. He was 6 denied the right to go to the mosque, seemingly in 7 Ramadan. He was subjected to excessive and unlawful use 8 of lockdown procedures, as the Hussein case [2018] EWHC 9 213 (Admin) confirms.</p> <p>10 The absence of any fulfilment of duty by any DCO or 11 medical officer. Turning again to the Detention Centre 12 Rules, if we manage to get those up, or in the appendix 13 to the written note, rule 45(2) of the Detention Centre 14 Rules imposes a statutory duty on every officer to 15 inform not only the manager but also the 16 Secretary of State promptly of any abuse or impropriety 17 which comes to his knowledge. There is no evidence that 18 any officer in the employ of G4S has ever fulfilled that 19 duty. They certainly did not in D1527's case.</p> <p>20 Yet let us recall the Home Office commends G4S. 21 The aftermath. Where a state breaches article 3 it 22 falls under a duty to do what it can to repair the 23 wrong. It might be thought that where it had been 24 exposed that, in the care of the state and at the hands 25 of a global corporation, a man has been tortured that</p> <p style="text-align: center;">Page 49</p>	<p>1 wait. The Secretary of State, for her part, has taken 2 every available point of defence and, where her position 3 has been indefensible, she has delayed. When D1527 4 brought judicial review proceedings in June 2017 while 5 detained, he was alleging article 3 breaches even then, 6 and seeking to compel his release. The 7 Secretary of State resisted his release in the 8 High Court and argued in court he should be detained 9 longer because she had not yet managed to assimilate the 10 medical report that described daily suicide attempts. 11 When he pursued the claim seeking to compel what has 12 become this investigation, the Secretary of State 13 resisted again. Her actions meant that proceedings in 14 the High Court did not conclude until August 2019, two 15 years after Panorama. Even then, this inquiry was not 16 instituted until November 2019 and the inquiry will 17 understand the course of delays since then better, but 18 D1527 does not, and it's not been explained to him.</p> <p>19 When D1527 asked for leave to remain in the UK so as 20 to enable him to vindicate his rights, the 21 Secretary of State refused to grant it. D1527 was 22 forced to challenge that position, again by judicial 23 review and only after the High Court granted permission 24 for his case to proceed did the Secretary of State 25 ultimately concede with the grant of a short period of</p> <p style="text-align: center;">Page 51</p>
<p>1 a minister and a chief executive would have knocked on 2 his door to apologise. The Home Office and G4S have 3 been represented by Queen's Counsel over four years in 4 relation to this man's case. They have had ample 5 advice. They have chosen their actions. There has been 6 no apology, no attempt to repair the damages. Both 7 organisations knew about Panorama before it aired. 8 Neither contacted D1527 or sought to contact him for the 9 purpose of investigating what had happened. No 10 compensation has been offered. Nobody has owned up to 11 take responsibility. At this inquiry, the 12 Secretary of State and G4S are in attendance through 13 their lawyers. Nobody is here from the Home Department 14 making an effort to learn lessons. Even before this 15 inquiry, the Home Office's corporate statement is 16 advanced by Mr Riley, somebody who had no involvement, 17 has no knowledge of what happened. His line is that 18 D1527's mistreatment was mainly the fault of G4S 19 employees, but that corporately G4S is apparently to be 20 commended and its contract was, of course, extended 21 after these events.</p> <p>22 The Secretary of State and G4S and the individuals 23 involved in the incidents on film have all been sued for 24 damages. Not one of them has sought to mediate or 25 settle the claims. They have resisted and made D1527</p> <p style="text-align: center;">Page 50</p>	<p>1 leave, but that's not been renewed, so now D1527 is 2 currently compelled to subsist on the barest form of 3 leave, by which he is not actually threatened with 4 removal, but which gives him no period of certainty and 5 no up-to-date biometric permit or resident's card. The 6 practical effect is, he cannot get a job, because few 7 employers will take someone without surety they will be 8 staying here and, when D1527 sought to have his abusers 9 prosecuted, the state failed him again. He lives in 10 a limbo, his life suspended, his psychological fragility 11 incapable of being resolved.</p> <p>12 Although Panorama is striking and shocking, a full 13 analysis of D1527's case shows that it is not just about 14 the incidents filmed by Mr Tulley. Even if he had not 15 been abused by several different officers on several 16 different occasions, even if he had not been strangled, 17 humiliated as a "baby" and a "mouse" and intimidated 18 with being put to sleep, his experience of detention 19 would constitute inhuman and degrading treatment.</p> <p>20 The Professional Standards Unit has already found 21 that he was degraded, reflecting the language of 22 article 3. As to inhuman treatment, he suffered it as 23 a result of the cumulative effects of his vulnerability, 24 the physical and psychological abuse by staff, the 25 conditions of his detention, the lack of adequate</p> <p style="text-align: center;">Page 52</p>

<p>1 medical treatment, particularly for mental illness, the 2 feelings of inferiority, the inability to complain to 3 seek redress, the duration of his detention and the 4 impact of the conditions on his physical and 5 psychological integrity. All the case law shows that 6 the inquiry must consider these factors in combination 7 in discharging the article 3 investigative duty.</p> <p>8 Finally, in relation to torture, I give the 9 definition in the written note. All the components of 10 that definition are satisfied. D1527 suffered severe 11 pain and suffering, both physical and mental. That 12 suffering was intentionally inflicted in the assaults. 13 It intimidated him. "I'm going to put you to sleep, you 14 fucking piece of shit". It was based on discrimination 15 against him on grounds of race, nationality, his 16 immigration and detention status, and on grounds of his 17 mental illness. It was inflicted by those acting in 18 official capacities.</p> <p>19 It is important this inquiry finds that D1527 was 20 subjected to torture; not to inhuman and degrading 21 treatment alone, but to the intentionally inflicted acts 22 of torture by state agents. It matters because of all 23 the reasons we have given in Ms Harrison's opening about 24 the purpose of article 3, rooted, as it is, deep into 25 the common law. It matters because one of the gravest</p> <p style="text-align: center;">Page 53</p>	<p>1 in Children's Services for G4S, and around eight months 2 later, at the end of 2010, he was offered a role 3 involving the redevelopment of the family suite at 4 Tinsley House, following the then deputy 5 Prime Minister's announcement to end child detention.</p> <p>6 The family suite was a section of Tinsley House that 7 held families with children prior to their removal from 8 the UK. Then, in January 2011, Reverend Ward became 9 head of Children's Services at Gatwick IRCs. Leading up 10 to 2012, he became the head of Tinsley House as part of 11 the senior management team, or, as we have heard it 12 referred to, the SMT for Gatwick IRCs. He resigned from 13 G4S on Monday, 14 April 2014.</p> <p>14 He had this to say about his resignation: 15 "Until this point, I have stuck it out because 16 I felt that I could still make a difference to people's 17 lives and help reform from within G4S. It was work that 18 was something of a vocation for me and rooted in my 19 Christian faith of service to disadvantaged, 20 marginalised people. Ultimately, however, after many 21 years of trying to make change, I felt I just could not 22 cope with continuing to work for G4S. I realised that, 23 by remaining in the system, I was perpetuating an 24 unjust, inhumane system, which I would now describe as 25 barbaric."</p> <p style="text-align: center;">Page 55</p>
<p>1 of constitutional lines has been crossed and that needs 2 to be said. The courage that D1527 and Mr Tulley have 3 shown presents a challenge to this inquiry to act with 4 courage, to vindicate the truth of what happened, to 5 acknowledge that in D1527's case the most fundamental 6 values of a democratic society were violated. That is 7 the challenge to this inquiry. Thank you, chair.</p> <p>8 Opening statement by MS MORRIS 9 MS MORRIS: Chair, I will address you now in relation to 10 Reverend Nathan Ward. Reverend Ward became employed by 11 G4S in 2001 at the time the organisation was known as 12 Group 4. His role at the outset was as a part-time 13 chaplain at the Medway Secure Training Centre. He 14 stayed in that role until 2007, and during the course of 15 that work was awarded a National Youth Justice Award.</p> <p>16 From 2007 to 211, he worked as an enrichment manager 17 at the same secure training centre, which included being 18 duty director.</p> <p>19 In 2011, he completed a secondment at Gatwick IRCs, 20 which includes Brook House and Tinsley House, and he was 21 based primarily, at that time, at Brook House.</p> <p>22 At first, Reverend Ward had no official role, but he 23 helped to develop the family and safeguarding policies 24 for Tinsley House.</p> <p>25 He was then seconded to work on business development</p> <p style="text-align: center;">Page 54</p>	<p>1 Following his resignation, Reverend Ward visited 2 a psychiatrist who referred him to a psychologist, and 3 he was informed by that psychologist that he had 4 post-traumatic stress disorder, which was due to the 5 trauma he witnessed and experienced whilst working for 6 G4S at Medway Secure Training Centre and also at Gatwick 7 IRCs and, in particular, Brook House.</p> <p>8 It is worth addressing you, chair, in relation to 9 what happened at Medway Secure Training Centre. Whilst 10 there, Reverend Ward had a number of concerns about the 11 treatment that he witnessed the children experiencing, 12 and he became a whistleblower and reported those 13 concerns to a number of individuals. He notes that 14 abuse that was exposed in an undercover Panorama 15 programme on Medway Secure Training Centre exposed 16 similarly harrowing evidence with close parallels with 17 what would be exposed a year later at Brook House.</p> <p>18 Chair, we would invite you to look in particular at 19 the Medway Improvement Board's final report of 20 the board's advice to Secretary of State for Justice. 21 That was a report that looked at the failings at Medway 22 Secure Training Centre and identified a number of them. 23 It is worth noting a number of those failings now and, 24 chair, we hope that you will see that there are some 25 parallels with the features of Brook House.</p> <p style="text-align: center;">Page 56</p>

<p>1 One of those findings is that there was a lack of 2 clarity on the purpose of a secure training centre. 3 Another finding was that leadership within the secure 4 training centre has driven a culture that appeared to be 5 based on control and contract compliance, rather than 6 rehabilitation and safeguarding vulnerable young people. 7 Another finding: 8 "Significant concerns this culture and emphasis on 9 contract compliance may be leading to reports of 10 falsification of records", as seen on Panorama. 11 Another finding: 12 "There are blurred lines of accountability and an 13 ambiguous management structure." 14 Another finding: 15 "Current safeguarding measures are insufficient and 16 outdated. There is too much emphasis on control and 17 contract compliance and not enough on the best interests 18 and mental well-being of the trainees." 19 That's what the children were referred to at Medway 20 Secure Training Centre. Here we can replace that word 21 with "detained people". 22 Another finding: 23 "The board is not convinced that the various 24 organisations involved in scrutinising and responding to 25 safeguarding at Medway STC are co-ordinated in their</p> <p style="text-align: center;">Page 57</p>	<p>1 For these reasons, the improvement plan needs to 2 incorporate effective mechanisms for continuity of 3 improvement, assessment of impact of improvement and 4 a timetable for handover. 5 This is what Reverend Ward has to say about that: 6 "These findings and the report as a whole present 7 stark similarities for the abuse and corruption exposed 8 in the Panorama documentary on Brook House. It is 9 notable that interim director Ben Saunders [who was 10 seconded as director from Brook House and later returned 11 in 2016] felt that the key to the problems lie in 12 organisational culture." 13 Peter Needham, president of G4S UK and Ireland also 14 commented that there was a need to encourage a change of 15 culture and for people to be able to openly raise their 16 concerns. What Reverend Ward had to say was: 17 "There does not, however, seem to be any reflection 18 on their own responsibility for the organisational 19 culture." 20 Furthermore, Reverend Ward is not aware of whether 21 G4S has done any analysis or undertaken any comparison 22 between the culture at Brook House with that seen at 23 Medway STC. Reverend Ward's view is that this should be 24 the starting point for this inquiry, the Medway 25 situation and the circumstances there, if lessons are</p> <p style="text-align: center;">Page 59</p>
<p>1 approach, increasing the risk of safeguarding issues 2 falling through a gap." 3 Another finding: 4 "There is a history of similar concerns being raised 5 repeatedly in letters from whistleblowers and former 6 staff. Policies forming part of the STC contract need 7 to be reviewed to ensure that they support the overall 8 safety of young people rather than focus on contractual 9 penalties." 10 Another finding: 11 "Whistleblowers and children inside of the STC need 12 to have an effective support framework in which they 13 feel safe to raise concerns and complaints. There is 14 a lack of understanding of the causes and drivers of 15 behaviour problems and too much focus on controlling 16 behaviour rather than dealing with underlying 17 vulnerabilities." 18 And the board in that case had concerns about how 19 Youth Justice Board manages their contract and monitors 20 safeguarding at the STC. 21 There is a need for formal separation of the often 22 conflicting YJB monitoring functions of ensuring 23 contractual compliance and monitoring safeguarding and, 24 finally, regardless of who manages Medway STC, changes 25 in culture, leadership and staff approaches are needed.</p> <p style="text-align: center;">Page 58</p>	<p>1 really to be learned and, more importantly, the real 2 change to be brought about. 3 Chair, I will just provide a few examples of what 4 Reverend Ward witnessed and experienced while working 5 for G4S at Gatwick IRCs. There are many more examples 6 contained within his witness evidence, but these 7 examples demonstrate the diversity of the issues that 8 Reverend Ward witnessed and experienced. 9 Number one. Witnessing or being aware of a number 10 of inappropriate uses of force at Brook House. 11 Number two. A culture of racism, including the use 12 of cultural stereotypes and generalisations and clear 13 evidence of an "us and them" mentality. 14 Number three. Healthcare assessments being 15 completed over a short period of time, often upon 16 a detainee's arrival at the centre, sometimes in the 17 middle of the night when someone had been brought in 18 after a traumatising enforcement experience and were 19 unlikely to be in a position to disclose a history of 20 torture, mistreatment or trauma. 21 And the fourth example -- as I have said, there are 22 many more, but the fourth example, for these purposes: 23 in around 2011 or 2012, Reverend Ward received an email 24 from a G4S accountant with an asset list for Cedars' 25 predeparture list asking him to highlight items that</p> <p style="text-align: center;">Page 60</p>

<p>1 were charged to the Home Office but that G4S would never 2 actually buy.</p> <p>3 Chair, four diverse examples of the concerns that 4 Reverend Ward had -- as I've said, there are many more.</p> <p>5 It is also worth referring to the question of 6 the use of force and Reverend Ward's experience of that. 7 This is the way in which he describes assaults and abuse 8 as shown on Panorama as a gross manifestation of an 9 institutional corrupt and toxic culture, the same 10 culture that he witnessed and experienced while working 11 at Gatwick IRCs at Brook House.</p> <p>12 This is what he says about that: 13 "Whilst the footage inevitably focuses on a core 14 group of staff, in my experience, it is likely the 15 behaviour of staff was perpetuated by the system in 16 which they were working. It represents a system in 17 which members of staff felt confident enough to take 18 this action and even cover up outrageous abuse without 19 repercussion. I do not believe, from my knowledge, that 20 they could have conducted themselves in this way without 21 the wider institutional culture of dehumanisation and 22 othering that was at play which made this conduct 23 accepted by many more staff."</p> <p>24 Reverend Ward will give evidence of a toxic, 25 masculine and bullish culture. This same toxic culture</p> <p style="text-align: center;">Page 61</p>	<p>1 Reverend Ward states at paragraph 308 of his statement, 2 his first statement, this is a major accountability 3 deficit that impacts on people's trust and confidence in 4 the system, and it is the lack of accountability and 5 sanctions to date that is Reverend Ward's primary reason 6 for participating in this inquiry and why he considers 7 it important. He's not motivated by money, he's not 8 motivated by status, and he has nothing to gain 9 personally from bringing his concerns to light, and, in 10 fact, as you have heard, chair, it's had a negative 11 impact on him.</p> <p>12 This is what Reverend Ward has to say about his 13 participation in this inquiry: 14 "I strongly believe that things will not 15 fundamentally change unless people are held to account 16 at all levels of the system and serious consequences 17 occur for the individuals and corporate bodies. I do 18 not understand how G4S could continue being the contract 19 provider for almost three years after the Panorama 20 broadcast, which included a two-year extension, and, 21 equally, why any contract could continue to be run with 22 G4S after the Medway and Brook House reporting. I also 23 do not understand how managers within G4S with oversight 24 for these centres, or onsite, like Ben Saunders, 25 Steve Skitt, Jules William or Steve Dix, were not</p> <p style="text-align: center;">Page 63</p>
<p>1 was also a feature of the training on control and 2 restraint, and Reverend Ward had this to say about the 3 training:</p> <p>4 "I witnessed staff being trained in degrading ways, 5 such as forcing them to dress up in boiler suits and 6 helmets to do warmups, with press-ups if they made 7 mistakes. I witnessed the visible adrenaline of staff 8 who would regularly engage in control and restraint 9 following the restraint. They seemingly enjoyed the 10 adrenaline rush, and it was reflective of the alpha-male 11 attitude."</p> <p>12 Reverend Ward, again, became a whistleblower. He 13 raised his concerns with a number of people. He raised 14 his concerns with deputy director Duncan Partridge. He 15 raised his concerns with director Ben Saunders. He 16 raised his concerns with Home Office monitor at 17 Tinsley House, Deborah Western. He raised concerns with 18 regional HR manager, Steph Philips. He raised concerns 19 with managing director Jerry Petherick. He raised 20 concerns with Kent Police and he was told that they had 21 shared those concerns with Sussex Police and the Serious 22 Fraud Office. And he raised concerns with the Home 23 Affairs Select Committee.</p> <p>24 And yet there have been no criminal prosecutions 25 arising from the events at Brook House. As</p> <p style="text-align: center;">Page 62</p>	<p>1 dismissed but were able to continue in their roles or 2 take up posts elsewhere. I also do not understand how 3 senior civil servants responsible for these contracts, 4 such as Paul Gasson or Mr Schoenenberger, and for 5 Detention Services generally have not been disciplined 6 but remain in post."</p> <p>7 He finishes with this: 8 "Until concerted action is taken and is seen to be 9 taken, complaints made will be ignored, or, more likely, 10 won't be made at all because people will have no 11 confidence in the system."</p> <p>12 So, in summary, chair, what Reverend Ward wants to 13 see is real state accountability, real corporate 14 accountability, real action and real change. Thank you.</p> <p>15 THE CHAIR: Thank you, Ms Morrison.</p> <p>16 Opening statement by MR ARMSTRONG 17 MR ARMSTRONG: Good afternoon, chair. I hope that a message 18 has got through to you that we were adjusting the order 19 of the speeches. I have an hour. What I propose to do 20 is get just shy of half of that done before the lunch 21 break.</p> <p>22 THE CHAIR: That sounds great. Thank you, Mr Armstrong.</p> <p>23 MR ARMSTRONG: Chair, I appear also with Ms Morris 24 representing, and instructed by Deighton Pierce Glynn 25 solicitors, three core participants in this inquiry.</p> <p style="text-align: center;">Page 64</p>

<p>1 They are D687, D390 and the charity Gatwick Detainee 2 Welfare Group, who will be known throughout as GDWG. 3 Can I just be clear that both D687 and D390 have 4 been present throughout the last three days, and are 5 present now. They are listening intently to all that is 6 being said. That is, of course, very often not easy 7 listening for them, and it is not easy watching, 8 particularly through D687's video that was played 9 yesterday. But they do that because it is something 10 that they want to do. They want to listen, they want to 11 contribute, in order to understand, to the extent that 12 they can, what happened to them and to assist you as 13 best they can at being as effective as this inquiry can 14 be. 15 Can I also just say this. I have circulated 16 a paper, and I know you have got the paper. I am going 17 to speak to that paper. I'm not going to do all of it. 18 I don't have the time to do all of that. But I do ask 19 that the original paper be formally adopted for the 20 purposes of this and the documents to which it refers be 21 formally adopted and we will sort out the mechanics 22 between your team and ours hopefully overnight. If 23 anybody else wants a copy of that paper, we can 24 circulate it directly. 25 I start my opening by referencing a point that's</p> <p style="text-align: center;">Page 65</p>	<p>1 be a time limit. As she says, that may be the only way 2 to reduce the kinds of distress shown in the BBC footage 3 and to foster the appropriate professional staff 4 culture. 5 We also, the DPG core participants, support that and 6 support also her invitation to be bold. 7 They also say, unsurprisingly, it is now very clear 8 that mentally ill people should simply not be detained 9 under immigration powers. Chair, it won't surprise you 10 to learn also that we invite you to accept what 11 Professor Bosworth says and seize the unique opportunity 12 to do something about these matters. Nothing like this 13 inquiry has ever happened in the immigration detention 14 context before. It was very hard to bring the inquiry 15 about. D1527 and D687 did have to take a judicial 16 review in order to achieve that and, given that, it may 17 be thought nothing like this will ever happen again. So 18 you may have the one and only opportunity to do 19 something about what we are seeing in these proceedings. 20 Now, just developing that point about the nature of 21 the cohort a little, and talk about the characteristics 22 which that cohort have, I've set this out in the paper 23 and a lot of it will already be familiar to you, so I'm 24 just going to draw out some particular points, if I may. 25 It starts with the prevalence of mental ill-health</p> <p style="text-align: center;">Page 67</p>
<p>1 been made by others already, and that is that there is 2 something uniquely toxic about immigration detention. 3 We say that that toxicity arises because of the scale of 4 the power imbalance that is in play here. There is 5 a power imbalance in any detention context, as I know, 6 chair, that you will know, but it is particularly 7 pronounced in this context because of the scale of 8 the immigration detention power which is often 9 unpredictable and often indefinite in its application. 10 That's an one side of the balance. 11 On the other side of the balance, you have the 12 particular nature of the immigration detention cohort, 13 who have a particular range of vulnerabilities, which we 14 say puts them at particular risk of abuses of power. 15 Now, ensuring that those abuses don't occur requires 16 particularly robust systems and safeguards, it requires 17 eternal anxious oversight and we say a system that's 18 calibrated for immigration throughput, if I can put it 19 that way, rather than welfare, that is managed at the 20 lowest possible cost and which leaves junior and 21 inexperienced staff operating without leadership, 22 guidance or proper oversight is not that system. We, 23 like others that you have heard from this morning, 24 support what Professor Bosworth says about this. She is 25 not alone in thinking that the only solution to this may</p> <p style="text-align: center;">Page 66</p>	<p>1 but can I emphasise that doesn't necessarily mean people 2 who have already had a formal diagnosis of mental 3 ill-health. It may be people have mental ill-health 4 that is only just emerging and that may be because this 5 cohort often comes from particularly traumatic 6 backgrounds, they may be fleeing persecution and they 7 may have the kind of trauma that is likely to be 8 exacerbated in the detention environment and suffer 9 retraumatisation. I mention that D390 in particular may 10 be an example of this. He had little in the way of 11 a formal diagnosis at the time that he arrived, but he 12 had a background of childhood trauma and some recent 13 time in prison for immigration documents offences. 14 The point is this: none of this is surprising or 15 unpredictable. The Home Office and G4S know very well 16 from the history, from the cases with which they have 17 been involved and from the studies that have been done 18 in this area that this is true of this cohort and that 19 they -- this is what they can see happening and they are 20 under an obligation or responsibility to ensure that 21 their systems are alert and responsive to such things 22 and are there to respond to mental health presentations 23 as they emerge. 24 Mental health obviously links to things like suicide 25 and self-harm, although the overlap is not a complete</p> <p style="text-align: center;">Page 68</p>

<p>1 one. The suicide and self-harm in immigration detention 2 is a reflection of the despair and the absence of hope 3 that many feel. It is unfortunate self-harm, in 4 particular, may afford many in immigration detention the 5 only control over their lives which they feel able to 6 exert. You can see that very clearly again in that 7 footage that we saw of D687 yesterday, on 13 May, which 8 is such a painful watch for anybody.</p> <p>9 Can I just, while I talk about suicide and 10 self-harm, just put down a marker in relation to 11 a particular point, and Mr Goodman referred to it in his 12 opening just a moment ago, which is that there is a real 13 issue -- there is a divergence between the number of 14 ACDTs in the system and the very small number of 15 rule 35(2) reports. He has referred to the case of 16 IS Bangladesh and I have put the reference to that in 17 the paper as well. There is a real system problem with 18 this and it may be as follows, which is that the ACDT 19 system is drawn from the ACCT system, which is the 20 prison system, and I suspect, chair, you are all too 21 familiar with the ACCT system from prisons. But there 22 is a difference between immigration detention and 23 prison. There are many, but this one matters for 24 present purposes, which is that, in prison, you do not 25 have an administrative detention power in play. You do</p> <p style="text-align: center;">Page 69</p>	<p>1 combine with challenging behaviour, and sometimes very 2 challenging behaviour, and that may sometimes be about 3 mixing people who are vulnerable with people who are 4 challenging, and we have heard reference to foreign 5 national offenders and the difficulty that comes in from 6 moving people from the prison estate into the 7 immigration detention estate. I put in the paper some 8 reference by way of context. This was 2017 and there 9 were very dramatic problems in the prison estate in 2017 10 as I imagine, chair, you already know. But it would be 11 far too simplistic a response to say that that is the 12 problem, that that is the -- that resolving that is part 13 of the solution, because, often, the very -- the most 14 vulnerable individuals also have some kind of 15 conviction. There are, of course, convictions and 16 convictions, and we will see that with cases where it is 17 just documents offences, for example, without anything 18 else. But often the most vulnerable people have those 19 kind of convictions as well.</p> <p>20 Because, chair, the reality is that people are often 21 both vulnerable and challenging and people who have 22 mental health problems are often the most challenging, 23 and then that's people who are in extremis are often the 24 most challenging. Then you get into people who have 25 learning difficulties or who are neuro diverse.</p> <p style="text-align: center;">Page 71</p>
<p>1 not have the possibility of release if somebody, for 2 example, is deteriorating. That means that the ACCT 3 system is not designed by reference to linking to the 4 detention power. There is no need to link ACCT to 5 a release valve because there isn't one in the prison 6 context.</p> <p>7 There is a need, however, to do it here, and it is 8 supposed to be the 35(2) system, but there appears to be 9 no link drawn. There is not, for example, on the ACDT 10 documents, a prompt, as I say, in an ACDT review, for 11 example, "Is this somebody who needs a 35(2) report". 12 It appears to be a system design problem. It may be 13 a carry-over from how the system was originally 14 designed.</p> <p>15 I have then talked in the paper about things like 16 vulnerabilities that arise from detained people and 17 their limited facility in English, in many cases. What 18 I want to say more about that, and counsel to the 19 inquiry also talked about that, is the extent to which 20 it can also be a basis of the mockery that some detained 21 people experience.</p> <p>22 Their limited facility in English is often the 23 subject of some of the mockery that goes on.</p> <p>24 Can I also deal with this. A particular complexity 25 in this context arises because these vulnerabilities may</p> <p style="text-align: center;">Page 70</p>	<p>1 Problems in the prison system: at least as much of 2 a problem in the immigration detention system. They may 3 have poor coping skills. We need to have a system which 4 is designed around recognising that you can be both 5 vulnerable and challenging at the same time.</p> <p>6 I then have talked about the importance of 7 relationships at paragraph 12 of my written paper, and 8 that is something because we know that in any detention 9 context relationships are critical. For the most part, 10 detention contexts are governed by reference to consent 11 rather than imposing things on them and most, if not 12 every, prison governor will tell you that. But those 13 relationships become much more difficult when you're 14 dealing with people who are mentally ill or who don't 15 speak English or have other things going on of that 16 kind.</p> <p>17 However, can I just give this particular example: it 18 is much -- often in the prison context, a relationship 19 is developed by giving somebody hope and talking to them 20 and explaining to them what they need to do in order to 21 progress. You can have the prison officer who says, 22 "Look, I know something has gone wrong in your life, but 23 what you need to do is put this behind you and do the 24 following work. You now have these opportunities. Do 25 the offending behaviour course. Take the educational</p> <p style="text-align: center;">Page 72</p>

<p>1 opportunity. Do the work that might get you a job. 2 Build the relationship that you need to build". Those 3 things are much more difficult, very often, in the 4 immigration context where you can't give somebody hope 5 because you're not supposed to be managing them towards 6 release, you're managing them towards removal, is the 7 idea, and that's not something that they want and may, 8 in fact, not be something that's going to happen in any 9 event because we know that the removal figures are very 10 small. But if you can't give that individual hope, if 11 you can't show them a way out, then that is going to 12 undermine the possibility of building a relationship. 13 It is going to undermine the basis upon which you 14 administer the centre. But, also, if you are in 15 a situation where not only can you not give them that 16 hope, you have to actively manage them towards a charter 17 flight that's coming in a couple of days' time that you 18 can't tell them about, so you have to keep that from 19 them, so you have to be talking to them only for them to 20 be forcibly taken to a flight a couple of days later, 21 that will dramatically destroy the possibility of 22 a relationship there. That's something, for example, 23 Lee Hanford talks about in his interview with Verita. 24 There is also a human response to all of that, 25 I suggest, which is, if you are facing with -- if you</p> <p style="text-align: center;">Page 73</p>	<p>1 a highly-sensitive trafficking claim didn't emerge the 2 first time somebody came into the country and it took 3 time, often years, for something to emerge. One has to 4 remember the immigration system is another system that 5 is under-resourced and creaking and it often misses good 6 claims. So the fact somebody is bringing a claim may 7 well mean, in fact, it is a good claim, it just wasn't 8 picked up the first time around. 9 I have spoken about despair and hopelessness in this 10 context. That, too, informs things, maladjusted 11 response, like drug taking. You know about new 12 psychoactive substances, NPSs, spice. We know they are 13 freely available in the immigration detention system, 14 just as they are freely available in the prison system. 15 They come in via other routes, including, and I've put 16 references in the paper, via staff. But I emphasise 17 this: those drugs are dangerous. They come in 18 concentrations that are very often unknown. I suspect 19 you will have heard of the concept of the "spice pig" 20 where people bring the vulnerable detained person and 21 give them the drugs and then see how they react in order 22 to see how concentrated or otherwise it is. Now, the 23 results of that awful practice can be very dramatic and 24 very loud, as some of the video footage shows, and all 25 of that goes into the atmosphere at Brook House and we</p> <p style="text-align: center;">Page 75</p>
<p>1 are faced with somebody who desperately needs help and 2 you're an officer and you can't give that to them, then 3 that is a very difficult thing to do. One of 4 the responses, one of the maladjusted responses, that 5 may flow from that is that you say, "Well, I can't help 6 you because you're not in fact deserving of help", and 7 that's where the dynamic changes. That's where you're 8 starting to cast somebody as "other", somebody who 9 doesn't deserve help, and in due course that develops 10 into something where it is harder to be unpleasant to 11 them -- it becomes easier to be unpleasant to them, 12 sorry, it becomes easier to swear at them and ultimately 13 it becomes easier to use force on them. These are the 14 myriad of ways in which these matters develop and the 15 culture that we saw in Brook House develops. 16 It is -- one of the things that happens in this 17 context -- I'm now at paragraph 16 -- is that progress 18 towards release or removal, part of that is also people 19 bringing in claims in order to stop their removal. The 20 Home Office is often very scathing about those attempts 21 saying they are abusive and unmeritorious. But one has 22 to remember that many of those claims are very well 23 founded because the original asylum claim that this 24 individual may have advanced may not have been properly 25 investigated or advanced. It may be that</p> <p style="text-align: center;">Page 74</p>	<p>1 have seen the examples on the video footage where you 2 have got people who are very loud and very vulnerable 3 and having those kinds of reactions. And it all 4 contributes to the atmosphere that is, as I put it, 5 ragged, febrile, often hostile, ultimately degrading and 6 brutalising. 7 How, then, are those problems, that range of complex 8 problems and needs, being managed and by whom? The 9 issue here that you then have is, you've got people 10 coming in who are -- have little or, if any, relevant 11 experience and very little training. We see the 12 reference in the Verita interviews where people are 13 asked about what their experience was before they came 14 to Brook House and you will see references to people 15 where they have worked in supermarkets or in other forms 16 of retail, they have been baggage handlers at Gatwick, 17 we see references to Pizza Hut and Argos, people have 18 done painting and decorating. There are others, prison 19 officers or who have worked in the military, who bring 20 aspects of that in and that can create its own problems. 21 It is a big ask of people who have done those kind of 22 jobs to manage problems as complicated and as pronounced 23 as these ones. To do it, you will note, on a flat rate 24 which actively discourages people from staying in the 25 job as they get more experienced and perhaps better able</p> <p style="text-align: center;">Page 76</p>

<p>1 to do it.</p> <p>2 That is what -- you need a system that fosters that</p> <p>3 age and experience because you need people who have the</p> <p>4 confidence and ultimately the authority, and by</p> <p>5 "authority" I mean moral authority, including the</p> <p>6 integrity, which needs people who, for example, will</p> <p>7 call out poor behaviour when they see it. That is not</p> <p>8 going to be fostered by a £25,000 flat rate.</p> <p>9 I've talked about training and the shortness of</p> <p>10 that. I will leave that to the paper. I have talked</p> <p>11 about understaffing, two people on a wing of 126. My</p> <p>12 learned friend counsel to the inquiry covered that the</p> <p>13 other day. But keep in mind that, when you have got</p> <p>14 insufficient staff, there are obvious and dramatic</p> <p>15 problems that that generates because there can be</p> <p>16 situations that are difficult and even dangerous. But</p> <p>17 even on a more mundane day-to-day level, if you don't</p> <p>18 have enough staff, you have staff who are ignoring basic</p> <p>19 requests because they don't have time to deal with them.</p> <p>20 You have staff who are responding to those requests too</p> <p>21 bluntly or it means it is taking people longer to get</p> <p>22 off a wing than it would otherwise take, which means</p> <p>23 they are getting frustrated and noisy. I just flag that</p> <p>24 because we know, and it is referred to in the material</p> <p>25 at several stages, the noise at Brook House is</p> <p style="text-align: center;">Page 77</p>	<p>1 will become swearing. It may become more maladjusted</p> <p>2 and difficult responses.</p> <p>3 When people are tired and they are looking and they</p> <p>4 are dealing with a situation, they may reach beyond</p> <p>5 their immediate tools and they may reach out into the</p> <p>6 wider context and culture. My learned friends from</p> <p>7 Duncan Lewis's team have been talking about the wider</p> <p>8 context and the hostile environment and the language</p> <p>9 about migration that is used by politicians and by the</p> <p>10 media, and that begins to inform the atmosphere, that</p> <p>11 begins to inform what is being said because that is all</p> <p>12 the individuals who are having to manage this process</p> <p>13 have to reach to because they have nothing else instead,</p> <p>14 nothing that is less dysfunctional.</p> <p>15 When you have that, something else is going on</p> <p>16 there, officers and other staff who are struggling with</p> <p>17 these -- the situations which they are having to manage</p> <p>18 may also feel the need to stick together. We have seen</p> <p>19 issues in the material about the way cliques develop and</p> <p>20 the way cliques may develop around unsuitable people.</p> <p>21 We have seen remarkable consistency in what is being</p> <p>22 said about this. We get that from the Verita report,</p> <p>23 from Nathan Ward's evidence, we are getting it now from</p> <p>24 what Mary Bosworth says as well. That is what is</p> <p>25 happening and this is a product of the situation in</p> <p style="text-align: center;">Page 79</p>
<p>1 astonishing and there is case law on the relevance of</p> <p>2 noise in relation to article 3 assessments, which we can</p> <p>3 come to in due course, if necessary. But we were</p> <p>4 watching the video yesterday, the video that was taken</p> <p>5 in the stairwell, where you can hear the noise --</p> <p>6 despite there are closed doors, you can still hear the</p> <p>7 noise of the wings. There is something about the</p> <p>8 physical environment and the noise of Brook House that</p> <p>9 contributes to its often, we say, degrading nature.</p> <p>10 I just put in a reference there to rule 3 of</p> <p>11 the Detention Centre Rules because that requires</p> <p>12 a relaxed regime with as much freedom of movement and</p> <p>13 association as possible, consistent with maintaining</p> <p>14 a safe and secure environment and to encourage and</p> <p>15 assist detained persons to make the most productive use</p> <p>16 of their time whilst respecting in particular their</p> <p>17 dignity and their right to individual expression.</p> <p>18 I flag that because, when we watch those videos, one</p> <p>19 needs to keep in mind whether or not really what we are</p> <p>20 seeing can be said to be compatible with that.</p> <p>21 I then talked about the shift hours. 13 and a half</p> <p>22 hours is a very long shift. Tired staff, along with</p> <p>23 inexperienced and ill-equipped staff, are not going to</p> <p>24 be improved in their ability to do that. Tired and</p> <p>25 inexperienced people will end up shouting. Shouting</p> <p style="text-align: center;">Page 78</p>	<p>1 Brook House.</p> <p>2 It requires significant personal and professional</p> <p>3 presence and confidence to do the right thing in many of</p> <p>4 these circumstances. It does require that integrity,</p> <p>5 and that may all be conferred in a number of ways -- by</p> <p>6 recruiting the right people, training them in the right</p> <p>7 way, enforcing and reinforcing proper behaviour, leading</p> <p>8 by example, and by providing constant and effective</p> <p>9 oversight. But, as all of those reports say, was that</p> <p>10 happening in Brook House in 2017? And they are all</p> <p>11 consistently saying, no, it wasn't. They are all</p> <p>12 talking about the void in leadership, talking about the</p> <p>13 dysfunction at the senior management team level of G4S.</p> <p>14 Also, as my learned friend Ms Morris has just been</p> <p>15 pointing out and referring to the Medway report, it is</p> <p>16 clear also from other sources -- there is reference --</p> <p>17 I have put reference in the paper to the Jerry Petherick</p> <p>18 file note that goes back to 28 October 2014, who talks</p> <p>19 about, "I was becoming increasingly concerned about the</p> <p>20 stability of the management team at Gatwick". You put</p> <p>21 that together with what then happens in Medway, you then</p> <p>22 put it together with things like the whistleblowing</p> <p>23 complaints -- it is not just Callum Tulley, there are</p> <p>24 others, and I put references in here to people like</p> <p>25 David Waldock who talked about the incomprehensible</p> <p style="text-align: center;">Page 80</p>

<p>1 levels of bullying at Brook House, and he wrote that in 2 April 2017. That complaint refers to a whole series of 3 individuals -- Ben Saunders, Steve Skitt 4 DCO Gayatri Mehraa and Vanessa Smith as the Home Office. 5 Chair, for your note, I'm now on paragraph 29 here. 6 Those are all names we now see regularly throughout 7 these papers. Vanessa Smith is somebody who came across 8 D687 only a very short period of time before the 13 May 9 incident. She is linked in with Gayatri Mehraa in that 10 complaint. Gayatri Mehraa is somebody who is cited in 11 the GDWG evidence. We all see how that is linking 12 together and we see how the atmosphere is connected and 13 amplifies itself.</p> <p>14 We say, chair, that the result of all of that mix, 15 all that coming together in that particular crucible, 16 should surprise nobody. What happens is the matters 17 escalate, the temperatures goes up, the problems that 18 are presented don't get solved, they get aggravated, and 19 you get all of the results that you then see. Mental 20 ill-health emerges or gets worse, you see references, 21 some people engage in food or fluid refusal and then you 22 see the language which becomes -- it may start as bleak 23 humour, designed as a maladjusted coping mechanism. It 24 then becomes swearing, it then becomes abuse, it may 25 then become physical abuse. I have made a note in this</p> <p style="text-align: center;">Page 81</p>	<p>1 to 1.00 pm, which is probably a good moment. 2 THE CHAIR: Thank you very much, Mr Armstrong. We will 3 reconvene at 2.00 pm. 4 (12.57 pm) 5 (The short adjournment) 6 (2.00 pm) 7 MR ARMSTRONG: Most of the points I was making just before 8 lunch, chair, were aimed inevitably at G4S, but I do 9 want to make it clear that the Home Office is also fully 10 implicated. 11 This is a point that Ms Harrison has already made, 12 and made in full, so I can take it relatively briefly 13 but can I make some key points about it, and this is 14 paragraph 40 of my paper. 15 The Home Office wrote the contract which contained 16 no, or no proper, provision around the monitoring of 17 welfare. It agreed the addition of 60 beds to a centre 18 which was already struggling. It has staff, including 19 contract monitors, on site and in particular we just 20 note, in respect of GDWG, Mr Gasson, the senior 21 Home Office manager on site at Brook House, is in all 22 those meetings. He's certainly in the key meetings 23 which are those meetings that complain about an agreed 24 action in respect of GDWG. There are also matters that 25 should put the Home Office on notice of the problems at</p> <p style="text-align: center;">Page 83</p>
<p>1 about the level of swearing. 2 The reason why Professor Bosworth talks in her 3 report about a completely unacceptable level of 4 swearing, and she talks about that against detained 5 people, and she talks about it between detained people 6 and she talks about it between staff, but we -- you know 7 that we have had a lot of video footage and the key 8 video footage is about four hours. We have done 9 a search, a keyword search, on those transcripts and you 10 end up with 1,407 instances of the word "fuck", 74 11 instances of the word "cunt" and 21 for the word 12 "bitch". That is an extraordinarily high level of 13 swearing. It has become endemic and it is coarsening 14 and hardening and it is leading back to that ragged, 15 febrile and hostile environment. I flag that, and this 16 is the last point I will make just before I finish for 17 lunch, that the reason why the language matters is 18 because of the effect that it has, which is recognised 19 as a matter of law, and between those paragraphs 33 20 through to 39, I set out why the language matters in an 21 article 3 context. It is partly because it evidences 22 object and what is the purpose of the treatment. But it 23 is also relevant in its own respect because of 24 the impact that it has. 25 Chair, by my watch, I make that now about 2 minutes</p> <p style="text-align: center;">Page 82</p>	<p>1 Brook House, quite apart from things like Medway, 2 include things like the use of force being significantly 3 higher at Brook House than it was at other centres. 4 There are also issues like this, and I flag this at the 5 bottom of paragraph 40, which is about the way the 6 contract does try to monitor things that it -- that are 7 at least linked to welfare. There are key performance 8 indicators in respect of self-harm resulting in injury 9 that comes about by a failure of procedures. So far as 10 we can see from the research we have done across the 11 materials, there was only one such KPI for the whole of 12 2017 and none at all in the period with which this 13 inquiry is concerned. 14 It follows from that that no such KPI was triggered 15 for any of the suicide/self-harm type incidents which we 16 have all seen on the footage. That is a significant 17 failure of the monitoring arrangements, such as they 18 were, and the Home Office must take at least some 19 responsibility for that, given that it designed those 20 monitoring arrangements. 21 The other reasons why the Home Office doesn't get 22 off the hook in relation to this is because you can see 23 the extent to which the attitudes and approaches to 24 detained people are shared by at least some Home Office 25 staff, and I go back to this Vanessa Smith point, which</p> <p style="text-align: center;">Page 84</p>

<p>1 is that the investigation conducted following control 2 and restraint training in February 2018, where there was 3 an upheld complaint in respect of a number of people, 4 but including her, about the language that was being 5 used, the abusive language, that was being used, 6 including Ms Smith reporting she would "go to town on 7 them", meaning detained persons, and laughing in that 8 context.</p> <p>9 The point I just make about that is, that 10 is February 2018. It is five months after Panorama was 11 broadcast and when the spotlight was, therefore, shining 12 very brightly on Brook House. If that is the kind of 13 attitude that can be shown in partially open training 14 five months after Panorama, then what kind of attitudes 15 were being shown in private?</p> <p>16 I also make this point, which is that both 17 Mr Goodman and Ms Harrison referred to Mr Riley's 18 witness statement and its attempts to dismiss or confine 19 the concerns in Brook House to being at least mostly G4S 20 problems and I support the points they make. But can 21 I just be clear about this: Mr Riley knows that these 22 are wider problems than just Brook House or just G4S. 23 He knows that because he's the head of Detention 24 Operations and he knows that about other litigation in 25 the area. Some of that is the article 3 litigation to</p> <p style="text-align: center;">Page 85</p>	<p>1 substantial financial interest in the contract for the 2 provision of those services.</p> <p>3 If you have a contract that you want and your role 4 is still to be independent and say, "This person should 5 be released via a rule 35 report" or "This person is not 6 fit to fly and therefore can't be released", there is an 7 obvious conflict between those two roles and making 8 those kind of unpopular decisions is going to be more 9 difficult because of that financial interest. I make 10 a reference there back to the Prince Fosu inquest as it 11 happens. Those contracts can be very substantially 12 valuable -- it was about £200,000 a year in the Fosu 13 inquest and that's in relation to a figure in 2012 -- we 14 might want to ask what the value of the contract was in 15 Brook House in 2017.</p> <p>16 I then deal with the Independent Monitoring Board. 17 I'm afraid that the DPG core participants ask whether 18 the IMB is fit for purpose. It is supposed to be a key 19 statutory safeguard against precisely the kind of thing 20 that was revealed by BBC Panorama. That's what 21 section 152 of the '99 Act sets up. That is what part 6 22 of the Detention Centre Rules set up. But not only did 23 the IMB not identify and correct what was happening, 24 there were a number of issues that were obviously very 25 concerning, including, and I set a number of these out,</p> <p style="text-align: center;">Page 87</p>
<p>1 which my learned friends have referred, but there are 2 also inquests that have occurred following immigration 3 detention deaths and I mention just two of them.</p> <p>4 Tarek Chowdhury had an inquest at the beginning of 2019, 5 following a death in 2016, and that was a case about 6 turning away from somebody who was mentally unwell, as 7 a result of which that individual went on to kill 8 somebody, went on to kill Tarek Chowdhury. Similarly, 9 the Prince Fosu inquest, conducted in the early part of 10 last year, that was also about a series of people -- 11 DCOs, GPs, members of the IMB and others -- all turning 12 away, again, from a very obvious mental health 13 presentation. Mr Riley knows about those cases because 14 Mr Riley gave evidence in both of those inquests. So it 15 is absolutely clear, and must be clear to the 16 Home Office, that there are much wider and deeper 17 problems in immigration detention than just saying, 18 "This is Brook House. This is G4S".</p> <p>19 Can I move on then to deal with healthcare. Again, 20 this is being dealt with by others in greater depth than 21 I intend to deal with it, but can I mention one point 22 that arises at paragraph 44 of my note, which is that it 23 must be, we submit, a clear question for this inquiry as 24 to whether it is wise to have the provider of GP 25 services in Brook House having a clear and presumably</p> <p style="text-align: center;">Page 86</p>	<p>1 the narrow approach that it took looking at systems 2 rather than individuals. Now, I'm not going to go 3 through the list of points that I make in the note, but 4 I will just flag one of them. It comes from the GDWG 5 evidence.</p> <p>6 There was a meeting, on 16 August 2017, where GDWG 7 were called in to have a meeting with Paul Gasson and 8 Steve Skitt -- so G4S and the Home Office -- where 9 a number of points about whether -- about the approach 10 of GDWG was put and threats were made, including in 11 relation to the restriction or removal of the drop-in 12 surgery. It's a threat that GDWG obviously took 13 extremely seriously because that was going to seriously 14 curtail what they could do for detained people. But 15 that meeting came about as a result -- as an action 16 point from an IMB meeting and is referred to in those 17 documents. Now, why does the IMB think it is any proper 18 part of their function to be dealing with GDWG in that 19 way or any other way or actioning in that way? It 20 looks, I'm afraid, very like assimilation of the IMB to 21 the cause of G4S and the Home Office.</p> <p>22 It is being used -- all of that was done in the name 23 of GDWG being said to be straying over boundaries, 24 acting as a protest movement and not to be trusted. 25 That sort of "us and them" thinking was absolutely key</p> <p style="text-align: center;">Page 88</p>

<p>1 and it showed the IMB and G4S and the Home Office on one 2 side and GDWG on the other.</p> <p>3 We recognise -- this may be part of the problem -- 4 that the IMB is a volunteer organisation with limited 5 resources. But that goes to the question whether it's 6 fit for purpose and we do ask you to look at those 7 structural points about the IMB. Because asking 8 volunteers to face down potentially senior members of 9 G4S or senior members of detention staff and say, 10 "That's not good enough. You can't do it in that way, 11 you need to act differently", is a big thing to ask them 12 to do. That certainly requires training, and probably 13 quite intense training, and probably reminders that that 14 is part of the role that is expected of the IMB. But it 15 may go wider than that. It may go into issues like 16 recruitment, because if you have an organisation that is 17 based entirely on volunteers, you are only going to 18 recruit people who can afford to work for free and that 19 has issues about diversity and the kind of people you 20 are going to have. This is not the only case where 21 there have been issues around the IMB in this role. It 22 may be that, structurally, they are simply not suitable 23 and equipped to discharge the role that they are being 24 expected to discharge.</p> <p>25 I mention here that it is not clear -- GDWG in</p> <p style="text-align: center;">Page 89</p>	<p>1 perfectly sensibly drafted emails, perfectly friendly 2 emails, and getting shut down in response.</p> <p>3 There is a moment in the Verita interviews, and 4 there is a moment in the Verita report, where Kate 5 Lampard is essentially putting to witnesses, "What's 6 wrong with that email? Why is it you're getting jumpy 7 about that email?" What that is revealing is the 8 mentality there.</p> <p>9 Again, I've got a list of points set out in the 10 paper. Can I just emphasise a single one of them, which 11 is this: one of the things that G4S appear to have got 12 particularly upset about is one of the GDWG members, 13 Naomi Blackwell, putting in a witness statement in 14 judicial review proceedings in support of a particular 15 detained person. Now, what she did -- we have an 16 example of at least one witness statement done in this 17 way, although I don't think it is this one -- was put in 18 a short witness statement that says what she is seeing 19 of that individual, because that individual was believed 20 to be lacking mental capacity. So she said, this is 21 what I'm seeing, this is their presentation at the 22 moment, and this is why I am concerned or think that 23 this person lacks mental capacity.</p> <p>24 What that results in, ultimately, is the High Court 25 accepting that and other evidence that that person did</p> <p style="text-align: center;">Page 91</p>
<p>1 particular would like me to make it clear -- that the 2 work that is being done by the IMB now is of a much 3 higher quality. The reports that are coming out, my 4 learned friends referred to these, are much stronger, 5 2020 and 2021. But it is not completely clear whether 6 that learning is based -- and that change is solid and 7 permanent because it is not clear that any of 8 the structural things have changed and that the learning 9 is done and the acknowledgement is being done on the 10 basis of what happened in 2017.</p> <p>11 I now turn to deal with GDWG because their evidence 12 goes a long way beyond the IMB. I set out material in 13 the paper. They do -- the key point arising from their 14 evidence is, of course, that much of it corroborates 15 what Panorama showed by showing their clients 16 consistently reporting issues of poor conditions, 17 dehumanising treatment, problems with access, and so on, 18 and also the way staff tended to speak abruptly to those 19 who were detained.</p> <p>20 But a further key point is the extent to which the 21 GDWG evidence shows a management attitude that was 22 defensive to the point of bunker mentality. You can see 23 it in the email exchanges. One of the advantages of 24 this bit of the evidence is, you can see it 25 contemporaneously with things like GDWG sending</p> <p style="text-align: center;">Page 90</p>	<p>1 indeed lack the mental capacity to take the relevant 2 decisions. That person was obviously, therefore, highly 3 vulnerable and, ultimately, that person was held by the 4 High Court to be unlawfully detained. That is obviously 5 not only a sensible and proper thing to do, it is an 6 absolutely necessary thing for people to do in order to 7 ensure that people like that are not detained. Not only 8 does G4S's attitude in relation to that show that they 9 don't think that sort of thing should be happening, that 10 was a witness statement provided in October 2015 and the 11 GDWG evidence shows they were still upset about it in 12 2018.</p> <p>13 The level of grudge bearing, completely misplaced 14 grudge bearing, that that reveals is very striking 15 indeed.</p> <p>16 It is also part of the picture that goes to why GDWG 17 were regarded as somehow having breached trust. What 18 that is doing is saying -- it is back to the "us and 19 them" attitude, but it is saying, "If you care about 20 welfare, even in a case where you're absolutely right to 21 care about welfare, you're 'them' rather than 'us'", and 22 that, again, is little short of extraordinary.</p> <p>23 And bear in mind, similarly to the Vanessa Smith 24 point, if GDWG as an organisation are being treated and 25 spoken to in that sort of way and getting that level of</p> <p style="text-align: center;">Page 92</p>

<p>1 resistance, what is happening in relation to detained 2 people? If you are treating GDWG like that, how are you 3 treating detained people? The point of that, of course, 4 is, we know how they were treating detained people 5 because we have the video evidence of how they were 6 doing it. But what the GDWG evidence tells us is that 7 that video footage is representative and those sorts of 8 attitudes go wide and go deep.</p> <p>9 I want to finish by talking about my formerly 10 detained person client, D687, as part of the original 11 judicial review and D390. I am going to deal with this 12 relatively lightly because neither man will be giving 13 evidence in this phase, it will only be in the second 14 phase, and I am doing it in the context that the inquiry 15 is, of course, looking at both men and asking the extent 16 to which they suffered article 3 ill-treatment, and that 17 requires a multifactorial assessment of factors which 18 include their personal characteristics, their relative 19 levels of vulnerability, what is they experienced 20 subjectively and objectively, over what period and what 21 was the object of that treatment. All of that is 22 relevant to the article 3 assessment and that's why 23 I have talked about things like language. I make that 24 point just for this reason: the assessment goes much 25 wider than just the individual uses of force on which we</p> <p style="text-align: center;">Page 93</p>	<p>1 meant that he missed -- he was in detention when both 2 his grandmother and his brother died and you can see the 3 significance of that because it's in the contemporaneous 4 notes but it is also one of the things he shouts on the 5 video when he is talking about that. That's why he is 6 talking about that. You can see the real impact.</p> <p>7 All of that is happening in what we now know were 8 the conditions at Brook House at the material time. The 9 Professional Standards Unit dismissed his complaint 10 about racist abuse, but it now seems absolutely 11 inevitable that he would have experienced it because we 12 can see how rife it was in the centre.</p> <p>13 We can see he will have experienced it -- the 14 ragged, febrile and hostile atmosphere that was present. 15 He may, of course, be wrong about some of the detail of 16 that, particularly on when exactly matters occurred or 17 who said it at what particular time, but that is because 18 he's somebody with a very high level of distress and is 19 mentally ill.</p> <p>20 Can I just -- you will see that I put in the note 21 some contemporaneous records of how he was, because at 22 this particular time, in the couple of weeks leading up 23 to 13 May, it was very clear that D687 had reached 24 a stage where he wanted to die.</p> <p>25 There was a GDWG database note, which is a telephone</p> <p style="text-align: center;">Page 95</p>
<p>1 are focusing in some respects -- 13 May in relation to 2 D687, 5 June in relation to D390. One has to look at 3 the lead-up to those things and look at how they ended 4 up in the position they did when force was applied.</p> <p>5 Just doing that firstly in relation to D687, can 6 I flag the following. First, his mental health, 7 diagnosis of recurrent depressive disorder and PTSD and 8 that's now confirmed by a recent report, for the 9 purposes of this inquiry, by Dr Galappathie. He has 10 a history of childhood trauma and abuse. He has 11 a history of being a child in care, a former 12 looked-after child. He is -- we have seen the suicide 13 and self-harm risk, which was at all material times, and 14 we have seen it on the video. Can I emphasise the 15 length of time also that he was detained, because that's 16 obviously relevant to whether or not -- whether D687 was 17 broken by immigration detention. By May 2017, he had 18 been held using immigration powers for two years and 19 three months -- a very long period of time. He had been 20 in Brook House since October 2015, so approximately 21 18 months. He couldn't see any material progress in his 22 position and so that's the foundation for the despair 23 and lack of hope that we saw on the video so 24 dramatically yesterday.</p> <p>25 I mention this also: the length of that detention</p> <p style="text-align: center;">Page 94</p>	<p>1 message, which records him at this point as being at the 2 end of his tether, frustrated by lack of progress, 3 doesn't want to go back in detention for two years, 4 grandmother and brother died before Christmas and he 5 hasn't been able to pay his respects. You then see it 6 in Callum Tulley's own impressions, recorded around 7 13 May 2017, but looking back at what he knew of D687 8 before then. Callum Tulley, one may think, was 9 displaying rather more insight into the needs and 10 presentation of a vulnerable person than much more 11 senior people and he recorded it as this:</p> <p>12 "He's just fed up with the lack of progress in his 13 case, he's just had enough. His health, his mental 14 health, has completely deteriorated. He said just 15 a couple of weeks ago someone was going to be taken out 16 in a body bag. Today he was quite determined to make 17 sure that that was him. Obviously that didn't happen 18 but he was promising on his way out that this wasn't the 19 end and he was going to make the news, he was going to 20 make a statement. He said to me, 'Watch out because I'm 21 going to be one of the first people to die in 22 a detention centre'. He's quite clear of his intentions 23 to kill himself."</p> <p>24 That is an accurate statement of the extent to which 25 D687 by that point was broken by what he had</p> <p style="text-align: center;">Page 96</p>

<p>1 experienced.</p> <p>2 Now, about that time, there is a rule 35(3) report.</p> <p>3 But the rule 35(3) report is dismissed by the</p> <p>4 Home Office on the grounds that, although it is accepted</p> <p>5 that you are an adult at risk, the doctor has not</p> <p>6 indicated that a period of detention is likely to worsen</p> <p>7 your symptoms. That is because that hadn't been</p> <p>8 addressed in the rule 35(3) report.</p> <p>9 Now, Dr Hard says that it should have been, but one</p> <p>10 of the points is, why wasn't there a rule 35(2) or</p> <p>11 a rule 35(1) report? Because both of those would have</p> <p>12 caused focus on exactly that question. Rule 35(3) asks</p> <p>13 a slightly different question and it is important to ask</p> <p>14 the proper question, which is why there are three</p> <p>15 components to the rule.</p> <p>16 Also -- so why wasn't that done? Why also --</p> <p>17 Dr Oozeerally was doing this, why wasn't an ACDT opened</p> <p>18 at that stage? It is a low threshold. You can see the</p> <p>19 circumstances in which he's beginning to talk. These</p> <p>20 are the obvious safeguards and they are not being</p> <p>21 operated.</p> <p>22 That was around 15 April 2017. On 27 April 2017, he</p> <p>23 saw a member of the Home Office and it was recorded in</p> <p>24 his GCID Home Office notes that D687 would only go back</p> <p>25 to Somalia in a body bag, that he had started to write</p> <p style="text-align: center;">Page 97</p>	<p>1 to the floor. One of the consequences that seems to</p> <p>2 have flowed from that is that he had bruising to his</p> <p>3 ribs of a sufficient seriousness that, when he got to</p> <p>4 the Verne later that day, they sent him off to hospital</p> <p>5 to be examined.</p> <p>6 Now, the fact that it was an unplanned use of force</p> <p>7 meant that there wasn't a healthcare person present</p> <p>8 until after the use of force. When he was examined by</p> <p>9 that healthcare person, still in Brook House, there was</p> <p>10 not even an entry in the SystemOne notes created --</p> <p>11 obviously there should have been, it was a medical</p> <p>12 examination -- and that person didn't pick up the chest</p> <p>13 contusion that was later picked up in the Verne and at</p> <p>14 the Dorset County Hospital.</p> <p>15 I have noted in my note the call that then resulted</p> <p>16 in another GDWG database note where he is talking</p> <p>17 contemporaneously in an unstructured way, having no idea</p> <p>18 it was ever going to be used in an inquiry of this kind,</p> <p>19 but you can see the real force of what he's talking</p> <p>20 about there. Again, it's relevant for your inquiry as</p> <p>21 to whether or not this evidence is article 3</p> <p>22 ill-treatment. "Never been through anything like this.</p> <p>23 Scary not knowing what's happening. Scary not knowing</p> <p>24 where I'll be next month. Goalposts have been moved but</p> <p>25 the problem will be there. Call for a chat Thursday</p> <p style="text-align: center;">Page 99</p>
<p>1 a suicide note, and that he's going to give it a week</p> <p>2 and, if things stay the same, he will do something.</p> <p>3 Still no ACDT was opened. It's very difficult to</p> <p>4 understand why. Although some insight may be gained</p> <p>5 into why that wasn't done when you find the Home Office</p> <p>6 person making that note was Vanessa Smith. We can see</p> <p>7 a little bit about her attitude and lack of sympathy to</p> <p>8 those in detention by the report and the investigation</p> <p>9 that I have already referred to, which is the</p> <p>10 Hibiscus-generated complaint arising from 2018.</p> <p>11 Those are the circumstances in which we find D687</p> <p>12 left on his own long enough to get into a toilet and</p> <p>13 apply a ligature. That is something, of course, that</p> <p>14 the inquiry is going to want to examine pretty closely.</p> <p>15 Again, you can see the despair, the repeated statement</p> <p>16 of "I've just had enough, bruv. I'm doing it." You can</p> <p>17 just see that and it is absolutely real and dramatic.</p> <p>18 There is around 11 minutes, we think, before the use</p> <p>19 of force is then applied. It is very difficult to</p> <p>20 understand, given that period of time, why it is an</p> <p>21 unplanned and slightly chaotic use of force rather than</p> <p>22 a planned one, which would have brought in cameras and</p> <p>23 safeguards and a member of the healthcare team.</p> <p>24 That is what happened. He was tricked into</p> <p>25 accepting a light for a cigarette and then was brought</p> <p style="text-align: center;">Page 98</p>	<p>1 2 pm". This is a man who is completely broken and was</p> <p>2 broken by Brook House.</p> <p>3 I make one final point about D687 before I finish,</p> <p>4 which is another contemporaneous note which is very</p> <p>5 revealing. If one reads the SystemOne notes for D687</p> <p>6 when he gets to the Verne, you immediately see a change.</p> <p>7 There is a change in the atmosphere. It is a step</p> <p>8 change in the treatment. Of course it is not perfect.</p> <p>9 It is the Verne. But he was, by 14 May, feeling better,</p> <p>10 he had antidepressants by 16 May -- those are the</p> <p>11 antidepressants that Dr Galappathie said he should have</p> <p>12 had certainly by mid April. On 19 May, he is recorded</p> <p>13 as saying he is actually surprised that people are</p> <p>14 seeing the potential in him, are saying good things</p> <p>15 about him. He said moving to this centre has given him</p> <p>16 a fresh start and hope. There is something about the</p> <p>17 atmosphere in Brook House that was different. That is</p> <p>18 a very clear insight into how it felt different to him</p> <p>19 immediately afterwards in the contemporaneous note. So</p> <p>20 that's D687.</p> <p>21 D390 is also a survivor of serious childhood trauma</p> <p>22 and abuse. Came to the UK as a student in 2004. He</p> <p>23 overstayed and worked for a period, as he accepted,</p> <p>24 illegally, and that led to three convictions for</p> <p>25 document and immigration offences and a sentence of</p> <p style="text-align: center;">Page 100</p>

25 (Pages 97 to 100)

<p>1 18 months. But I do need to emphasise that those are 2 his only convictions either before or since. He has no 3 history of any other kind of conviction, no evidence of 4 violence or anything of that kind. The reason I mention 5 that is because, when he serves his sentence in 6 Maidstone, his mental health concerns had begun to 7 emerge. But around that time and as he arrives in 8 Brook House on 15 May 2017, he somehow gets categorised 9 as representing a risk of disruption and escape and he 10 is put on an escape risk list which turns up in the 11 senior management team handovers on shift handovers. 12 Now, it is very difficult to understand how that 13 assessment was reached, given D390's history, but it did 14 make its way into those documents and it is one of 15 the things we would like to see explored, the extent to 16 which that influenced or impacted upon the way that he 17 was treated, because Brook House staff do seem to have 18 concluded that D390 was actively resisting transfer, 19 that he was absolutely, "I'm not going, you may as well 20 bring a team" seems to be the attitude. That's 21 completely inconsistent with any way D390 has ever 22 behaved. What he was, in fact, doing was advancing an 23 asylum claim which required an interview but which he 24 had also made an application for bail. The reason he 25 didn't want to go on 5 June is because -- it seems to be</p> <p style="text-align: center;">Page 101</p>	<p>1 footage was made -- that's on the forms -- but one can 2 also see in the transcript of the note from 3 Callum Tulley's engagement with D390 that D390 is asking 4 Callum Tulley why is there a camera? So it clearly was 5 there. But we apparently can't now find it. That's 6 a matter of, as I say, significant regret. And we only 7 learnt in his legal team that that footage was missing 8 at the early part of last week. We think your legal 9 team probably found out about the same time. 10 But it means that we are looking, we are trying to 11 unwrap this, we seem to have -- back to this febrile 12 atmosphere in Brook House -- people getting wound up and 13 thinking that D390 is somebody that he, in fact, isn't. 14 He is not a disruptive, escape-risk, violent man. He 15 just says he wants to go to a bail hearing. That's all 16 perfectly sensible. He wasn't boiling a kettle of water 17 in order to use it as a weapon. He was boiling a kettle 18 of water in order to make a cup of tea because it was 19 5.30 and they had just had lock-up. But that is not 20 what happened and you will hear evidence about that not 21 just from him, but also from his roommate. What happens 22 after that is that he is transferred, his mental health 23 deteriorated, he gets a significant use of force, he is 24 then transferred to Harmondsworth. His mental health 25 deteriorates quickly. A rule 35 report is generated.</p> <p style="text-align: center;">Page 103</p>
<p>1 true -- he had a bail hearing listed at Taylor House 2 sometime later that week, the date is not clear, he was 3 expecting to be released so he didn't want to be moved 4 and miss that date. He wanted to be there in order to 5 get out. So that is all that he was doing. But that is 6 not how he was treated. We will need to investigate, we 7 say, why that came about. Some of the evidence in 8 relation to D390 includes material about an earlier 9 incident which involved some other detained person 10 boiling a kettle, apparently, for potential use as 11 a weapon. We can see evidence from Callum Tulley's 12 video materials which are about staff, including in 13 particular DCO Sean Sayers -- a name familiar to many in 14 the room -- feeling wound up. That being wound up and 15 being wound up in relation to a previous incident with 16 another detained person, seems to have meant that the 17 team stayed wound up when they came to encounter D390. 18 Now, we will need to untangle all of that at some 19 stage, and I will also say this: it is a matter of very 20 deep regret that it now appears that the camera footage 21 of that episode, which would have helped enormously in 22 unwrapping exactly what happened, is completely missing 23 and apparently, so far as we can see, without 24 explanation from G4S. It is absolutely clear from the 25 documents that both camcorder and body-worn camera</p> <p style="text-align: center;">Page 102</p>	<p>1 He begins to be seen by a clinical psychologist and has 2 later been assessed as having PTSD and depressive 3 disorder and we are in the process of getting evidence 4 in this inquiry which confirms that. 5 So that's those two core participants, chair. In 6 very brief summary, that's their stories. It has 7 required a BBC film and the bravery of Callum Tulley to 8 tell those stories. Nothing else, nothing in the 9 systems from G4S, Home Office or anybody else has told 10 those stories. It was a 21-year-old not long out of 11 school who wanted to be a football referee who had the 12 presence and integrity and bravery to tell those stories 13 and that is a matter of significant concern. 14 Can I just finish by saying this: it is worth 15 bearing in mind the history. Callum Tulley started work 16 at the centre in January 2015. He says that he 17 developed those concerns over the course of the next 18 year and they came to a head when he saw the BBC 19 Panorama on Medway in January 2016. 20 He then wrote his email to Panorama, but Panorama 21 couldn't take the case at that point and they weren't 22 sure about it and it took them another 14 months to do 23 that. So it took them from January 2016 until 24 April 2017 where, as you know, the filming started and 25 it was filmed between April and July 2017.</p> <p style="text-align: center;">Page 104</p>

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<p>1 That means that what -- they start filming and they 2 are filming and seeing a version of what they have seen 3 over the preceding two and a half years. I make that 4 point for this reason: that filming, that three-month 5 period, isn't a snapshot. It is a continuum. It is 6 a continuum of that period. It is representative of 7 the whole of that period, it seems. It is absolutely 8 not a snapshot. It is a panorama, in the real sense of 9 that word.</p> <p>10 The problems at Brook House were long standing and 11 they were deep. It is hoped that you and your inquiry 12 can identify them and bring about real change. Unless 13 I can assist you further.</p> <p>14 THE CHAIR: Thank you, Mr Armstrong.</p> <p>15 Opening statement by MS HARRISON</p> <p>16 MS HARRISON: Chair, it now falls for me to make an opening 17 on behalf of the charity Medical Justice. As you're 18 aware, I also represent other individual clients who 19 instruct Bhatt Murphy Solicitors, and you are going to 20 hear about the detail of those individual cases from my 21 learned friends Ms Luh and Ms Profumo, if we have time 22 to accommodate Ms Profumo. It may be that we have to go 23 over, but I think that's probably very likely that we 24 will.</p> <p>25 But certainly from the perspective of</p> <p style="text-align: center;">Page 105</p>	<p>1 inquiry will consider.</p> <p>2 The inquiry will also have, therefore, the benefit 3 of informed expert and experienced practitioners who, 4 through their director and casework manager, as well as 5 input from their key clinical experts, will be able to 6 provide the inquiry with the assistance of their wealth 7 of knowledge and experience.</p> <p>8 There were four parts of Medical Justice's work that 9 led you to conclude that it was appropriate for them to 10 participate as core participants in this inquiry. It 11 was their direct casework; their monitoring, research 12 and investigation; policy advisory work; and their work 13 in bringing strategic litigation.</p> <p>14 Dealing with those in turn, and what you will be 15 assisted by in terms of what they can contribute, and 16 starting with direct casework, again, it was an 17 important part of your decision to grant them CP status 18 that Medical Justice holds a database of cases where, 19 during the relevant period, they had direct access to, 20 and involvement with, individuals subject to detention 21 at Brook House and were able to access their medical 22 records and, in a number of cases, themselves provide 23 medico-legal reports.</p> <p>24 You will be provided in due course with that summary 25 of their database. They were able to identify 31</p> <p style="text-align: center;">Page 107</p>
<p>1 Medical Justice, what we would like to emphasise on 2 their behalf is, first of all, their unique position. 3 They were granted core participant status because they 4 are the only independent charity in the United Kingdom 5 that has access to individuals in detention and is there 6 to assess and to identify clinical needs that they have, 7 whether that be arising from a past history of torture 8 or trauma or other physical or mental disability. It is 9 the only organisation in the United Kingdom that 10 specifically monitors and investigates the adequacy or 11 otherwise of healthcare provision in immigration 12 detention and the effect of detention on the mental 13 health of detainees. This does give Medical Justice 14 informed and valuable insight, which you recognised when 15 you agreed to grant them core participant status.</p> <p>16 It is an organisation with 14 members of staff -- 17 three part-time clinical advisors, but also 65 volunteer 18 doctors who provide a range of expertise and of 19 relevance to immigration detention.</p> <p>20 Medical Justice also is involved with the Royal 21 College of GPs and the Royal College of Psychiatrists. 22 It works and has fed into the British Medical 23 Association's seminal report on healthcare in detention, 24 "Locked in, locked out: health and human rights in 25 immigration detention", which we hope in due course the</p> <p style="text-align: center;">Page 106</p>	<p>1 individual studies, and their evidence is critically 2 important to this inquiry because the delay occasioned 3 by the factors that my learned friend Mr Goodman talked 4 about this morning, the need for the two years of 5 judicial review before this inquiry as instituted, meant 6 that, in the meantime, there were no proactive steps 7 taken to ensure that the key critical material, the 8 detainee experience that is, as we rightly have said, 9 central to this inquiry, was properly and systematically 10 obtained and recorded so that other individuals, not 11 those who are somewhat arbitrarily and randomly before 12 the inquiry, are able to give their accounts to this 13 critical investigation.</p> <p>14 Nevertheless, we do have 31 individual studies. 15 What Medical Justice will tell you about their analysis 16 of those cases, at least in opening form, is this. They 17 will show fundamental deficits in the operation of 18 statutory safeguards for adults at risk. They will show 19 significant failure to conduct rule 34 mental and 20 physical examinations. Significant failure to initiate 21 rule 35 referrals following reception, screening and 22 clinical appointment. Refusal to prepare rule 35(3) 23 reports if one had already been done before, and that's 24 by GPs themselves. Defective rule 35 assessments and 25 reports, in particular, failure to consider the impact</p> <p style="text-align: center;">Page 108</p>

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<p>1 of continued detention at all or properly, despite that 2 being the critical element in the Adults at Risk policy. 3 Complete failure to produce rule 35(2) reports, even 4 when the individual is on ACDT or is actively 5 self-harming and suicidal, and that, as we now know, is 6 ongoing and continuous. Almost complete failure to 7 produce rule 35(1) reports. Inability of the rule 35 8 process to properly identify indicators of trafficking 9 and modern slavery, and in some respects of greatest 10 concern, even if all of those obstacles and failures 11 have been overcome and a report has been provided to the 12 Home Office, defective rule 35(3) responses by the 13 Home Office and a misapplication of its own policy. And 14 lastly, and perhaps also most importantly, failure of 15 the Adults at Risk policy to secure release of 16 vulnerable detainees with a history of torture- or 17 trauma-related mental illness, an evident risk of 18 self-harm or further harm in detention, not because the 19 policy was wrongly applied but because the policy itself 20 is defective in seeking to -- in making sure that 21 individuals falling into those categories of persons at 22 particular risk of harm, it's outweighed always by 23 immigration factors. That fundamental rebalancing of 24 the policy meaning that, even when the evidence is 25 provided by the detention centre, the Home Office still</p> <p style="text-align: center;">Page 109</p>	<p>1 illness, often directly related to the need to transfer 2 the person into segregation, force is used and misused. 3 In addition to its casework, Medical Justice will be 4 able to assist the inquiry in drawing on the information 5 that it has provided in numerous forms in reports over 6 the years. Its research going back to at least 2007 has 7 identified systemic flaws in the legal and policy 8 framework and its application to the detention in 9 particular of vulnerable people. 10 Through that research, Medical Justice will hope to 11 show the inquiry that this is directly relevant to the 12 range of issues that this article 3 investigation has at 13 its heart because it demonstrates longstanding systemic 14 and operational failures for which the Home Office is 15 not only responsible, it is on notice. I won't list 16 those reports now, but they will be provided to you in 17 due course, and there are 12 of them. They each, and in 18 every way, relate directly to the topics that we have 19 been discussing -- to the use of force, to segregation, 20 the imprisonment -- the detention of torture victims and 21 a failure of the complaint system. Most recently, 22 Medical Justice has focused on the continuing failures 23 in the Adults at Risk policy in 2018 and 2019, again 24 indicating that the passage of time, as far as this is 25 concerned, has in no way meant that the problems with</p> <p style="text-align: center;">Page 111</p>
<p>1 refuse to release. 2 In respect of clinical care issues, 3 Medical Justice's analysis of the case studies will show 4 that there are significant failures in the provision of 5 adequate physical healthcare and widespread failures in 6 mental health provision. It will show that, as far as 7 the ACDT process is concerned, it is a containment 8 strategy. Whilst it may stop self-harm and suicide by 9 physical restriction and isolation, it has no effective 10 clinical or therapeutic input or effect, and it will 11 show that, in the regard with suicide and self-harm, 12 there's a fundamental disconnect between rule 35 and the 13 Adults at Risk policy. 14 In respect of food and fluid refusal, this is 15 routinely treated inappropriately. It is not recognised 16 as a sign of distress or a potential symptom of mental 17 illness or an issue of self-harm or protests often born 18 out of despair. 19 Their analysis will also show rule 40 wrongly 20 deployed as a management and containment strategy for 21 vulnerable detainees suffering mental distress, again 22 without recognition of the significance of the mental 23 health context. 24 Finally, use of force and risk of use of force 25 pursuant to this containment strategy for mental</p> <p style="text-align: center;">Page 110</p>	<p>1 that policy evident in 2017 have yet been remedied. 2 So that research will show these longstanding 3 patterns of failure. They will also show how the 4 Home Office and its private contractors have been on 5 notice for many years, that they are operating a failing 6 and unsafe system, particularly for clinically 7 vulnerable detainees at particular risk of harm and 8 abuse, at risk of and/or subject to breaches of 9 article 3 ill-treatment. 10 It is Medical Justice's position and it is the 11 evidence that it will give, contrary to what is said in 12 the witness statement on behalf of the Home Office, that 13 the abuse exposed by Panorama as occurring in 14 Brook House in 2017 was inevitable. It is his view that 15 it was not. That belies any understanding of those 16 longstanding systemic problems which were always going 17 to lead, one way or the other, to what was happening at 18 Brook House. The only variable and uncertainty was 19 whether it would be uncovered. 20 It will further be explained by Medical Justice that 21 it has shared its information and its monitoring of 22 these matters with a number of independent and 23 government-led inquiries -- again, I won't list them 24 now, but they are multiple -- over the many years. In 25 providing that material to these statutory bodies and</p> <p style="text-align: center;">Page 112</p>

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<p>1 international bodies, such as the UN committee on 2 torture, it has contributed to findings frequently made 3 by multiple independent bodies of the need for 4 fundamental change to policies that have consistently 5 failed.</p> <p>6 Medical Justice will also point to the fact that it 7 has been involved in at least nine consultations on 8 various issues to do with detention, all relevant to 9 this inquiry's scope, and that's since 2014. When the 10 Home Office formulates its policy and practice, it is 11 always told and is always provided with cogent 12 explanation and evidence as to why the existing policies 13 and practices and the proposals that they make will not 14 remedy the deficits, but the truth is that the 15 consultations from Medical Justice's point of view have 16 become little more than tick-box exercises, often 17 conducted under very tight timeframes, but they always 18 do their best to provide that information, and however 19 well evidenced or cogent, it is largely ignored. But 20 what this inquiry will know is that, in no uncertain 21 terms, the Home Office is on notice, and it is on notice 22 not only because organisations like Medical Justice -- 23 and they are not the only ones; there are many others -- 24 providing the Home Office with key material where they 25 could do something different, it's not only that, it's</p> <p style="text-align: center;">Page 113</p>	<p>1 factors in favour of the latter. Medical Justice had 2 several meetings, face-to-face meeting with Home Office 3 policy makers, and provided written evidence, making it 4 clear that the Adults at Risk policy would fail to meet 5 the stated intention of the Immigration Minister to 6 accept the recommendations of Stephen Shaw to improve 7 the protections and reduce the numbers of vulnerable 8 detainees in detention. Those warnings were ignored.</p> <p>9 Medical Justice then brought a legal challenge to 10 part of the Adults at Risk policy. In finding in 11 Medical Justice's favour, the judge noted: 12 "Medical Justice made much the same points as it did 13 in these proceedings during the consultation." 14 That was in respect of the definition of torture. 15 The judge found that the formulation of the Adults at 16 Risk policy in that way undermined the statutory purpose 17 of the legal framework introduced by Parliament in 2006. 18 And the judge ordered the Home Office to amend the 19 policy.</p> <p>20 It is a salutary lesson and a learning in 21 understanding that, whilst the Home Office may say one 22 thing to Parliament and to the public, that it accepts 23 the findings of Mr Shaw's report, that it will act to 24 improve the protections for the vulnerable in detention, 25 the practice is diametrically opposed to that reality.</p> <p style="text-align: center;">Page 115</p>
<p>1 that that material then often becomes the basis of 2 litigation, and Medical Justice will be able to provide 3 the inquiry with experience of challenging through the 4 courts systemic illegality and failure in the 5 Home Office policies and practice on detention and what 6 it will tell the court about that is that legal 7 proceedings have no effect on the conduct and practices 8 of the Home Office in sticking with and maintaining with 9 its flawed and failing policies.</p> <p>10 This has been most evident in the context of 11 challenges relating to rule 34 and 35 of the Detention 12 Centre Rules. It is a good example of how the 13 Home Office, whilst asking for information and seeking 14 advice, ignores it.</p> <p>15 When the Home Office agreed, following Shaw 1, to 16 review its policy and to formulate the Adults at Risk 17 policy, Medical Justice provided it with detailed 18 information. It warned the Home Office that the policy 19 lacked adequate mechanisms for identifying vulnerable 20 people and that it failed to provide adequate safeguards 21 for those in detention. They also made it clear that it 22 increased the evidential burden on individuals to prove 23 that they are vulnerable and made it more difficult for 24 individuals to be released from detention by rebalancing 25 vulnerability against a wide range of immigration</p> <p style="text-align: center;">Page 114</p>	<p>1 Whilst it may apparently concede in principle, it 2 may wring its hands, it may say it's appalling, but 3 simultaneously it will conduct a rear-guard action to 4 entrench its position in favour of detention and 5 enforcement and against protection and welfare.</p> <p>6 Recognising that is critically important to what 7 recommendations this inquiry makes.</p> <p>8 It is important for this inquiry to know that 9 Medical Justice's findings about the operation of 10 the Adults at Risk policy, which it will give first hand 11 evidence about, is entirely consistent with what other 12 independent bodies have said and are continuing to say. 13 We will, through their witnesses, give evidence about 14 other findings. Most recently, the Independent Chief 15 Inspector of Borders and Immigration, in 2021, 16 identified that the effectiveness of the Adults at Risk 17 policy is negatively impacted by existing and known 18 flaws within the examples and the way in which the 19 policy is implemented by staff on the ground. This is 20 2021.</p> <p>21 It is recognised that flaws in the Adults at Risk 22 policy remain unaddressed and are likely to remain so 23 for some time. He commented upon the fact that the 24 Home Office's principal concern has been the perceived 25 abuse of the system, for example, of medico-legal</p> <p style="text-align: center;">Page 116</p>

<p>1 reports which coloured how staff at all levels thought 2 about detainees and safeguarding mechanisms which 3 existed in the Adults at Risk policy. 4 Those concerns, as was indicated this morning, are 5 only confirmed, and confirmed in the most dramatic and 6 significant way, by the findings of the Independent 7 Monitoring Board that I referred you to this morning, 8 and I won't repeat them now, but it is a very serious 9 concern for Medical Justice that all of those factors 10 continue to operate and now operate with Independent 11 Monitoring Board identifying those as creating an 12 inhumane environment and treatment currently operating 13 within Brook House when the pressure is on to remove 14 people on charter flights. 15 For Medical Justice, it is the use of force that is 16 of primary concern, obviously, as it is central to this 17 inquiry. It has been, again, a longstanding concern, 18 and Medical Justice, in one of its very first reports in 19 2007, set out and identified incidences of assaults as 20 long ago as then in the report "Beyond comprehension and 21 decency", and a year later, in 2008, Medical Justice 22 published a further report "Outsourcing abuse". So it 23 has been a long-standing feature of their experience 24 as charities working in this area that abuse and 25 assaults have been an aspect of the ill-treatment of</p> <p style="text-align: center;">Page 117</p>	<p>1 management rather than having any clinical or 2 therapeutic input. 3 Medical Justice intend to be able to identify, 4 through its analysis, both of its own caseload of 5 the case studies that we have, married up with the 6 inquiry's extensive disclosure on use of force, to 7 identify the themes, and some of them now will be 8 repetitive, but if I can just identify some of them. 9 Medical Justice will say to the inquiry that the forms 10 of use of force applied in immigration detention are 11 inappropriate and prison techniques should not be 12 transferred into the immigration detention estate as 13 they have. The use of prison-based systems of physical 14 intervention designed for refractory and violent 15 offenders within the prison estate is premised on 16 high-level restraint interventions of teams of officers 17 using techniques such as locks, pain compliance and 18 prone restraint. This is inappropriate for those who 19 are clinically vulnerable and for others who present no 20 real risk of refractory behaviour, but it's nevertheless 21 a default position. 22 It leaves little scope for alternatives and 23 de-escalation, all of which should be first resort, but 24 there is clear evidence that it is not. 25 It simply fails to take account of the complex needs</p> <p style="text-align: center;">Page 119</p>
<p>1 detainees. For Medical Justice, it will be important 2 for this inquiry to have a clear focus on the links 3 between the high incidence of clinically vulnerable 4 detainees and the use of force. This leads to 5 individuals with unmet, complex needs, whose mental 6 health deteriorates in detention, exhibiting signs of 7 overt distress, disturbed, bizarre and sometimes violent 8 behaviour, self-harm and suicidal ideation; people who 9 are profoundly unsuitable for detention and whose 10 clinical needs cannot be, and are not, adequately 11 treated in detention is clear; officers who have no 12 training or skills to address these challenging 13 situations, except by use of force, ACDT and 14 segregation; Brook House has no medical wing and its 15 mental health services are limited. These are the 16 conditions for misuse and abuse of force and segregation 17 on clinically vulnerable people which Medical Justice's 18 evidence will demonstrate, as does the extensive 19 material now before the inquiry. 20 The misuse of segregation has likewise been 21 a longstanding issue for Medical Justice. It issued 22 a report in 2015 exactly on that topic, calling it "The 23 secret punishment". It has remained, and continues to 24 remain, deeply concerned about the misuse of segregation 25 powers as a punitive measure used as a means of</p> <p style="text-align: center;">Page 118</p>	<p>1 and vulnerabilities of those they are looking after. It 2 is not premised, but it must be, on a clinical model for 3 intervention, incorporating preventative and therapeutic 4 approaches to challenging situations, rather than just 5 punitive action. 6 Secondly, Medical Justice will say to the inquiry 7 that the inappropriate use of control and restraint 8 interventions or clinically vulnerable people is what is 9 at the heart of risks of article 3, ill-treatment. 10 Applying restrictive practices, such as restraint 11 through shields, armlocks, handcuffs, back hammer locks, 12 to effect relocation into segregation, purportedly for 13 the individual's own protection, is not only contrary to 14 the Mental Health Act code of practice, which would be 15 operated in a hospital environment, it risks article 3 16 ill-treatment. 17 There is a clear evidence not just of a failure to 18 respond to indicators of physical and mental 19 vulnerability in control and restraint interventions, 20 but, as we saw over the last few days, a wilful tendency 21 on the part of staff to treat a vulnerable detainee's 22 expression of distress as signs of non-compliance, 23 resistance or aggression, which results in the use of 24 further, prolonged, high-level restraint, which is 25 totally inappropriate and takes no proper account of</p> <p style="text-align: center;">Page 120</p>

<p>1 the individual's vulnerability.</p> <p>2 It is clear, and Medical Justice have identified</p> <p>3 this for a number of years, there is no appropriate</p> <p>4 clinical training for the staff to recognise, manage and</p> <p>5 support vulnerable detainees in distress exhibiting</p> <p>6 symptoms of trauma and other mental illness, and that is</p> <p>7 a fundamental failure.</p> <p>8 The inquiry has already had numerous examples of</p> <p>9 heavy-handed, inappropriate use of force on detainees</p> <p>10 who are self-harming. But Medical Justice will provide</p> <p>11 further examples of the way in which those in mental</p> <p>12 health crises, instead of being offered assistance and</p> <p>13 treatment, are instead subject to shield force,</p> <p>14 armlocks, application of back hammer cuffs, all forms of</p> <p>15 violent and punitive forms of restraint when people are</p> <p>16 actively engaged in self-harm or suicidal ideation.</p> <p>17 There was even reference yesterday to the National</p> <p>18 Tactical Response Group deploying pepper spray on</p> <p>19 detainees who are on the suicide netting. This form of</p> <p>20 overt use of force, more akin to what would be used in</p> <p>21 a police raid, or in an act of public disorder, is all</p> <p>22 the more concerning when one recognises that it is in</p> <p>23 order to deal with those who are in mental health</p> <p>24 crisis.</p> <p>25 Finally, in terms of the use of segregation, it is</p> <p style="text-align: center;">Page 121</p>	<p>1 of this form of restraint, segregation and punitive</p> <p>2 measures on clinically vulnerable people, as the</p> <p>3 article 3 case law establishes, this is as much</p> <p>4 a question of breach of article 3 as the misapplication</p> <p>5 and deliberate misuse of restraint powers that were so</p> <p>6 graphically exposed in particular with regard to the</p> <p>7 detainee D1527. But that is not the entire scope of</p> <p>8 what this inquiry must consider when it comes to the</p> <p>9 application of the use of force.</p> <p>10 Medical Justice will urge on the inquiry to take an</p> <p>11 holistic review of force and segregation on clinically</p> <p>12 vulnerable detainees as a key component of its</p> <p>13 understanding of the institutional cultures operating at</p> <p>14 Brook House.</p> <p>15 Medical Justice stands with those in the inquiry who</p> <p>16 have to date asked that there is no countenance of</p> <p>17 the idea that this abuse occurred because of bad apples,</p> <p>18 individuals acting in isolation outside of an</p> <p>19 institutional culture. There is no doubt that it</p> <p>20 reflects institutional dehumanisation and</p> <p>21 Medical Justice would agree institutional racism is also</p> <p>22 clearly an issue.</p> <p>23 Examination of the flaws in the institutional</p> <p>24 arrangements and culture are therefore vital in</p> <p>25 understanding the abuse and in lessons learned. It has</p> <p style="text-align: center;">Page 123</p>
<p>1 absolutely clear, and Medical Justice will assist the</p> <p>2 inquiry to consider the evidence and the implications of</p> <p>3 it, the use of segregation as a means of managing</p> <p>4 serious mental health crisis and risk of self-harm. It</p> <p>5 is supposed to be an exceptional measure, but it is</p> <p>6 clearly routine. There is no regard for how damaging</p> <p>7 segregation and isolation is for those who are suffering</p> <p>8 from a mental health crisis.</p> <p>9 Medical Justice's clinical perspective is important</p> <p>10 for this inquiry's task. The inquiry has two experts.</p> <p>11 It has a use of force expert and it has a clinical</p> <p>12 expert, Dr Hard and Mr Collier. However,</p> <p>13 Medical Justice would suggest to the inquiry that it is</p> <p>14 necessary to combine that expertise. Looking at the two</p> <p>15 in isolation will not assist the inquiry to understand</p> <p>16 and properly investigate the full scope of article 3</p> <p>17 ill-treatment that was occurring at Brook House in 2017.</p> <p>18 There is a need for that to be correlated and the use of</p> <p>19 force evidence to be analysed in the context of its</p> <p>20 clinical implications, where it is concerned with those</p> <p>21 who are clinically vulnerable, and if that correlation</p> <p>22 does not take place, there will be a deficit in the</p> <p>23 inquiry's proper understanding of this key part of its</p> <p>24 investigation.</p> <p>25 What is, however, clear is that the use and effects</p> <p style="text-align: center;">Page 122</p>	<p>1 to be recognised that it is a corrupted culture which</p> <p>2 allows for the misuse of restraint, where acts of overt</p> <p>3 assault or nominally approved control and restraint</p> <p>4 techniques take place. The toxic staff culture which is</p> <p>5 exposed by Panorama means that explanation cannot also</p> <p>6 come from the fact that you have stressed, overworked</p> <p>7 and ill-equipped staff. They are not the root causes of</p> <p>8 the mistreatment, although they certainly contributed.</p> <p>9 It is a pervasive culture of abuse sanctioned by the</p> <p>10 application of prison-like control and restraint</p> <p>11 methods, whereby staff perceive the use of force and</p> <p>12 segregation as necessary to punish detainees regardless</p> <p>13 of the circumstances.</p> <p>14 You have been referred, and you have even been given</p> <p>15 the numbers of times on which abusive and derogatory</p> <p>16 language was used, and it's particularly focused on</p> <p>17 those who have vulnerability, although not exclusively</p> <p>18 so.</p> <p>19 THE CHAIR: Ms Harrison, excuse the interruption, but</p> <p>20 I wonder if we should take a break at this point? How</p> <p>21 much longer do you have to go?</p> <p>22 MS HARRISON: I think it may be an appropriate time for</p> <p>23 a break. I have probably another 15 minutes.</p> <p>24 THE CHAIR: We will return at 3.25 pm. Thank you very much.</p> <p>25 (3.11 pm)</p> <p style="text-align: center;">Page 124</p>

<p>1 (A short break)</p> <p>2 (3.32 pm)</p> <p>3 MS HARRISON: Chair, I was just beginning to start on the</p> <p>4 topic of institutional culture and had made reference to</p> <p>5 the overt language, bad language and abusive language,</p> <p>6 that is used.</p> <p>7 What I would like to just emphasise in connection</p> <p>8 with the methods of use of force is that there is an</p> <p>9 interaction between both the forms of use of force and</p> <p>10 the language that is used. Mary Bosworth,</p> <p>11 Professor Bosworth, in her report at paragraph 3.13</p> <p>12 described how the response of staff to their training</p> <p>13 was to deploy concepts more commonly associated with</p> <p>14 counter-terrorism, such as conditioning, in discussion</p> <p>15 of their interactions with those who were detained.</p> <p>16 We see from the records primarily from the</p> <p>17 transcripts that were disclosed the language, the often</p> <p>18 violent use of language, that is associated with</p> <p>19 attitudes to those who staff are holding.</p> <p>20 The appendix to Reverend Ward's witness statement,</p> <p>21 annex 8, which is DL00/40 pages 098 to 109, have</p> <p>22 extracted, for the assistance of the inquiry, a summary</p> <p>23 of some of that abusive language. What I would just</p> <p>24 like to draw to your attention is in the context of</p> <p>25 officers discussing internment camps and so-called</p> <p style="text-align: center;">Page 125</p>	<p>1 "Good for you, man, too right. No, I'll be doing</p> <p>2 the same, don't worry. They're not allowed on Facebook</p> <p>3 so they're not going on Facebook."</p> <p>4 Eddie Fiddy says:</p> <p>5 "They're basically like your mum is going to die of</p> <p>6 cancer and all this shit."</p> <p>7 Joe Marshall says:</p> <p>8 "Albanians, no, Moroccans."</p> <p>9 Unknown says, "Er" and Eddie Fiddy answers:</p> <p>10 "Absolute cunts."</p> <p>11 So there's a clear example of racially derogatory</p> <p>12 language being related to a person's race and</p> <p>13 nationality.</p> <p>14 There's a further example on 29 April, again</p> <p>15 involving Callum Tulley recording a male officer who is</p> <p>16 unidentified, but referring to how he was communicating</p> <p>17 with a detainee who was swearing at him, and in that</p> <p>18 context expressed this view:</p> <p>19 "He didn't speak English. I was, like, you're in</p> <p>20 fucking England. Speak English."</p> <p>21 Again, at this stage, those are only examples, and</p> <p>22 they're not isolated, and you have them set out there.</p> <p>23 So that overt derogatory and racist language and</p> <p>24 stereotyping is also the context in which use of force</p> <p>25 is applied to detainees who are treated with profound</p> <p style="text-align: center;">Page 127</p>
<p>1 second-generation British Muslims also commented on the</p> <p>2 fact of solutions to individuals who had left the</p> <p>3 United Kingdom to join ISIS in Syria, the answer that</p> <p>4 they came up with as to what to do was to "Lock them up</p> <p>5 or fucking deport them". "Well, what is the solution?",</p> <p>6 "Try bullets. That would be an ideal solution. Send</p> <p>7 a drone in. Delightful. Job done".</p> <p>8 That's one example, but there are other examples</p> <p>9 where overt violent action is discussed and proposed as</p> <p>10 a way of dealing with others who are, what was described</p> <p>11 there as second-generation British Muslims, but would</p> <p>12 similarly apply to the detainees themselves. We say</p> <p>13 that there is a connection between this form of training</p> <p>14 and methods of restraint that are used and the attitudes</p> <p>15 that officers expressed.</p> <p>16 We also do say that it is also closely related to</p> <p>17 racial stereotyping and racial profiling and, again,</p> <p>18 must be looked at in the context of overt racist phrases</p> <p>19 and observations that are made that you are already</p> <p>20 aware of. But if I can just provide you with additional</p> <p>21 references, again, this is from the extracted in annex 8</p> <p>22 to Reverend Ward's witness statement, on 25 April 2017,</p> <p>23 there is a conversation between Joe Marshall,</p> <p>24 Callum Tulley, Ed Fiddy and other officers discussing</p> <p>25 detained people using social media. Callum Tulley says:</p> <p style="text-align: center;">Page 126</p>	<p>1 disrespect.</p> <p>2 It is clear that that has an impact embedding within</p> <p>3 staff culture, normalising the use of violence and</p> <p>4 excessive force, as well as overt abuse.</p> <p>5 The final topic relevant to Medical Justice's</p> <p>6 medical expertise is its information that it can provide</p> <p>7 to the inquiry about the operation of healthcare more</p> <p>8 generally and the deficiencies within it. What</p> <p>9 Medical Justice's evidence will show, in addition to</p> <p>10 those repeated concerns about rules 34 and 35, is that</p> <p>11 there are clear inadequacies in the ACDT policies, the</p> <p>12 failure to report and treat people experiencing suicidal</p> <p>13 ideation and feelings of self-harm effectively and</p> <p>14 properly, that there is a clear inadequacy of training</p> <p>15 and expertise of detention staff in the care and</p> <p>16 management of mental illness and suicidal ideation, and</p> <p>17 a lack of clinical involvement in important decisions</p> <p>18 that have significant impact on mental health, including</p> <p>19 ACDT and segregation. That's particularly important in</p> <p>20 the context of individuals who lack mental capacity or</p> <p>21 whose capacity is compromised. There is no provision</p> <p>22 within the detention centre for any form of adjustment</p> <p>23 or assistance for those whose mental health is</p> <p>24 compromised and may need assistance in understanding and</p> <p>25 contributing to decisions to segregate or otherwise</p> <p style="text-align: center;">Page 128</p>

<p>1 restrain them. That's a longstanding further problem 2 that has also been subjected to extensive litigation, 3 but, nevertheless, the Home Office has failed to put 4 into place, and even now to put in place, adequate 5 arrangements that meet the legal obligations under the 6 Equality Act to make adjustments for those with mental 7 health problems, including, and in particular, those 8 whose mental health is so compromised by lack of 9 capacity.</p> <p>10 Medical Justice can also identify other problems 11 relating to the lack of continuity of medical care as 12 a consequence of detention and frequent situations which 13 was that of the experience of detainee 1527 of a lack of 14 medication, particularly on arrival, even where 15 medication has been prescribed in the community or in 16 other facilities. Detainees experience prolonged 17 periods where their medication is stopped and they have 18 difficulty reinstating it.</p> <p>19 There are clear failures of clinical staff to 20 identify, report and engage in any form of safeguarding 21 duty. There are inadequacies in recording and assessing 22 detainees who are refusing food or fluids.</p> <p>23 Finally, in respect of mental illness, there is 24 a fundamental inadequacy in the assessment of whether 25 a detainee is fit to fly and fit to be removed and an</p> <p style="text-align: center;">Page 129</p>	<p>1 inquiry with direct evidence of the Home Office's own 2 failure to engage in and respond to the evidence of 3 systemic failure. It, itself, carries out no effective 4 monitoring of practices, despite knowing that this is 5 a major issue, and an ongoing one. It singularly fails 6 to ensure that it monitors what is happening within 7 these facilities, and that is a fundamental failure in 8 its oversight responsibilities.</p> <p>9 Medical Justice has also tracked for many years 10 complaints and responses to them. Its report in 2014, 11 "Biased and unjust. The immigration detention 12 complaints process" laid bare some of the fundamental 13 difficulties and failings in the complaints process. 14 Medical Justice is not aware that any significant change 15 or improvement has been introduced to address those 16 mechanisms. It underscores the concern the culture of 17 disbelief also invades the PSU and it is stark looking 18 at the investigation that was conducted into D1527 that 19 it was only if his complaints were recorded and 20 corroborated by video footage were they accepted.</p> <p>21 This complaints process does not start from the 22 premise that the individual may be telling the truth 23 and, on that basis, it is always going to be 24 fundamentally compromised.</p> <p>25 Medical Justice does believe that improved</p> <p style="text-align: center;">Page 131</p>
<p>1 insufficient consideration on the impact of removal on 2 detainees with a serious medical condition. That, too, 3 is a topic that the IMB considered in 2020, with numbers 4 of individuals actively suicidal on ACDT actually being 5 forcibly removed from the United Kingdom. Those 6 problems are ongoing and continuous.</p> <p>7 Medical Justice strongly concurs with the 8 observations that were made by Mr Armstrong about the 9 way in which the role of the medical practitioner is 10 compromised by their role in immigration removal centres 11 and that their independence is not properly safeguarded. 12 That is compounded by what we have heard about the 13 Home Office's lack of confidence in its own system. 14 Those words were carefully used by Mr Shaw, but what 15 they mean is that the Home Office does not accept, and 16 rejects, the opinions of those it employs to carry out 17 these important functions, and that creates 18 a fundamental deficit in the system and it risks 19 compromising the doctor in giving their opinion and in 20 ensuring that doctors continue to see their role as 21 effective and useful if their opinions are constantly 22 rejected. Medical Justice also has important 23 information to provide to the inquiry about the adequacy 24 of complaints and monitoring mechanisms. 25 Medical Justice, in particular, is able to provide the</p> <p style="text-align: center;">Page 130</p>	<p>1 effectiveness for the IMB is an important safeguard, so 2 long as those individuals employed have the capacity and 3 will to act independently. Being able to have access to 4 and monitor a closed environment is obviously 5 a critically important function if it's conducted 6 effectively, but its recommendations need to have teeth. 7 We have seen nothing in the evidence at all, in the 8 Home Office evidence, to even indicate that in 2020 the 9 IMB issued a notice that it considered its operation of 10 Brook House was inhumane. One would have thought that 11 Mr Riley might have deposed to that, but he hasn't. So 12 the fact that the IMB is now operating, at least 13 relatively speaking, more effectively is not the answer; 14 the critical focus has to be on what was the response of 15 the Home Office. Has it, again, recognised and learned 16 any lessons from its practice of effectively rounding up 17 individuals to place them on charter flights, 18 irrespective of their mental or physical health and 19 their histories of torture.</p> <p>20 Has it committed itself to desist in that practice? 21 It is a matter of public record that it has not and 22 Brook House will continue to be the centre for removal 23 on charter flights.</p> <p>24 Ultimately, whilst oversight mechanisms are 25 necessary, they cannot ensure this abuse does not occur</p> <p style="text-align: center;">Page 132</p>

<p>1 without Home Office commitment and rigorous commitment 2 to comply with the law and policy and to ensure a safe 3 and humane environment. It is for this reason that 4 Medical Justice also support the principal position 5 adopted by Professor Bosworth after her careful review 6 of the institutional cultures of concluding that 7 immigration detention should not be used and 8 alternatives should be considered.</p> <p>9 For Medical Justice, like the British Medical 10 Association, the use of detention is an unethical 11 choice. If one wants to prevent harm, one needs to 12 either end or severely limit the use of this power. If 13 it is not, it will continue to be harmful, it will 14 continue to be unnecessary in the individual case and it 15 will continue to be ineffective. For this reason, 16 Medical Justice urges this inquiry to act on the advice 17 of Professor Bosworth, supported by other evidence and 18 the evidence that it will in time give to it, again, to 19 ensure that the most effective safeguard against abuse 20 in immigration detention, particularly for the 21 vulnerable, is to make sure that they are not detained 22 at all.</p> <p>23 THE CHAIR: Thank you. 24 25</p> <p style="text-align: center;">Page 133</p>	<p>1 extended beyond this narrowly fixed time period. In 2 fact, in the case of D1275, he continued to be subjected 3 to recurring mistreatment at Brook House for a further 4 326 days after the Panorama documentary first aired on 5 4 September 2017. In total, he was at Brook House for 6 422 days.</p> <p>7 All five Bhatt Murphy core participants experienced 8 immigration detention for longer than the time that they 9 were at Brook House. In D1275's case, he spent 839 days 10 in total in immigration detention between December 2015 11 and June 2018. He would have languished in immigration 12 detention for longer but for judicial review proceedings 13 being brought. All felt that there was no end in sight.</p> <p>14 The inquiry cannot, and should not, ignore this in 15 the context of indefinite detention because that is 16 essential to its understanding of the causes of 17 mistreatment. Otherwise, the inquiry will be 18 necessarily partial and incomplete. After all, the same 19 framework of statute and policy that operated at 20 Brook House during the relevant period governed, and 21 still governs, the immigration detention system as 22 a whole. It would be a suspension of disbelief if we 23 were to think that the gross mistreatment shown in the 24 footage or documented elsewhere in the evidence before 25 the inquiry only happened during this narrow period of</p> <p style="text-align: center;">Page 135</p>
<p>1 Opening statement by MS LUH 2 MS LUH: Chair, together with Ms Profumo, I make this 3 opening statement on behalf of Bhatt Murphy's cohort of 4 non-state core participants, D801, D2158, D1275, D1713 5 and D1473.</p> <p>6 I will deal with the experiences of D801, D2158, 7 D1275 and Ms Profumo will deal with the other two.</p> <p>8 Save in the case of D1713, it hasn't been able to 9 finalise witness evidence in relation to these CPs, but 10 their direct evidence will be before the inquiry in 11 phase 2. For the purposes of this phase, we provide an 12 outline of their experiences in opening because it's 13 essential and important that this is before the inquiry 14 as part of the context for the evidence that you will 15 receive next week and the week after.</p> <p>16 Can I make four general points on behalf of this 17 cohort of core participants before coming on to the 18 three CPs that I will be dealing with? The first is as 19 to the relevant period. Each of these five individuals 20 were designated non-state CPs because they were former 21 detainees who were held at Brook House for some time 22 between 1 April and 31 August, the relevant period for 23 your investigation. But it is important to note that, 24 at the outset, in the cases of D801, D1275 and D1713, 25 their experiences of ill-treatment at Brook House</p> <p style="text-align: center;">Page 134</p>	<p>1 time, perpetrated only by specific detention healthcare 2 staff and only at Brook House. The recent IMB annual 3 report which Ms Harrison highlighted in her opening 4 speaks to this very point.</p> <p>5 Second, and as to scope, it is not possible to 6 distil and reduce each of these core participant's 7 experiences at Brook House to a schedule of specific 8 incidents because the mistreatment that they experienced 9 pervaded the whole time that each of them was at 10 Brook House. Ms Harrison QC already has emphasised in 11 her opening statement that article 3 does not only 12 concern incidents of physical abuse, but also mental 13 abuse, which is harder to describe as neat incidents. 14 Ill-treatment can further arise from situational, 15 environmental and systemic factors, and the serious and 16 often persistent omissions on the state's part to take 17 any positive and effective steps capable of safeguarding 18 against real risks of abuse.</p> <p>19 Therefore, it is right that you, chair, said 20 in January of this year in your scope determination that 21 an effective inquiry must go where the evidence takes 22 it, and we fully endorse that.</p> <p>23 Third, and as to context, what BBC Panorama exposed 24 was just the tip of the iceberg in respect of the sorts 25 of circumstances leading to the abuse and mistreatment</p> <p style="text-align: center;">Page 136</p>

<p>1 that has occurred and is still occurring in immigration 2 removal centres across the UK. One only needs to look 3 at Stephen Shaw's first report, published in 2016, 4 a year before Panorama was aired, and that review 5 exposed fundamental defects in the operation of 6 statutory safeguards across the immigration detention 7 system as a whole, not only at Brook House. The abuse 8 exposed by the BBC cannot be explained away by a few bad 9 apples in one detention centre. It must be understood 10 at a policy level with a toxic background of the hostile 11 environment in sight.</p> <p>12 Fourth, and as to outcome, it is trite to say that 13 all of the Bhatt Murphy core participants share an 14 outrage at the experience each of them suffered whilst 15 at Brook House. They, of course, deserve answers for 16 the experiences that they have suffered and to 17 understand what went so badly wrong during their time at 18 Brook House: but, more importantly, all of them are 19 present here through their legal representatives because 20 they want the lessons and recommendations from the 21 inquiry to be forward looking and for relevant guidance 22 to be given to the Home Office and contractors so that 23 this kind of mistreatment and abuse is not allowed to 24 continue, not just at Brook House, but at any 25 immigration removal centre. After all, this inquiry was</p> <p style="text-align: center;">Page 137</p>	<p>1 authorities which included beatings, rape, sexual 2 assault and suffocation. He came to the UK on a student 3 visa. When that ran out, D801 applied for asylum in 4 2012 but was unsuccessful. He was detained firstly at 5 Brook House in 2015, April, but removal directions were 6 cancelled and he was released in late May 2015. On 7 release, his mental state deteriorated rapidly, 8 immigration detention having re-traumatised him -- the 9 closing of the doors, jangling of the keys and the 10 environment mimicked his detention in Sri Lanka and 11 triggered flashbacks. This led to overdoses on at least 12 two occasions and that led to hospital admissions.</p> <p>13 On one further occasion he was found in London, some 14 distance from where he lived, hanging on some railings 15 on the side of the road, not knowing where he lived, why 16 he was there, how he got there. The mental health 17 crisis team assessed him to have Post-Traumatic Stress 18 Disorder. An independent consultant psychiatrist found 19 him to suffer from psychotic depression. The 20 Home Office knew this. The Home Office knew this 21 because his immigration solicitors told them about this. 22 In fact, the Home Office referred him to the adult 23 safeguarding team in the local area where he was 24 residing and they told the Home Office, before the 25 second period of detention, that he was at serious and</p> <p style="text-align: center;">Page 139</p>
<p>1 established because lessons have not been learned, 2 despite the multitude of views, inspection and 3 monitoring reports and court judgments finding article 3 4 breaches in respect of individuals held at Brook House. 5 The state could no longer turn a blind eye. It was 6 forced to undertake this inquiry into the decisions, 7 actions and circumstances surrounding the mistreatment 8 of detainees at Brook House. If embraced properly, this 9 inquiry is an important and unique opportunity for 10 much-needed reflection and change, where other 11 mechanisms have failed to achieve this.</p> <p>12 With that in mind, could I turn to D801. He is 13 a Sri Lankan national of Tamil ethnicity and now 14 a recognised refugee. He was detained at Brook House 15 from 1 March to 3 April 2017, for 35 days, but this was 16 not the first time he was detained there. Although his 17 earlier detention in 2015 is strictly outside the 18 inquiry's time parameters, this history is important to 19 understanding how his mistreatment during the second 20 period occurred. It is also important context for 21 understanding how the Adults at Risk policy actually 22 operates and why, at a policy level, it is incapable of 23 ensuring that mentally ill and particularly vulnerable 24 detainees do not suffer harm in immigration detention. 25 D801 is a victim of torture by Sri Lankan</p> <p style="text-align: center;">Page 138</p>	<p>1 immediate evidence-based risk of suicide or serious 2 self-harm.</p> <p>3 One more factual context before his detention 4 in March 2017. He was preparing further submissions in 5 support of a fresh claim for leave to remain based on 6 article 3 suicide risks. He was due to submit the 7 representations in person at the Home Office's Further 8 Submissions Unit in Liverpool on 8 February 2017. This 9 was later rescheduled for 30 March 2017.</p> <p>10 Immigration rule 353A operates as a barrier against 11 removal of a person whilst their fresh claim is under 12 consideration. Until that fresh claim is considered, 13 the Home Office cannot and should not be actively 14 pursuing removal action. At a minimum, they need to see 15 what the person has to say. But in D801's case, the 16 Home Office decided to pursue his removal anyway, before 17 the fresh claim appointment.</p> <p>18 On 6 February 2017, they made that removal decision, 19 but made it without any consideration of his overdoses, 20 high suicidal risks and diagnosis of psychotic 21 depression. The only reference in the consideration to 22 his health was a reference to his being on 23 antidepressants; a gross understatement as to what his 24 true mental state was at the time. 25 The detention gatekeeper who authorised his</p> <p style="text-align: center;">Page 140</p>

<p>1 detention for 1 March 2017 assessed him to be an adult 2 at risk, level 2. As you may already know, by 3 definition, an adult at risk is someone who is suffering 4 from a condition or has experienced a traumatic event, 5 such as torture, sexual violence, that would likely 6 render him particularly vulnerable to harm if placed in 7 detention or remain in detention. The risk level is on 8 a spectrum set by the Home Office in order to assess the 9 likely risk of harm to the individual if detained for 10 a period of identified time to effect their removal.</p> <p>11 In D801's case, the provisional medical evidence did 12 not only establish that he had mental disorders, it also 13 established likely harm if he were to be redetained, 14 supported by evidence of his deterioration after the 15 previous detention. In the face of this evidence, he 16 should have been treated as an adult at risk level 3, 17 the highest level, but he was not. He should not have 18 been detained under the Adults at Risk policy, because 19 there was no imminent fixed date for removal and because 20 he was not a serious public protection concern. He 21 would not have been exposed to any of the mistreatment 22 he later experienced had a competent decision been made 23 about his detention.</p> <p>24 But even putting that to the side, the Home Office's 25 recognition of him as a level 2 adult at risk ought to</p> <p style="text-align: center;">Page 141</p>	<p>1 very, very last day of his detention, on 3 April 2017.</p> <p>2 He was one of the only two rule 35(1)s referred to 3 by counsel to the inquiry that were produced during the 4 relevant period, but that report came too late and the 5 damage to his dignity was already done.</p> <p>6 Within 24 hours of his redetention, he was seen by 7 an IRC psychiatrist who immediately concluded that he 8 required urgent treatment and a hospital transfer under 9 section 48 of the Mental Health Act. This gives you 10 a real insight into just how unwell he was at the outset 11 of the second period of detention at Brook House and how 12 obvious that was. It also exposes just how the adults 13 at risk safeguards failed to work from the very outset 14 of detention to safeguard his redetention.</p> <p>15 He was moved to the E wing in Brook House in 16 a situation of de facto removal from association pending 17 the section 48 assessment. This was on day 2, and he 18 would remain there until he was eventually released on 19 3 April 2017. The only course of treatment he got was 20 containment on the E wing and antidepressants on ACDT.</p> <p>21 In relation to ACDT, the frequency of observations 22 under that provision fluctuated over the course of his 23 detention. No assessments have been disclosed as to how 24 the level of ACDT observations were determined, by whom 25 and based on what evidence.</p> <p style="text-align: center;">Page 143</p>
<p>1 have resulted in a strong presumption being applied in 2 his favour and against detention.</p> <p>3 Chair, as Ms Harrison QC has already alluded to in 4 her earlier opening, the policy dating before the Adults 5 at Risk policy had a presumption against detention which 6 can only be displaced in very exceptional circumstances. 7 Under that policy, D801 was unlikely to have been 8 detained or, if detained, would have been released. But 9 that was not the outcome under the Adults at Risk policy 10 because the Home Office has recalibrated the strength of 11 presumption afforded to vulnerable detainees by allowing 12 more weight to be put on immigration factors. This is 13 contrary to the parliament's clear intention that the 14 adults at risk statutory framework would enhance and 15 strengthen protection against the detention of 16 vulnerable people.</p> <p>17 Although D801 disclosed a history of torture, past 18 overdoses and self-harming, no rule 35 assessment was 19 done. No report was raised under any of those limbs 20 until the very end of his detention.</p> <p>21 You have heard already about the importance of 22 rule 35. He received no rule 35(3) after disclosure of 23 torture, no rule 35(2) because of his suicide risk, and 24 no rule 35(1) about the concerns raised about detention 25 being likely to be injurious to his health until the</p> <p style="text-align: center;">Page 142</p>	<p>1 He was assessed to be ineligible for hospital 2 transfer under section 48, but that was erroneously 3 taken as sanction to keep him at Brook House, when one 4 simply does not follow the other. In fact, the IRC 5 psychiatrist said that he was "also not fit to be at 6 Brook House because he cannot receive appropriate 7 treatment", so his recommendation for D801's release on 8 health ground was ignored.</p> <p>9 The ACDT "treatment" was a wholly inadequate 10 response, was not therapeutic and was purely 11 containment. This was most apparent when he attempted 12 suicide by hanging himself using a shoelace as 13 a ligature. The only response by healthcare was to move 14 him to constant supervision for three days, and then he 15 was downgraded again. None of this was based on any 16 clinical or risk assessment about its appropriateness or 17 effectiveness.</p> <p>18 What was the Home Office doing? The detention 19 reviews were silent about his medical condition, and all 20 it did was repeat that he was an adult at risk level 2. 21 There was no engagement as to what that meant and how 22 serious his mental illness was. In fact, the 23 Home Office's reviews repeatedly said there were no 24 exceptional circumstances or risk indicators rendering 25 him unsuitable for detention, and they maintained that</p> <p style="text-align: center;">Page 144</p>

<p>1 position after his suicide attempt.</p> <p>2 In his responses to requests for temporary</p> <p>3 admission, the Home Office kept saying his health could</p> <p>4 be, and was, managed by IRC healthcare, but none of that</p> <p>5 was true. The only provision that was used for him in</p> <p>6 relation to the suicide attempt was a notification under</p> <p>7 IS91RA Part C, not rule 35(2). The problem with Part C</p> <p>8 is that it merely is a form of notification of concern.</p> <p>9 There is no corresponding obligation on the Home Office</p> <p>10 to look at the information, think about it and take any</p> <p>11 steps in relation to it.</p> <p>12 Indeed, in 801's case, nothing was done in the light</p> <p>13 of the Part C. When detention was reviewed ten days</p> <p>14 later, it was maintained on the asserted basis that</p> <p>15 there was an absence of risk and he was an ACDT, so</p> <p>16 everything was fine.</p> <p>17 Given all that has been said about this, it would be</p> <p>18 hard not to describe the treatment that D801 experienced</p> <p>19 at Brook House as premeditated, not in the sense of any</p> <p>20 subjective intention to damage his mental health, but,</p> <p>21 rather, in the sense that those responsible for the</p> <p>22 well-being of detainees at Brook House knew he had</p> <p>23 a mental illness history and persisted in a medical</p> <p>24 regime for him which involved neglect and recourse to</p> <p>25 de facto removal from association. The acts and</p> <p style="text-align: center;">Page 145</p>	<p>1 persistent omissions to take steps to identify him as</p> <p>2 vulnerable and at risk of harm in detention, to provide</p> <p>3 him with the much-needed medical treatment and to</p> <p>4 provide him with means to communicate with detention</p> <p>5 staff, Home Office, healthcare, to understand why he was</p> <p>6 there and how to seek help when he was unwell.</p> <p>7 D2158's experience has to be understood against the</p> <p>8 backdrop of Home Office decision making. He wasn't</p> <p>9 detained, actually, when he first arrived in the UK. He</p> <p>10 was assessed as low risk of harm, low risk of</p> <p>11 absconding. But, on 30 March 2017, the Home Office</p> <p>12 decided that he needed to be detained pending removal to</p> <p>13 Germany, and this was unlawful because the test for</p> <p>14 detention in a Dublin III case is if you are at</p> <p>15 significant risk of absconding, and they had already</p> <p>16 decided that he wasn't.</p> <p>17 But, rather than grapple with the truth of its own</p> <p>18 risk assessment, the Home Office instead raised his risk</p> <p>19 level from low to high in successive detention reviews</p> <p>20 in order to justify detention. There is no evidence of</p> <p>21 a material change in circumstances to support this, and</p> <p>22 it is a classic example of engineering assessments to</p> <p>23 fit the conclusion. It is the kind of decision that</p> <p>24 landed a lot of detainees in immigration removal centres</p> <p>25 in the first place.</p> <p style="text-align: center;">Page 147</p>
<p>1 omissions at Brook House intruded on his human dignity</p> <p>2 in breach of article 3. Now, those are not my words.</p> <p>3 Those are actually the words used by Charles George QC,</p> <p>4 sitting as a Deputy High Court judge in the case of</p> <p>5 D v Secretary of State for the Home Department, a case</p> <p>6 about article 3 ill-treatment in Brook House in 2012.</p> <p>7 But they apply equally to D801 and it shows just how</p> <p>8 little has changed.</p> <p>9 Can I then turn you to the next core participant,</p> <p>10 D2158. He is Iranian and was detained at Brook House</p> <p>11 from 10 April to 15 May 2017. He is a victim of torture</p> <p>12 who suffered beating and had cloth soaked in oil shoved</p> <p>13 into his mouth and has long-term dental bleeding as</p> <p>14 a result.</p> <p>15 However, because his fingerprints were matched to</p> <p>16 his having been through Germany, the Home Office was on</p> <p>17 a singletrack mind to removing him there and took no</p> <p>18 interest in his background and history, made no effort</p> <p>19 to elicit an account of his experience of torture.</p> <p>20 Although he was treated as an adult at risk level 1,</p> <p>21 this is only because he disclosed he was suffering from</p> <p>22 heart palpitations. Nothing was done to investigate the</p> <p>23 underlying causes of this and the impact of detention in</p> <p>24 this context.</p> <p>25 His is a case of mistreatment by a series of</p> <p style="text-align: center;">Page 146</p>	<p>1 Being an adult at risk level 1 was meaningless</p> <p>2 because it afforded him no protection at all against</p> <p>3 harm in detention. This is part of the problem because</p> <p>4 the Adults at Risk policy devalues information about</p> <p>5 likely harm that comes directly from the detainee on the</p> <p>6 purported basis that it was self-declared and therefore</p> <p>7 self-interested; symptomatic of the culture of disbelief</p> <p>8 operating across the immigration system.</p> <p>9 Putting aside that this was contrary to parliament's</p> <p>10 intent, this approach only works if the Home Office</p> <p>11 accepts responsibility for and ensures the proper</p> <p>12 operation of adults at risk safeguards so that</p> <p>13 professional evidence independent of the individual is</p> <p>14 actually capable of being generated promptly and</p> <p>15 competently. That didn't happen in D2158's case.</p> <p>16 The disclosure of torture to the nurse at the</p> <p>17 reception health screening didn't result in a rule 35</p> <p>18 referral. He didn't get a full physical and mental</p> <p>19 state medical examination, in accordance with rule 34,</p> <p>20 within 24 hours of being detained, or at all.</p> <p>21 The importance of a rule 34 examination and the</p> <p>22 significance of failure to complete one cannot be</p> <p>23 understated, for the reasons that Mr Goodman has already</p> <p>24 explained earlier this morning. When the rule functions</p> <p>25 properly, any rule 35 assessment as to whether a person</p> <p style="text-align: center;">Page 148</p>

37 (Pages 145 to 148)

<p>1 is a victim of torture or has other vulnerabilities 2 forms part of this medical examination so that the 3 adults at risk can be identified and information fed 4 into decision making on detention. 5 But it failed in his case, and it failed in a lot of 6 people's cases, and the failure can result in an adult 7 at risk never being able to get professional evidence 8 capable of supporting their self-declared risk of harm 9 or suffering a delay at a serious cost of leaving them 10 at risk of harm. 11 Even when D2158 repeatedly sought medical assistance 12 for his heart palpitation, his toothaches, for hearing 13 voices, for feeling like someone is choking him at 14 night, little was done to identify the root causes. 15 A mental health referral made early in the detention 16 centre was delayed by two weeks. In fact, for 16 days 17 of his detention, the first 16 days, he didn't see any 18 doctors whatsoever. When he did finally see a doctor, 19 no clinical investigation was carried out into all of 20 the physiological and psychological symptoms of his 21 torture past, symptoms that were brought to the 22 forefront from being locked in, once again, by the state 23 from which he thought he would be seeking protection. 24 A rule 35(3) that was finally made did not result in 25 release. We haven't yet seen that disclosed in any of</p> <p style="text-align: center;">Page 149</p>	<p>1 and he saw his GP immediately soon after, and he was 2 diagnosed with PTSD. 3 If I can turn you to the final one, it is D1275, an 4 Iranian national who suffered from PTSD as well as 5 bipolar affective disorder. D1275 has discretionary 6 leave to remain, granted as part of the settlement from 7 the Home Office for unlawfully detaining him under 8 immigration powers and subjecting him to immigration 9 bail conditions with which he couldn't comply because he 10 lacked mental capacity to understand the conditions and 11 make decisions about compliance. 12 The fragility of his mental state is a product of 13 the inhumane and degrading treatment he suffered in 14 immigration detention over 839 days, 442 in Brook House. 15 Within a month of release from Brook House, he was 16 detained under the Mental Health Act, under section 2 17 and then section 3, because his mental health had 18 deteriorated so much in Brook House. He was discharged 19 on a community treatment order in December 2018. That's 20 been discharged but his mental state is still frail. 21 He was designated a CP on 24 September 2021 further 22 to the disclosure to the core participants' of excerpted 23 footage of key incidents captured on the BBC footage. 24 In his opening statement, counsel for the inquiry 25 referred on several occasions to a specific incident on</p> <p style="text-align: center;">Page 151</p>
<p>1 the tranches to date, and we hope to see that before 2 phase 2. 3 It did lead the Home Office to elevating his risk 4 level to level 2, but that made no difference because he 5 was a removal case. He was powerless to challenge any 6 of this because he was never given an interpreter for 7 any of his appointments with healthcare, immigration 8 detention officers, with anyone, so he couldn't know 9 what was going on, who to talk to, how to ask for help; 10 to put it bluntly, he was given no voice. 11 Significant aspects of the institutional culture at 12 Brook House were disempowering and oppressive and 13 threatening to him, and you will hear that in due 14 course, I hope. 15 One of the main features also is that he was 16 powerless to even try to make a complaint because, first 17 of all, he couldn't speak to anyone without an 18 interpreter, and he also therefore couldn't find out the 19 people who perpetuated abuse against him. 20 When he conducted food refusal for several days 21 because of a fear of removal, this didn't result in any 22 assessment of his mental health. Instead, his food 23 refusal was described as "concern re his diet" and 24 nothing more. 25 His mistreatment finally ended when he was released,</p> <p style="text-align: center;">Page 150</p>	<p>1 14 June 2017 in which D1275 was suffering a spice attack 2 and mocked by detention custody staff Nathan Ring and 3 Derek Murphy. You have heard what those disparaging 4 remarks are, and I won't repeat them here other than to 5 highlight the one that the counsel to the inquiry 6 described as particularly "chilling", Derek Murphy 7 recorded as saying, "Absolutely no sympathy for them at 8 all. If he dies, he dies". In due course, we hope to 9 show the footage itself so that this inquiry and the 10 public can get a real sense of what was actually 11 happening. 12 This incident obviously intruded on his dignity and 13 illustrated the disdain and cavalier indifference for 14 the safety and welfare of detainees exhibited by 15 detention centre staff and healthcare. A G4S support 16 plan produced a few days later, inquiry reference 17 <CJS001127>, noted that he was being used as 18 a guinea pig for drugs, exploited and bullied by other 19 detainees because of his vulnerability. A security 20 information report, <CJS005347>, noted that detention 21 custody staff knew this was going on, didn't report it 22 and, in effect, allowed it to happen. 23 A G4S own investigation into the incident, 24 <CJS005928>, in September 2017 found the allegation 25 substantiated, noted that DCM Murphy displayed little</p> <p style="text-align: center;">Page 152</p>

1 remorse in relation to the comments he admitted to
 2 making about D1275. Nathan Ring's actions were also
 3 found to be unprofessional and negligent towards the
 4 management of care of detainees, <CJS000814>.
 5 As chilling and disdainful as the incident captured
 6 on camera was, if the inquiry's investigation into
 7 D1275's mistreatment were to stop there, it will not
 8 have achieved what it set out to do and to follow the
 9 evidence.
 10 By the time judicial review proceedings were made
 11 in May 2018, he was unable to communicate with any
 12 coherence or sense with staff, healthcare, charitable
 13 detainee welfare groups or his lawyers. Unbeknownst to
 14 him at the time, the Home Office was fully aware that he
 15 was someone who couldn't be removed from the UK and knew
 16 that that had been the state of play since, at the
 17 latest, January 2017, when the Iranian authorities told
 18 the Home Office they couldn't issue a travel document
 19 for him at all. Yet the Home Office, nevertheless, left
 20 him to languish in detention -- first at Harmondsworth,
 21 then Colnbrook, then Brook House. By the time he
 22 arrived at Brook House, he had been in segregation for
 23 two months under rule 40 at Colnbrook because he was
 24 acting "bizarrely and inappropriately" towards staff and
 25 "made no sense and was confused and rambled".

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1 Judicial review proceedings settled in 2019 with the
 2 bare omission by the Home Office that his detention may
 3 have become unlawful by the end of his time at
 4 Brook House, when he had entirely lost his mental
 5 capacity, and, but for a referral for legal
 6 representation by Gatwick Detainee Welfare Group, D1275
 7 may well have languished indefinitely at Brook House.
 8 That muted omission by the Home Office of unlawful
 9 detention was an entire mismatch with the settlement
 10 agreement to pay out a significant sum of damages and to
 11 grant D1275 a period of leave to remain.
 12 Now, more than 100 pages of disclosure has been
 13 provided by the inquiry to date. It is not possible,
 14 nor efficacious, to set out in forensic detail just how
 15 the litany of acts and omissions at Brook House intruded
 16 on his dignity, individually and collectively breached
 17 his article 3 rights. Much of this has never been
 18 investigated, or properly investigated, at all because
 19 the bulk of that disclosure provided to the inquiry from
 20 state and institutional CPs had been withheld from D1275
 21 and his legal team during his judicial review by the
 22 Home Office in what can only be described as a blatant
 23 breach of the duty of candour and a wholly miscalculated
 24 attempt at keeping the truth about his mistreatment
 25 cloaked in secrecy and hidden from public scrutiny.

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1 How, you may ask, did this panoply of policies
 2 directed at protecting vulnerable detainees from harm,
 3 or further harm, in detention allow this to happen?
 4 What possible explanation could be given for putting
 5 someone like him at Brook House for 442 days? And why
 6 did no-one do anything about it?
 7 An opportunity must be given in phase 2 to take
 8 a forensic approach to interrogating his experience at
 9 Brook House because it is a paradigm example of how the
 10 different parts of the immigration detention system and
 11 the individuals responsible for operating those parts
 12 collectively and individually mistreated him through
 13 reckless indifference for his safety, neglect of his
 14 health and acquiescence to his bullying, exploitation
 15 and abuse.
 16 The root cause is not poor training, not poor
 17 application of policies and not the bad behaviour of
 18 a few; it is the systems and institutional culture of
 19 the immigration detention system that allowed this abuse
 20 to go on for so long -- 839 days, 442 at Brook House.
 21 Thank you very much.
 22 THE CHAIR: Thank you, Ms Luh. In view of the time,
 23 I wonder if we maybe will begin with you tomorrow
 24 morning, Ms Profumo.
 25 MS PROFUMO: I'd be grateful, chair, thank you.

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1 THE CHAIR: Just as a reminder, we are actually starting at
 2 9.30 am tomorrow. Thank you very much. I look forward
 3 to seeing you tomorrow.
 4 (4.24 pm)
 5 (The hearing was adjourned to
 6 Friday, 26 November 2021 at 9.30 am)
 7
 8
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