IN THE BROOK HOUSE INQUIRY

OPENING STATEMENT ON BEHALF OF
D687, D390 AND GDWG

INTRODUCTION

1. This opening statement is made on behalf of the three core participants ("CPs") represented by Deighton Pierce Glynn solicitors ("DPG"), i.e. the formerly detained people D687 and D390, and the charity Gatwick Detainees Welfare Group ("GDWG"). This statement is scheduled to be given on Wednesday 24 November 2021. It may be adjusted on delivery. This written version is designed to assist, particularly with regard to references.

IMMIGRATION DETENTION IS TOXIC

2. Others will already have touched on this, but it falls for emphasis. There is something toxic about immigration detention. That toxicity arises because of the scale of the underlying power imbalance. On one side of that scale is a detention power which produces unpredictable and potentially indefinite periods of detention, and which generates a special kind of fear and despair. On the other side is the nature of the cohort being detained. Those in immigration detention have a particularly wide range of illnesses, vulnerabilities and disabilities, rendering them particular at risk of abuses of power.

3. Ensuring that does not occur requires particularly robust systems and safeguards, and eternal anxious oversight. A system calibrated for immigration throughput rather than welfare, at the lowest possible cost, and which leaves junior and inexperienced staff operating without leadership, guidance or proper oversight, is not that system. Dysfunction moves in; it adores a vacuum.

4. The expert to the Inquiry, Prof Bosworth, is not alone in thinking the only solution may be a time limit[1]. As she says, that may be the only way to reduce the kinds of distress shown in the BBC footage, to foster the appropriate professional staff culture, and to help avoid a recurrence of what happened in Brook House in 2017. The DPG CPs support a time limit; they support Prof Bosworth's invitation to be bold[2]. They also say it is clear that mentally ill people should simply not be detained.

5. This Inquiry will see, for the first time and in detail, what happens otherwise. This Inquiry must seize its unique opportunity to do something about that. Nothing like this has happened in this area before. Given how hard it was for D1527 and D687 to secure the Inquiry, it may be thought nothing like this will ever happen again.

DETAINED PEOPLE

6. Developing this, and starting with the detained cohort, it is obvious that many will suffer from mental ill health. That does not mean all will have received a formal diagnosis. Many of those detained may have mental ill health just emerging, or have traumatic backgrounds which make them vulnerable to mental ill health, especially in a detention environment. Many will be at risk of being retraumatised by detention. D390 may be an example of this: little in the way of a formal diagnosis when he arrived at Brook House, but with a background of childhood trauma and some recent time in prison. His symptoms were beginning to intensify. None of that, however, is unusual or unpredictable. G4S and the Home Office have seen enough studies concerning the impact of detention. They can see it happening in their centres and they have been successfully sued about it sufficiently frequently. They and their systems must be alert and responsive to such things.

[1] [INQ000064] at §2.28.
[2] Paragraph §2.27.

7. Mental health links to suicide and self-harm ("S/SH"), though it is not necessarily the same thing. S/SH is common throughout the detained person population. It reflects the despair, and the absence of hope, which many feel. It affords many the only control over their lives which they feel able to exert. The despair can be seen clearly in the unbroadcast footage of D687 on 13 May 2017, supported by Callum Tulley's video diary (see further below). That does not make for easy viewing. That was the place to which D687 had been taken; how far he had been reduced: applying a ligature in a Brook House toilet rather than face yet another move; yet another extension of a detention which by then had already lasted well over two years[3]. We will return to that and what it means, including in Article 3 terms. For now it is sufficient just to note the scale and depth of what it conveys, and to reflect on what it means not just for D687, but also for the staff who have to try and deal with that despair. One recalls the unbroadcast sequence where Callum Tulley cries in the toilets following one of the episodes with D1527. Immigration detention impacts on staff as well and not all react as Callum did on that occasion. Some may develop more maladjusted coping mechanisms.

8. Another marker to put down now, in the S/SH context, is the extraordinary divergence between the number of open ACDTs in Brook House in 2017, and the paucity of Rule 35(2) reports. Rule 35(2) is of course the part of Rule 35 which focuses explicitly on S/SH. Its focus is different to Rule 35(1), and is very different again to Rule 35(3). Yet in the final quarter of 2017 when there were 528 open ACDTs in the immigration detention estate, only ten Rule 35(2) reports were completed. That is for the whole of the estate, over the whole of the year[4]. That shows very high levels of S/SH, and an almost complete absence of one of the key safeguards; the Rule 35 safety valve for release. Those numbers alone mean something had gone very wrong; the other provisions of Rule 35 seem to have been forgotten about. It is not at all clear that anything has improved.

9. Other features of the detained cohort include, for many, having limited English. That in turn gives rise to issues about how those people are to communicate their needs (especially in times of distress, when their ability in English may reduce further); how they are to complain about ill-treatment; and how they are vulnerable to bullying, including by staff. The language used throughout Brook House will be a feature of this Inquiry: the routine swearing; the goading

[3] D687's period of detention lasted from March 2015 to November 2017, so two years and eight months. He had also been in immigration detention before, for at least several months ending in 2012. D687 is now 37 years old and has been in the UK since he was 10 years old. All the family he knows is here.
[4] See *IS (Bangladesh)* [2019] EWHC 2700 (Admin) at [194].

and the mocking, much of it racist and xenophobic; even the laughing in the faces of those detained. As will be seen, humiliation is a key factor in the determination of whether treatment reaches the Article 3 threshold. For now it should just be noted how much of that language also includes mocking the way some detained people speak, or struggle to communicate.

10. Another obvious feature is that many in immigration detention also often lack family or friends in the UK. This is another key way in which this cohort is often more vulnerable than are prisoners. They do not have the same sources of support. They may be lonelier; more isolated. They will have fewer people to check on them. People without these networks *and* with limited English are likely to be very isolated indeed.

11. A complexity arises because these vulnerabilities sometimes combine with challenging (sometimes very challenging) behaviour. That is partly about mixing vulnerable and less vulnerable people. There are many references, throughout the Inquiry materials, to the difficulties associated with former prisoners arriving in Brook House with all they have learned there (especially in 2017, when much of the prison estate was also in clear disarray[5]). At the same time, however, people who are challenging may also be vulnerable, even sometimes the most vulnerable. That is inevitable when people are mentally ill, but also when people are in extremis. It may also reflect poor coping skills, or neurodiversity or learning difficulties. Such presentations are present in immigration detention, just as they are in prison[6]. The Chair will have seen this time and again in her Prison and Probation Ombudsman ("PPO") work. Such individuals usually need time, listening and understanding, perhaps reasonable adjustments; much more, in fact, than they need something imposing on them, which may well be counterproductive. Again, none of this is surprising, or new. It is however particularly vivid within the immigration detention population, with their wider vulnerabilities and particular characteristics.

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[5] This is touched upon in Lee Hanford's first interview with Verita [VER000266/0010]: problems deriving from benchmarking and related problems in the prison estate were finding their way into the immigration detention estate. Note that 2017 was the year that HM Inspectors had to develop urgent notifications ("UNs") for use in the prison estate: https://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/urgent-notifications/. Note too that the third UN ever given was given, in August 2018, to HMP Birmingham, until then a G4S run prison but which then had to be taken back into MOJ control. That followed a riot in 2016. Several of the senior G4S staff members with which this Inquiry is concerned worked, at various stages, at HMP Birmingham, including Lee Hanford, and Steve Skitt.

[6] See *eg* https://www.justiceinspectorates.gov.uk/cjji/inspections/neurodiversity-in-the-criminal-justice-system-a-review-of-evidence/. Note that as well as D687 whose medical reports raise the prospect of him having ADHD, one of the witnesses for whom DPG acts (D393) has a diagnosis of ADHD and will give evidence about the issues to which this gave rise at Brook House. Dr Hard touches on these issues at §6.2.1.2-6.2.1.4 of his report for the Inquiry [INQ000075/0165].

12. Linked to that, consider also this: many (perhaps the majority of) prison governors will say that they govern, for the most part, by consent, and that they gain that consent through developing relationships[7]. Prisons often fail at this too, but establishing those relationships is even harder with a population that is unwell, or does not speak English, or which is moved between centres much more frequently than would occur in the prison estate. Immigration removal centres do not have settled populations. They become even more unsettled where trust has been lost and hope cannot be given. A prison officer can take a prisoner who is struggling and tell them how to progress, and how to deal with what has happened in his past. They may be able to point them towards courses, or offending behaviour programmes, or educational opportunities. In that way they may be able to offer hope. A detention custody officer, by contrast, cannot easily do that for someone in immigration detention. It is clear that the activities available in Brook House were extremely limited[8]. But the immigration context makes matters much harder. Even if officers understand what is happening to someone (which may require an understanding of a complex immigration legal position, and the Home Office does not like to teach that[9]) an officer cannot, and certainly cannot be seen, to be supporting progress towards release. That undermines Home Office objectives. Equally, hope cannot be found in progress towards removal when the individual is terrified of removal. The same officer may also be required to report on the detained person, or to keep quiet news of an imminent no-notice enforced removal. The tension which such things create is obvious; and real[10]. It undermines any chance of good relationships.

13. It may be added: all this is done for very little immigration gain. Very few removals take place. In the year ending March 2020, 23,101 people entered immigration detention. The same year, the number of enforced returns from the UK was 3,327[11]. The vast majority of people who enter detention, therefore, are released not removed. That obviously says something about the very limited justification for all the horrors of immigration detention. On a day to day basis, however, it means officers are having to hand people over for flights, sometimes using force, only to have them return a day or so later. That process is often a difficult one – sometimes

[7] See *eg* the interview of Majella Pearce - Deputy Head of Health Inspection, HMIP [VER000245_0007].
[8] See *eg* Lee Hanford [VER000266/0005]: "I've raised this myself with the Home Office, they will get a better regime in a prison, because a prisoner will have the activity, the workshops, much fuller education facilities, a much better curriculum, really, because this is aimed at short detention…"
[9] See the Owen Syred interview at [VER000252/0003].
[10] Another problem touched on in the Lee Hanford interview: [VER000266/0022].
[11] See https://www.gov.uk/government/statistics/immigration-statistics-year-ending-march-2021/how-many-people-are-detained-or-returned.

very traumatic - and it is obvious that it will affect and sometimes destroy staff/detained person relationships. It is a pointless, wearing, and degrading cycle.

14. It may also be added: it may be hard for some individual officers not to help someone who is clearly in need of help. The human instinct is usually to do just that. But where one is prevented, by the circumstances, from doing that, one may develop responses, telling or persuading oneself, that the individual does not in fact need help; or that they do not deserve it. This is in part what immigration detention does: it puts two individuals in an impossible position where one needs help and the other cannot give it. The result can be a dysfunctional response. In the end an officer may reach for the justification in the wrong places: first they try to explain; then they stop engaging; it becomes wearisome and degrading; later it becomes abusive. In the detention context, where the power imbalance is obvious, it can become dehumanising. The relevance of that dynamic is expressly and repeatedly recognised in the Article 3 case law (see below).

15. There is more here: as already indicated, immigration detention is different to serving a sentence in prison because it can, in principle, be indefinite. It is often very long. Look again at D687's case: two years and eight months of immigration detention (on this occasion); well over any period he was required to serve on a sentence. Throughout that time he, like many others, had no idea when he might be released. Contrast prisoners, who on arrival in custody receive a release notification slip or, at the very least, a parole eligibility date. Not having that is extremely wearing, and again leads to despair. Progress may depend on the vagaries of the emergency travel document process, so when Somalia, or Iran, or Algeria (all countries who tend to be less than helpful about such things) decide to cooperate. More often, release may just depend on when someone's mental health deteriorates sufficiently. By a process of slow accretion, all too unpredictable to the individual, the detention may become unbearable and unjustifiable enough to become unlawful.

16. Progress towards release or removal may also, of course, depend upon whether someone is able to mount a claim resisting removal. The Home Office is often very scathing about legal attempts to block removal. It sees them as abusive. The answer is that many of these attempts are properly brought. The original asylum claim may not have been properly investigated or advanced. A highly sensitive trafficking claim may just have emerged. The immigration system is under resourced and creaking and often misses good claims. Sometimes the system works so badly, and takes so long, that new claims emerge for that reason alone. Even claims that fail

may be properly brought and understandable. It is entirely understandable, for example, that someone who has been in the UK a long time, perhaps since a child, perhaps now with family here and now in poor mental health, will not want to return to a country of which he or she has no or virtually no knowledge.

17. Despair and hopelessness also feeds other things, notably drug-taking. New psychoactive substances, or NPS, also called "spice", are freely available in immigration removal centres just as they are freely available in the prison estate. They are brought in by a variety of routes including, it seems, through staff (many of the Verita interviews suggest that, and it is clear that someone was at least suspended for it [CJS000813/0014][12]). These drugs are dangerous. The concentrations are usually unknown. The vulnerable may be forced by others to take them in order to test their strength (ominously known as "spice pigs"). The results can be dramatic, and very loud, as some of the video footage shows. All this goes to inform the atmosphere at Brook House: ragged, febrile, often hostile.

18. These therefore are the features of many detained people: vulnerable, afraid, often unwell or becoming unwell, sometimes responding to their impossible situations in the way that people who are unwell or afraid often do respond.

MANAGING

19. How then are these people and their problems being managed, and by whom? Often by people with no relevant experience, and very little training. With regard to the former, review the answers to the opening questions in the Verita interviews: DCOs may be former supermarket workers, or from other retail, or they may be former baggage handlers from the airport. Pizza Hut and Argos are both mentioned; so is painting and decorating. Some are former prison officers, which brings its own problems because it can bring in a different culture or mindset. DCOs (and DCMs) are paid very little, and at Brook House it was a flat rate which never increased so there was no reward for the kind of experience, or authority, which might have helped do the job. Also, in this context "authority" includes moral authority, i.e. the personal confidence and integrity that, it may be hoped, comes with age and experience and which enables things like calling out poor behaviour when it is seen. It is hard to encourage that on a flat rate of £25,000 (£30,000 for DCM).

[12] G4S report on outcome of allegations: "Corruption Prevention operation took place and a member of staff was suspended. Availability of 'spice' reduced".

20. With regard to the training, that is very limited. The initial training course ("ITC") is eight weeks, six weeks of which is spent in the classroom[13]. There appears to be little or nothing in the way of additional training for DCMs[14]. Time and again officers refer to learning the most important lessons on the job[15]. Some, of course, do the ITC training and then disappear, saying Brook House is not for them. All this raises proper, and important, questions about the preparedness of these officers, as they approach the complex and difficult situations with which Brook House will present them. Prof Bosworth also speaks of training in secondary trauma and a graduate programme which could assist in building resilience and professionalism among the staff group[16].

21. There is also, of course a clear issue around under-staffing. It is probably unnecessary to spell this out, because it is all extensively documented in the materials from the Verita interviews and report through to the more recent Rule 9 statements made by staff. All complain that there were not sufficient staff. There were not enough staff on the wings. There were often just two for potentially 126 detained people[17]. It is obviously impossible to expect two individuals to get anywhere near the satisfactory management of 126 complex individuals with 126 sets of questions and 126 sets of varying needs. It only requires a moment to imagine what that looks like on the ground. Some illustration comes from individual accounts such as those contained in Callum Tulley's video diaries: a new DCO[18] being left alone on a wing after an attack took place; someone else having to remain on constant observations for several hours because there was no-one to relieve them[19]. At a more mundane level it also means staff ignoring basic requests because they have no time to deal with them; or responding too bluntly; or detained people being left waiting to progress off wings because there are insufficient staff to deal with the doors. That in turn leads to other problems, including more frustration, and noise. The

[13] Verita report/§1.36.
[14] Interview with DCM Ryan Harkness [VER000238/3]. Also at A119 on the DCO training: "Yes, sat in a classroom, but the same as when I became a DCM. You are just dropped in the ocean and told to get on with it. You have to find your feet and if you don't you won't last two seconds in this place…"
[15] There are many examples but see *eg* Yvonne Fuelle [VER000234 at 3,4, 8 and 9]; and Imam Zeeshan Qayyum at [VER000230] at 23.
[16] [INQ000064/11] at §2.24.
[17] This is the figure which seems most often to be used: see *eg* Harkness again at [VER000238/9].
[18] TRN0000037: BBC000595 - KENCOV3010, relating to 24 April 2017. See also BBC Relevant Footage V2017042400004 of the same date. In response to DCO Victoria describing being left on a Wing by herself, DCO Dan Lake says, "Fuck! That's bad, isn't it?"
[19] TRN0000045: BBC000603 - KENOV3021, relating to 8 May 2017.

physical environment of Brook House (everyone talks of the noise[20], and the toilets[21]) is another issue. These matters are an issue for everyone, never mind (for example) neurodivergent individuals whose conditions may mean increased auditory sensitivity. The descriptions of the Brook House environment, seen in part on the footage, stand in stark contrast to what is required by Rule 3 of the Detention Centre Rules[22].

22. The staffing arrangements also meant that staff were working very long shifts: 13.5 hours[23]. That too leads, inevitably, to further serious problems. Tired staff will also struggle to solve problems by listening and understanding and supporting. That would be true anywhere, but it is all the more so given the other circumstances pertaining in Brook House. Where problems cannot be solved they tend to escalate. Where staff cannot manage by care and consent they will need to impose. The nature of that imposition may be clumsy. It may become loud and ultimately abusive. Inexperienced and ill-equipped people often end up shouting. Where a situation is challenging the staff reaction may also be informed by fear. The language then hardens, and becomes more abrasive. This may have started as bleak humour, introduced to help people cope with what they are seeing (such as a person with an extreme reaction to NPS). The swearing also starts. But before long that becomes the language of abuse. Staff who are struggling to cope grab for whatever is fastest. It is easy to see how this develops, and how ultimately it heads towards a need for physical intervention. This is how environments and particularly detention environments brutalise.

23. Another aspect to this is the wider context and culture, and the way immigration is spoken about by politicians, and the media, and others. The government deliberately sought to establish a hostile environment for migrants. Its language often supports that hostile aim. That is all the more pronounced with regard to those in detention, who are seen and portrayed as even less worthy or deserving. There is much that can be said about that, but the immediate and obvious risk is that a DCO with nowhere else to turn, who is left unguided and unled,

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[20] See *eg* the Verita report at [8.93], from the head of Tinsley House: "It is built like a prison – it is prison wings. I think the whole environment that that brings, the acoustics, the noise, the numbers can be really overwhelming for people who haven't experienced it before".
[21] "It was not disputed that some toilets did not have curtains to screen them": *R (Soltany) v SSHD* [2020] EWHC 2291 (Admin) at [85].
[22] "A relaxed regime with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environment, and to encourage and assist detained persons to make the most productive use of their time, whilst respecting in particular their dignity and the right to individual expression." See also DCR 3(2): "Due recognition will be given at the detention centres to the need for awareness of the particular anxieties to which detained persons may be subject and the sensitivity that this will require, especially when handling issues of cultural diversity".
[23] Verita report/§8.10.

reaches for that language in order to inform their responses. It is a very short step from that to abuse, including racist abuse, and to institutional racism, defined in the following way (from Sir William Macpherson's report into the death of Stephen Lawrence):

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

24. Something else happens here: officers and other staff who are struggling, and who may sometimes be slightly afraid, feel the need to stick together. They may in particular stick with those they perceive as strong. Cliques therefore develop, and develop around unsuitable people. If those people behave badly, other staff will be reluctant to call them out, because in other circumstances they know they may be reliant on those same individuals for their own safety. Equally, staff who are not yet in that position, but who are exhausted by what they are having to deal with, or who are wearied by being repeatedly asked to resolve that which is fundamentally irresolvable, will also not call out this behaviour. They have other things to do; they are fire-fighting.

25. As already indicated, it requires significant personal and professional presence and confidence to do the right thing in difficult circumstances. It requires integrity. That may all be conferred in a number of ways: recruiting the right people; training them in the right way; enforcing and reinforcing proper behaviour; leading by example; and by providing constant and effective oversight.

26. Was that happening in Brook House in 2017? Were the DCOs in particular getting proper help and guidance from their senior staff, in order properly to equip them to do the job in sometimes difficult circumstances? Was the fact and content of that guidance being properly checked? The answer would seem, very obviously, to be "no". The Verita report, whose findings G4S at least has accepted (it remains to be seen the extent to which the Home Office has also done so), found a "void in leadership", informed in part by dysfunctional dynamics between members of the senior management team[24]. The senior staff were doing little or nothing beyond falling out with each other, or concentrating on immigration "throughput" so

[24] See the Verita report [CJS005923] at §15.7 – 15.12. This conclusion is adopted by Prof Bosworth: §4.33.

that they could meet Home Office contractual requirements[25]. They were not on the wings; they were not visible. In some cases, Brook House seems to have weakened whatever resolve or decency someone might once have had[26].

27. This state of affairs appears also to have been known, and certainly partially known with the rest knowable, at the highest levels of G4S, and for some time. The Jerry Petherick file note of 28 October 2014 [VER000103] shows general concerns ("I was becoming increasingly concerned about the stability of the management team at Gatwick") as well as specific criticisms of the leadership of Ben Saunders. The names cited in that note are the same names that appear throughout the 2017 material.

28. Similarly, there are the obvious and very close parallels between what Panorama revealed in Brook House, and what it had previously revealed in the Medway Secure Training Centre broadcast at the start of 2016 (the programme which originally prompted Callum Tulley to write his own e-mail to Panorama: [CPS000023]). The Medway Improvement Board report, which contains these closely paralleling findings, is dated 30 March 2016: [INQ000010]. Ben Saunders was at Medway between 2007 and 2012, and then returned there following the Medway Panorama in 2016, only to return to Brook House before resigning over the Brook House Panorama. The similar fact evidence is striking.

29. There was also material from the few complainants who did, to some extent, feel able to say something. Some of this material is still emerging, and it is hoped there may yet be more. The Inquiry will be aware of concerns raised about G4S's whistleblowing processes and their initial failure to disclose such material to the Medway Improvement Board. However it is already likely that the Inquiry will want to hear from Owen Syred about staff bullying, including racist bullying, of other staff. See also David Waldock, who on 15 April 2017 wrote about the "incomprehensible levels of bullying" at Brook House [VER000061]. That complaint is against Ben Saunders, Steve Skitt, DCO Gayatri Mehraa and Vanessa Smith of the Home Office. All are now familiar names. As set out below, Gayatri Mehraa also features in the GDWG evidence as well as frequently within G4S's register of complaints in 2017. Vanessa Smith features in D687's case, and was the subject of the extraordinary (and upheld) Hibiscus complaints: see *eg* [HOM005901]. More on that also to follow, below.

[25] Verita/§14.71.
[26] See *eg* what Callum Tulley says about Dan Lake in one of his video diaries.

30. See also the many complaints from the senior manager Stacie Dean. Others will have covered those (they are addressed, in particular, in the evidence of Nathan Ward) but they clearly bring the same matters about the same individuals to the attention of Jerry Petherick (who already knew: see above) well in advance of Callum Tulley starting filming. It should also be noted that Luke Instone-Brewer and Babatunde Fagbo, both cited in one of Dean's complaints (in the context of bullying and, specifically, bullying away from cameras, as well as provoking detained persons in order to provide a pretext for using force on them) are also cited in D687's complaint to the Professional Standards Unit as a source of racist abuse. Again, the same names, the same types of allegation.

31. Despite these complaints and the knowledge to which they gave rise, however, these individuals and these managers remained in post.

THE RESULT

32. The result should surprise no-one. Matters escalated; the temperature went up. The problems presented by detained people were not resolved, but instead were aggravated by the responses they received. Some despaired. Some used NPS because there was little else to do, and they had no other form of respite. Mental ill health emerged or got worse. Some turned to S/SH. Some engaged in food or fluid refusal. And some of the staff, at least, responded in kind. Sometimes they laughed at those being detained. Sometimes they mocked their language or the symptoms of mental ill health or of having taken NPS. Sometimes there was goading. Swearing became routine (carry out a word search on the footage transcripts; the results number in their hundreds[27]). There is also language tainted with anti-migrant rhetoric ("why don't you fuck off home") and the acknowledgement: "this job made me racist"[28]). All of this served to debase further. Further, of course, once someone has been debased, and cast as undeserving, or as different to yourself, it is easier not to help them, and easier in the end to do things like apply force to them. This is how matters develop. The use of force becomes

[27] DPG's search returns 1407 instances of the word "fuck", with 74 for "cunt" and 21 for "bitch". See also Prof Bosworth at §7.17: "completely unacceptable level of swearing"; also swearing at detained people directly, and staff at each other.

[28] See also Dan Lake's statement made on 14 June 2017, included in transcript TRN0000092: KENCOV1035 - V2017061400017, Clip 2. When discussing deaths following what is described as an "attack", DCO Lake laughs and says, "12 foreigners, man… This job has made me racist. … I can't bear them. Get [DP] earlier. 'I come from Jamaica and I'm gonna fucking kill you, any English person' [said in a Jamaican accent]. I said well why are you here then? Why are you in Britain? Fuck off back. Cunt. No wonder if you're in shithole Jamaica, you want to come to our plate of heaven."

more frequent, faster (without properly trying to understand or de-escalate), and more inappropriate.

33. The language used therefore matters. It also matters in law. As will be seen, Article 3 in its degrading treatment aspect is concerned with treatment which:

> "Humiliates or debases an individual showing a lack of respect for, or diminishing, his or her human dignity or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance"

34. See amongst many other sources, *Pretty v UK* (2002) 35 EHRR 1 at [52].

35. The assessment of whether this threshold is met is multi-factorial and cumulative. Relevant matters include:

    a. The individual characteristics, including age and health, of the victim: see *eg Tyrer v UK* (1978) 2 EHRR 1. It follows that being mentally ill, or otherwise vulnerable including, it is submitted, through the exhibition of a S/SH risk is highly relevant.

    b. Whether the treatment is suffered in detention, and so by a person who exercises control over the victim: *Bouyid v Belgium* (2016) 62 EHRR 32. Treatment given in a position of such control is more likely to debase a person's dignity, and dignity is a key part of the measure (*ibid).*

    c. It is not necessary for treatment to have the object of debasement but where it does that is also highly relevant in assessing whether the threshold has been reached: *Price v UK* (33394) 34 EHRR 53; also *V v UK* (1999) 19 EHRR 112.

    d. A special importance must be attached to discrimination based on race. Differential treatment of a group of persons on the basis of race is likely to be more capable of constituting degrading treatment when differential treatment on some other ground would raise no such question: see *East African Asians v UK* (1981) 3 EHRR 76) at [207].

    e. It is sufficient for a victim to be degraded in his or her own eyes (*Smith & Grady v UK* (2000) 29 EHRR 493) at [121]. In that case it was accepted (although the Article 3 threshold was not reached on those facts) that the simple putting of questions

could be degrading: [119]. The fact that such questioning was unnecessary was relevant. See also *Bouyid,* where the chastisement was not necessary.

36. Abusive language cannot be justified. Its object is to debase, and it has that effect both objectively and subjectively. As already seen, much of the language with which this Inquiry will be concerned was racist. Other language may not have been directly racist, but was casting those in detention as somehow "other" and lesser with the result that other ill-treatment, and the use of force, became easier and more likely. That is of course what "dehumanising" is about. This was experienced by those who were mentally ill and vulnerable and over whom G4S and the Home Office had full control. All that is highly relevant to the treatment received, and the question whether such treatment humiliated and debased, to the extent that it was degrading treatment and so in breach of Article 3.

37. An example of the Strasbourg court taking language into account in order to find a breach of Article 3 is *Iwanczuk v Poland* (2004) 38 EHRR 8. At [57]:

> "In the assessment of the treatment complained of, regard must be had to the intentions of the persons inflicting it, namely whether they acted with a deliberate intention to degrade or humiliate. It is noted in this connection that the applicant was insulted and derided by four prison guards."

38. Also at [59]:

> "In the present case, the prison's guards verbally abused and derided the applicant. Their behaviour was intended to cause in the applicant feelings of humiliation and inferiority. This, in the Court's view, showed a lack of respect for the applicant's human dignity."

39. The Article 3 assessment must also, of course, be carried out in the context of the wider conditions at Brook House. That includes matters such as the physical environment, already touched upon. It also includes any failures to meet needs including health and S/SH needs.

THE HOME OFFICE

40. Much of the above is necessarily directed at G4S, and the failure of its managers to get a grip and provide leadership. But the Home Office is also fully implicated. It is, of course, ultimately responsible for all the detention arrangements. It wrote the contract which contained no, or no proper, provision requiring the monitoring of welfare. It agreed the addition of 60 beds to a centre which was already struggling. It has staff, including contract monitors, on site. The

Home Office had its senior officer (Mr Gasson) in all relevant meetings, including those which complained and agreed action in respect of GDWG (see further below). The Home Office knew what had happened at Medway. It knew some of the same people were implicated. Certainly it must be taken as having known about the difficulties at a senior leadership level, not least because those were so long standing (back at least to 2014). It must have known, or should have done, about the failures of its own monitoring arrangements. The contrast between the number of ACDTs and the number of Rule 35(2) reports was stark and should have prompted investigation. The use of force was significantly higher at Brook House than at other centres. There is also, it should be noted, a key issue about the categorisation of key performance indicators ("KPIs"). As is well established, the contract provides little in the way of monitoring of welfare-related matters[29]. However there are KPIs for self-harm (see *eg* KPI10 in the list at [INQ000011/37]). There was however only one such KPI for the whole of 2017, and none in the reporting period [CJS004584]. The incident involving D687 on 13 May 2017 did not, for example, produce a KPI report.

41. In addition to these matters, however, there is the evidence that individual Home Office staff share the same attitudes towards detained persons that the worst of the G4S staff held. See in particular the upheld complaint against Vanessa Smith following what she said in use of force training. That report is extraordinary, not least because it post-dated Panorama. If Home Office staff were prepared to express themselves in those terms, apparently openly, *after* Panorama had been broadcast, then how were they expressing themselves privately, *before* it went out? Note again that Ms Smith is also implicated in one of David Waldock's complaints, linking her to Gayatri Mehraa, a G4S officer with a particularly high number of complaints about her, and someone who is also named in the GDWG materials. It seems likely that this is another clique: two staff members, from different parts of the centre, amplifying each other's negative attitudes towards those for whom they were supposed to be caring.

42. This material is revealing about why the Home Office did not see and/or did not prevent what had developed at Brook House. It was part of it, and shared many of the same attitudes. It also fostered those attitudes, with its relentless focus on throughput rather than welfare. This is also, of course, consistent with wider concerns, expressed about the Home Office and its

[29] See *eg* the Verita report at §14.44: "The Home Office compliance manager told us that the overall welfare of detainees and the quality of life of detainees was not a matter he was required to report on to his managers". See also the absence of any mention of welfare in contract review documents (*eg* [CJS000768]), and Kate Lampard picking up the implications of this with DD Haughton at [VER000277] at line 194: "there is no monitoring at all of that, and if there were, you'd probably be building up quite a good picture of how this places feels".

attitudes and culture, in a number of different contexts and by a number of different people, including around the issue of institutional racism. See *eg* the Wendy Williams report on Windrush at [117][30]:

"In the current context I have not found, on the evidence that I have reviewed, that the organisational failings satisfy the Macpherson definition in full. Nevertheless, although the context for the Macpherson Inquiry was different to this lessons learned review, I have serious concerns that the factors that I set out in this section demonstrate *an institutional ignorance and thoughtlessness towards the issue of race* and the history of the Windrush generation. Institutional thoughtlessness towards race and institutional ignorance were found to have been elements of the definition of institutional racism considered in the Macpherson Inquiry."

43. See also the Equality and Human Rights Commission report on the hostile environment[31].

HEALTHCARE

44. Clinical staff should also have acted as a brake on what was happening. That is what the Detention Centre Rules 2001 ("DCR") expect. There is a reason why only GPs can carry out Rule 34 assessments and complete Rule 35 reports: in devising those Rules, Parliament expected to be able to rely on GPs' professional responsibilities; their independence; their primary duties being to their patients. That expectation has not been fulfilled. There is extensive evidence of failures of healthcare, including dismissive attitudes (palming everyone off with paracetamol). There is evidence (see for example D687's case, but also the wider picture regarding the absence of Rule 35(2) reports) about training in the relevant provisions. The evidence is also that clinical staff were seen as too close, even indistinguishable, from discipline staff or the Home Office. The response of the nurse in the MA incident is well established. But there are other reasons for thinking that the relationship was too close. A clear question for the Inquiry must be whether it is wise to have the provider of GP services having a clear and presumably substantial (what was the contract worth each year?[32]) financial interest in the maintenance of a contract for services with G4S. That does not appear to be an arrangement likely to incentivise sometimes unpopular decisions, such as decisions that someone should be released, or cannot fly.

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30 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874022/6.5577_HO_Windrush_Lessons_Learned_Review_WEB_v2.pdf.

31 https://www.equalityhumanrights.com/sites/default/files/public-sector-equality-duty-assessment-of-hostile-environment-policies.pdf.

32 The inquest into the death of Prince Fosu (see further below) heard that the equivalent contract at Harmondsworth in 2012 was worth £17,000 a month, or £204,000 a year. That is a substantial sum to a small GP practice.

THE INDEPENDENT MONITORING BOARD ("IMB")

45. The DPG CPs ask whether the IMB is fit for purpose. It is supposed to be a key statutory safeguard against precisely the kind of thing that was revealed by BBC Panorama: see s.152 of the Immigration and Asylum Act 1999 together with Part VI of the DCR. Yet not only did the IMB not identify and correct any of the abuse that was shown by Panorama:

    a. It took an approach which confined its interest to what it sees as systems issues, rather than issues concerning individuals [GDW000003/0038]. There is nothing in the 1999 Act or the DCR which so confines the IMB; rather the opposite. Such an approach would make no sense, not least because an individual failure might be evidence of a wider systems failure. The statement from Dame Anne Owers seems to refute that this is what was happening[33], but the documents speak for themselves. So how did the IMB come to agree such an approach? How long had it been operating in that way? It may also be noted that the IMB defended this approach to Verita: see the Verita report at §14.28 (to which Dame Anne refers).

    b. The IMB appears to have supported an approach towards GDWG, based on G4S and Home Office language which it also adopted (saying that GDWG was "straying over boundaries", acting as a protest movement, and suggesting there were issues of "trust"). The meeting of 16 August 2017 [IMB000003] and the resulting letter to Board members shows that, and shows also the IMB agreeing an action point for Steve Skitt and Paul Gasson to meet the director of GDWG "to discuss" this alleged concern [IMB000003/2]. That is the meeting to which James Wilson refers at paragraph 44 of his first statement (prepared for the purposes of the judicial review), where Mr Skitt was angry, and where there were threats to end the GDWG drop-in surgeries altogether. The IMB had agreed to this meeting; it was an IMB action point. Why was this thought to be a proper action for the IMB? It will be noted that Verita, which following Panorama met with the IMB and observed one of their meetings, was also "struck" by their collegiality and over-

[33] [IMB000199/0024] at §73.

empathising with G4S and the Home Office: see the Verita report [CJS005923] §14.18; also §14.33. The IMB rejected that criticism out of hand: §14.21.

c. The IMB was also alone in responding to Panorama with a suggestion that it had been improperly edited, or otherwise misrepresented the position (it was said Panorama "gave a distorted picture"[34]). All other relevant organisations – including G4S, the Home Office and HM Chief Inspector of Prisons – immediately expressed shock and regret. Further, the IMB had the material to show what Panorama was showing: see the volume and nature of complaints now revealed in the IMB disclosure[35]. The IMB should have been unsurprised.

46. It is of course acknowledged that the IMB is a volunteer organisation with limited resources. That however goes to the question whether it is fit for purpose. Other cases have raised doubts about the IMB and how effective it is capable of being; how able to recognise abuse and to maintain independence and integrity[36]. There are issues around training in order to achieve that. A wider issue is about recruitment to the IMB. An organisation which depends entirely upon volunteers (and so those who can afford to work for free) raises obvious concerns about the diversity of its membership. This is another point now made by Prof Bosworth (§10.34).

47. It is unclear the extent to which the IMB recognises any of these criticisms. GDWG's experience is that the Brook House IMB is working much more effectively now than it did in 2017. However proper learning requires proper acknowledgement and Dame Anne's statement appears to accept relatively little. It is submitted that the IMB failed in this case.

GDWG

48. The GDWG evidence, however, goes beyond the IMB. The first key point arising from the GDWG material is the extent to which it corroborates Panorama by showing that their clients were consistently reporting issues of poor conditions, dehumanising treatment, problems with access to, and the quality of, healthcare, and a culture of disbelief from healthcare staff and their alignment with G4S and the Home Office. GDWG staff and visitors witnessed officers speaking openly to detained people and their visitors in an abrupt, impatient and rude manner

[34] Mr Wilson's judicial review statement/§63.
[35] See *eg* [IMB000150]
[36] The inquest into the death of Prince Fosu, which concluded in March 2020, raised such concerns (amongst many others). See *eg* https://www.thejusticegap.com/the-lonesome-death-of-prince-fosu/.

(§66 first statement of Anna Pincus). They presented research to Sir Stephen Shaw, gathered during the relevant period, concerning the scale of mental illness and vulnerability amongst their detained clients and the failure by healthcare to identify vulnerable people and refer them to the Home Office. The GDWG evidence describes how the detention of extremely vulnerable people was normalised at Brook House as staff became desensitised[37] to the immense suffering they witnessed every day at work.

49. A further key point is the extent to which the GDWG evidence shows a management attitude that was defensive to the point of bunker mentality (including to the extent of having drawn the IMB into that mentality: see above). Brook House and nearly all those within it were incapable of taking criticism or anything that they perceived, on the slightest of grounds, as amounting to criticism, and including when such criticism was well founded. GDWG were at all times trying to carry out a sensible, and helpful, welfare role. Yet:

    a. GDWG visitors were subject to often arbitrary restrictions and attempts to control and confine their work and access. The restrictive Memorandum of Understanding, produced in February 2016, was drafted on behalf of both G4S and the Home Office. Many meetings were arranged in order to "clarify the role" of GDWG[38].

    b. Sensible and proper suggestions about improving the GDWG service were met with resistance and often, straight refusals[39].

    c. Sensible and proper work on the part of those in detention who clearly needed it, and about whom all should have been concerned, was often met with warnings and threats, including to reduce the GDWG service or its level of access. The August 2017 meeting, referred to above, is just one example, but it is a serious one, and that is not the only time that threat was made. Removing drop-ins would have seriously impaired the critically important casework that GDWG was able to do.

    d. In many of the relevant exchanges, senior G4S staff and others seemed to take matters personally, and to bear perceived slights as grudges. Further, these grudges

[37] To use Prof Bosworth's word: §§2.18 and 2.19 [INQ000064].
[38] See *eg* James Wilson's judicial review statement/§28.
[39] *Ibid* §27.

were often long standing, and deriving from GDWG actions that were obviously entirely legitimate. By way of example only, it was very obviously proper for GDWG staff member Naomi Blackwell to provide a witness statement in support of High Court proceedings. That evidence was to the effect that someone with whom she was dealing appeared to lack capacity. That was obviously very important evidence, in respect of someone who was very vulnerable, and the court ultimately concluded that that individual did indeed lack capacity and was unlawfully detained[40]. Yet the provision of that statement was something which G4S complained about for *years*[41]. This, therefore, is G4S believing that Ms Blackwell should not have told the court what it clearly needed to know. Further, this episode went to inform the belief, held also by the Home Office and the IMB, that GDWG had somehow breached *trust* (see above).

e. Another example of Ms Blackwell providing such evidence is [HOM004003]. The Inquiry can see for itself the obvious care, and properly restrained, nature of her evidence in another obviously important case.

f. It is submitted that the response to these sorts of actions, and what that says about relevant attitudes, is little short of extraordinary. It suggests a "with us or against us" attitude, where anyone who was seen as slowing down or impeding G4S/Home Office objectives was seen as "against". Acting in the interests of people's welfare – even in the most anxious cases, like those with which Ms Blackwell was involved - was seen as "against". The response of G4S was to attack GDWG. It bears repeating: promoting welfare was seen as "against" G4S and Home Office objectives.

50. A further question to which this episode, and others like it, gives rise, is similar to that which was asked above in respect of Vanessa Smith: if G4S and others behaved in this way towards GDWG, how were they behaving towards those who were detained? Part of the answer to that, of course, is in the video footage. It can be seen how staff behaved. The GDWG evidence, however, confirms just how widespread, and entrenched, all this was, and at all levels. The attitudes; the beliefs; and above all, the bullying, were pervasive.

[40] See *R (VC) v SSHD* [2018] EWCA Civ 57 (CA).
[41] See James Wilson's judicial review statement at §18.

D687 & D390

51. Turning then to how this impacted upon the formerly detained persons with whom this statement is concerned, i.e. D687 and D390, this will be taken lightly at this stage because both men will not be giving evidence until Phase Two of these hearings. However, the question with which the Inquiry will then be concerned is whether either or both experienced treatment which reached the Article 3 threshold. As already indicated, that requires a multi-factorial assessment. Relevant factors include the personal characteristics of the individuals, including indicators of their respective levels of vulnerability; what they experienced both subjectively and objectively; over what period; and what was the object of those responsible for the treatment. Did they receive treatment which humiliated or debased them; which showed a lack of respect or diminished their human dignity; or which aroused feelings of fear, anguish or inferiority capable of breaking their moral or physical resistance?

52. An immediate point arises, for both men, this assessment is about more than just the application of force on 13 May and 5 June 2017 respectively. The multi-factorial nature of the Article 3 assessment means that the Inquiry must also examine the lead up to those uses of force.

D687

53. Relevant points to consider about D687 include the following:

    a. His mental health. He had a diagnosis of recurrent depressive disorder and PTSD (see Dr Galappathie's report dated 22 September 2021). He may also have ADHD.

    b. His history of childhood trauma and abuse.

    c. His history of being a child in care.

    d. The S/SH risk which he exhibited at all material times.

    e. The length of time he had been detained: by May 2017, D687 had been held using immigration powers for two years and three months. This was also his second period of immigration detention. He could see no material progress in his position.

D687 was of course anxious to oppose removal. This was unsurprising given that he had arrived in the UK aged 10 and was by now nearly 33.

f. The length of D687's detention was such that he suffered two close bereavements whilst in detention: his grandmother, and his brother. He was refused permission to attend the funerals.

g. All that is now clear about the conditions in Brook House in 2017. That is not just about the physical environment. The wider material now corroborates much of what D687 said all along, and what was dismissed in his Professional Standards Unit complaint in 2018, concerning the levels of abuse including racist abuse in Brook House. It seems inevitable that D687 experienced that. His complaints about being wrongly excluded from the cultural kitchen, on the false and very damaging ground that he was a sex offender, were also well founded. Things he has said about Luke Instone-Brewer and Babatunde Fagbo also now seem likely to have been true (see above).

h. Even if D687 was wrong about some of the detail of this, or about when exactly matters occurred, his mental health must be kept in mind. That mental illness was also untreated. Dr Galappathie says that there was a clear failure of clinical care in April 2017: D687 should have been on antidepressants (as he was, soon after he arrived at The Verne following the transfer on 13 May): see his report at §193. No doubt this failure contributed to D687's mental state, his ability to recall, and to his level of frustration and despair.

i. It is also relevant to note that throughout this period D687 was being clear about his intention to die. His growing despair and anguish was clear. It is recorded in a number of different ways. By way of example only:

    i. The GDWG database notes, which record D687 as being "at the end of his tether, frustrated by lack of progress, though doesn't want to go back – in detention for 2 years. Grandmother and brother died before Christmas and he hasn't been able to pay respects".
    ii. Callum Tulley's own impressions, recorded in his video diaries [TRN0000047], and which take in the whole of this period:

> "He's just fed up with the lack of progress in his case. He's just had enough. His health, his mental health has completely deteriorated. He said just a couple of weeks ago that someone is going to be taken out in a body bag. Today he was quite determined to make sure that that was him. Obviously that didn't happen but he was promising on his way out that this wasn't the end and that he was going to make the news. He was going to make a statement. He said to me, "Watch out because I'm going to be one of the first people to die in a detention centre". He's quite clear of his intentions to kill himself."

j. The seriousness of the position was therefore clear to anyone who looked. Yet when D687 saw the GP in April, there was no focus on these obvious risks. Dr Hard touches on this in his report[42], where he points out that the Home Office's Rule 35(3) response (dated 26 April 2017) stated: "Although it is accepted that you are an Adult at Risk, the Doctor has not indicated that a period of detention is likely to worsen your symptoms". That was just because that question had not been asked, but (as Dr Hard also says) the caseworker appears not to have gone back to the doctor. However, quite apart whether this should have been picked up in the Rule 35(3) context, why was a Rule 35(3) report the only one produced? Why not Rule 35(1) or 35(2)? All three were relevant, and had they been considered, they would have caused a focus on both D687's suicidal intentions (Rule 35(2)) *and* that he was someone whose health was being injuriously affected by continued detention. Also, why did Dr Oozeerally not open an ACDT?

k. On 27 April 2017 D687 saw Vanessa Smith. She recorded in the GCID notes the point above: D687 would only go back to Somalia in a body bag. She also recorded that he had started to write a suicide note, and that "he is going to give it a week and if things stay the same he will do something" [HOM000115/0007/8]. Ms Smith also, however, failed to open an ACDT, still less take any steps towards obtaining a Rule 35(2) report. She did not think it was necessary: [HOM002501]. Ms Smith's unsympathetic attitude towards those who were detained is now clear from the upheld Hibiscus complaints (see above).

l. Matters came to a head shortly afterwards. As already said, D687's despair is clear in the footage for 13 May. As he is recorded repeatedly as saying, and had said many times recently: he had had enough. Now he was being moved again, and

[42] [INQ000075/94] at §5.181.

away from what little support he had managed to secure, which included GDWG. D687 was left alone, he went to the toilet, and he applied his t-shirt as a ligature.

m. A number of exchanges with officers then took place over a period which lasted at least 11 minutes.[43] However no representative of healthcare was summoned. One officer, listed as Officer 4, said that if D687 should let himself go, "then we'll wait for a minute until you pass out and then we'll cut you down".

n. D687 was ultimately tricked into accepting a light for a cigarette; the officers got the ligature; and there was an unplanned use of force. As it is set out in a contemporaneous GDWG note three days later, after he called them from The Verne, he was:

> "feeling sad, down, tried to hang himself at Brook. Didn't lock toilet properly. Hand cuffed, 6 or 7 officers jumped on him. Taken to the verne. Feels like being neglected, forgotten about, entire world doesn't know whats going on, community forgotten, noone knows, noone can see, has appointed with mental health nurse. Supposed to get anti depressants from doctor, but moved to the verne on Saturday, doing head in. Never been through anything like this. Scary not knowing what is happening, scary not knowing where will be next month. Goal posts been moved but problem still there. Will call for a chat Thursday 2 pm".

o. It is not clear why the use of force was unplanned, given the length of time officers were there, but the fact it was unplanned is one of the reasons why there was no member of healthcare present. A nurse attended afterwards, when a check was carried out which is not recorded in the SystmOne clinical notes, and which did not pick up the bruising to the chest which staff at The Verne thought sufficiently serious to require a check at Dorset County Hospital later that night.

p. The use of force also appears to have been unfilmed, save for Callum Tulley's footage, and despite Director Dan Haughton saying on the use of force form that a Body Worn Camera had been used. The absence of this material, which should exist, makes it difficult to judge the use of force and, in particular, (i) why it was necessary at all (particularly once the ligature had been secured); and (ii) why force was required at a level which resulted in a chest contusion. That requires explanation. It may be noted that Mr Haughton, in his later interview with the

[43] It is 10 minutes 57 seconds from the start of the video clip to the application of force, and the clip starts after the officers arrive and the exchange has started. D687 is engaged with the officers throughout.

Home Office, suggests officers just "got involved (reacted to him dropping)" after D687 tried to keep holding the t-shirt: [HOM002654/0003]. It is difficult to see how that amounted to a controlled, justified, use of force at a level which bruised a chest wall.

q. What is particularly striking about D687's case, however, is what happened next: his SystmOne notes from 13 May 2017 onwards, when he has arrived at The Verne on a constant watch, show him quickly starting to recover. He was feeling better on 14 May. He had anti-depressants by 16 May (the same day he rang GDWG). On 19 May he is recorded as saying "he is actually surprised that people are seeing the potential in him and are saying good things about him. He said moving to this centre has given him a fresh start and hope…"

54. The Verne, in other words, approached D687 differently. With more sympathy and understanding, without shouting and abuse, and with medication, D687 responded in kind. It follows that it was Brook House which reduced him to what was seen on 13 May, and which resulted in the use of force. D687 is a vulnerable man. Brook House broke him. The cumulative effect of all of the above is clear to see, and it is submitted it amounts to a breach of D687's Article 3 rights.

D390

55. D390 is also a survivor of serious childhood trauma and abuse. He came to the UK in 2004 as a student. He ultimately overstayed, and worked, for a period, illegally. He was discovered and this led to three convictions for document and immigration offences and a sentence of 18 months, imposed on 1 August 2016.

56. Those are D390's only convictions. Notably, he has no history of violence or other harm of any kind.

57. Most of D390's sentence was served at HMP Maidstone where mental health concerns began to emerge. He completed his sentence on 2 May 2017 and he was transferred to Brook House on 15 May 2017.

58. For reasons that need to be explored, by then the Home Office had concluded that D390 represented a risk of disruption and escape. It is difficult to understand how that assessment was reached, but it made its way into Brook House documents including shift handover documents where it was repeated. For just one example see [CJS001179/0006].

59. Over the course of his detention at Brook House staff also seem to have concluded that D390 was actively resisting transfer, to the extent that a forced removal by a "suitable crew" would be required. He was not. D390 was by now pursuing an asylum claim, which required an interview, but he had also made an application for bail which he understood had been listed for hearing that week at Taylor House. This was why, on Monday 5 June, D390 told DCM Povey-Meier that he did not want to move. He was expecting to be released on bail; he did not want to miss that hearing.

60. DCM Povey-Meier made enquiries about the hearing. He seems to have been told, by the Home Office, that D390 had to move anyway.

61. The Inquiry will need to examine in some detail what happened next, and it is also going to hear evidence from D390's roommate. It is a matter of deep regret that it now appears camera footage of the episode has disappeared, and apparently without explanation. It is clear from the use of force form [CJS005624/0026] that both camcorder and body worn camera footage was made. D390 can also be heard asking why it is being used after the incident: see [TRN0000080/12]. This is important material. It is a matter of serious concern if G4S failed to secure it, and adverse inferences may need to be drawn. It will be remembered that in the context of Article 3 and detention the burden of proof works differently: it is for the state to explain what has happened: *Aksoy v Turkey* (1996) 23 EHRR 553 at [61]. Those representing D390 only learned that the footage was missing on Monday 15 November 2021.

62. As matters stand, however, there is evidence that when officers (including DCO Sean Sayers) were assembled for a forced transfer they were wound up, including from an earlier episode where there was a suggestion a different detained person might have been about to use boiling water as a weapon: see the BBC transcripts at [TRN0000080] and [TRN0000063]. DCO Sayers says in his statement appended to the use of force report [CJS005624/0026] that he had been briefed that D390 "had refused to leave the centre and was willing to fight officers that entered the room". That appears to be a long way from the truth, and a long way from D390's history. It seems to reflect, once again, the febrile atmosphere in Brook House at the time.

63. The team was therefore assembled, and they went in. Something is said about D390 boiling a kettle. That may be right; VE usually made a cup of tea after lock up. He was then forcibly restrained. Nothing like this had ever happened to him before, and he found it profoundly shocking. D390's case is that the use of force on him was entirely unnecessary, and breached his Article 3 rights.

64. D390 was then transferred. As may now be seen, his mental health deteriorated very quickly. A Rule 35(3) report was completed on 21 June 2017. Three attempts were made to carry out an asylum interview, at least one of which had to be stopped after he was unable to continue. By then D390 was seeing regularly a clinical psychologist. He was later assessed as suffering from PTSD and that, together with major depressive disorder, is also the preliminary indication from Dr Basu, instructed for the purposes of the Inquiry.

CONCLUSION

65. These, in summary, are therefore D687 and D390's stories. To tell them has required a BBC film; they would not otherwise have come out. That is despite Medway and the other, earlier, indications that should have resulted in urgent change. G4S, the Home Office and the IMB did not act. A 21 year old just out of school had to act instead.

66. It is also worth noting the following concerning the history: Callum Tulley wrote his e-mail to the D687C in January 2016. That e-mail was based on concerns he had developed over the preceding 12 months, since he started at Brook House on 26 January 2015. He did not then start filming until April 2017. Throughout that second period he kept diaries, confirming that the abuse was still occurring, and the BBC – through whatever (no doubt appropriately robust) editorial process they undertook – agreed. The filming then confirmed what Callum had been seeing over the last two and a half years.

67. This history shows that this Inquiry is not concerned with a brief, and unrepresentative, period of time. It was not a snapshot; it was indeed a panorama. The problems at Brook House were long standing, and deep. It is hoped this Inquiry can identify them, and bring about real change. It is of course the first public inquiry in this area. The opportunity which it represents must not be lost.

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24 NOVEMBER 2021