
GARDEN COURT
CHAMBERS

GARDEN COURT CHAMBERS

FREE HYBRID CONFERENCE

Brook House Inquiry

What Lessons have been Learned?

130pm - 6.45pm

Wednesday 6 Dec 2023

Welcome & Introduction

Stephanie Harrison KC, Garden Court Chambers

6 December 2023

Panel 1 - Article 3: Mistreatment in the Detention Context

Emma Ginn, Medical Justice (Chair)
Alex Goodman KC, Landmark Chambers
Alex Schymyck, Garden Court Chambers
Gordon Lee, Garden Court Chambers

6 December 2023

LANDMARK CHAMBERS

Brook House Inquiry

Article 3 Systems Duty

Article 3 Systems Duty

Alex Goodman KC

The Brook House Inquiry
Background to Art. 3 Breaches

The Brook House Inquiry into the inhuman and degrading treatment of detainees uncovered by the BBC's *Panorama* in 2017 held hearings from November 2021 until 6th April 2022 and its report was published on 19 September 2023.

Prior to 2017:

R (BA) v SSHD [2011] EWHC 2748 (Admin);

R (S) v Secretary of State for the Home Department [2011] EWHC 2120 (Admin);

R (HA) v SSHD ([2012] EWHC 979***;***

R (D) v SSHD [2012] EWHC 2501 (Admin);

R ***(MD) v SSHD*** ([2014] EWHC 2249).

There have subsequently been two further article 3 cases on immigration detention:

R (VC) v SSHD [2018] 1 WLR 478 (appeal to Supreme Court conceded on basis of article 3 breach) and ***R(ARF) v SSHD*** [2017] EWHC 10 (QB).

Background to Art 3 Breaches: Shaw Review

In Stephen Shaw's 2016 review (following a visit on 22 May 2015), he asked Jeremy Johnson QC (as he was) to review these cases. Mr Johnson's report (at Appendix 4) was summarised at page 108 of Stephen Shaw's report, including the following points:

- The nature and pattern of the findings "**tend to suggest that these cases may be symptomatic of underlying systemic failings** (as opposed to being wholly attributable to individual failings on the part of the clinicians or public servants who were involved in the particular cases)".

- None of the findings was attributed to a failing in the legislative framework or policy. Nor was there any finding of a deliberate intention to cause harm.

- The findings focus upon a lack of healthcare assessment and treatment: "The nature and pattern of findings are such that they are more likely to be a **reflection of a systemic problem** (i.e. insufficient medical – particularly psychiatric – provision) rather than individual failings."

- Explicitly in two cases, and implicitly in others, there are findings relating to a failure in communication between the immigration removal centre and the Home Office: "An important example concerns the compilation and use of rule 35 reports …"

- In each of the cases the detention of the vulnerable and mentally ill claimant was unlawful as chapter 55 of the policy had not been properly applied. This related to a number of detention reviews over long periods of time.

Article 3 - Summary

Article 3 to Schedule 1 to the Human Rights Act 1998 provides that:

> "No one shall be subjected to torture or to inhuman or degrading treatment or punishment".
>
> Encompasses:
>
> (i) the substantive negative duty to refrain from and to prevent taking life or inflicting torture or inhuman or degrading treatment or enslaving a person (operational duty);
>
> (ii) the positive duty to put in place a suitable framework of laws, policies and systems including training, monitoring and oversight to ensure operational decisions and actions safeguard people in immigration detention from treatment in breach of Articles 2/3/4 ECHR (systems duty) and
>
> (iii) where a breach has occurred, a duty to investigate

(i) Duty not to Mistreat

Duty includes:

a. Where a naturally occurring illness, risks being exacerbated by treatment for which the state can be held responsible, that may engage article 3 (***R (HA) v SSHD*** **([2012] EWHC 979** at [176])

b. Where a person with mental health problems is in custody there may be a combination of factors both acts and omissions such as inadequate medical records, lack of resource to specialist psychiatric input, the imposition of seven days segregation and the imposition of 28 days imprisonment for an assault on officers which combine to breach article 3 *Keenan v United Kingdom [2001] 33 EHRR 38* A particular duty is owed to vulnerable detainees (*Slimani v France* [2006] 43 EHRR 49) were repeatedly flouted.

(ii) Investigative Duty

- Home Office was forced to hold a public inquiry with powers to compel witnesses and with funding for representatives.

- May J in *R (MA and BB) v SSHD* [2019] EWHC 1523 (Admin) who held that the investigative duty under article 3 required it.

- An inquiry was instituted under the Inquiries Act 2005.

(iii) Systems Duty

- *Öneryildiz v Turkey* (2005) 41 EHRR 20 (Grand Chamber) at §§89-90 it was held that there is a compulsory requirement for all concerned to take practical measures to ensure effective protection of those who might be endangered.

- Such a "framework" duty, also referred to as a '*systems*' duty, was afforded domestic recognition in *Smith v Ministry of Defence* [2013] 3 WLR 69 *per* Lord Hope at §68 and Lord Mance at §105.

- Lord Filkin in 2002 said

> "… evidence [of torture] may emerge only after the detention has been authorised. That may be one of the circumstances referred to by the noble Lord, Lord Hylton. If that happens, the evidence will be considered to see whether it is appropriate for the detention to continue. We reinforced that in the Detention Centre Rules 2001. Rule 35(3) specifically provides for the medical practitioner at the removal centre to report on the case of any detained person who he is concerned may have been the victim of torture. There are systems in place to ensure that such information is passed to those responsible for deciding whether to maintain detention and to those responsible for considering the individual's asylum application."

Chair's Findings- Briefly

- 19 incidents- at least one a week- amounting to inhuman or degrading treatment.

- "the entire safeguarding system in a number of areas to be dysfunctional" (Report para 40, page 9).

- There was a misuse of force against 11 of the 13 detainees whose cases were examined in detail and pain was deliberately and unnecessarily inflicted on four of them. Monitoring and oversight was inadequate and led to dangerous situations (Vol II. Page 158).

- "serious failings in the application of rule 34 and 35" (para 32, page 8) which amounted to a wholesale failure in processes designed to protect vulnerable detainees like suicidal people and torture victims from being detained,

- racist; homophobic and other degrading language. (para 15.8- homophobic). In many cases such language was intensified during times when detainees were self-harming or attempting suicide

The prime responsibility lay with the Home Office and its contractor G4S, yet there was alarming reliance on monitoring by volunteers at the Independent Monitoring Board. The Home Office accepted it did not sufficiently resource staff to monitor its contract (para 21 page 5).

Chair's Recommendations

- 33 Recommendations.
- Recommendation 7: a 28-day time limit on detention
- Recommendation 9 The operation of Rule 35 be reviewed and compliance be regularly audited.

Systems Duty and Compliance with Article 3

- The Political Sphere: The Chair has required the relevant organisations identified to publish details of the steps that they will take in response to each recommendation within six months of publication of the report (by 19 March 2024) and implementation of and compliance with the recommendations will be regularly monitored and reported on by the Home Affairs Select Committee and the Joint Committee on Human Rights.

- Article 3 continues to exert a legal on the state to have in place a clear and effective legal framework and procedure to prevent a further breach: *Savage v South Essex Partnership NHS Foundation Trust* [2009] 1 AC 681 and *VC* at [113-114, 118]. Accordingly, a further period of failure will no doubt result in further findings of breaches of the article 3 duties by the Courts.

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Mistreatment

Alex Schymyck, Garden Court Chambers

6 December 2023

Background to findings of mistreatment

BHI Terms of Reference:

Purpose

...

To reach conclusions with regard to the treatment of detainees where there is credible evidence of mistreatment contrary to Article 3 ECHR, namely torture, inhuman or degrading treatment, or punishment; and then make any such recommendations as may seem appropriate. In particular the inquiry will investigate:

1. The treatment of complainants, including identifying whether there has been mistreatment and identifying responsibility for any mistreatment.

Evidence:

- +100,000 pages of documentary material
- 90 hours of undercover footage, in addition to Callum Tulley's video diaries and CCTV
- 73 witnesses (including 4 former detained persons)

Approach to Article 3 ECHR (1)

MA & BB v Secretary of State for the Home Department [2019] EWHC 1523 (Admin) at Para 63:

In my view the power to compel witnesses in these circumstances is necessary to satisfy each of elements (2), (4) and (5) of an effective investigation identified at paragraph [42] above. First, to establish the full facts: whilst the PSU and Lampard investigations interviewed (some of) the alleged perpetrators, their evidence was not shown to the Claimants for comment, and ***the Claimants had no opportunity to see or confront their (alleged) abusers.*** *Even if the material garnered to-date from alleged perpetrators and others about events of mistreatment of MA and BB at Brook House could be said to have uncovered full facts (which must be doubtful, for reasons already given),* ***the full extent of the culpable and discreditable behaviour has not been exposed to public view.*** *The allegations made by MA and BB go much wider than events shown in the Panorama programme.* ***The full extent of Article 3 abuse said to have been experienced by both Claimants needs to be investigated.*** (emphasis added)

Approach to Article 3 ECHR (2)

- Factual v legal findings
- SSHD and G4S: use 'non-legal' meaning of mistreatment
- Chair applied two stage test (Volume 1, Chapter C.1, Para 13):

  Stage 1: Is there 'credible' evidence of acts or omissions that are capable of amounting to mistreatment contrary to Article 3 – that is to say, torture, inhuman and/or degrading treatment or punishment?

  Stage 2: Where that evidence is 'credible', what are the underlying facts?

Fact-finding Methodology

- Three different standards of proof applied (Volume 3, Appendix 1, Para 7):
  - Starting point is civil standard on the balance of probabilities
  - But Chair will say 'sure' if criminal standard of beyond reasonable doubt is met
  - And 'I suspect' if unable to reach a conclusion on the civil standard but thinks an event happened
- Evidential requirements vary depending on what is being alleged (Volume 3, Appendix 1, Para 11):

The level of persuasion necessary to make a particular finding will depend on how specific the evidence is, the type of allegation made, and the right at stake

Mistreatment – Use of Force

- Outright assaults (D1527, D2953, D313)
- Use of force 1) unnecessary 2) level of force used disproportionate (D2416, D687, D1527)
- Use of prohibited/inappropriate techniques (D1234, D149)
- Failure to apply techniques properly leading to prolonged use of force and suffering (D1234, D149)
- Failure to provide clothes/opportunity to dress (D1234, D2416)
- Inappropriate and unnecessary PPE including balaclavas (D390 & D1851, D2416)
- Healthcare sanctioning use of force/failing to step in to protect detainees (D1914, D1527)

Other Forms of Mistreatment

- Abusive words (D1538, D1275, D1527)
- Bullying (D728, D1275)
- Mismanagement of mental illness (D1527, D865, D1275)
- Misuse of removal from association (D1914, D1527)
- Disrespect towards religious beliefs (D728)

No findings of torture

- D1527 – Four incidents of mistreatment. On 25 April 2017, Yan Paschali choked D1527 accompanied with a threat to kill. BHR report (Volume 1, Page 123): "*the most extreme and disturbing example of mistreatment*".

- But not torture as 1) of short duration 2) lack of significant physical injury.

- *Gafgen v Germany* (2011) 52 EHRR 1 at Para 90:

As noted in previous cases, it appears that it was the intention that the Convention should, by means of such a distinction, attach a special stigma to deliberate inhuman treatment causing very serious and cruel suffering… In addition to the severity of the treatment, there is a purposive element to torture, as recognised in the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which in Article 1 defines torture in terms of the intentional infliction of severe pain or suffering with the aim, inter alia, of obtaining information, inflicting punishment or intimidating (see Akkoç, cited above, § 115).

Conclusions on Mistreatment

- Civil claims for each former detained person
- Re-opening case for prosecution of perpetrators
- Robust evidence of mistreatment which occurs in immigration detention. *MA & BB v Secretary of State for the Home Department* [2019] EWHC 1523 (Admin) at Para 69(iii):

  A detention centre, with its population of vulnerable persons, is a place where erosion of the rule of law may be thought to be both particularly likely and (because of that) particularly dangerous.

- Template for future Inquiry

Thank you

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Medical Conditions

Gordon Lee, Garden Court Chambers

6 December 2023

Medical Conditions

- Lessons learnt
- What does the future hold?

How did we get here?

MA & BB v Secretary of State for the Home Department [2019] EWHC 1523 (Admin):

[3] ‘The covertly recorded material showed scenes later described by the Immigration Minister as " *appalling* ": a detainee with mental health issues being ridiculed…’

[23(vi)] ‘DCO F shouts at a detainee with mental health issues through the door *"clean this fucking window or I'll beat the fucking shit out of you" "If this keeps going I'm going to smash the fucking shit out of him" "you'll be in trouble boy"* . The detainee in question is so ill that he is taken to hospital and sectioned.’

cont...

[23(vii)] ‘Another detainee with mental health issues throws milk at officers who respond *"for fuck’s sake" "your fucking attitude depends on how it is going to be for you" "piss us off and you won’t have a shower"* .

[23(viii)] DCM 1; Nurse X; DCO E; DCO G: Film of emergency on E wing. MA has tried to kill himself making a ligature with his own t-shirt and tried to swallow batteries. Detainee A says, *"I’ll die". "I don't care what I do"* DCM 1 comments *"If he wants to suck batteries plug him up like a Duracell bunny"* Nurse X says, *"he's an arse basically"* . Reporter then does observations during which Detainee A tries to strangle self with own hands. DCO E comes to cell, holds Detainee A's head and says, *"I'm going to put you to f ucking sleep. Don't move you fucking piece of shit"*

Tip of Iceberg

- [24] MA argued that abuse revealed by Panorama was 'tip of the iceberg' and cited wholesale failures by healthcare and staff to identify and mitigate medical vulnerabilities

- (1) Should never have been detained as ought to have been identified as an Adult at Risk:

- (2) Total failure to abide by Rule 34 and 35 of Detention Centre Rules:

- (3) There was both a systemic and operational failure to identify, protect and monitor MA as a vulnerable detainee in breach of the positive duties arising from Article 3

(see *R (HA) Nigeria v SSHD [2012] EWHC 979 Admin* at (70(f)).

D643

- British infantry soldier between 2001 and 2012
- Medically discharged
- Developed combat related PTSD since 2007
- Convicted of an offence after discharge
- Immigration detention at the conclusion of his sentence
- Detained between October 2016 and May 2018
- 558 days at Brook House – 4 separate occasions

Prior to Brook House

- D643 made a very serious attempt on his life whilst in Germany in 2011 and spent three weeks in hospital, before being discharged from his service in 2012 on medical grounds.
- Following discharge, D643 received specialist therapy from 'Combat Stress' to attempt to manage his PTSD. Whilst D643 was in HMP Channing Wood, around May 2015, he was referred for treatment for his PTSD.
- Was awarded compensation under the Armed Forces Compensation Scheme from the Ministry of Defence for the debilitating effects of his PTSD in 2017

Brook House

- Patently unsuitable for detention – complex combat related PTSD

- The things he saw and heard, such as fighting and loud, unexpected noises, left him feeling like he was being “mentally tortured”.

- In January 2017 and March 2018, he was assessed by Brook House doctors, who agreed and informed the Home Office that continuing detention would worsen his symptoms, but he was not released. He said:

- “Each time I heard a door banging I thought it was an explosion in a war zone and I would throw myself to the floor and I would become breathless and panicked.”

Failings (selected)

- Detention Gatekeeper no knowledge of medical condition upon assessment in 2016
- ‘"claims to have depression and PTSD however there is no evidence of this”
- Received a Rule 35(1) report on 9 December 2016 which recorded his health was likely to be injuriously affected by detention. The Home Office response to this records, inexplicably, that he was "fit to be detained". There was also a failure to classify D643 as an Adult at Risk
- D643 received another Rule 35(1) Report on 29 January 2017, again finding that his health was likely to be injuriously affected by detention, warning that the risks to his health were "very serious".
- Review of D643's detention on 11 March 2017 repeats inaccuracy that he merely "claims" to have PTSD, despite this having been conclusively diagnosed and evidenced in two Rule 35(1) assessments and prior to entry into detention.

Thank you

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Brook House Inquiry

What Lessons have been Learned?

130pm - 6.45pm

Wednesday 6 Dec 2023

Panel 2 - Detention Safeguards: Judicial Review, Civil Actions & Complaints

Hamish Arnott, Bhatt Murphy (Chair)
Shu Shin Luh, Doughty Street Chambers
Dr Rachel Bingham, Medical Justice
Lewis Kett, Duncan Lewis

6 December 2023

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Brook House Inquiry: Learning Lessons

doughty street chambers

Rules 34 and 35 Detention Centre Rules 2001: Failing Safeguards

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TOPICS TO COVER

- Adults at Risk and Rules 34 / 35 Detention Centre Rules 2001: requirement and relevance
- Findings of the Brook House Inquiry
- Recommendations
- What now? Learning lessons

Rules 34 and 35: Requirements and relevance

RULES 34 / 35: REQUIREMENTS AND RELEVANCE

Rule 34: (i) Every detained person **shall be given** a **physical and mental examination** by the **medical practitioner** within **24 hours** of admission to the detention centre.

- **Medical practitioner** = GP (see R 33(1) DCR)
- Different to health screening conducted by a nurse or healthcare assistant

Purpose: to identify any immediate and significant mental or physical health needs, the presence of a communicable disease and whether the individual may have been the victim of torture. (*Detention Services Operating Standards Manual*, p36)

Important 1st safeguard to identifying people unsuitable for continued detention: *R (D and K) v SSHD* [2006] EWHC 980 (Admin)

RULE 34 / 35 (2)

Rule 35: 3 limbs

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

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

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

RULE 34 / 35: ADULTS AT RISK FRAMEWORK

Adults at Risk statutory guidance (issued under s. 59 Immigration Act 2016):

- **At risk**: where on available evidence, an individual is suffering from a condition or has experienced a traumatic event that "would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention – whether or not the individual has highlighted this themselves."
- **Evidence of, and strength of, evidence of risk bears on strength of presumption** against detention and the weight of immigration factors necessary to outweigh.
- **Rule 35(3)**: at least Level 2 evidence of risk unless contains evidence that period of detention is likely to cause harm (*AAR Casework Guidance*; *DSO 09/2016 on Rule 35*)
- **Rule 35(1)**: Level 3 (ibid)
- **Rule 35(2)**: no link necessarily drawn with AAR framework notwithstanding the report deals with suspicions of suicide.

Brook House Inquiry: Findings and recommendations

DEFICIENCIES IN RULE 34

1) Rule 34 routinely not done; nurse screening wrongly treated as meeting requirement and badly as "tick box" exercise: §§11-12, Vol 2, p74
2) Even when screening identifies vulnerabilities, not lead to R35: §16, Vol 2, p75.
3) Purpose of GP appointment not explained so detained people don't understand its purpose as a safeguard to identify health needs / vulnerabilities that could lead to R35, review of detention and consideration of release: §13, Vol 2, p74
4) R34 not carried out within 24 hours. When done, lasting only 5 mins; not sufficient to complete adequate examination, or to complete a R35: §§14-15, Vol 2, p74-75.
5) R34 appointments not lead to write up of R35. Imposition of additional R35 appointment delays identification of vulnerabilities: §§17-19, Vol 2, pp75-76.
6) Practice of requiring request for R35 risks detained people falling through cracks: §20, Vol 2, p76
7) Unacceptable lack of training on rules : §23-25, Vol 2, p77

DEFICIENCIES IN RULE 35

1) Few R35(1) reports and no R35(2). Vast majority are R35(3) reports: Table 5, Vol 2, p81.
2) Mental health conditions and symptoms not considered or linked with impact of detention. Imposition of (wrong) threshold of psychosis for determining whether detention likely to harm: §§34-36, Vol 2, p83.
3) Disconnect between information known by healthcare and assessment by GP of vulnerabilities under R35: §§38-39, Vol 2 p85.
4) Systemic deficiencies in reviewing detained people who self-harm / have suicidal ideations; not lead to R35(1) and absence of consistent mechanism for routine follow-up of adults at risk: §§39-41, Vol 2, p85-86
5) HO not informed because no consistent monitoring which is a **serious systemic failure and breakdown in safeguards for adults at risk.**: §41, Vol 2, p86.
6) No adequate oversight over R35 operation: §44, Vol 2, p89
7) Detention gatekeeper not effective safeguard against detention of AAR because lacks independence : §45, Vol 2, p89

INAPPROPRIATE USE OF OTHER MECHANISMS

1) AAR and R34/35 failed to safeguard vulnerable detainees because (in part) healthcare resort to inappropriate use of alternatives not designed / capable of adequately fulfilling purpose as safeguard and notifying HO of vulnerabilities to ensure detention reviewed: §47, Vol 2, p89
2) Reliance on IS91 RA Part Cs instead of R35 bypasses safeguard of notification to HO and trigger for detention review: §§48-53, Vol 2, p90-92
3) ACDT is risk management tool, not therapeutic. Not mechanism for addressing underlying causes of risk of self-harm or suicide: §§54-59, Vol 2, pp92-95
4) ACDTs do not relate to numbers of R35(1) and R35(2): §§60-64, Vol 2, pp95-97
5) Food and fluid refusal not generally considered as form of self-harm or treated as indicative of deterioration in mental health: §39, Vol 2, p186.
6) GP letters on fitness to fly and fitness for detention not based on adequate physical / mental examination. Inappropriate for GP to play role in sanctioning detention / removal or use of force., contrary to safeguarding role: §58, Vol 2, p359

INAPPROPRIATE APPLICATION OF "SATISFACTORY MANAGEMENT"

1) Despite strong recommendation in Shaw review for removal of "satisfactory management in detention" as threshold for whether to maintain detention of mentally unwell person, still retained and relied on by healthcare (despite not forming part of AAR policy). Healthcare / doctors appear not to be aware of the change: §§65-66, Vol 2, p97.
2) "Satisfactory management" is obstacle to proper use of safeguards to ensure AARs are notified to HO to have detention reviewed: §67, Vol 2, p97.

ABSENCE OF SAFEGUARDS FOR MENTALLY INCAPACITATED

1) No proactive investigation into presenting mental ill health and missed mental health appointments. Instead, wrong discharge from mental health services: §59, Vol 2, p360.
2) No evidence of system in existence or guidance available to staff for routine transfer of relevant information about mental health concerns from residential wings to healthcare staff
3) DSO 04/2020 on mental vulnerability not adequately address concerns about efficacy of safeguards for vulnerable people who miss healthcare appointments. For example, no assessment of mental capacity or provision of independent advocacy for people who may severely unwell or lack capacity: §§59-60, Vol 2, p360

LESSONS NOT LEARNT

1) R34/35 have not be amended to reflect the wider concept of Adult at Risk
2) Disconnect between policies to manage AARs and R35 safeguard leading to dysfunctions of layers of detention safeguards
3) Problems with R34/ 35 known to SSHD: Shaw Review, Tavistock report; 2nd Shaw Review; Home Affairs Select Committee's *Immigration Detention* inquiry; ICIBI report on Adults at Risk
4) Continued unjustifiable rejection by HO of criticisms or concerns raised about safeguards: (a) obvious indicators of processes not working as intended; policies not being followed; and deficiencies in the operation of safeguards ignored; (b) healthcare / GP and HO staff failed to apply safeguards; (c) system was itself dysfunctional. All led to vulnerable people who were at risk remaining in detention, with deterioration in mental and physical health and increased risk of self-harm, suicide, distress.

SPECIFIC RECOMMENDATIONS ON SAFEGUARDS

Recommendation 8: Mandatory R34 / 35 training

Recommendation 9: Review of operation of R35 DCR including adequate resourcing and audit of the safeguard and any training requirements.

Recommendation 20: update guidance on fit to fly / detain letters to give GPs working on IRCs guidance on duties, responsibilities, and training.

Recommendation 21: Ensuring effective communication of medical information under DSO 04/2020 and implement systems for information sharing, assessment of capacity, and mental health assessments

Recommendation 23: Review and update DSO 04/2020 to set out comprehensive guidance for detention and healthcare staff where concerns a person is suffering mental ill health or lack capacity. Need system for routine information sharing between detention custody staff and healthcare, identification and follow up missed appointments, capacity assessments and mental health assessments where indicated.

OTHER RELEVANT RECOMMENDATIONS

Recommendation 10: Amendment to Rules 40 / 42 on segregation and confinement to clarify who has authorization to use these powers in urgent and non-urgent situations

Recommendations 12 and 13: Training and auditing re Rules 40 / 42 to ensure not used as punishment, for administrative convenience, and has regard to adverse impact on a person's physical or mental health

Recommendations 15, 16, 17: Need for comprehensive DSO on use of force, and circumstances in which force used against mentally ill and independent review of current use

Recommendation 19: Guidance and training for healthcare staff on use of force

As well as **recommendations** concerning culture, physical arrangements of Brook House and general regime in the IRC.

What now? Learning Lessons

STEPS TO LEARNING LESSONS

1) Read report and its findings and acknowledge the harm to detained people at Brook House, captured on Panorama are not result of “bad apples” but dysfunctions in systems and culture.
2) Admit that dysfunctions go beyond “relevant period” between 1 April and 31 August 2017.
3) Admit and recognise that the Home Office sets the policy and direction of travel for implementation, including training, contractual arrangements and arrangements for the regime at detention centres.
4) Open itself up to greater external scrutiny and transparency
5) Change its culture to recognise that the relationship between migration and wider Home Office policy and the use of detention, and that this is about people.
6) Understand and accept individual responsibility for individual decisions made about detained people and its impact.
7) Improve understanding of detention safeguards and their objectives as tools rooted in humanity notwithstanding wider objectives for the use of detention policies.
8) Root recruitment and training of healthcare and custody staff more in humane practices, less in prisonisation.

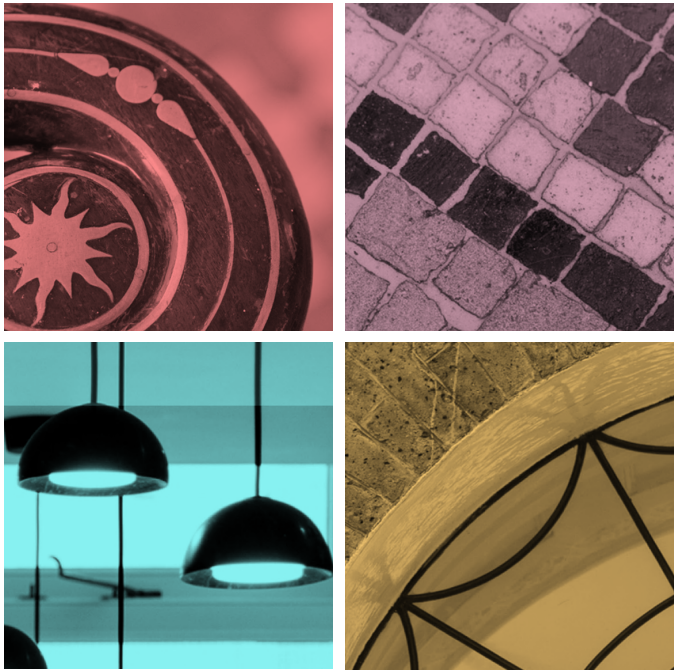
CARROT OR THE STICK?

Litigation as the stick - Examples

- **Dysfunction of Rule 34 / 35**: see e.g. *R (EO and Ors) v SSHD* [2013] EWHC 1236 (Admin), *R (SW) v SSHD* [2018] EWHC 2864 (Admin) and *R (KG) v SSHD* [2018] EWHC 1767 (Admin).
- **Unlawful use of satisfactory management / failures of R35(1):** see e.g. *R (VC) v SSHD* [2018] EWCA Civ 57
- **Unlawful discrimination against the mentally ill / those lacking mental capacity**: *VC v SSHD* but also *R (MDA) v SSHD, R (ASK) v SSHD* [2019] EWCA Civ 1239

Advocacy / contribution to policy as the carrot through

- National Asylum Stakeholder Forum and its sub-groups;
- Evidence to HASC / JCHR
- Parliamentary advocacy
- Demand for consultation on policy changes



THANK YOU FOR LISTENING!

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Or through my practice managers

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Safeguarding failures in Immigration Detention

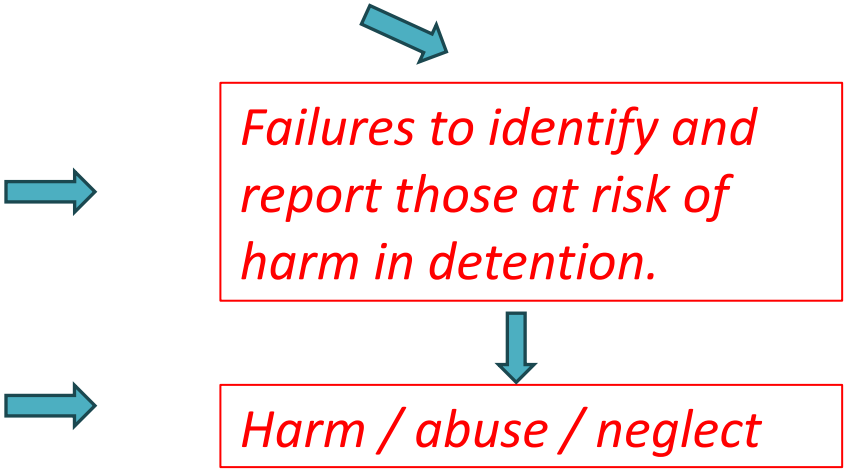
DR RACHEL BINGHAM, MEDICAL JUSTICE

Medical Justice
working for health rights for detainees

SAFEGUARDING FAILURES: A MEDICAL PERSPECTIVE

Failures of healthcare staff to protect people from harm, abuse and neglect

- Lack of understanding of roles and responsibilities
- Failure of recognition, including:
  - Inadequate healthcare
  - Culture of disbelief
  - Disinterest
  - Failures to challenge others
- Sanctioning of use of force / other harmful processes



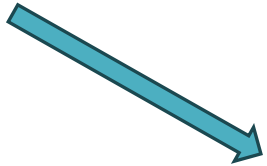
BACKGROUND RISK FACTORS

High risk population

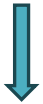
- Many people with history of torture / other trauma
- High rate of mental health problems

High risk situation

- Mental health likely to deteriorate
- Mechanisms to 'manage' further exacerbate
- Contextual risk factors (high risk places)



Failures to identify and report those at risk of harm in detention.



***High risk** of harm / abuse / neglect*

Brook House Inquiry

Chair's report: Safeguarding failures

"I FOUND THAT HEALTHCARE STAFF DID NOT SUFFICIENTLY UNDERSTAND THEIR SAFEGUARDING RESPONSIBILITIES TOWARDS DETAINED PEOPLE…

AND WERE TOO QUICK TO DISMISS DIFFICULT OR CHALLENGING BEHAVIOUR AS DISOBEDIENCE RATHER THAN AS AN INDICATION OF MENTAL ILL HEALTH."

"SERIOUS FAILINGS IN THE APPLICATION OF SAFEGUARDING RULES … NOTABLY AROUND RULES 34 AND RULES 35 …

THESE FAILURES LEFT DETAINED PEOPLE EXPOSED TO THE RISK OF HARM AND, IN SOME CASES, CAUSED ACTUAL HARM …."

"THIS WAS NOT BECAUSE THE SAFEGUARDS THEMSELVES ARE POOR. RATHER, THERE WAS TOO OFTEN A WIDESPREAD DISREGARD OR A LACK OF UNDERSTANDING OF HOW TO IMPLEMENT THEM"

https://brookhouseinquiry.org.uk/

Update - 2023

Medical Justice MLR Audit

66 clients for whom we had done an MLR June 2022 – March 2023 – across all IRCs in England

All participants had significant mental health issues. Many are survivors of torture and trafficking; 41 of the Medical Justice MLRs documented scarring.

Overall:

- Ongoing, severe systemic failures to identify and protect people at risk of harm in IRCs
- No meaningful improvements
- Failure to identify mental health problems and mental capacity
- Deterioration of mental health in detention, absence of adequate treatment
- Increase in suicide risk
- Disregarding of measures to protect people who were suicidal or self-harming.

Failure of identification

Rule 34: "*A physical and mental examination by a medical practitioner within 24 hours*"

Of the 66 clients audited, only 35 clients had a Rule 34 appointment within 24 hours of detention For the others, waiting times of nearly 2 months. 3 not seen by a doctor at all.

Mental health diagnoses were missed in 34 cases

Where identified, management was inadequate: e.g. Trauma pack, elastic bands.

Use of force, segregation, "ACDT"

Suicide risk

Rule 35(2) reports: for *"any detained person [the IRC doctor] suspects of having suicidal intentions"*

43 of our clients had a risk of suicide increased by their being in detention

Only 5 of these had a Rule 35(2).

13 of our clients went on to attempt suicide in detention

Only 3 of these had been reported as being at risk

Yet, these risks were known within the IRCs…

22 of the 49 people who self-harmed, had suicidal thoughts and/or attempted suicide were put on ACDT during their detention

11 of the 13 who attempted suicide were put on constant watch. **10** of the 17 who self-harmed were put on constant watch.

5 *had a Rule 35(2)*

These figures reflect the very low reporting of risk across the detention estate:

In the same 9 month period:

667 ACDT episodes across the IRCs.

240 episodes of continuous observation

26 *Rule 35(2) reports*

Deteriorating health in detention

Rule 35(1): report for ***"any detained person whose health is likely to be injuriously affected by continued detention"***

Our audit includes 64 people whose health had deteriorated in immigration detention

5 Rule 35(1) reports were done

In all 5 cases, the person remained in detention

In two cases the Home Office had given a decision to release the person, but the person remained detained several months later anyway, waiting for a further administrative decision on accommodation

Torture

Rule 35(3) report: ***"for any detained person who [the IRC doctor] is concerned may have been the victim of torture".***

- Missed cases: 5 with scarring in MLR had no R35(3) at the IRC
- Missed scarring: 3 Rule 35(3) reports found "no scars" when our MLR found scars
- Inclusion of body chart implies full body examination

Overall

- No meaningful improvement
- Findings from IRCs across the UK and up to the present year

Medical Justice

working for health rights for detainees

Thank you

www.medicaljustice.org.uk

r.bingham@medicaljustice.org.uk

Brook House Inquiry – Misuse of Segregation Powers

LEWIS KETT, DUNCAN LEWIS SOLICITORS – 6 DECEMBER 2023

Overview

Detention Centre Rules 2001 ('DCR') provide two separate powers to segregate immigration detainees:

Rule 40 – Removal from Association: where necessary in the interests of safety and security that a detained person should not associate with others detained persons

Rule 42 – Temporary Confinement: ordering a refractory or violent detained persons to be confined temporarily in special accommodation

The vast majority of segregation occurs as 'removal from association' ('RFA') under Rule 40 and so we will concentrate on that rule.

This presentation will provide an overview of the requirements of when a person can be subject to RFA and the ways it can be challenged, particularly by reference to:

1. The procedural requirements of authorising and maintaining Rule 40;
2. The substantive reasons for the decision, and some of the common ways it is misused.

The findings of the Brook House Inquiry are helpful in assisting such challenges

Rule 40 DCR

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

The DCR supplemented by Detention Services Order 02/2017 on Rule 40 and 42 which provides practical guidance on the application of the Rule:

https://www.gov.uk/government/publications/removal-from-association-and-temporary-confinement

Bases of Challenge

Rule 40 decisions can and have been challenged in the following ways:

- A breach of Rule 40 under the DCR itself can form the basis of a judicial review on standard public law grounds– in *Muasa* a breach of Rule 40(3) was found where the Secretary of State failed to authorise continued Rule 40 beyond 24 hours, even where only held for a few hours beyond that (see further below);
- It may be a breach of Article 8 ECHR – (e.g. also *Muasa*);
- It may contribute to detention conditions/treatment being in breach of Article 3 (e.g. *HA (Nigeria) v SSHD* [2012] EWHC 979);
- It might be an aggravating factor for damages in an unlawful detention/false imprisonment claim;
- The Rule 40 process has been found to be procedurally unfair for someone with significant mental illness (see *VC v SSHD* [2018] EWCA Civ 57

Procedural Requirements

RFA must be properly authorised – either by:

- The Secretary of State (R40(1)); or
- The Centre Manager in cases of urgency (R40(2))

Cannot be removed longer than 24 hours without the authority of the SSHD (40(3));

Authority beyond 24 hours can be no longer than 14 days (R40(4));

Detainee must be given written reasons within 2 hours (R40(6));

Particulars of each RFA needs to be recorded by the manager (R40(8));

Must be visited daily by the Manager, GP and SSHD (R40(9)).

Authorisation

RFA must be properly authorised in writing and by the appropriate person to be lawful. Holman J in *Muasa* at [71]: *"To argue that the absence of the required authorisation is merely "procedural" or "technical" is indeed to treat the authorisation as merely a rubber stamp. It is not*."

Muasa – RFA beyond 24 hours was in breach of R40(3) and Article 8 because no evidence that authorised by SSHD. Period of approx. 4 hours still engaged Art 8(1) and found not to be in accordance with the law under Art 8(2).

RFA authorised by either:

- The SSHD in non-urgent cases from the outset (R40(1)) and beyond 24 hours in all cases (R40(3));
- The Centre Manager in cases of urgency but only up to 24 hours (R40(2)).

SSHD authorisation largely straightforward; permitted to delegate to a local HO manager (*TM (Kenya) v SSHD* [2019] EWCA 784,see DSO at [40-42]– EO rank for initial 24 hours, SEO for longer

Authorisation by Centre Manager-R40(2)

R40(2) allows 'the manager' of a contracted out detention centre to authorise in cases of urgency

S148 Immigration and Asylum Act 1999- 'The manager' is the Centre Manager/Director appointed to oversee the running of the Centre and is given specific functions under the DCR. At Brook House, this was Ben Saunders of G4S.

Rule 65 DCR allows the manager to delegate his powers to other officers, such as DCMs or assistant directors, if the SSHD expressly approves. Home Office confirmed during the Inquiry that no agreement in place for Mr Saunders to delegate the his powers under R40(2).

The legal effect of no R65 delegation was that only Mr Saunders could authorise urgent R40(2) decisions during the Relevant Period.

See also R40 Interim Guidance in place 26/10/16 to 18/7/17- which temporarily restricted initial R40 decisions to HO only pending DSO.

Misauthorisation under R40(2)

The Inquiry found significant evidence of a complete misuse of this urgency power by Brook House staff during the Relevant Period.

232 of the 236 initial uses of R40 during the Relevant Period were authorised under the urgency procedures of R40(2). None of them were approved by Ben Saunders, 'the manager'. Instead approved by DCMs and duty directors despite no powers to do so. The Chair found these decisions were all improperly authorised.

The Chair also found in any event that G4S were routinely using the urgency procedure under Rule 40(2) inappropriately and when there was clearly sufficient time to seek authorisation from the Home Office.

The Chair found that Rule 40 and 42 were *'poorly understood and were being misinterpreted and misapplied routinely at Brook House during the relevant period. The Inquiry has not identified any basis by which Duty Managers or DCMs at Brook House were able to authorise use of Rule 40 and Rule 42 during the relevant period".*

Evidence from current Centre Manager Steve Hewer suggests R40(2) still being improperly used at Brook House – still no R65 delegation scheme in place – likely the same at other IRCs too.

Substantive Test under Rule 40

Rule 40 is intended to be a strict necessity test – as Holman J emphasised in *Muasa v SSHD* [2017] EWHC 2267 at [27]: *"the threshold test is one of necessity and no lesser test will suffice*."

It must be necessary in the interest of safety or security and necessary in one of those interests that the detainee should not associate with other detained persons (see *Muasa* at [26]).

DSO 02/2017

DSO on R40 and R42 supplements the DCR.

Designed to give guidance on the practical and procedural application of the Rules. Key passages include:

"It must be used as a measure of last resort, when all other options have been exhausted" [2]

"...must be justified and proportionate to the risk presented… must be the minimum time necessary in all the circumstances. There can be no advanced designated blanket use of Rules 40 or 42 for specific types of cases [3]

"*Neither measure under Rule 40 or 42 can be used as punishment as stated expressly within the Rules*" [29]

Gives guidance also where mental illness or self-harm risk [31-33] - see further below

Use as Punishment

Evidence in Inquiry that R40 was being used as punishment and/or disciplinary measure against detainees

Deputy Director Steve Skitt said R40 was “only policy” to deter poor behaviour. DCM Nathan Ring said it was used as a “repercussion” for misbehaviour.

Repeated reference in decisions to ‘compliance’/’behaviour’ and used as a management tool by officers to deal with deemed ill-discipline.

40 of 147 R40 decisions that Duncan Lewis analysed had wrongly cited the wider Prisons Rules test of “Good Order and Discipline”.

Use as Punishment (cont.)

Repeated examples of R40 as punishment found by Inquiry. E.g. D1527 on 4 May 2017 was taken to segregation by force because he protested on the wing netting. DCM Dix's decision stated it was "the consequences of his actions" and later in live evidence to Inquiry he stated "*when someone is on the netting, then obviously the procedure was for them to go to rule 40*".

This was not only an affront to rule but is now contrary to the DSO which states there can be " *no advanced designated blanket use of Rules 40 or 42 for specific types of case*" [3].

Blanket use for netting protests is still continuing– DL have an FI claim at County Court where the C was twice placed on R40 for netting protest.

Note also the R40 regime as punishment – e.g. removing TVs/restricting internet access even when no link to claimed safety/security risk –see D1527 on 25 April 2017 where removing TV was one of triggers leading to ligature attempt in build up to his assault.

Use for administrative convenience

Evidence that used in particular to facilitate removals and make them go smoother. E-wing/CSU routinely used to accommodate detainees in advance of removal as much more controlled environment. The Chair cited concerns about repeated use at Brook House in the Inquiry report. But note was also basis for R40 decision in *Muasa* where they thought the Claimant would be disruptive –found to be rational on facts.

Particularly common during Charter Flights where additional pressures. Chair noted 2020 IMB report where R40 had simultaneously been used on 45 people in Feb 2020 to manage Jamaican charter flight.

Financial penalties in BH contract if G4S failed to present detainees for removal. Use of force and segregation essential tools to avoid that.

Often used where they thought a detainee might resist removal by self-harming. DCM Stephen Webb referred to using R40 as "killing two birds with one stone" where they had a detainee with self-harm risk and imminent RDs.

Most egregious example in Inquiry – D1914 on 27 May 2017 – detainee in significant cardiac ill-health with RDs next day. Flimsy intelligence he might overdose on spice to avoid removal. Taken by force by C+R team to E-wing then placed on R40 because of perceived resistance to that force. Chair found credible evidence of Art 3 breach for incident.

Use to manage mental illness

The Chair found that R40 being routinely used to manage mental illness or in response to self-harm, in breach of the Rule and the DSO

DSO: *"…should not be used as a normal means to manage detained individuals with serious psychiatric illness or presenting with mental health …special care and caution is needed in relation to decisions …for such vulnerable individuals. Specific account must be taken of any adverse effect …and steps taken to mitigate any adverse effects.* [31]

"…a detained individual at risk of suicide or self-harm must not be placed under Rule 40 or 42 accommodation other than:

- *In exceptional circumstances…*
- *For the shortest time possible; and*
- *As a last resort where all other options for manage the behaviour have been considered and exhausted or considered to be inappropriate…"* [34]

Use to manage mental illness (cont.)

Evidence to the Inquiry showed two patterns:

1. Using R40 to manage mental illness and self-harm/suicide risk;
2. Misinterpreting symptoms of mental illness – which should have suggested unsuitability for detention – as behavioural issues to be managed.

Dr Bingham's evidence to the Inquiry: "*not only that segregation was not a mental health treatment, but also that it was "worse than nothing, because it's actually something that would harm [their] mental health… a recurrent pattern that emerges on the available evidence is the use of segregation… as a mechanism to manage detainees suffering from mental illness or risk of suicide and harm"*

Dr Paterson's evidence: "…*widespread culture of disbelief that the perception of at least some staff was that such behaviour was attention seeking or manipulative and the act of removal to segregation provided an opportunity to punish the person for exhibiting the behaviour.*"

Use to manage mental illness (cont. 2)

D1527 an example of both patterns. DCO Sanders called him an "attention-seeking prick" whilst doing his constant watch. Placed on R40 next day for refusing to return to E-wing for his constant watch – a needless punishment designed to further control management of his mental illness and self-harm risk. Yet he got significantly worse in segregation, and attempted to ligature twice before being assaulted by officers in response.

D1527's own witness statement to the Inquiry: *"They take everything out of the rooms so it is harder for you to hurt yourself I think. I told the officer who brought me to E-wing that I wanted a TV, because if there was nothing to distract me while I was locked up on my own I would be stuck with just my thoughts and I would feel worse and worse. My mind would be racing, I would have nothing to take my mind off it and I would become lost in my thoughts… I was taken to E-wing after I had self-harmed or tried to commit suicide, but being in Ewing with nothing to take my mind off my thoughts just made me feel more suicidal. Being on E-wing is like a prison inside a prison*."

Very little protection from healthcare in practice on R40 despite DSO [at 93] and 40(7)/(9) requiring healthcare to visit every day and raise concerns. GP Dr Oozeerally's live evidence was that he had never recommended a person be taken off R40 and his daily visits were "not to run an entirely clinical and full assessment" – see undercover filming of example of him doing R40 round: https://www.youtube.com/watch?v=0ZbZa4ZJXI0

Use to manage mental illness (cont. 3)

The Chair was concerned that R40 to manage mental illness is still continuing at Brook House. Current Centre Director and current head of healthcare both gave evidence that E-wing and CSU was a 'quieter environment'

The Chair urged Home Office and Serco to urgently review its use.

Practice still on-going - *MT v SSHD* (CO/1267/2023) – currently listed for Feb 2024 – C placed on R40 for 11 days due to concerns over increasingly 'bizarre behaviour' after he stopped taking his Schizophrenia medication. Evidence place on R40 in attempt to force him to comply with medication - without proper oversight under MHA 1983 and MCA 2005.

Some final practical considerations

1. Always chase the paperwork which will confirm the justification, who authorised and when. A detainee must be given written reasons within 2 hours (40(6)) but they are not always provided the full paperwork. See the annexes to the DSO which shows you what needs to be completed in each case. This often needs to be obtained through litigation disclosure requests, and is rarely disclosed in SARs.

2. Always request a copy of healthcare's assessment from the IRC healthcare team.

3. Check who has authorised it and whether they have the power to authorise. If a decision is beyond 24 hours, check that it was approved by the Home Office.

4. If under Rule 40(2), were the reasons genuinely urgent? Would there have been time to seek Home Office approval?

5. Check the reasons and that they are genuinely necessary in the interests of safety and security and necessary in one of those interests that the person should not associate with other detained persons. What other alternatives could have been considered? Was it genuinely the last resort?

6. Look out for wording that suggests it has been used as a disciplinary measure – 'good order and discipline', 'compliance', or done as blanket measure in response to a certain type of behaviour (e.g. netting protest).

Some final practical considerations (cont)

7. The Rules do not expressly provide for an individual to make representations or for those to be taken into account, but procedural fairness arguments can and should be considered in relation to any Rule 40 decision when there has not been a reasonable opportunity to do so, even if informally:

a. *VC v SSHD* [2018] EWCA Civ 57 in relation to repeated Rule 40 decisions against an individual with significant mental illness: *"Given the available information on the appellant's mental state during the periods of segregation commencing on 15 and 21 February and 24 March, I have concluded that decisions concerning these periods of segregation did not meet the requirements of procedural fairness. The applicable procedure did not assist the appellant to understand the reasons for his detention to the best of his ability, whatever that may have been, or to make representations, or have representations made on his behalf, about the decision*." [186]

b. *Muasa* – the judge declined to decide the procedural fairness argument as RFA beyond 24 hours already unlawful. Obiter comments though that challenge undermined somewhat by fact representations had been made by solicitors (albeit unreasonably rejected).

GARDEN COURT CHAMBERS

FREE HYBRID CONFERENCE

Brook House Inquiry

What Lessons have been Learned?

130pm - 6.45pm

Wednesday 6 Dec 2023

Panel 3 – Misuse of Force & Segregation: Civil Actions & Judicial Review

Mark Hylands, Deighton Pierce Glynn (Chair)
Una Morris, Garden Court Chambers
Dr Brodie Patterson, Queen Mary's
Nick Armstrong KC, Matrix Chambers

6 December 2023

Use of force: Necessary and proportionate?

Una Morris, Garden Court Chambers

6 December 2023

The legal and policy framework considered by the Inquiry

- Rule 41 of the Detention Centre Rules 2001
- The Detention Services Operating Standards Manual
- Prison Service Order 1600: Use of Force

5-8/p134-135/Vol.II

Rule 41 of the Detention Centre Rules 2001

"**41. – Use of force**

(1) A detainee custody officer dealing with a detained person shall not use force unnecessarily and, when the application of force to a detained person is necessary, no more force than is necessary shall be used.

(2) No officer shall act deliberately in a manner calculated to provoke a detained person."

The Detention Services Operating Standards Manual

"1. The Centre will ensure that force is used only when necessary to keep a detainee in custody, to prevent violence, to prevent destruction of the property of the removal centre or of others and to prevent detainees from seeking to prevent their own removal physically or physically interfering with the lawful removal of another detainee.

2. Force will only be used as a measure of last resort and strictly within the terms of Rule 41 of the Detention Centre rules 2001."

The Prison Service Order 1600: Use of Force

"2.2. The use of force will be justified, and therefore lawful, only:

- If it is reasonable in the circumstances
- If it is necessary
- If no more force than is necessary is used
- If it is proportionate to the seriousness of the circumstances

…"

The approach taken by the Inquiry: Use of force

"Deliberate humiliation and debasement of a victim is a factor that may be taken into account when considering degrading treatment, but such a purpose is not required in law to find a breach of Article 3…Case law has also established that the use of unnecessary force on a detained person can diminish human dignity and be contrary to Article 3, even where there has been no injury caused as a result…"

14.3/p.74/Vol.I

The approach taken by the Inquiry: Use of force

"If physical force was used, was this strictly necessary?"

15/p.76/Vol.I

What reasons were recorded for uses of force?

- Based on the Inquiry's review of Use of Force reports, there were 109 use of force incidents during the relevant period (1 April 2017 to 31 August 2017).
- The majority were recorded as unplanned (or spontaneous or responsive) incidents.
- Reasons included the prevention of self-harm or assault or for personal safety of officers.
- However, the most common reason recorded was to "maintain good order and discipline".

15/p.137/Vol.II

Concerning themes

Force used to provoke or punish:

"I consider that DCO Ioannis (Yan) Paschali deliberately, and with intention to provoke and punish D1527 for what Mr Paschali considered poor behaviour, placed his hands around D1527's neck while threatening to harm him…"

18.2/p.138/Vol.II

Concerning themes

Use of an unauthorised technique

The handcuffing of detained people with their hands secured behind their back when seated had been removed from the Use of Force Training Manual following the unlawful killing of Jimmy Mubenga.

Despite this, it was found to have been used against D1234, D1914, D149 and D2054 during incidents between 28 March 2017 and 28 June 2017

20-21/p.139-140/Vol.II

Concerning themes

Use of an unauthorised technique

"Recommendation 14: handcuffing behind backs while seated

The Home Office and contractors operating immigration removal centres must ensure that all staff are aware that the technique of handcuffing detained people with their hands behind their back while seated is not permitted, given its association with positional asphyxia."

20-21/p.139-140/Vol.II

Concerning themes

Staff incompetence

"In a number of use of force incidents, staff struggled with "basic techniques…"

19/p.139/Vol.II

"…at times, staff used authorised techniques that became dangerous due to their incompetent application."

…

22/p.140/Vol.II

Use of force not as a last resort

"There was considerable evidence that, during many incidents, officers were too quick to employ force. Indeed, force was used on these occasions as a first resort rather than a last resort. During the relevant period, de-escalation techniques were either not used at all or were not used for long enough. It appears that, even at DCM level, there was a lack of understanding of how to de-escalate a situation and explore all other reasonable options before using force…"

26/p.142/Vol.II

Use of force against naked detained people

"Force was used inappropriately against naked detained people…It is important that there are guidelines in place to protect the dignity of detained people in these circumstances. It is clear that a strategy did not exist, which resulted in what may otherwise have been unproblematic use of force incidents becoming humiliating for the detained person."

43/p.149/Vol.II

Inappropriate application of a Prison Service Order

"The…issues demonstrate that the application of the Use of Force PSO to govern the use of force inside IRCs is inappropriate. IRCs have a different purpose to prisons and a different type of population, and so different types of issues arise."

47/p.151/Vol.II

Concluding remarks

- As well as demonstrating the prevalence of unnecessary and disproportionate uses of force in immigration detention, the Inquiry report provides a useful framework for considering use of force in the context of immigration detention claims under the Human Rights Act 1998, as well as in claims in assault and battery.

Thank you

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Mental Health and the use of Force

Dr Brodie Paterson

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Trauma Informed Practice

"*Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individual involved*"

(NASMHPD, 1998)

The British Psychological Society

Division of Clinical Psychology

Pain Compliance Usage

- Assumes
- Access to higher cognitive functions to discriminate cause and effect
- Application of pain graduated
- Pain will only be used as last resort to prevent serious harm to others

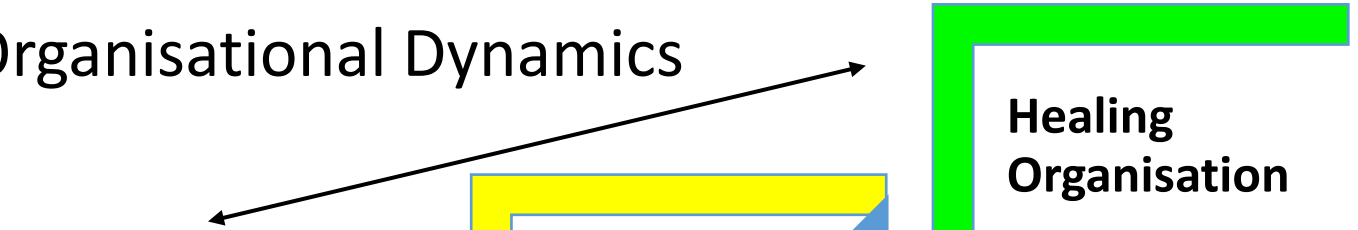
- No long term harm

- Reality
- Survival Brain. Flashbacks. Dissociation

- Evidence does not support this
- Pain if permitted as a last resort will almost inevitably be misused

- Traumatising / Retraumatising

Organisational Dynamics



Trauma Organised

Reactive

Crisis Driven

Fragmented

Conflict hidden

Authoritarian

Controlling

Fear Driven

Trauma Informed

Shared

Meaning

Understanding

Implications

Power

Responsibility

Healing Organisation

Reflects

Co-creates

Learns

Meaning making

Positive conflict

Compassionate Leadership

(Adapted from Vivian and Horman 2015)

GARDEN COURT CHAMBERS

FREE HYBRID CONFERENCE

Brook House Inquiry

What Lessons have been Learned?

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Wednesday 6 Dec 2023

Institutional Culture & Racism - What's Changed?

Stephanie Harrison KC, Garden Court Chambers
Professor Mary Bosworth, Oxford University Centre for Criminology

6 December 2023

@gardencourtlaw

Institutional Culture & Racism - What's Changed?

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Closing - Excerpts from evidence and testimony of Core Participants

6 December 2023

GARDEN COURT CHAMBERS

FREE HYBRID CONFERENCE

Brook House Inquiry

What Lessons have been Learned?

130pm - 6.45pm

Wednesday 6 Dec 2023

Additional resources

- What is immigration detention?
- BBC Panorama programme on Brook House IRC - "Undercover: Britain's Immigration Secrets"
- Brook House Inquiry website

  All evidence submitted to the inquiry is available to view on the Inquiry website. Some submissions of interest include:

  - First report and supplementary report – Prof. Mary Bosworth (Inquiry expert)
  - First report and supplementary report – Dr James Hard (Inquiry expert)
  - First report, first supplementary report and second supplementary report – Jonathan Collier (Inquiry expert)
  - Statement – Anna Pincus, Gatwick Detainees' Welfare Group; statement – James Wilson, Gatwick Detainees' Welfare Group
  - Statement – Dr Brodie Paterson (expert in restraint reduction)
  - Statement – Deborah Coles, INQUEST
  - Statement – Prof. Cornelius Katona, consultant psychiatrist
  - Statement and submission – Sile Reynolds, Freedom from Torture
  - Opening oral statement (from 45:27) and closing statement – Medical Justice and various detained individuals
  - Closing statements – all other participants