BROOK HOUSE INQUIRY

FIRST STATEMENT OF PROFESSOR CORNELIUS KATONA

I provide this statement in response to a request dated 11 January 2022 under Rule 9 of the Inquiry Rules 2006.

I, Professor Cornelius Katona, Medical and Research Director of the Helen Bamber Foundation and voluntary clinician for Medical Justice, of Wingham Barton Manor, Westmarsh, Canterbury CT3 2LW will say as follows:

<u>Professional qualifications and background</u>

1. I hold a Doctorate in Medicine from the University of Cambridge and was first appointed as a consultant psychiatrist in 1986. I am Emeritus Professor of Psychiatry at the University of Kent. In 2012 I was appointed an Honorary Professor in the Division of Psychiatry at University College London, where I had previously been a full professor for many years. Between 1998 and 2003 I was Dean of the Royal College of Psychiatrists (RCPsych). I was appointed as the RCPsych's lead on Refugee and Asylum Mental Health in 2012. In that capacity I convened the College's Refugee and Asylum Mental Health Working Group and have continued to chair it. I was a member of the Committee that updated the National Institute of Health and Care Excellence (NICE) guidelines on post-traumatic stress disorder (PTSD)[1]. In 2019 I was awarded the Royal College of Psychiatrists' Honorary Fellowship, the College's highest honour.

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[1] Published here: https://www.nice.org.uk/guidance/ng116.

2. I am currently the Medical and Research Director of the Helen Bamber Foundation which was established in 2005 by the late Helen Bamber OBE[2]. I was appointed to this post in 2012. I oversee the Foundation's clinical research and provide expert psychiatric assessment relating to our clients' asylum claims. I am part of a team of therapists, doctors and legal experts providing integrated care to individuals who have experienced torture, trafficking and other extreme human cruelty, in the form of specialist programmes of therapeutic care, detailed medical assessments and co-ordination of external healthcare services, the provision of expert Medico-legal Reports and referral to specialist lawyers and organisations for legal, welfare and housing advice.

3. I was a trustee of Medical Justice between 2006 and 2012. I continue to work in a voluntary capacity as clinician for Medical Justice, having done so since 2006. I have completed approximately 30 medico-legal reports on behalf of the charity, assessing people in detention centres across the UK. I have visited Brook House IRC on several occasions to complete medico-legal assessments. I did not assesses a Medical Justice client within the time period considered by the this Inquiry, but I believe that the matters of concern to the Inquiry relating to the treatment of those with mental disorder are not time-limited but reflect long standing serious concerns and systemic practice that has failed to ensure that those with particular vulnerability in detention are identified, protected from harm in detention and that their medical conditions are identified and addressed.

4. I have published over 300 papers and written and/or edited 16 books on various aspects of psychiatry. I have appended a summary of my recent research publications to this statement. A number are directly relevant to the terms of reference and subject matter of this Inquiry because they concern clinical research on the mental health and treatment of

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[2] Helen Bamber was a pioneer in the care of survivors of torture and extreme cruelty, having entered Bergen-Belsen Concentration Camp as one of the first relief and rehabilitation teams to work with survivors of the Holocaust. On her return to England she was appointed to the Committee for the Care of Children from Concentration Camps, where she looked after 722 child survivors of Auschwitz. She formed the first medical group of the British Section of Amnesty International. In 1984 she founded the Medical Foundation for the Care of Victims of Torture and was appointed Secretary General of the International Society for Health and Human Rights and in 2005 the foundation in her own name.

those detained in IRCs under immigration powers, particularly those with pre-existing vulnerability relating to a history of torture or other trauma.

5. I also work independently preparing expert psychiatric reports in the context of asylum and unlawful detention claims. I have prepared over 2000 such reports, including many assessments in the immigration detention setting. It is part of my role and expertise to make clinical assessments of the accounts given by individuals of torture, other serious ill treatment, and trauma. In doing so, as well as following the relevant Practice Directions on Expert witnesses, I apply the best practice methodology in the UN OHCHR Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The "Istanbul Protocol").[3] These international guidelines on the documentation of torture and the identification of the physical and psychological sequelae and consequences of torture have been approved as authoritative guidance domestically by the UK Supreme Court[4] and the Home Office.[5]

6. I understand that the Inquiry's terms of reference are to investigate into and report on the decisions, actions and circumstances surrounding the mistreatment of detainees broadcast in the BBC Panorama programme 'Undercover: Britain's Immigration Secrets' on 4 September 2017 and in particular to investigate:

   (i) The treatment of complainants, including identifying whether there has been mistreatment and identifying responsibility for any mistreatment.
   (ii) Whether methods, policies, practices and management arrangements (both of the Home Office and its contractors) caused or contributed to any identified mistreatment.
   (iii) Whether any changes to these methods, policies, practices and management arrangements would help to prevent a recurrence of any identified mistreatment.
   (iv) Whether any clinical care issues caused or contributed to any identified mistreatment.

[3] UN OHCHR (2004) Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Istanbul Protocol")
[4] *KV(Sri Lanka) v Secretary of State for the Home Department* [2019] UKSC 119.
[5] *Medical evidence in asylum claims* (v. 1.0, dated 5 August 2021).

(v) Whether any changes to clinical care would help to prevent a recurrence of any identified mistreatment.

7. For at least the past decade in my roles as a Consultant Psychiatrist, as the clinical lead for Royal College of Psychiatrists, as Medical Director at the Helen Bamber Foundation and in my voluntary work with Medical Justice, I, along with my professional colleagues, have been providing a wide range of first hand evidence of the systemic failure of the policies and practices of the Home Office and its contractors to safeguard the fundamental rights and welfare of vulnerable people held in immigration detention. Since at least 2012, we have sought to draw to the attention of the authorities the many adverse consequences for the clinical care of those with mental disorder which has repeatedly been identified as inappropriate and inadequate - sometimes woefully inadequate. I am in agreement with Stephen Shaw that this is "*an affront to civilised values*"[6] , but, in my experience and that of my colleagues, the Home Office and its contractors have failed to take the necessary action to remedy these dangerous practices and to heed the warnings from all the evidence we and others have provided over the years. This has included evidence given to other investigations, consultations and reviews, as well as in medical reports in a large number of individual cases, many of which result in successful legal action before the courts. Given this context, in my view the Home Office and its contractors knew or ought to have known that for a number of years before 2017, the conditions for abuse and mistreatment of vulnerable detainees were operating in immigration detention centres. Use of force and excessive use of force as a response to challenging and disturbed behaviour is predictable, particularly if that behaviour was not properly identified as symptomatic of mental disorder and distress and as itself representing a clear contraindication to continued detention. It is my experience that these same failing polices, practices and conditions have not been changed fundamentally despite the Panorama broadcast and subsequent investigations, reports and extensive recommendations, many of which are essentially repetitions of similar previous recommendations.

[6] *Review into the welfare in detention of vulnerable persons: a report to the Home Office by Stephen Shaw*. January 2016, §4.36.

8. I have, therefore, sought to set out the evidence that I understand was known and available to the Home Office and its contactors prior to 2017 and subsequently - primarily by reference to the work of the RCPsych but also drawing upon my wider clinical and research experience. I hope to provide evidence relevant to the Inquiry's terms of reference, and to make recommendation within the body of my statement to identify changes that may help to prevent a recurrence of the mistreatment of detainees in immigration detention. I have annexed to this statement a summary of the cases where the courts have found there to be a breach of article 3 ECHR in the treatment of those suffering from mental illness in IRCs (Annex 1), a list of my recent articles (Annex 2) and a bibliography with hyperlinks of documents referred to in this statement (Annex 3). I also have exhibited a number of the key documents and articles referred to and they are listed in the cover sheet to the exhibits.

RCPsych Working Group

9. In 2012, after being appointed the RCPsychs' lead, I set up and chaired the College's working group on Mental Health of Asylum Seekers and Refugees. It was recognised by the RCPsych that this was an area that that required a specific focus within psychiatry reflecting the high incidence and complexity of mental disorder within these groups, the barriers to access to treatment they experienced, and the consequent need to enhance the knowledge and skills of psychiatrists treating them. The RCPsych Working Group comprised a multidisciplinary team with a range of clinical experience and expertise with the intention of covering sub-specialities such as child and adolescent psychiatry, learning disability and forensic psychiatry. Although the group consisted primarily of psychiatric colleagues with medical expertise, Medical Justice agreed to participate. Their research and casework manager Theresa Schleicher became part of the group to provide policy and informed practical case work experience.

RCPsych Position Statements

10. Like other Colleges, the RCPsych adopts a practice of issuing concise statements of College policy. Such statements by the RCPsych are formally approved by the College's

Policy and Public Affairs Committee. Specialist working groups carry out research and review of the available clinical and other relevant evidence and provide draft Statements (which include policy and practice recommendations) for consideration by the College. Approval only follows a rigorous internal review process by experts independent of the working group.

Royal College of Psychiatrists' Working Group on Mental Health of Asylum Seekers and Refugees (2013)

11. The RCPsych Working Group on Refugee and Asylum Mental Health prepared its first Position Statement on the detention of persons with mental disorder at Immigration Removal Centres in 2013. This was reviewed, accepted, and published by the RCPsych in April 2013, and was subsequently updated in 2014[7] and again in 2021.[8] The detention context was chosen for the first published Position Statement because there was a consensus within the Working Group that this was the most pressing issue of concern at the time. This was primarily for three reasons.

12. Firstly, in August 2010, the Home Office had made it explicit in its policy that persons suffering from a serious mental illness were no longer being 'considered unsuitable for detention' (save in very exceptional circumstances) *per se*, but only if their mental illness 'cannot be satisfactorily managed within detention'.[9]It appeared to the Working Group that this effectively reversed the presumption against detaining mentally ill people. I am not aware the Home Office consulted either on this change to the wording of the policy or on the practice of seeking to manage serious mental illness in immigration detention rather than treating it as a powerful contra-indicator to detention or to continuing

[7] http://www.medicaljustice.org.uk/wp-content/uploads/2016/06/Appendix-A-The-Royal-College-of-Psychiatrists-Position-Statement-on-detention-of-people-with-mental-disorders-in-Immigration-Removal-Centres.pdf
[8] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/position-statement-ps02-21---detention-of-people-with-mental-disorders-in-immigration-removal-centres---2021.pdf?sfvrsn=58f7a29e_6
[9] Home Office (August 2010) Enforcement Instructions and Guidance: Chapter 55 v.10

detention. The Home Office had also failed to comply with the public sector equality duty then in force relating to race and disability when reviewing the policy in 2010.[10]

13. Secondly, in the two years since this change to Home Office policy, the High Court had also found breaches of the absolute prohibition of inhuman and degrading treatment in Article 3 of the European Convention on Human Rights (ECHR) in three immigration detention cases, in relation to the ill treatment of detainees with mental illness.[11] One of those cases concerned detention in Brook House IRC.[12] It was of profound concern that grave breaches of fundamental rights were occurring within this cohort of mentally ill patients. We were aware of evidence indicating that the practices that had led to the ill-treatment in these cases was not limited to them. Our concern was that it arose from the practice of seeking to '*manage*' serious and severe mental illness in detention rather than treating such mental illness as a strong indicator that the person was unsuitable for such detention. We were especially concerned that the evidence from the High Court cases revealed a number of alarming wider themes that are relevant to the Inquiry's current investigation of the evidence relating to Brook House (albeit five years later in 2017):

(i) the provision of psychiatric care was woefully below that considered best practice;
(ii) there was a failure to release or transfer the detainee promptly for psychiatric treatment in hospital when needed;
(iii) psychiatric treatment was not provided for several months even in obvious and serious cases;
(iv) there was evidence of neglect;
(v) the detention policy was not properly understood and applied by those authorising detention, and decisions and subsequent reviews failed to assess and understand the impact of detention on the individual mental health;
(vi) segregation and repeated segregation were used to manage the symptoms of mental illness;

[10] *R (HA) v Secretary of State for the Home Department* [2012] EWHC 979 (Admin).
[11] See Annex 1 and cases of *R (S) v Secretary of State for the Home Department* [2011] EWHC 2120 (Admin); *R (BA) v Secretary of State for the Home Department* [2011] EWHC 2748 (Admin); *R (HA) v Secretary of State for the Home Department* [2012] EWHC 979 (Admin) and *R (D) v Secretary of State for the Home Department* [2012] EWHC 2501 (Admin).
[12] *Ibid* (HA)(Nigeria).

(vii) there was evidence of recourse to disciplinary sanctions using rule 40 or 42 of the Detention Centre Rules 2001 and of segregation being used as punishment for behaviour that was seen as disruptive rather than symptomatic of a deteriorating mental disorder.

14. Thirdly, 'serious mental illness' and 'satisfactory management' were being equated with illness so severe that it required in-patient care in a psychiatric hospital under the Mental Health Act 1983. This led to situations where detainees' mental disorder deteriorated or relapsed into florid mental illness (and associated lack of mental capacity to challenge their detention) before they were considered by the IRC healthcare and the Home Office as being "unfit for detention".

15. The RCPsych Working Group therefore, set out to review the clinical and other evidence available at that time addressing two key questions:

    1. Under what circumstances (if any) does the presence of a mental disorder make it inappropriate for a person with a mental illness to be subjected to administrative immigration detention?
    2. Can any mental disorders be managed satisfactorily in the immigration detention setting?

16. In answering those questions, the focus was upon three main elements, namely:

    (i) the nature of the individual's medical condition;
    (ii) the impact of detention on the individual's health; and
    (iii) the adequacy of the medical assistance and care provided in detention.

17. Review of the available clinical and research literature and evidence by the RCPsych Working Group led to the following findings:

    - A high proportion of immigration detainees display clinically significant levels of depression, Post Traumatic Stress Disorder (PTSD), and anxiety, as well as intense fear, sleep disturbances, profound hopelessness, self-harm, and suicidal ideation.

- Systematic review of the literature then available[13] reported high prevalence of mental disorders and use of psychotropic medications among detainees.
- Experience also suggests that conditions seen in these detention centres were complex and difficult to treat. Conditions like PTSD are often unresponsive to treatment with medication alone and require expert interventions or specialist therapeutic input which are not available or cannot be delivered effectively in the detention setting.
- Detention is in any event likely to cause painful reminders of past traumatic experiences and to aggravate fears of potentially imminent return. Separation from family and social and professional support is also likely to have negative impact on mental state. Under these circumstances, therefore, most existing mental health disorders are likely to deteriorate significantly in detention.
- Treatment of mental illness requires a holistic approach and continuity of care; it is not just the treatment of an episode of mental ill health but an ongoing therapeutic input focussing on recovery and on relapse prevention. Success of such treatment is dependent on the development of therapeutic relationships, providing a multi-disciplinary and multi-agency intervention, and using bio-psychosocial model of therapeutic intervention. Management of the complex conditions that are often present in asylum seekers may also require more specific specialist therapeutic interventions that are not routinely available in detention.

18. On the basis of the evidence reviewed, the conclusions endorsed by the RCPsych were that:

- People with mental disorder should only be subjected to immigration detention in very exceptional circumstances.
- Detention centres are likely to precipitate a significant deterioration of mental health in the majority of cases, greatly increasing both the suffering of the individual and the risk of suicide and self-harm.

[13] Robjant, Hassan and Katona: *Mental health Implications of detaining asylum seekers: systematic review* British Journal of Psychiatry (Apr. 2009, 194(4) pp. 306-12).

- Individuals with mental disorder should receive the same optimum standard of care if they are in a detention centre as they would in any other NHS setting.
- Detention centres are not appropriate therapeutic environments to promote recovery from the mental ill health due to the nature of the environment and the lack of specialist mental health treatment resources. The current ethos of mental health services is on recovery and community rehabilitation, and this cannot be provided in a detention centre.
- Current guidelines for good clinical practice also emphasise protecting individual rights through providing the least restrictive treatment option. This is reflected in the 2007 revision of the Mental Health Act 1983 and in the 2005 Mental Capacity Act, and is consistent with an ethos of using the least restrictive option and more specifically of avoiding inpatient admission or detention under the Mental Health Act where treatment in the community or informal admission is possible.

19. The RCPsych also emphasised the following matters:

- It remains of great concern that there are repeated cases where asylum seekers are detained despite a clear and documented history of mental illness and against the specific advice of mental health professionals.
- It was also of great concern that there are repeated examples where mental disorder has not been managed satisfactorily or adequately in the detention centres. In some court cases the provision of psychiatric care was not only found to be woefully below that considered best practice, but to be so poor that the overall treatment of the people concerned was found to be inhuman and degrading.
- It was therefore crucial that clinical and other staff working in detention centres were given adequate training and support to identify mental disorder when it does arise or deteriorate significantly in a detention centre setting, and clear guidelines on how to manage this appropriately and to link up with existing local mental health provision outside the detention centre. This should include specific attention to appropriate monitoring and management of risk.

20. The Home Office did not respond formally to the RCPsych Position Statement either in 2013 or when it was updated in 2014. There was no discernible change in Home Office

practice with regard to detention that we were aware of. There were subsequently two further cases in which the High Court found that the treatment of individuals with deteriorating mental illness were subject to inhuman and degrading treatment in breach of Article 3 ECHR following similar patterns discerned in the three previous cases.[14] The case of *R (D) v Secretary of State for the Home Department* [2012] EWHC 2501 (Admin) concerned detention at Brook House IRC. D's mental state deteriorated to the point that he lacked mental capacity. The treatment he received for his mental illness was found to be "*negligent*", and "*recourse was had to sanctions under rule 40 and 42*" which were said to be "*unsuitable for a man with his condition*". The case of MD is also notable in that detention at Yarl's Wood IRC precipitated a breakdown in her mental health despite her having had no pre-existing mental illness. She was diagnosed with major depression with psychotic features and anxiety disorder which was thought to be a result of her detention. Her distress, self-harm and aggressive outbursts in detention were frequently dealt with by placing her in segregation. Her self-harming was responded to by restraining and handcuffing her (see the judgment at §21). On many occasions physical force was used to "*manage*" her (§136). Pain techniques were also applied (§128).[15]

21. As practitioners in the field, we also continued to see high numbers of people with serious mental illness, including many survivors of torture and other serious mistreatment or trauma, who were being detained, and whose mental condition was exacerbated and not properly treated or "managed" in detention. Compulsory transfer to segregation in particular was a recurrent feature of that "management".

The first Stephen Shaw report

22. The RCPsych Working group welcomed the Home Office's decision, (following the critical 2015 report by the Tavistock Institute),[16] to commission an independent review

[14] *R (D) v Secretary of State for the Home Department* [2012] EWHC 2501 (Admin) and *R (MD) v Secretary of State for the Home Department* [2013] EWHC 2249 (Admin).
[15] See Annex 1.
[16] The Tavistock Institute (2015) Review of Mental Health Issues in Immigration Removal Centres

of policies and procedures affecting the welfare of those held in immigration removal centres and to appoint Stephen Shaw to carry it out. However, we remained deeply concerned about the delay in making any real change, and the continuing practice of detaining people with serious mental illness despite the evidence of its damaging effects as underscored by detailed judgments made by the Courts now three years previously. The RCPsych Working group made written representations to Stephen Shaw in May 2015 pointing out then that the experience was that:

(i) decisions on detention are integral to the chain of events that had led to current failings;

(ii) our members had seen a considerable number of detainees whose health deteriorated significantly in the time it took to establish that their health could not be 'satisfactorily managed'. This risk of causing deterioration in health and significant suffering could in our view only be avoided by returning to a general presumption against the detention of the mentally ill;

(iii) the evidence was overwhelming from across the globe: immigration detention can be highly deleterious to both physical and mental health;

(iv) there were deficiencies, and in some cases gross failures, in areas directly within the terms of reference of the Shaw Review - namely in identifying vulnerability and taking appropriate action, preventing self-harm and self-inflicted death, assessing risk effectively, safeguarding adults and children and managing the mental and physical health of detainees.

23. I met with Stephen Shaw in person on two occasions, first as part of a joint meeting with other concerned NGOs, and then separately in my role with the Helen Bamber Foundation and as the RCPsych Lead in 2015. Stephen Shaw was provided with supporting insight and evidence for the RCPsych Position Statement and for our submissions. It was therefore no surprise to us that Stephen Shaw's first report into the Welfare of Vulnerable Detainees in Immigration Detention (which was eventually published in 2016) was highly critical.[17] His conclusions with regard to the detention of

[17] Shaw. S (January 2016) Review into the Welfare in Detention of Vulnerable Persons (a report to the Home Office)

those with mental illness reflected the RCPsychs' 2014 Position Statement. In particular Stephen Shaw noted (at §1.84) the change in policy from one where mentally ill people would not normally be detained at all to one in which mentally ill people would only not be detained if they could not be managed in detention and concluded that:

- People with mental illness could not be satisfactorily managed in detention. There was a clear link between peoples' experience of suffering in their own country of origin, PTSD and exacerbation of mental illness in detention" (§1.85)
- Detention worsened mental health because it diminished the sense of safety and freedom from harm, it was a painful reminder of past traumatic experiences, it aggravated fear of imminent return, it separated people from their support networks and it disrupted their treatment and care (§1.99)
- Because he considered the situation of detainees suffering from serious mental illness whose "*treatment and care does not and cannot equate to good psychiatric practice (whether or not it is 'satisfactorily managed'*") to be "*an affront to civilised va*lues", Stephen Shaw recommended that the detention policy should be amended to remove the 'satisfactory managed' caveat (see further below) (§4.36)
- In relation to PTSD, in light of the evidence that "*that detention, as a reminder of painful post traumatic experience, can trigger re-traumatisation. The effects of such re-traumatisation can include self-harm and worsening psychiatric morbidity*", he concluded that those with such a diagnosis should be "considered unsuitable for detention" (§4.40).

24. Stephen's Shaw's Recommendation 11 was that:
"the words '*which cannot be satisfactorily manged in detention'* are removed from the section of the EIG that covers those suffering from serious mental illness." (p. 89)

25. The importance of this recommendation should not be underestimated by the Inquiry. Stephen Shaw found that those with serious mental illness should not be detained on the basis that their conditions could be satisfactorily managed in immigration detention. His conclusion was also consistent with our view that *good psychiatric practice* could not be obtained in IRCs and that the frequent resort to segregation, ACDT and force was indicative of flawed psychiatric practice. He used the strongest language to underscore

his conclusion that keeping seriously mental ill people in a context where their mental disorder could not be properly treated was "*an affront to civilised values*".

<u>The Adults at Risk Policy</u>

26. This was a conclusion with which the RCPsych Working Group agreed. In my view it is one that the Inquiry should consider as its starting point. It was for these reasons that the RCPsych Working Group was generally encouraged and relieved that Stephen Shaw had come to conclusions that broadly reflected our own analysis of the evidence and our concerns that existing safeguards were inadequate and failing. Shaw made other wide-ranging recommendations, 62 in all, that, if implemented by the Home Office, appeared to give a real possibility that significant changes would be made to improve the safeguards for vulnerable detainees and to reduce the numbers of those with mental illness in detention and at risk of harm. It was, therefore, a matter of deep concern when the Home Office published the Adults at Risk Statutory Guidance and in particular its associated caseworker policy on 12 September 2016. This policy was the centrepiece of the Government's response to Shaw 1. Much to our shock and dismay, however, rather than enhancing and extending protection (as Shaw had intended and the Minister had publicly agreed to in a number of significant ways[18]), the policy actually weakened the safeguards - in particular:

(i) by narrowing the scope of those accepted to be vulnerable and at particular risk of harm by limiting the definition of victim of torture to that contained in the UN Convention Against Torture (UNCAT), thereby excluding many victims where the perpetrator was a non-state actor; and

(ii) whilst accepting those with serious mental disorders were particularly vulnerable, the new policy did not treat them as unsuitable for detention save in very exceptional circumstances. Instead, detainees were required to provide specific evidence of harm, with such harm (even if accepted) being balanced against a range of immigration and other factors weighing in favour of detention.

[18] See ministerial statement responding to the Shaw report, January 2016, cited in *R (Medical Justice) v Secretary of State for the Home Department* [2017] EWHC 2461 (Admin), 4 WLR 198 at §23.

Definition of torture in the context of immigration detention policy: Position Statement (PS07/16)

27. The RCPsych Working Group was very concerned about the unexpected and regressive decision to narrow the definition of torture and could not understand how this would improve the failing safeguards. It was all the less explicable because the very same issue had been the subject of a High Court case in 2013[19] when the Court had rejected the Home Office's position. The High Court's decision recognised that whether torture or ill-treatment is inflicted by a state or non-state actor is not determinative of vulnerability to harm in detention. Expert evidence had been provided to the Court in *E and O* from a number of sources, including Helen Bamber OBE and myself, which confirmed the clinical consensus on this topic. It was, therefore, very difficult to reconcile the Home Office's stated intention to enhance protection for vulnerable groups with this decision to go against the Court's judgment and to disregard the clinical evidence that had been submitted to the Court.

28. The RCPsych issued a Position Statement in December 2016[20] and stated as follows that:

- the new AAR policy will significantly weaken the existing safeguards for vulnerable people with a history of torture, trafficking or other serious ill-treatment and will not, as ostensibly intended, provide better protection for vulnerable groups against their detention and from the disproportionate adverse effects of such detention on those with a history of serious traumatic experiences.
- the issue of state responsibility for torture does not in itself determine either the impact of the ill-treatment or the resultant therapeutic needs of the individual.
- the issue of state responsibility for torture is not determinative of any consequent vulnerability to the adverse effects of immigration detention.
- Loss of agency and powerlessness is the common feature, and it is this that is critical to the consequent risk of harm if the person is again subject to constraint,

[19] *R (EO) v SSHD* [2013] EWHC 1236 (Admin).

[20] RCPsych (December 2016) Position statement PS07/16: Definition of torture in the context of immigration detention policy

rather than the identity of the agent and their relationship to the state. This can arise in a range of scenarios where individuals were deprived of their liberty or where their movements were constrained.

29. The RCPsych further expressed its concerns regarding:

- The adverse clinical consequences of any change from previous practice that was based on the long-standing consensus that torture victims are not suitable for detention and are at particular risk of the adverse effects of detention, to a new and additional obligation placed on the detainee to establish whether anticipated harm has occurred or is occurring.
- The evidence and findings summarised in the Statement shows that individuals who have survived trauma, torture or ill-treatment are especially vulnerable to the harmful impacts of detention, irrespective of the issue of state responsibility for the treatment.
- The clinical evidence that a history of torture in itself predisposes an individual to a greater risk of harm, including deterioration in mental health and increased risk of anxiety, depression and PTSD, than would be experienced in the general detained population.

30. In 2017, I provided evidence to this effect in legal proceedings. The High Court again accepted this position to be correct and declared this part of the AAR policy to be unlawful because it was inconsistent with purpose of improving protections for vulnerable groups and was contrary to and disregarded the consensus of expert opinion[21]. Both these points had been made in the College's Position Statement and by other NGOs during the prior consultation including Medical Justice who brought the legal claim. These representations had apparently been simply ignored by the Home Office. I believe this Inquiry should inquire into why the Minister and Senior Officials in the Home Office adopted this approach which actually undermined detainees' protections whilst purporting to have accepted the findings and recommendations of Shaw 1 and agreeing to improve those protections.

[21] *R (Medical Justice and others) v SSHD* [2017] EWHC 2461 (Admin); 4 WLR 198.

31. The RCPsych Position Statement also addressed our second major issue of more general, but equally pressing, concern with the AAR policy and stated that:

- Any change in policy that required medical practitioners to identify evidence of actual harm or deterioration in mental health in order for a detainee to benefit from the strong presumption against detention was in our view unacceptable.

32. The AAR policy was a move away from the previous approach of identifying categories of person accepted to be at particular risk of harm and as such unsuitable for detention except in very exceptional circumstances. We considered it a retrograde step to require specific evidence of proof of harm in each individual case rather than acting upon the assumption of risk of harm which underpinned the previous policy. Moreover, the very strong presumption against detention in all cases in the previous policy was replaced by a lower level of presumption that would vary according to the level of evidence rather than the degree of vulnerability. Again, it was very difficult to see how this could be seen to enhance existing safeguards, and consequently to reduce the numbers of mentally ill people in detention, when it appeared instead to diminish them. Unfortunately, practice have proved those concerns to be correct in 2017 and indeed since.

33. However, even where the AAR policy did lead to identification of vulnerability, it did not in our experience appear effective in preventing detention or in securing prompt release in those identified as vulnerable. Significant numbers of people identified as AAR under the policy were nonetheless detained and remained in detention - some for prolonged periods. The largest group appeared to be those where a Rule 35(3) report had been made and who were assessed as Level 2 under the AAR but for whom the Home Office nonetheless refused release. Under the previous policy, a Rule 35 report raising concern that the person was a victim of torture was in principle sufficient to secure release unless there were very exceptional circumstances. In my clinical practice I have also seen a number of cases where the individual had been assessed as Level 2 AAR because of evidence of torture but where no proper assessment was then made of the adverse impact of detention on that individual's mental health, even when there was clear evidence in the healthcare records of psychological harm or mental deterioration. From discussion

with colleagues, I am aware that other clinicians have reached the same conclusions. In my experience many of these cases should have been assessed as Level 3 AAR (giving rise to the strongest presumption against detention) but they were not. Many were on ACDT, had self- harmed or had suicidal ideation, and some had deteriorated to the point that they lacked mental capacity and required urgent transfer to hospital. It was notable that Rule 35(1) and (2) reports were rarely if ever issued.

The second Stephen Shaw report

34. The RCPsych prepared a further report (dated 22 November 2017)[22] which was submitted as part of the formal consultation response to Stephen Shaw when he carried out his follow up review in 2017 (Shaw 2).[23] I met him again in person in the context of that review. The RCPsych representations reiterated that:

- detention centres are likely to precipitate a significant deterioration of mental health in the majority of cases, greatly increasing both the suffering of the individual and the risk of suicide and self-harm.
- those with a history of torture and severe ill-treatment are at increased risk of suffering harm in immigration detention and should only be subjected to immigration detention in very exceptional circumstances.
- We are concerned that the current Adults at Risk policy is leading to highly vulnerable persons being detained, as specific evidence of a risk of deterioration is required to achieve 'level 3 evidence'. For those in respect of whom there is 'level 2' or 'level 1' evidence, detention appears to continue on the basis of immigration factors which are far from 'very exceptional'.
- The new mental health service specifications for Immigration Removal Centres provide for better treatment facilities, though this has not yet been implemented uniformly. However, we feel that even with improved mental health support available, detention centres are not appropriate therapeutic environments to

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[22] RCPsych (November 2017) Submission to assessment of progress in implementation of Review into the Welfare in Detention of Vulnerable Persons

[23] Shaw. S (2018) Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons (a follow up report to the Home Office)

promote recovery from mental ill health due to the nature of the environment and the lack of the requisite specialist mental health resources.

- We would like to emphasise that the current ethos of mental health services is on recovery and community rehabilitation, and this cannot be provided in a detention centre.
- It remains of great concern that there are repeated cases where asylum seekers are detained despite a clear and documented history of mental illness and against the specific advice of mental health professionals.

35. The RCPsych also emphasised that:

- It is therefore crucial that clinical and other staff working in detention centres are given adequate training and support to identify mental disorder when it does arise or deteriorate in a detention centre setting, and clear guidelines on how to manage this appropriately, this should include specific attention to appropriate monitoring and management of risk. The provision of care in IRCs should link with existing local mental health provision outside the detention centre, with clear protocols for communication of clinical information and transfer of care if required.
- There should be regular training for all Home Office and healthcare staff on the circumstances in which capacity assessments should be triggered; this should be linked to safeguarding training along with the development of a screening tool for assessment of capacity for all detainees.

Mental Incapacity

36. The question of mental capacity was of increasing concern to the Working Group because cases in which questions were raised about the mental capacity of the individual were illustrative of the severity of the detainee's mental condition and its deterioration. Such cases confirmed that people with the most severe mental illness were remaining in detention. It was apparent that there was no system in place to ensure that mental capacity (in relation to key issues such as challenging detention, conducting their immigration case, agreeing to or refusing treatment and food refusal) was assessed and monitored

adequately or indeed at all. Capacity issues can arise in detainees with mood disorders (anxiety, depression, PTSD) or psychotic disorder (which can distort cognition due to high levels of anxiety or delusional beliefs). There was clear evidence that these kinds of conditions are exacerbated by detention. If they are not identified or adequately treated this can result in relapse and florid mental illness requiring in-patient hospital treatment under the Mental Health Act 1983 as well as increased risks of self-harm and suicidal ideation. This has also been a recurrent feature of the cases in which an Article 3 breach was found including the 3 cases at Brook House IRC.[24]

37. The Tavistock Review in 2015[25] had recommended (Recommendations 1 and 7) appropriate levels of training in mental health awareness and appreciation of when specialist treatment is required should be extended to all staff who have contact with or make decisions in relation to people who are detained. Psychiatric advice should be available to the team in order to provide a stronger basis for decision-making. The 2016 Shaw report had also identified a lack of training on the MHA 1983 and MCA 2005 for IRC staff, and that staff did not understand how the two statutory regimes relate to each other and how to recognise when a detainee's capacity needs to be assessed. (Shaw 1 §1.40). We had seen no discernible improvement in practice it this area. There was troubling evidence that behaviour relating to such cognitive deficits and other mental disorders was continuing to be misconstrued as attention-seeking behaviour (See Shaw 1, Johnson review §62)[26] or disruptive rather than indicators of severe illness.

38. The response to food / fluid refusal was also an issue in this context. By their nature, these would be expected to warrant repeated assessments of decision-making capacity by appropriately trained healthcare professionals, but, as Shaw had identified, "*proper mental capacity assessments are rarely carried out*." (Shaw 1 §6.29) and this continued

[24] See e.g. *VC v SSHD* [2018] EWCA Civ 57; [2018] 1 WLR 4781; *R (S) v Secretary of State for the Home Department* [2011] EWHC 2120 (Admin); *R (BA) v Secretary of State for the Home Department* [2011] EWHC 2748 (Admin); *R (HA) v Secretary of State for the Home Department* [2012] EWHC 979 (Admin) and *R (D) v Secretary of State for the Home Department* [2012] EWHC 2501 (Admin).
[25] *Ibid 16.*
[26] Johnson.J QC (August 2015) Assessment of cases where a breach of Article 3 of the European Convention of Human Rights has been found in respect of vulnerable immigration detainees. Appendix 4 Shaw Review (2016)

to be the case in 2017 during the Inquiry's relevant period at Brook House and indeed across the detention estate.

The Royal College Position Paper 2017 (RCPsych PS 03/2017 (November 2017)

39. As a result of these concerns, the RCPsych Working Group undertook a review during 2017 and the RCPsych published a Position Statement concerning the decision-making capacity of detainees in IRCs in November 2017.[27]

40. We noted first that the issues were not new and that they had been identified by Stephen Shaw and recommendations made in Shaw 1 about the lack of training on the MHA 1983 and MCA 2005 for IRC staff, how the two statutory regimes relate to each other and how to recognise when a detainee's capacity needs to be assessed (Shaw 1 §1.40).

41. The view of the RCPsych was that:

- existing evidence (medical, legal and government reports) provides grounds for serious concerns that both pre-existing mental disorders (which are likely to be aggravated by detention) and those arising during detention may result in detainees losing decision-making capacity with regard to healthcare and legal matters.
- the processes in place within IRCs to address these concerns are not sufficiently robust.
- to begin to make progress in addressing these issues, the recommendations made in this Position Statement need to be implemented.

42. Those Recommendations for Action were as follows:

[27] RCPsych (November 2017) Position statement PS03/17: Decision-making capacity of detainees in immigration removal centres (IRCs)

(i) The Home Office should keep and regularly disclose accurate figures regarding the number of immigration detainees who are assessed for decision-making capacity and number found not to have capacity.

(ii) IRC healthcare providers should investigate the possibility of an appropriate tool for screening of likely impairment in capacity and for reassessing such capacity at significant junctures during an individual's detention (e.g. if a new treatment is initiated, if the detainee refuses food or fluids, or if there is a significant change in the detainee's immigration status). Such a screening tool would need to be sufficiently sensitive and specific and to be administrable by detention centre or healthcare staff. The tool would also need to take account of language and cultural barriers, and provision should be in place for multiple assessments to confirm the presence or absence of decision-making capacity. Implementation of a screening tool would however only be worthwhile alongside a robust and reliable pathway for taking action if a detainee were found to lack capacity or to need support to make decisions or access remedies, and for keeping capacity under review. I understand that NHS England undertook a very small pilot into implementing a screening tool for intellectual disability, but that no further action was taken.

(iii) There should be regular training for Home Office and healthcare staff on circumstances in which capacity assessments should be triggered, linked to safeguarding training. Experienced and appropriately trained professionals are needed to assess capacity – to follow the individual's cognitions and ascertain whether a mental disorder directly affects, and to the required degree, the decision in question.

(iv) Assessment of decision-making capacity in IRCs should be to at least the same standard as best practice in NHS psychiatric hospitals and capacity should be reviewed regularly in detainees with known mental disorders as well as those displaying changes in behaviour.

(v) NHS England service specifications should require named mental capacity leads in each IRC healthcare unit; named person should not be the institution as a whole or the overall provider.

43. As far as we were aware, none of these safeguards and practices were in place or applied effectively in 2017 in Brook House or elsewhere across the detention estate.

44. In this context it is of grave concern that this Inquiry has received evidence that G4S and the Home Office took active steps to prevent staff at GDWG from assisting those with serious mental illness and lacking mental capacity in securing legal representation and from providing evidence in legal cases to challenge the lawfulness of their detention and treatment in detention. As I understand it, this continued following the Panorama programme and despite the evidence we set out in the RCPsych Position Statement in 2017 and other reports regarding the dangers of failing to identify those who are so mentally ill that they may lack relevant mental capacity.

Brook House Panorama Broadcast - Mistreatment of those with Mental Disorder

My Response to Panorama

45. The RCPsych was approached by Jo Plomin from the Panorama programme and asked if I would provide an expert opinion on a number of incidents recorded by the undercover officer Callum Tulley. Mr Plomin and Mr Tulley attended the RCPsych and I reviewed extensive footage, not all of which is in the broadcast. My opinions on some of the incidents were broadcast as part of the Panorama documentary on the 4th September 2017. I address the clips in turn below.

I. Impact of Prolonged detention[28]

46. I saw footage of a detainee who I know to be D687 (a Core Participant) with a ligature around his neck, with officers intending to remove the ligature and transfer him to another detention centre. D687 expressed the kind of despair that I have frequently encountered. I explained that "*It's, from a clinical point of view, not at all surprising that this man is enormously distressed by the length and indefiniteness of his detention. The chances of not being adversely affected mentally by prolonged and indefinite detention are very low*". I also described how "*Detainees very often talk about that notion of being*

[28] Panorama (2017) *Undercover: Britain's Immigration Secrets* at 38.38. Accessible here: https://www.youtube.com/watch?v=_fp0QLDKgME

somewhere where you are confined, where you have very little control/ very little choice over anything, over what happens in your day. That lack of control, I think, is an important part of the distress that leads to worsening mental health".[29]

II. Failure to Record Food Refusal

47. I was shocked at the attitude of the officer, who I now know to be DCM Nathan Ring to the fact of and the recording of food refusal. He referred to the person who was not eating in derogatory terms as a "prick" and a "penis".[30] As I explained from a clinical perspective, "*The* r*ecording of food refusal ought to be the start of finding out a bit more. It's extremely serious because food refusal may be indicative of poor mental health, and it may cause deteriorating physical health. In extreme form it may even be fatal".*

III. Misconduct in respect of mental illness

48. I was also shown two clips of an officer who is threatening and abusing apparently severely mentally ill detainees being held in E Wing and on ACDT measures because of risk of self -harm.[31] The abusive language and aggressive threats including to deny the man a shower, is obviously grossly inappropriate and demeaning. It revealed a deeply concerning attitude which reflects one of the recurring themes from case work experience and the Article 3 cases which is failing to treat difficult behaviour as symptoms of mental illness. This is evident in detention records from both the IRC and in Home Office decision making that I have seen over the years. In the particular clip it was apparent to me that "*The people* [officers] *behaving in this way seem to be attributing his behaviour to wanting to annoy them, rather than entertaining the possibility that it might be because of the underlying mental illness*". This is all the more alarming because I understand that this man was then transferred to a psychiatric hospital 2 days later and sectioned. I assume this was pursuant to the powers under s 47/48 of the Mental Health Act 1983. If so this means that at the time this man would have been assessed by clinicians as requiring *urgent* psychiatric treatment in a hospital.

[29] Panorama at 39.28.
[30] Panorama at 41.00.
[31] Panorama at 43.45.

49. The second of these two clips records conduct which, if anything, is even more menacing with the officer saying to the distressed man: "*Dick us about and we'll make your life a living fucking misery.*" [32] My view of this threat and its likely impact on the man was that "*They are going to punish him – to show a contempt for him. That is extremely bad for anyone, but it is even worse for someone who they know is mentally ill*".

RCPsych Response to Panorama

50. The RCPsych Working Group had prepared its submissions to the second Shaw inquiry and prepared the Position Paper on mental capacity for publication before the broadcast of the Panorama documentary in September 2017. It is now clear that, although we already had serious concerns about the treatment of those with mental disorder in detention, the true gravity of the potential consequences and adverse impacts of the regime and environment at Brook House were not fully understood. Despite working in this field since 2004, I (as well my colleagues in the RCPsych and at HBF) had not even imagined the extreme physical and psychological abuse that Callum Tulley recorded. In my opinion several of the incidents documented in the Panorama programme clearly constitute deliberate ill-treatment and cruelty. On viewing the strangulation incident involving D1527 on the 27 April 2017, the mistreatment and threat to kill appears to have had a profound emotional reaction and psychological consequences for D1527 that induced an intensity of suffering sufficient from the footage of it, to cross the very high threshold to constitute torture,[33] if the other elements of the definition of being deliberately inflicted by a state agent for a purpose, for example, intimidation are met. The Istanbul Protocol identifies a number of factors that are relevant to the assessment of the psychological impact of deliberate ill-treatment that are taken into account when documenting torture. These include whether its aim was to reduce an individual to a position of extreme helplessness and distress leading to a deterioration of cognitive, emotional and behavioural functions. It is action which strives not only to incapacitate a

[32] Panorama at 44.02.
[33] Istanbul Protocol.

victim physically, but also psychologically, to dehumanise and break the will of the person.[34]

51. I am firmly of the view that there was already ample cogent evidence available to the Home Office and its contractors that detaining and continuing to detain those with serious mental disorders had frequently resulted and remained likely to result in treatment which was (at least) inhuman or degrading. This is because IRCs are not able to manage serious mental disorders satisfactorily, and because detention causes or contributes to exacerbation and serious deterioration of pre-existing disorders and can even cause mental breakdown in otherwise healthy people. The resort to containment measures such as force, segregation and constant watch almost inevitably follow and becomes routine. IRCs are simply not equipped to treat or manage appropriately these challenges humanely, particularly if it involves high numbers of people with complex and acute disorders.

52. As I understand the position from the Article 3 cases referred to above and described in Annex 1, this alone may constitute inhuman or degrading treatment. If, however, inadequate and inappropriate management of such serious mental disorder also involves as it appears to, control and restraint and resort to use of force by staff with no clinical expertise, this also carries a real risk of inappropriate and excessive use of force and even to the kind of mistreatment recorded by Panorama. This is the kind of environment in which detachment and dehumanisation occurs. It is manifest on the Panorama footage in the physical ill-treatment, derogatory abuse and racism exhibited by some staff and the indifference of others, in the face of acute human suffering.

53. What I would therefore emphasise as of particular significance for the Inquiry, is that Panorama exposed in a graphic and horrifying form the effects of long-standing failings and systemic issues that, despite intense scrutiny as a result of the various reviews, investigations, consultations, the work of the RCPsych and NGOs as well as extensive legal cases, had not been adequately addressed or remedied. Such grave repercussions, even if they were not anticipated specifically, could have been prevented if action

[34] Istanbul Protocol at [235].

(including action the Home Office Minister and senior officials promised) had been taken and implemented promptly and effectively post Shaw 1.

54. I would identify the following as of particular significance and relating to issues that were already well known to the Home Office before April 2017:

   (i) The long-standing failure of pre-detention screening to identify those unsuitable for detention (in particular survivor of torture/trauma and those with pre-existing mental disorder) even if these factors were already known to the Home Office;
   (ii) The long-standing failure of the Rule 34/35 process to identify and secure the release of those unsuitable for detention in particular survivors of torture/trauma and those with pre-existing mental disorder;
   (iii) The weaknesses in the AAR policy as a replacement safeguard to ensure identification and release of those unsuitable for detention in particular survivors of torture/trauma and those with pre-existing mental disorder;
   (iv) The long-standing failure of the Rule 35(2) and ACDT processes to ensure that reports of self-harm and suicide were made to the Home Office and that they secured a detention review and the release of those unsuitable for detention - in particular for survivors of torture and other trauma and for those with pre-existing mental disorder;
   (v) The symptoms of trauma and deterioration in mental disorder being inadequately and inappropriately managed by ill-equipped detention staff with limited clinical input through ACDT and by removal from association, often involving force and constraint to do so.
   (vi) Otherwise, limited and inadequate mental health provision unable to meet the needs of those complex and serious mental disorder in the detention environment.

55. I address these factors in more detail below, but would reiterate that all of them were well-known and could have been addressed if the Home Office had had the will and commitment to ensure effective mechanisms to identify and prevent detention or secure prompt release of vulnerable groups - by treating them as simply unsuitable for detention in the absence of very exceptional circumstances and even then, only if removal could take place within a very short period following the individual's detention.

Post Panorama

56. In my understanding. Stephen Shaw's follow up report in 2018 identified and addressed a number of these issues and made further detailed recommendations for change and improvement to the Home Office and its contractors on these and related matters. The response and action taken to date in response to that follow-up report has, however, been very disappointing.

57. During 2019-2020, the RCPsych's Working Group decided that it was necessary to conduct a further review and to update its Position Statement in light of the developments in the AAR policy, practice, research and evidence since 2014. We were concerned that the fundamental issues remained and that limited lessons had been learned from what was exposed by the Shaw reports, the Panorama programme, and the subsequent critical reports by Kate Lampard,[35] the Joint Committee on Human Rights,[36] the Home Affairs Select Committee,[37] Medical Justice,[38] and the Independent Chief Inspector of Borders and Immigration.[39]

58. Our work was delayed by the pandemic, but the RCPsych Working Group reviewed the available evidence and updated the Position Statement which received approval through the RCPsych and was published in April 2021.[40]

[35] Lampard. K and Marsden. E, Verita (November 2018) *Independent investigation into concerns about Brook House immigration removal centre*. For earlier Verita reports into IRCs see: *Independent investigation into concerns about Yarl's Wood immigration removal centre*. A report for the chief executive and board of Serco plc, January 2016. *Follow-up review*, October 2016.
[36] *Immigration detention: Government's Response to the Committee's Sixteenth Report of Session 2017-19*, HC 216, 25 October 2019.
[37] *Immigration detention*, HC913, 21 March 2019.
[38] *Failure to protect from the harm of immigration detention* (2019).
[39] *Annual inspection of 'Adults at Risk in Immigration Detention'* (2018-19), published 29 April 2020. Second Annual Inspection of 'Adults at Risk in Immigration Detention' (2020-21), published October 2021.
[40] RCPsych (April 2021) Position statement PS02/21: Detention of people with mental disorders in immigration removal centres (IRCs)

Detention of people with mental disorders in immigration Removal Centres: Updated Position Statement in 2021 (RCPsych PS 02/2021)

59. In summary, the RCPsych Position Statement restated the earlier recommendations that people with mental disorders should only be subjected to immigration detention in very exceptional circumstances. There was substantial and consistent further research evidence that detainees with pre-existing vulnerabilities (e.g. mental health issues or survivors of torture and other forms of cruel or inhumane treatment, including sexual violence and gender-based violence) were at particular risk of harm as a result of their detention. Detention centres were likely to precipitate a significant deterioration of mental health in most cases, greatly increasing suffering and the risk of suicide.

60. Whilst welcoming recognition by the Home Office of the particular vulnerability of people with mental disorders to the effects of detention, the RCPsych continued to have ongoing serious concerns about a number of the same underlying issues with regard to healthcare provision as follows :

- The limitations of being able to provide mental health care successfully within the context of immigration detention.
- The limited nature and extent of mental health care that can be provided in the immigration detention setting.
- Treatment of mental illness requires a holistic approach and continuity of care – not just treatment of an episode of mental ill health but an ongoing therapeutic input focusing on recovery and relapse prevention.
- Psychotropic medication is very unlikely to achieve a good outcome unless given as part of broader multi-model therapeutic approach.
- Detention severs links with family and social support networks, adversely affecting recovery.
- The recovery model cannot be implemented effectively in a detention centre setting.
- It was crucial that clinical and other staff working in detention centres are given adequate training and support and are offered regular supervision.

Adults at Risk Policy

61. Specifically with regard to the Adults at Risk Policy (AAR), the evidence reviewed by the RCPsych Working Group was that it had failed to provide effective safeguards preventing the detention or securing the prompt release of those with a mental disorder at risk of serious harm in detention. The primary concerns are that:

- Level of evidence does not equate to level of risk/vulnerability. People with significant mental illness may have particular difficulty in being effective self-advocates. Their very vulnerability may prevent them from providing adequate evidence for that vulnerability.
- In practice, evidence at Levels 1 and 2 has often been held to be outweighed even by relatively minor adverse immigration factors. To benefit from the claimed strong presumption against detention, it appears that specific evidence is required showing that detention is likely to cause harm. In our view this creates the same risks as the previous requirement for detainees to demonstrate that they could not be "*satisfactorily managed*" in detention.
- Recent experience suggests that persons with significant mental illness, as well as those with evidence of past torture, sexual or gender-based violence and those with PTSD, remain detained despite their mental health-related vulnerability and that their mental health deteriorates in detention.
- Detainees who may the lack mental capacity to make decisions relating to their detention and related immigration situation, do not have access to a robust assessment process or, even if identified as lacking relevant capacity, to a system designed to safeguard them or to advocate for them in their best interest.

62. We also considered it necessary to re-state and expand upon the nature of i) mental disorders within the cohort of those in immigration detention and ii) the adverse impacts of detention emphasising in summary the following :

(i) Mental Disorder among detainees

- The need to consider a broader concept of mental disorder, including those with intellectual disabilities and those with neuro-developmental conditions.
- Research suggests that a high proportion of immigration detainees display clinically significant levels of depression, PTSD and anxiety as well as intense fear, sleep disturbances, profound hopelessness, self-harm and suicidal ideation.
- An updated review of the clinical research literature by my team[41] which updated our previous review,[42] confirmed consistent evidence of the severe mental health consequences of detention and evidence demonstrating a link between the duration of detention and severity of mental health symptoms, and that experience of trauma prior to detention was associated with symptom severity.
- Being in a detention centre acts as a painful reminder of past traumatic experiences.
- Detention is likely to trigger memories of previous traumatic experiences and may also increase distress through the threat of impending removal or deportation. Success of treatment is dependent on development of therapeutic relationships, providing a multi-disciplinary and multi-agency intervention and using a biopsychosocial model of therapeutic intervention.

(ii) Adverse Effect of detention on those with mental disorder

63. The RCPsych Position Statement reiterated the nature of the adverse effects of detention stating that:

- Substantial and consistent research evidence shows that detainees with pre-existing vulnerabilities (e.g. mental health issues or survivors of torture and

[41] *The impact of immigration detention on mental health: a systematic review.* von Werthern et al. BMC Psychiatry (2018) 18:382

[42] Robjant, Hassan and Katona: *Mental health Implications of detaining asylum seekers: systematic review* British Journal of Psychiatry (Apr. 2009, 194(4) pp. 306-12).

other forms of cruel or inhuman treatment, including sexual violence and gender-based violence) are at particular risk of harm as a result of their detention.

- There is a higher rate of self-harm in IRCs. Stephen Shaw's second review at (§§5.13-5.19) suggests that in 2017 at least 30 detainees per month were on ACDT constant watch.
- Despite a high-level partnership between the Home Office and NHS since 2014, there are limits to the extent to which mental health care can be successfully provided within context of immigration detention because:

  a) The fact of detention impedes community rehabilitation.

  b) Psychotropic medication on their own is unlikely to achieve good outcomes without a broader multi-model therapeutic approach.

  c) The experience of detention itself is likely to be a barrier to achieving full recovery after treatment

  d) There are environment factors and detention is not a therapeutic environment.

64. It was also thought important to give further emphasis to the particularly adverse effects of detention on those suffering from PTSD and/or depression because this still did not appear to be understood nor acted upon with the IRCs, health care or in Home Office decision making despite wide ranging evidence including the RCPsych's previous Position Statements and Shaw's two critical reviews. Accordingly in relation to these areas we stated that:

<u>PTSD</u>

- More likely to be aggravated by detention triggering reminders of original trauma.
- Treatment of PTSD requires specialist psychological intervention in a setting conducive to a sense of safety and a growing sense of trust toward therapist.
- Trauma-focused therapy is not possible in detention settings.

Depression

- Asylum seekers often have significant symptoms of depression and anxiety which may occur independently or coexist with PTSD as part of complex traumatised state.
- Depression is likely to be exacerbated by detention owing to arrest, indefinite period of stay, threat of imminent return and exacerbation of helplessness and state of intense fear.

Identification of mental illness

65. The long-standing inadequacy of the rule 35 process to identify and report on mental disorders was also emphasised noting:

- Consistently low numbers of R35(1) reports suggesting problems with identification of mental illness, deterioration in mental health and risk thereof.
- The need for the R35 process to identify deterioration in mental health and escalating suicide risk.

Conclusion and Recommendations

66. The revised RCPsych Position Statement noted that in the judgement *Aswat v UK,*[43]the European Court of Human Rights observed that both the fact of detention of a person who is ill and the lack of appropriate medical treatment may raise Article 3 issues (i.e. may constitute inhuman or degrading treatment). There are, therefore, three main elements to be considered in relation to the compatibility of an individual's health with her/his stay in detention:

[43] *Aswat v UK* 17299/12 Chamber Judgment [2013] ECHR 322.

- the individual's medical condition
- the impact of detention on the individual's health
- the adequacy of the medical assistance and care provided in detention.

67. The updated RCPsych Position Statement made the following conclusions and recommendations which I quote in full for the assistance of the Inquiry:

 a. People with mental disorders should only be subjected to immigration detention in very exceptional circumstances. Even in such circumstances, the length of detention should be minimised and the availability of alternative settings considered at every stage.

 b. Detention centres are likely to precipitate a significant deterioration of mental health in the majority of cases, greatly increasing both the suffering of the individual and the risk of suicide and self-harm.

 c. Individuals with mental disorder are entitled to receive the same optimum standard of care if they are in a detention centre as they would in any other NHS setting though, as noted above, the very fact of detention can make this impossible.

 d. Detention centres are not appropriate therapeutic environments to promote recovery from mental ill health, due to the nature of the environment and the lack of specialist mental health treatment resources. The indefinite nature of detention further exacerbates the detrimental impact of detention on mental health.

 e. The current ethos of mental health services is on recovery and community rehabilitation, which cannot be fully provided in a detention centre where treatment has to focus primarily on treatment of symptoms and reduction of risk.

 f. It is crucial that clinical and other staff working in detention centres are given adequate training and support to identify mental disorder when it does arise, or deteriorates significantly in a detention centre setting, and clear guidelines on how to manage this appropriately and link up with existing local mental health provision

outside the detention centre. This should include specific attention to appropriate monitoring and management not only of risk but also of recovery.

g. It is also crucially important that clinical and other staff working in detention centres are offered regular supervision, either individually or in groups, preferably by somebody external to the organisation, and provided with adequate access to continuing professional education.

h. The provision of care in IRCs should link with existing local mental health provision outside the detention centre, with clear protocols for communication of clinical information and transfer of care if required. All attempts should be made to ensure continuity of care, both within primary and secondary healthcare services. This requires proper discharge arrangements to be made prior to release. Transfer to hospital should be carefully planned to minimise the need for restraint during the journey which can cause a great deal of distress.

i. There should be regular training for all Home Office and healthcare staff on early indicators of mental health conditions and the circumstances in which capacity assessments should be triggered. This should be linked to safeguarding training along with the development of a screening tool for assessment of capacity for all detainees and robust pathways including the provision (in keeping with the conclusions of the Mental Welfare Commission for Scotland, 2018) of appropriate advocacy services for those found to lack mental capacity to make relevant decisions.

j. If a detainee is transferred to hospital during immigration detention, every attempt should be made to ensure good working relationships between IRCs and hospital staff to ensure that return to immigration detention following successful treatment is avoided – because otherwise the benefits of treatment in hospital risk being undone by the return.

68. It, therefore, remains very much the position of the RCPsych and my own view based on the evidence available to me through my clinical and research roles are that the

changes made in response to the Shaw and other Reviews and those subsequently made or proposed by the Home Office have not and will not address these long-standing underlying problems which contributed to the conditions in which mistreatment of detainees at Brook House took place. In particular, detainees with serious mental disorder will continue to be exposed to risks of inhuman or degrading treatment of the kind that has been at the forefront of the concerns of the RCPsych since 2012 without fundamental change.

Learning Lessons

69. In considering what lessons need to be learnt from the evidence about the mistreatment at Brook House in 2017 and what recommendations should be made to finally address and remedy the long-standing problems referred to above, I would ask that the Inquiry take into account the following evidence and conclusions.

Those with serious mental illness are unsuitable for detention

70. There is now substantial evidence from clinical research and practice over at least the last decade which shows that effective treatment of mental disorders is not possible within immigration detention and that, given the likelihood of deterioration, it should only be used in the most exceptional circumstances and even then, for very limited periods.

71. It is the view of the RCPsych that the standard of healthcare provision should be the same for detainees as is found in other NHS settings. This principle underpinned the high-level partnership agreement between NHS England, Public Health England (PHE) and the Home Office and completed and approved by the NHS England Chief Executive in November 2017 as part of a national framework of care, standards and inspection. This is an improvement on the previous system of subcontracting via custodial suppliers. It is by these standards that the health care provision in IRCs must be judged – but in our view these standards cannot be met in the immigration detention environment.

72. The standard in NHS services for people with a mental disorder is the 'recovery model'. This means not only treating the symptoms of a mental illness but also providing a holistic, integrated approach to enable rehabilitation, i.e. being able to function in society. Appropriate treatment plans for mental disorder often incorporate biological interventions such as medication as well as monitoring of mental state and of treatment of side effects. However, such treatment is unlikely to be effective without an integrated care plan that includes psychological and social interventions. The nature of the immigration detention environment precludes such holistic interventions and does not provide support for rehabilitation, which are integral components of modern treatment of mental disorders. So even where there might be some possibility of symptom relief, the care available in detention would not fulfil the modern medical approach to treatment for mental disorder that encompass a focus on rehabilitation and recovery. Academic research in the UK[44] has found high levels of unmet need amongst those with mental health problems in immigration detention. In the light of this, in my clinical opinion, appropriate and comprehensive management of mental health needs cannot be satisfactorily achieved in the IRC setting.

73. The recovery model cannot be implemented effectively in a detention centre setting. The very fact of detention (which, as I understand it, has a purely administrative function and, unlike imprisonment, has no punitive or retributive role) also mitigates against successful treatment of mental illness.

74. An IRC is not only an inappropriate therapeutic environment but is itself likely to have an adverse effect on detainees' mental disorder and chances of recovery, particularly where the mental disorder is linked to a history or torture other serious ill-treatment or trauma.

75. I understand that there is substantial evidence that there were high levels of serious mental disorder, distress, self-harm, suicidal ideation and other disturbed and disturbing behaviour in Brook House detainees during the relevant period. This is likely in itself to

[44] See for example the 2018 systematic review I co-authored published in *BMC Psychiatry* discussed earlier in this statement and another article I co-authored the same year published in *Epidemiology and Psychiatric Sciences* also referenced below.

have had a distressing and therefore, detrimental impact on many of those detained there - especially those with pre-existing clinical vulnerability. This would be compounded by other highly disturbing behaviour linked to drug taking or violence between detainees.

76. Exposure to others exhibiting high levels of distress particularly witnessing disturbed behaviour and self-harm can also have significant adverse effect on any detainee's mental wellbeing but this is particularly so for a person with a diagnosis of PTSD.

77. The use of force by detention staff at Brook House revealed by Panorama would be likely to have a very profound psychological impact on the individual directly subjected to it. However, the impact of the use of physical restraint (both for those subjected to it and those witnessing it happening to another detainee) is likely to be traumatising in itself and risks re-traumatising any detainee with a past history of trauma.

78. Being subjected to or witnessing physical restraint resonates badly with those who have an experience of ill-treatment or abuse by the authorities in their home country. More generally, many former detainees have told me that they came to the UK expecting to be treated better, to obtain security and safety, and to have their human rights respected. They are often bewildered and find it difficult to cope with the contrast between their expectations and their experiences in detention. It is likely to be a source of acute distress and anxiety and psychologically destabilising if they feel that they cannot rely upon those from whom they expect protection and respect for basic human rights.

79. I would add that, because of the profound loss of freedom and agency associated with the higher security IRCs such as Brook House (which I understand is built to category B prison standards and operates a restrictive regime), such environments are in my clinical opinion likely to be experienced as particularly negative and distressing by people with a mental disorder particularly if there are prolonged periods of confinement when locked in.

80. I understand that the design specification for Brook House IRC related to the fact that it was intended by the Home Office to be used as a short-term facility, with people only being held immediately prior to their removal within 72 hours of their being detained. As

far as I am aware however, Brook House, like other IRCs, often holds people for very much longer periods. If people with mental disorders are held for prolonged periods in very restrictive facilities designed for only short periods of detention, this will be an important factor in contributing to the adverse mental health impact of such detention. If periods of immigration detention in facilities like Brook House were limited to the planned maximum of 72 hours or even (as stated in policy) only implemented where removal was "imminent" (i.e. within 4 weeks,[45]) then this would significantly reduce (although not entirely eliminate) the risks of harm caused to those detained with a history or torture or trauma and/or mental disorder and mitigate against the adverse effects of the detention environment.

Prevalence of mental illness in immigration detention

81. The high incidence of mental disorder at Brook House is not peculiar to that IRC nor to the time period in 2017 on which the Inquiry is focusing. The research summarised in the RCPsychs' 2021 Position Statement shows that, across the board, many immigration detainees display clinically significant levels of PTSD, depression and anxiety symptoms. I was a co-author of a paper published in *Epidemiology and Psychiatric Services* in 2018.[46] This found that the most prevalent mental disorders in immigration detention were depression, personality disorder and PTSD. The study also found that 21.8% of the sample were at moderate to high risk of suicide.

82. My colleagues and I first reviewed the evidence regarding mental illness and distress in detention in the UK in a paper published in 2009.[47]The paper concluded that immigration detainees are highly vulnerable to psychological distress and that detention is likely to have an independent adverse effect on mental health. There was a strong recommendation for a review of detention policies in light of the research.

[45] *Detention: General instructions* (v. 1.0, dated 9 June 2021), p. 16.
[46] *Mental health morbidity among people subject to immigration detention in the UK: a feasibility study.* Epidemiology and Psychiatric Sciences (2018), 27, 628–637.
[47] Robjant, Hassan and Katona: Mental health Implications of detaining asylum seekers: systematic review *British Journal of Psychiatry* (2009).

83. I am also a co-author of a more recent systematic review of the literature of the prevalence of mental illness in immigration detention published in *BMC Psychiatry* in 2018[48]. This review identified a substantial body of more recent studies. These supported the findings of our earlier research – i.e., that immigration detainees experienced high levels of mental health problems compared to people seeking asylum living in the community, with anxiety, depression and PTSD most commonly reported. It also found that most studies found mental symptoms to be associated with longer duration of detention.

84. Given the consistent and now well-established body of clinical evidence that immigration detention has adverse mental health consequences, the review also recommended reconsideration of detention policy to ensure recognition of the likely harm of detention as well as work to identify vulnerability of detained people and minimise the length of detention.

<u>Research about the effect of detention on mental health</u>

85. I am aware that the Inquiry has instructed Professor Mary Bosworth as an expert. Her literature review, which was published as part of the Stephen Shaw1[49], reached clear conclusions that immigration detention had an adverse effect on mental health and that this increased with length of detention. These findings were supported by our subsequent 2018 systemic review published in *BMC Psychiatry*.

<u>Survivors of Torture</u>

86. The available published evidence, summarised in our 2016 Position Statement and explored in the Bosworth review for Shaw 1, shows that a history of torture itself predisposes an individual to a greater risk of harm, including deterioration in mental health and increased risk of anxiety, depression and PTSD, than would be experienced in the general detained population. Our systematic review came to the same conclusion.[50]

[48] von Werthern, Robjant, Chui, Schon, Ottisova, Mason and Katona: The impact of immigration detention on mental health: a systematic review *BMC Psychiatry* (2018).
[49] The Impact of Immigration Detention on Mental Health: A Literature Review *Criminal Justice, Borders and Citizenship Research Paper* 2016.
[50] Von Werthern et al 2018, *supra.*

Similar considerations apply to survivors of human trafficking/modern slavery, whose ill-treatment can be considered equivalent to torture.[51] The research evidence also indicates high rates of mental illness (including PTSD) in survivors of human trafficking/modern slavery.[52]

87. The Quality Standards for Healthcare professionals working with victims of torture in detention[53] contain guidance on the assessment of those with mental health conditions and with possible impairment of mental capacity. In particular, the standards draw attention to the need for a care plan and for proper follow-up of detainees to identify their healthcare needs and to monitor for the effects of treatment or for evidence of deterioration of their condition, as well as the duty of the doctor to raise a concern where their recommendation to release has not been followed. These standards have not been adopted by and are not consistently adhered to in IRCs. In my opinion they should be.

88. There is little by way of proactive reassessment of mental health in IRCs after the initial screening and Rule 34 examination. Further assessment largely depends upon the detainee proactively seeking medical attention or requesting a Rule 35 assessment. [54]Even in cases where mental health issues have been identified. I have frequently seen files closed if individuals do not attend appointments, with little if any follow up. Referrals to psychiatrists are, in my experiences, quite rare.

89. In the text below, I address the specific problems faced by detainees with particular psychiatric diagnoses.

<u>People with a diagnosis of Post-Traumatic Stress Disorder (PTSD)</u>

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[51] *Trafficking in Human Beings Amounting to Torture and other Forms of Ill-treatment.* Organisation for Security and Co-operation in Europe, October 2013.
[52] *Prevalence and risk of violence and the mental, physical, and sexual health problems associated with human trafficking: an updated systematic review*. Ottisova et al, Epidemiology and Psychiatric Sciences SCI. 2016 Aug; 25(4):317-41.
[53] *Quality Standards for healthcare professionals working with victims of torture in detention*. FFLM HWVT Working Group, co-chaired by Dr Juliet Cohen and Dr Peter Green on behalf of the Faculty of Forensic & Legal Medicine. May 2019.
[54] *R (D and K) v Secretary of State for the Home Department* [2006] EWHC 980 (Admin).

90. An important subgroup of people particularly vulnerable to harm in detention are those with a diagnosis of PTSD. PTSD symptoms are particularly likely to be aggravated by detention triggering reminders of the original trauma. This is especially the case if asylum seekers have previously been detained, kept in isolation, tortured, or deprived of their liberty prior to their immigration detention. In these cases, the very fact of being detained, and associated factors such as being in a cell, seeing officers in uniform, the sound of keys jangling, heavy footsteps or doors closing or being locked and unlocked, will trigger intrusive memories of their previous traumatic experience. For some it will trigger re-living experiences in the form of flashbacks (when they experience past events as happening in the present) and/or nightmares. More generally, symptoms of PTSD, including debilitating fear, insomnia, noise sensitivity, intense agitation, autonomic nervous system hyperarousal and dissociative symptoms, are likely to worsen. So too will feelings of helplessness and depression. In this context, the risk of agitation, including self-harm, aggression and suicide, are likely to increase significantly, leading to the high rates of such behaviour being observed in detainees. Torture survivors have a right to rehabilitation,[55] and this cannot be carried out while they are in detention.

91. People with a diagnosis of PTSD are likely to find it very difficult to access appropriate treatment in detention, compounded by the fact that a prison-like environment is likely to worsen their symptoms and will also prevent treatment from being effective.

92. Treatment for PTSD is unlikely to be effective in a detention setting. A sense of safety and security is a pre-requisite for treatment to be effective. This is, difficult to achieve in a detention situation where the very fact of detention and the imminent risk of return is a constant preoccupation, acting as perpetuating factors for the individual's fears and symptoms.

93. Even in the most supportive therapeutic environments, the process of disclosure can be slow and painful. The discussion needs careful management by a clinician demonstrating sympathy, being non-judgmental and conveying a sense that the consultation is

[55] https://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx - Article 14.

unhurried. At the Helen Bamber Foundation, we focus on developing an environment of active listening and of giving the person the sense that they will have all the dedicated time they need. Although individual appointments are, of course, time limited, the explicit expectation conveyed is that the individual can return to continue the discussion at the next meeting and at their pace. We are clear that, in order for people to make progress with their treatment, disclosure needs to take place in an unforced and safe situation and as part of a clinical relationship based on the sense of trust and safety necessary to enable disclosure and discussion to take place. The practical limitations of the healthcare service of an IRC therefore represents a significant barrier to people disclosing symptoms of PTSD and indeed of reporting details of the trauma they suffered. If there is actual or perceived pressure of access to appointments and their duration is short, this will inhibit examination of a history of trauma or their symptoms. Where staff are or are perceived as being unsympathetic, disinterested or verbally aggressive, then detainees' ability to disclose and engage will be impaired very significantly.

94. Discussion about the trauma and disclosure of symptoms (and even anticipation of such discussion and disclosure) will make the person feel worse and inhibit even the start of a discussion about the illness. This means that detainees often contact healthcare with symptoms such as insomnia which have a less overt connection to their history of trauma. Careful clinical evaluation is necessary to 'follow the trail' of such presenting symptoms which are not necessarily but may well be indicators of underlying past trauma and ongoing PTSD. In a population (such as that of an IRC) with high rates of PTSD and depression, when an individual presents with disturbed sleep, the symptom should not be manged in isolation (for example by prescribing sleeping tablets or recommending sleep hygiene measures) but should trigger further clinical assessment or specialist referral. This approach requires active listening skills from healthcare staff who are appropriately trained and who are allocated sufficient time to enable such investigation.

Clinical Depression

95. Detained persons and, in particular, asylum seekers often have significant symptoms of depression, which may occur independently or may coexist with PTSD symptoms as part of a complex traumatised state. Many have suffered multiple traumatic losses including

bereavements and separation from loved ones and loss of home, status and identity in their country of origin. Such losses are well recognised as predisposing, precipitating or perpetuating factors in severe and recurrent depressive illness, and are often further compounded by the poverty and emotional isolation of asylum seekers in the UK. Uncertainty regarding asylum status, and fear of impending removal/deportation, are further factors likely to contribute to depressive and/or anxiety symptoms. This makes it very difficult to sustain hope, leading to a chronic state of helplessness and despair and, potentially, increased risk of suicide.

96. These factors are likely to be exacerbated by detention. In particular, the unpredictable event of arrest, the indefinite period of stay, and the threat of imminent return will exacerbate helplessness and a state of intense fear. Detainees are also likely to suffer further loss of hope or motivation, particularly in relation to their reduced sense of safety and inability to work towards their future life goals associated with staying in the UK. This further increases their risk of suicide. Significantly, when they are detained, asylum seekers also suffer loss and separation from the therapeutic and social networks they may have built up in the community since they have been in the UK. Such discontinuities of care and support would in themselves be sufficient to cause deterioration in their mental state because of the loss of therapeutic and sustaining factors which have protected them against further deterioration and providing motivation to stay alive and recover. However, in addition, losses and separation in the present are also likely to trigger feelings associated with losses in the past, again increasing the likelihood of deterioration and potentially the risk of self-harm and/or suicidal ideation.

97. Individuals who are clinically depressed often experience loss of motivation and feelings of hopelessness and despair. Such symptoms may act as a barrier to a person taking active steps to seek medical care. Similarly, the avoidant behaviours that are a core feature of PTSD may impede detainees from accessing the mental health care they need –. Whilst clinical depression will occur in isolation, it is often co-morbid with PTSD. Where a patient has both conditions, the combination of symptoms may well reinforce difficulties in accessing care and will require a proactive intervention if it is to be properly identified, monitored and deterioration prevented.

Anxiety

98. Anxiety disorders are often disregarded in immigration detention because they are seen as understandable responses to the stress of removal and rather than as clinical conditions requiring healthcare intervention. This carries significant risk that they go untreated and deteriorate.

Psychosis illness and secondary psychotic phenomena

99. People with pre-existing psychoses, such as schizophrenia, even if their condition is stable and well-managed by anti-psychotic medication, are at risk of deterioration in the detention environment. They are also at increased risk of suicide. If not stable and insight or capacity to consent to medical treatment is impaired, then risks of deterioration are high and consequences likely to be severe.[56]

100. In addition, any asylum seekers who have PTSD may experience transient secondary psychotic experiences which are typically precipitated by stress. They may be triggered by the stress of detention, as a result of which they may lose the capacity to distinguish flashbacks of persecutory events from current reality and can become acutely paranoid, believing they are being pursued by their previous persecutors in the present, and can also experience visual and auditory hallucinations linked to their past traumas. If they are transferred to a hospital setting for treatment of psychosis and improve, there is a high risk that they may deteriorate again if returned to the detention setting following successful treatment (as happened in the HA case).[57]

101. Symptoms of psychosis may result in the individual lacking the insight necessary to understand their need for contact with healthcare professionals and for treatment. The

[56] See annex 1 and summary of Article 3 ECHR cases.
[57] See annex 1.

false beliefs or imaginary experiences at the core of their psychotic illness can mean that patients' hold on reality is tenuous. At other times (for example if they have persecutory delusions about detention centre and healthcare staff) this can lead to an active refusal to engage with healthcare services. IRC medical staff have no power to compel treatment without consent. A detainee's lack of insight or compromised mental capacity, therefore, should call into question the appropriateness of their continued detention.

102. In my professional experience, some of the people who most need help from healthcare do not seek it themselves. There is a real need for proactive identification and monitoring to ensure that their psychotic symptoms do not go untreated and that they deteriorate as a result.

Challenging behaviours

103. A further and significant barrier to the proper identification and treatment of mental disorder in immigration detention is where symptoms of the mental disorder are misinterpreted as a behavioural issue rather than as manifestations of a clinical disorder. The Panorama Clips 3 and 4 are stark examples of this. Conditions such as PTSD and anxiety disorders impact on a person's emotional response including hyperarousal and a tendency towards anger and irritability. Recognising that this may be a clinical issue rather than 'bad' behaviour requires staff with appropriate medical training as well as sufficient time, engagement and empathy with the detainees in their care to identify the need for medical intervention. This is crucial in cases where mental disorders show themselves in the form of disturbed, refractory, or violent behaviour. The key need is for the underlying mental disorder to be identified and treated appropriately.

104. It is the collective experience of the RCPsych Working Group that this has often been the case and reflects a wider phenomenon of what is sometimes called a culture of disbelief. It is also a long-standing feature of Home Office decision making and extends not just to detainees but also to those who provide evidence on their behalf including medical experts whether independent or even from within the IRC.[58]

[58] This was recognised in Shaw 1 at §4.118:"*the Home Office does not trust the mechanisms it has created to support its own policy*".

105. When viewed against the background evidence of high rates of mental illness in detention and the known effects of detention on those with pre-existing mental illness, the consistently low numbers of Rule 35(1) Reports indicates that the problems with the identification of mental illness, deterioration in mental health and the risk thereof, remain.

106. Failure to recognise these symptoms as manifestations of a mental disorder rather than as 'bad' behaviour creates a context in which resort to control and restraint is likely and inappropriate force tends to be deployed. This in turn risks exacerbation of the disorder especially if occasioned by a removal from association and into segregation.

107. This was a recurrent theme in the cases where the Courts had found a breach of Article 3 ECHR.[59]

108. I would agree with the evidence of Dr Brodie Paterson[60] provided by Medical Justice that these factors appear to have been a significant contributory factor to the toxic culture, dehumanisation, mistreatment and inadequate clinical care that occurred at Brook House in 2017.

<u>Detainees who self-harm and those at risk of suicide</u>

109. There is considerable literature and research concerning the risk of suicide. This is a hugely complex area[61]. Overall, the best indicator of risk of suicide is a history of deliberate self-harm, though even this is a poor metric. Rates of suicide differ according to age and other factors. Rates of suicide are higher in people with diagnoses of clinical depression and of PTSD; there is the evidence set out above that these are condition experienced by a significant proportion of detainees.

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[59] See Annex 1.

[60] Witness Statement of Dr Brodie Paterson for the Brook House Inquiry. 21 January 2022 (§93 -145).

[61] Gonda X, Fountoulakis KN, Kaprinis G, and Rihmer Z (2007) Prediction and prevention of suicide in patients with unipolar depression and anxiety *Ann Gen Psychiatry.* doi: 10.1186/1744-859X-6-23; Gradus JL, Qin P, Lincoln AK et al (2010) Posttraumatic stress disorder and completed suicide. *American Journal of Epidemiology*, *171*, 721-727

110. High rates of deliberate self-harm are present in immigration detention and were not peculiar to Brook House in 2017. They have been found to be considerably higher in IRCs when compared to prisons[62] and appear from the second Shaw Report to have increased substantially over time. As stated, Stephen Shaw recorded 30 detainees on constant watch every month over the 12-month period in 2017.[63] The approach of trying to manage this via the ACDT process is inadequate and is flawed by the focus on the self-harming behaviour itself rather than on addressing its underlying causes: i.e., the detainees' underlying psychiatric conditions, the emotional distress of detention and its adverse effects. ACDT processes in detention have an administrative focus (to reduce the self-harming behaviour in the immediate term) but do not address the underlying cause of the behaviour itself and the drivers of self-harm and suicidal ideation. This is particularly so where it is detention itself which is causing or contributing to the exacerbation of the mental disorder.

111. As I understand it, the ACDT process is not clinically led and lacks any effective requirement for mental health monitoring. The complex task of risk assessment for suicide can only take place where there is an open, non-judgmental relationship with custodial staff that is clinically informed and where clinical assessment and review is integral to the care plan. As explained above, a detention centre is a very difficult environment in which to foster and develop this approach. Instead, the practice is primarily procedural, managing the behaviour and not addressing the underlying human suffering.

112. Without effective therapeutic input, constant observation is likely to be a negative experience that may well aggravate distress and other symptoms.

113. I am aware that the Detention Centre Rules 2001 provides (in Rule 35(2)) a mechanism for GPs at detention centres to report concerns about patients at risk of suicide but also that there is, as with other aspects of the Rule 35 process, a systemic failure in its application. The specific wording for R35(2) is to 'suspecting suicidal intentions' and

[62] *Safe in our hands?: a study of suicide and self-harm in asylum seekers*. Cohen, J Forensic Leg Med 2008 May; 15(4)235-44.
[63] Shaw 2, §5.17.

is very broadly drafted. This would be expected to lead to high levels of reporting reflecting the numbers on ACDT. However, I understand that reporting under Rule 35(2) is extremely low across the detention estate, has been non-existent at Brook House, and continues to be so even after the Panorama programme.[64] This indicates that detainees with some of the most serious mental disorders who are actively harming themselves or contemplating doing so are not notified to the Home Office and that their suitability for continued detention is not being considered. It is my view that where there are suspicions that a detainee has suicidal intent and a Rule 35(2) report is issued, that detainee is likely to fall into the category of people not suitable for detention and that it is very likely that they cannot not be treated adequately in the detention environment. From a clinical perspective, it follows that, in the absence of very exceptional circumstances, they should be promptly released and enabled to access the mental health care they need in a community setting.

Removal from Association

114. I understand that the ACDT procedure is often accompanied by removal from association either formally under Rule 40 or 42 of the Detention Centre Rules 2001 or informally to segregation units which in Brook House is on E Wing and what is called the Care and Separation Unit (CSU). I have already highlighted the dangers of treating symptoms of mental disorder as a behavioural problem rather than as a manifestation of a mental illness. If it results in action which is actually punitive or is perceived by the detainee to be so, this is likely to have adverse mental health effects and exacerbate mental symptoms. Moreover, separation and isolation can themselves be harmful. Again, it does not address the underlying condition, and whilst it may mitigate the immediate risks, the price of that may well be aggravation of the underlying disorder and of associated distress.

[64] https://www.freemovement.org.uk/wp-content/uploads/2020/07/2019-Rule-35-FOI-stats.pdf

Detainees with a Criminal Conviction

115. I have co-authored a recently published study[65] concerning a comparison of the mental health disorders of people with a history of criminal offences held in IRCs compared to detainees that had no criminal convictions[66]. This identified that ex-prisoners are a particularly vulnerable group with higher levels both of mental illness and unmet needs than other detainees. These results led to our conclusion that foreign national offenders have a need for enhanced and specialist service provision within detention. The study highlighted the need for targeted mental health screening and needs assessment for foreign national ex-prisoners at the point when they are transferred into IRCs, along with careful monitoring and active treatment for those who screen positive for mental health difficulties. We identified a strong case for their ex-prisoner status being flagged as a vulnerability factor and they be subject to enhanced screening processes and access to prior healthcare records. At the least, information should be sought from the prison about any potential mental health vulnerability identified in prison.

116. Rates of self-harm and suicidality amongst foreign national ex-prisoners have been identified as a cause for concern,[67]accounting for nearly 20% of self-inflicted deaths in prisons in England and Wales in 2015–2016 despite representing only 12% of the prison population.[68] In Shaw 2, particular concern was expressed about the application of the Adults at Risk policy to ex-prisoner detainees. Shaw identified a number as 'very

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[65] Sen et ALr: *Mental Health in Immigration Detention: A Comparison of Foreign National Ex-Prisoners and Other Detainees Study Criminal Behaviour and Mental Health* (2021)
[66] In 2018 House of Commons Home Affairs Committee reported that, at the end of December 2018, there were 944 foreign national ex-prisoners detained under immigration powers, accounting for 53% of the detained population (House of Commons Home Affairs Committee, 2019). Following the Covid-19 pandemic, there was a further increase in the proportion of ex-prisoners— with estimates being over 90% (Stevens, 2020).
[67]Bhui, K., McKenzie, K. & Rasul, F. (2007) Rates, risk factors & methods of self-harm among minority ethnic groups in the UK: a systematic review. BMC Public Health 7, 336.
[68] Prisons & Probation Ombusman *A Review of Self-inflicted Deaths in Prison Custody in 2016*. Published October 2018. Accessible here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/747470/review-of-deaths-in-custody-2016.pdf

vulnerable with complex needs', but that their vulnerability was not being given sufficient weight due, they said, to Home Office case workers being 'risk-averse'. Shaw recommended that the Home Office work with the National Probation Service and Community Rehabilitation Companies to consider community support and supervision for them. This group is also specifically excluded from automatic consideration for bail, and the Shaw report accordingly commented that 'in consequence, there need to be more safeguards in place rather than fewer'. Despite this, however, the report by the Independent Chief Inspector of Borders and Immigration in 2019[69] suggested that there existed a culture to detain for this group, in deportation cases.

117. The study concluded from a clinical point of view that ex-prisoners are particularly likely to need engagement from a range of relevant services, including health and social services, as well as Home Office input. Service commissioners and planners should consider specific needs assessments, potentially leading to enhanced service provision, for this group.

118. It is notable that of the seven cases in which the Courts have found the treatment during detention constituted inhuman and degrading treatment in breach of Article 3 ECHR, four had convictions for serious criminal offences and had been transferred to IRCs after serving lengthy prison sentences. [70]

<u>Assessments and Safeguards for Mental Capacity of people in detention</u>

119. As I have indicated, mental capacity has been another long-standing problem despite being raised on a number of occasions by the Royal College and others as well as being the subject of repeated legal cases. [71]

[69] ICIBI *Annual inspection of 'Adults at Risk in Immigration Detention'* November 2018 – May 2019 (published 2020).
[70] See Annex 1.
[71] See *R (VC) v Secretary of State for the Home Department* [2018] EWCA Civ 57; [2018] 1 WLR 4781 and *R (ASK and MDA) v Secretary of State for the Home Department* [2019] EWCA Civ 1239.

120. I co-authored an article published in 2016[72] setting out the difficulties that arise where there is a failure to identify the need to assess a detainees' mental capacity. This recognised the practical difficulties in immigration detention of identifying a person who may lack capacity without a system. Mental illness and distress are common in detainees, there are language and cultural barriers, and their access to legal representation is limited. We emphasised as critical that there is no system of independent mental health advocates (IMCA). My co-authors and I recommended a very high threshold to justify the detention of people lacking capacity to make decisions concerning their immigration and detention position.

121. Given the high risk of deterioration of mental illness in detention and, in turn, of disturbed behaviour, self-harm and suicide, that are associated with such deterioration, it is crucial that the clinical professionals involved, and the staff providing ongoing care, are able to identify and monitor the risks and develop appropriate strategies and care pathways to manage this adequately. Appropriate structures are required to ensure support for individuals who lack capacity to navigate not only their access to healthcare and the treatment they need, but also the processes relating to their detention, conditions of detention and immigration processes. These are summarised in the Quality Standards for Healthcare Professionals working with Victims of Torture in Detention.[73]

122. I am aware that in 2018 the Court of Appeal made a declaration that the Home Office had failed to make any reasonable adjustments in breach of sections 20 and 29 of the Equality Act 2010 (EA 2010) for those with a serious mental illness who may lack mental capacity.[74] The primary reasonable adjustment identified by the Equality and Human Rights Commission (EHRC) was the provision of a system of Independent Mental Capacity Advocate ("IMCA"), available to help a patient obtain information and understand the provisions relating to treatment, and decisions relating to ongoing detention, segregation, transfer to hospital. This deficit and breach of the EA 2010 was not yet been remedied despite a further Court judgment in 2019.[75]

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[72] Grant-Peterkin et al: *Mental Capacity of those in Immigration Detention in the UK*. Medicine, Science and the Law (2016) 56:4, 285-292.
[73] https://fflm.ac.uk/wp-content/uploads/2019/07/HWVT_QualityStandards_May19-ONLINE-FINAL.pdf
[74] *R (VC) v Secretary of State* for the Home Department [2018] EWCA Civ 57.
[75] *R (ASK and MDA) v Secretary of State for the Home Department* [2019] EWCA Civ 1239

123. I am aware that it was not until July 2020 that the Home Office published a Detention Services Order (*Mental Vulnerability and Immigration Detention*)[76] to address the issue of detainees who may lack capacity. The delay is inexplicable, and it still does not implement any system for Independent Mental Capacity Advocates. Instead, it places obligations on Home Office and detention staff to facilitate a role in decision making and fails to recognise the need for this role to be independent and of the conflicts of interests at play in the proposed arrangements.

124. I would support the establishment of a system of IMCAs. Their availability within the IRC could play an important role not only in advocating on behalf of the most vulnerable but in challenging the inhumane attitudes, practices and culture that permitted past mistreatment of those with mental disorder to occur.

<u>Support for staff- Impact on Institutional Culture and Practice</u>

125. In the 2021 RCPsych Position Statement, we identified the need for adequate support for staff working in such settings as crucial. We identified that there could be a significant impact on staff of the detainees' traumatic experiences, and therefore of what is called vicarious traumatisation or secondary traumatic stress. This could have a significant emotional impact on staff, who might deal with it maladaptively - either by being completely withdrawn and avoidant or by being over-involved and over-identify with the experiences of the detainee.[77] Good supervision, individually or in groups, preferably offered by somebody external to the organisation, is crucial to reduce the risk of burn out, allowing staff to maintain a degree of therapeutic self-awareness. What is also extremely important is to allow opportunities for continuing professional education to avoid professional isolation and enable staff to keep a balance between empathy and proper professional distance from clients. Any pressure, or perceived pressure, on clinical staff to participate in the removal process, for example by returning patients from hospital

[76] Home Office Detention Services Order 4/2020: *mental vulnerability and immigration detention (July 2020)*..
[77] *The principle of equivalence and the future of mental health care in prisons*. British journal of psychiatry 2004, Feb. 184(1):5-7.

sooner[78]or certifying them fit to fly or be detained, undermines the professional expertise of clinical staff, risks encouraging poor care and is likely to be inimical to staff morale.

126. The focus in the RCPsych Position Statement was on health care staff with professional qualifications, medical training and expertise. These concerns would apply to an even greater extent to non-clinical detention staff. This is a further reason for limiting the role of detention staff in management of mental illness through ACDT and removal from association, and for ensuring appropriate resources so that, if truly necessary, the ACDT process is clinically led. In my view, non-clinical staff are particularly vulnerable to withdrawing and avoiding contact and involvement with detainees. They have conflicting roles in maintaining order within the detention centre and in facilitating removals (sometimes using force to do so). They are more likely to misperceive (and therefore mismanage) symptoms of mental disorder as a behaviour or non- compliance issue. They may not be able to deal appropriately with the complex and challenging presentation of detainees with serious mental disorders, particularly given the high numbers of such people in detention and the high rates of self-harm and suicidal ideation.

127. As previously noted, I have read the evidence of Dr Brodie Paterson[79] prepared on behalf of Medical Justice and considered the evidence given to the Inquiry by former G4S employees Callum Tully[80], Owen Syred[81] and Reverend Nathan Ward.[82] It seems clear from this evidence that the environment and conditions arising from high levels of mental disorder amongst the detained population at Brook House led to profound withdrawal and disassociation from the welfare of detainees and significantly contributed to a process of dehumanisation, 'othering' and even institutional racial discrimination based on an 'us and them' mentality.[83] Whilst the factors at play are multiple and complex, in my opinion, this evidence further underscores the significance of the systemic failure of the Home

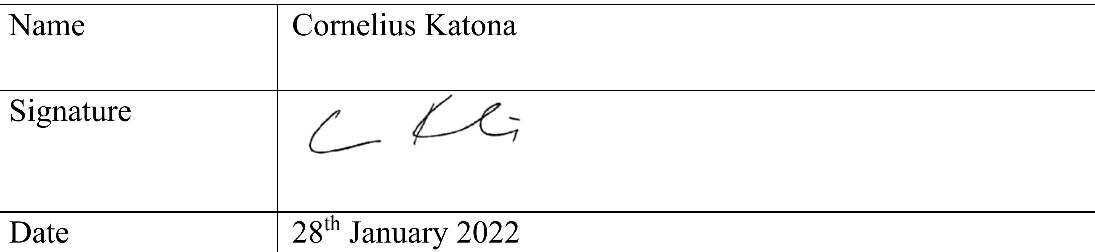
[78] Mental Welfare Commission for Scotland (2018) *The Right to Advocacy: A review of how local authorities and NHS Boards are discharging their responsibilities under the Mental Health (Care and Treatment) (Scotland) Act 2003.*
[79] Rule 9 Statement of Dr Brodie Paterson for the Brook House Inquiry 21 January 2022 §93 -145.
[80] Rule 9 statements of Callum Tulley for the Brook House Inquiry: INQ000052 and BBC000651.
[81] Rule 9 statements of Owen Syred for the Brook House Inquiry: INN000007 and INN000010.
[82] Rule 9 statements of Reverend Nathan Ward for the Brook House Inquiry: DL0000141 and DL0000154.
[83] E.g., Witness evidence of Callum Tulley 2 December 2021 at 2:10 day 8 hearing transcript, Witness evidence of Owen Syred 7 December 2021 at 46:2 day 11 hearing transcript, Witness evidence of Reverend Nathan Ward 7 December 2021 at 169:4 day 11 hearing transcript (Phase 1 of the Brook House Inquiry hearings).

Office to take due heed of, and act upon, the extensive evidence reported and the conclusions and recommendations made by Stephen Shaw and others. These indicated the urgent need to take effective action to prevent those with mental disorder being detained or, if detained, to be identified promptly and released to avoid the inevitable risks of deterioration including self-harm, suicide risk and other deeply disturbing behaviour that was not and could not be properly treated and humanely manged in detention.

128. Whilst high quality training and supervision of non-clinical staff on trauma and mental health related issues is required and good practice, in my view even such training and supervision would not make detention an appropriate environment for those with serious mental disorders for the reasons the RCPsych has repeatedly sought to explain. In my opinion the more effective means of dealing with these issues would be to reduce the numbers of those detained with mental disorder significantly and to ensure that if such individuals are detained, it is only for very short periods of time immediately before and with the specific aim of facilitating their removal. This is in keeping with the clinical evidence and with Stephen Shaw's recommendations.

Recommendations for Change

129. The Recommendations for change made in the various RCPsych Position Statements referred to above remain relevant because the evidence and many of the concerns identified have not been adequately met (or in some cases at all) to date. The recommendations from the 2021 Position Statement are set out in full at paragraph 67 and are commended to the Inquiry. What appears critical to me and my colleagues is that, whatever specific changes are recommended to the policy and safeguards for vulnerable people, there must be a fundamental change in approach based upon the clinical evidence and research of the kind identified by the RCPsych, if the specific changes are to have any effective remedial impact on these long-standing systemic failings.

Statement of Truth	
I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth. I am content for this witness statement to form part of the evidence before the Brook House Inquiry and to be published on the Inquiry's website.	
Name	Cornelius Katona
Signature	
Date	28th January 2022

Annex 1

Note regarding Article 3 ECHR cases cited in Professor Katona's statement and recommendations

Article 3 cases

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

1. S was convicted unlawful wounding and three counts of assault occasioning actual bodily harm, relating to an attack on four people. He was sentenced to 16 months for these offences together with a previous failure to answer bail.

2. S was detained in Harmondsworth IRC and started to hallucinate and self-harm by cutting himself shortly after being detained under immigration powers. During his first period of detention he was placed on ACCT due to very low mood and threats of self-harm. He was given anti-psychotic medication but continued to deteriorate. After he tried to kill himself repeatedly he was placed on constant watch (§16). It was noted at an early stage that he required psychiatric assessment (§18). He was subsequently detained under the Mental Health Act 1983. He was subsequently re-detained and his reasons for detention noted that there was "*no evidence*" to support his claim of mental illness (§53). The extent of the medical involvement at this stage was a prescription of Risperidone and a note in his file to "*Keep a very close eye ? suicidal*" (§56). He was subsequently placed on an ACDT with hourly observations (§59). This was later increased to constant watch (§71). The use of ACDT was criticised by the Court at §209 as follows:

   > "*It was not enough simply to place S on ACDT given that the expert view was that detention itself was harmful to his mental state and it did not advance UKBA's understanding of his condition.*"

3. Despite clear medical evidence of his severe mental health problems, his condition was allowed to deteriorate to the point of loss of capacity and hospitalisation the Court noting that "*as with so many critical aspects of the handling of D's case, the Defendant has failed to provide any explanation to the Court for this lack of action which continued for several months*" (§209). The Court held that "*there should have been no doubt in the mind of any responsible public official that S was an individual whose condition should be reviewed*

as a matter of urgency in order to determine whether continued detention was likely to exacerbate S's mental problems and whether his condition could in any real sense be treated in detention" (§209). This was not done. He detention was detained notwithstanding the view of IRC medical staff and the psychiatrist who visited fortnightly that detention was harmful to S and he could not be adequately treated whilst in detention (§209). He was also treated in a humiliating fashion by other detainees as a result of his mental health problems (§212).

4. The judgment records that the Defendant "*failed to have in place measures which were designed to ensure that S was not subjected to such treatment*" (§215).

***R (BA) v Secretary of State for the Home Department* [2011] EWHC 2748 (Admin)**

5. BA was detained at Isleworth Crown Court convicted of involvement in importation of a Class A drug as a courier and sentenced to 10 years' imprisonment.

6. As in *S*, in *BA* the Article 3 failures was the "*deplorable failure … to recognise the nature and extent of BA's illness*" accompanied by a "*complete absence of any monitoring of BA's condition in the early stages of his detention*" (§236). There were serious delays in his being seen by a psychiatrist despite showing early signs of mental health problems. It appeared that the failures in his medical treatment contributed to his relapse and refusal of food and drink.

7. BA was discharged to Harmondsworth IRC from compulsory detention under the 1983 Act. The judgment notes that "*many complaints were made by inmates [about the healthcare at Harmondsworth] and a 'recurrent theme' [noted by HMCIP] was the uncaring attitude of healthcare staff.*" (§53). BA was not monitored "*at all*" by the healthcare unit at Harmondsworth despite his well-established history of serious mental health problems (§56). BA could not be interviewed by the Home Office as he was visibly unwell and complaining that he had run out of medication three days earlier and was unable to see healthcare staff (§57). He was not seen by a psychiatrist for seven weeks after his symptoms were noted (§60).

8. The Judge concluded that there had been "*a combination of bureaucratic inertia, and lack of communication and co-ordination between those who were responsible for his welfare*", with the SSHD showing "*a callous indifference to BA's plight*", amounting to a breach of Article 3 ECHR (§237).

R (HA) v Secretary of State for the Home Department **[2012] EWHC 979 (Admin)**

9. HA was sentenced to 14 months' imprisonment for supply of Class C drugs.

10. HA was held in Brook House IRC placed in segregation after displaying strange, disturbed behaviour and was placed on an ACDT whilst in segregation (§30). This was maintained notwithstanding the Defendant recognising that he had serious mental health problems and needed to be transferred to a more suitable environment. He was again placed in segregation after being moved to another IRC and being referred for a psychiatric assessment (§31). He was identified as having serious mental health problems again and then transferred back to Brook House, where he was again placed in segregation as a result of his bizarre behaviour (§33). He was noted to be sleeping in the toilet area, refusing to wash and exhibiting very strange behaviour.

11. After several months of inadequate treatment at Brook House he was transferred to Harmondsworth where he was again placed in segregation and on return to Brook House, remained for a further four months (§61) in segregation before being transferred to hospital. It was found that his treatment, including the prolonged use of segregation, breached his Article 3 rights (§§179-181).

12. The Judge concluded that HA was "*not given appropriate medical treatment to alleviate his mental illness for a prolonged period of more than 5 months*" (§179(4)). In particular:

    a. A nurse erroneously recorded that he had "*nil psychotic symptoms*", which was wrongly attributed to a psychiatrist and repeated (§33, 41);

    b. A doctor who reviewed HA without any background information and who noted he was unable to undertake a mental state examination, noted that the claimant "*may eventually need transfer to an appropriate unit for psy. input*" (§34), but this was not done;

c. Medical staff deferred to UKBA for decision-making regarding transfer before making psychiatric referrals (§36);

d. A doctor's recommendation of urgent transfer to a suitable secure unit was ignored in favour of attempted removal (§§43 - 48). Instead he was kept under segregation (§52);

e. He was treated without his consent, including compulsory injections (§66);

f. A consultant psychiatrist who reviewed the claimant in December 2010 wrote a report detailing "*the inappropriateness of this setting* [i.e. the IRC] *with a severe mental illness and the lack of adequate psychiatric care within it*" (§75).

13. The judgment also referred to the fact that, during this period, the use of force had been authorised against him on several occasions (§179(5)).

***R (D) v Secretary of State for the Home Department* [2012] EWHC 2501 (Admin)**

14. The Claimant was detained at Brook House and later Harmondsworth and Colnbrook IRCs several years after receiving a nine-month sentence for using false documents in an attempt to open a bank account (§5).

15. The claimant, a paranoid schizophrenic, was placed in segregation after attending the healthcare unit to inform them he was hearing voices and wanted to be seen by a psychiatrist (§39). He was segregated as a result of a 'dirty protest' (§58), despite his mental health problems being well-established. Segregation was often used as a means of controlling his symptoms and presentation, which was sometimes violent (§§64, 83, 86).

16. The medical regime was described as "*brusque and insensitive*" (§184). Despite having serious mental health problems, several visits to medical officers at the IRC resulted in notes recording "*no health concerns … no medical concerns*" and his prescription of antipsychotics was overlooked (§20). He was never seen by a psychiatrist, despite one visiting Harmondsworth fortnightly (§21, 30). He was never seen by any doctor at Harmondsworth for the purposes of mental health review (§31). The Court concluded

that "*even detainees with a serious mental illness, such as D, were not provided with regular visits by the visiting psychiatrist*" (§156).

17. The Judge accepted that the Claimant was at all material times suffering from serious mental illness. He found at §151 that "*I can find no evidence that in February 2011 anyone at UKBA considered whether the particular features of D's mental state were satisfactorily manageable at Brook House (or indeed any other detention centre)*". It was accepted by an immigration judge that D did not receive "*proper and sustained medical treatment*" in detention (§160).

18. While there are no clear findings regarding use of force, it was noted that whilst in Brook House he was charged with assaulting a detention officer in an incident in which the claimant said he had been punched in the mouth by the officer. Charges were eventually dropped by CPS (§28).

***R (MD) v Secretary of State for the Home Department* [2013] EWHC 2249 (Admin)**

19. MD was held at Yarl's Wood IRC mental health deteriorated within detention to the point that she started self-harming. She was diagnosed with major depression with psychotic features and generalised anxiety disorder (§134). Her distress, self-harm and aggressive outbursts were frequently dealt with by placing her in segregation. Her self-harming was responded to by restraining and handcuffing her (§21). On many occasions physical force was used to deal with her, often by a number of male officers (§136). Pain techniques were also applied (§128).

20. At §§139-142 the Judge concluded that:

> "*…the Claimant was an individual whose condition should be reviewed as a matter of urgency to determine whether continued detention was likely to exacerbate her mental state. That was not adequately done. Her behaviour was seen as an attempt to thwart her removal and dealt with in that light and not as a symptom of an underlying deteriorating mental illness. … such treatment as was provided was inadequate leading to the deterioration of her condition and her continued suffering.*

[Her segregation and restraint]… was degrading because it was such as to arouse in the Claimant feelings of fear, anguish and inferiority likely to humiliate and debase the Claimant in showing a serious lack of respect for her human dignity…

The Defendant did not have in place measures to ensure that the Claimant's mental health was properly examined and considered and such measures as were in place were not used effectively to diagnose and properly treat and manage her condition."

***ARF v Home Office* [2017] EWHC 10 (QB)**

21. Only limited details of ARF's offending are given. Between 2004 and 2011 ARF was convicted of 35 offences resulting in 18 convictions, including offences against the person, public disorder, theft, offences against property and relating to police, courts and prisons. Her final prison sentence was for theft, which put her in breach of a suspended sentence imposed in relation to a child cruelty matter (§60). Her convictions includes an assault on a police officer (§29). On 6 July 2011 she was notified of her liability to deportation after receiving custodial sentences totalling more than 12 months in a five year period (§15). Her crimes were characterised by the Judge as "*minor*", other than a conviction for child cruelty which he accepted would not be repeated (§131).

22. ARF was variously diagnosed with schizophreniform psychosis, emotionally unstable personality disorder, and PTSD. During her detention under immigration powers she was detained under the Mental Health Act 1983. The Judge found that ARF's mental health deteriorated markedly within detention and was not effectively managed there (§121).

23. The Judge concluded that ARF's behaviour in detention "*was seen throughout [by the SSHD] as being a result of her deliberate disruptive and violent behaviour was as I find in fact as a direct consequence of her mental illness*" (§131). The SSHD's attitude demonstrated "*a clear sense of a presumption of detention rather than of liberty*" (§131).

24. As to the Article 3 claim, the Court held:

"*…it does seem to me that the Claimant's treatment as somebody who was showing disruptive behaviour rather than mental illness did breach her Article 3 rights. This led*

> *to her being isolated in a segregation cell, watched by officers rather than medical staff under what I find to have been a punishment-based regime (Removal From Association) and removed forcibly on one occasion. She was clearly in significant distress. She was clearly significantly mentally unwell at the time. It may be that within a psychiatric unit she would have been "put" in a safe place where she could not harm herself, but the Kingfisher Unit at Yarl's Wood is a segregation unit. It is used for punishment for poor behaviour and this was not a medical decision or one taken for the Claimant's benefit. Those aspects of her detention as somebody suffering serious mental illness from mid May 2012 does amount in my view to a breach of her Article 3 rights*." (§148)

***R (VC) v Secretary of State for the Home Department* [2018] EWCA Civ 57**

25. VC had a total of 16 convictions for 27 offences, including two offences for possession of controlled drugs with intent to supply. The judgment notes the submission of leading counsel that his offences related "*primarily to cannabis use and shoplifting*". He was sentenced in 2010 to nine months' imprisonment for two offences of possessing a controlled drug with intent to supply and in 2013 to six months for the same offence (see High Court judgment *R (VC) v SSHD* [2016] EWHC 273 (Admin)).

26. VC was held in Brook House IRC in 2015 and placed in segregation on six occasions (§25).

27. The use of segregation was accompanied on several occasions by the use of force. When removing him to segregation it was claimed that he was '*aggressively*' refusing to go to segregation and so the detention offices entered his room "*in arrow formation and [struck] him with a shield*", handcuffed him and 'took control' of his hands and legs, despite being aware he had apparent mental health problems (§27(8)(a)). Segregation was used with increasing frequency up to the point at which VC was released on mental health grounds and as someone lacking capacity (§142).

28. A Rule 35 report was prepared on 30 June 2014 concerning VC, which noted that he had been diagnosed with bipolar effective disorder with psychotic features, had been subject to multiple sections and a compulsory treatment order. It concluded that:

> "*[He] is very unstable currently and the stress of detention is impacting negatively on his mental illness. I have significant concerns that should he continue to deteriorate he will be unfit for detention and will pose a risk to himself or others*" (§25, High Court)

29. By March 2015 it was noted that VC appeared to have lost capacity (§29, High Court). Shortly before this he was subject to '*medical single occupancy*' (§28, High Court).

17 January 2022

Annex 2

<u>Cornelius Katona – selected recent publications</u>

Katona C, Robjant K. Editorial: Complex Post-Traumatic Stress Disorder in the Context of Human Rights Abuse. Front Psychiatry. 2017 Aug 14;8:142.

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Chaplin L, Ng L, Katona C Refugee mental health research: challenges and policy implications. BJPsych Open. 2020 Sep 3;6(5

Walker S, von Werthern M, Brady F, Katona C Mental health of forced migrants recently granted leave to remain in the United Kingdom. Int J Soc Psychiatry. 2020 Jul 20

Abbas P, von Werthern M, Katona C, Brady F, Woo Y The texture of narrative dilemmas: qualitative study in front-line professionals working with asylum seekers in the UK. .BJPsych Bull. 2020 Apr 22:1-7

Waterman LZ, Katona C and Katona CL Assessing asylum seekers, refugees and undocumented migrants. BJPsych Bulletin (2019) Page 1 of 6, doi:10.1192/bjb.2019.67

Brady F and Katona C Complex Trauma and Complex Responses to Trauma in the Asylum Context Chapter 18 in Social Scaffolding. Williams R et al (eds) Cambridge Medicine 2019

Hameed Y and Katona C. Migrants, refugees and asylum seekers. Chapter 25 in Butler R and Katona C (eds) Seminars in old age psychiatry. Cambridge Medicine 2019

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35. *R (D) v Secretary of State for the Home Department* [2012] EWHC 2501 (Admin)

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38. *R (EO, RA, CE, OE and RAN) v Secretary of State for the Home Department* [2013] EWHC 1236 (Admin)

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