

THE MANSTON INQUIRY

DUNCAN LEWIS INQUIRY PARTICIPANTS SUBMISSIONS FOR PRELIMINARY HEARING

15 January 2026

1. These submissions are provided on behalf of the Duncan Lewis Inquiry Participants (“IPs”). Our clients are grateful to the Chair for granting them IP status and for the opportunity to provide these submissions in advance of the Inquiry’s first preliminary hearing. They also wish to thank the Inquiry Team for their work in progressing the Inquiry. We look forward to working with the Inquiry Team to assist the Chair in her important work. We intend – as in previous inquiries in which we have acted – to work closely and collaboratively with the teams representing the other victim IPs in order to advance the Inquiry’s work while minimising duplication.

Opening observations

2. As the Chair is aware, we act for 75 individuals who were detained at Manston House (“Manston”) during the period that this Inquiry is investigating. Those individuals are vulnerable and were subjected to a range of highly concerning and damaging conditions and ill-treatment. They welcome the Inquiry’s efforts to examine how and why they were mistreated as they were, to identify those responsible, to hold them to account, and to ensure that lessons are learnt and real changes are made to prevent future recurrence. They want to assist the Inquiry in its vital endeavours. These submissions are informed by that intention. We have sought to provide brief, focused submissions on issues that are likely to assist the Inquiry Team by being raised now, rather than waiting for the further hearing due to take place in the Spring.

The Inquiry’s provisional list of issues

3. The Duncan Lewis IPs welcome the Inquiry’s provisional list of issues: they agree with its contents and note that it is – deliberately – framed as a provisional and flexible document, and that the Inquiry will follow where the evidence leads. With that in mind, we have identified some additional and supplementary issues to frame and assist the Inquiry’s work; they are set out in red text in the Annex A document filed with these submissions. We invite the Chair and her Team to consider and, where they consider appropriate, to incorporate them into the existing list of issues.

4. Reflecting the provisional and flexible nature of the list of issues, the Duncan Lewis IPs will provide further, focused suggestions on any additional issues as the Inquiry progresses, including following the receipt of Inquiry disclosure.

Inquiry Participants

5. We note the list of those designated as IPs to date: CTI §19. That list does not currently include a number of organisations that appear to meet the criteria for IP status, including the relevant NHS Trust(s), NHS England, the British Red Cross, the medical sub-contractors operating at Manston during the relevant period (Medivent and IPRS), and all relevant bodies responsible for monitoring and oversight of conditions and treatment at Manston (including the ICIBI). We anticipate that the Inquiry is seeking material from those organisations, but the Inquiry may wish to consider formal designation as IPs given their central role in events and as they are likely to be subject to the Inquiry's investigation. We note that we have seen the list of proposed IPs in the submissions from Wilsons, Gold Jennings and Bindmans. We agree with their submissions on IPs.

Disclosure to Inquiry Participants

6. We note the update from Counsel to the Inquiry ("CTI"). We are conscious that the process and timing of disclosure is a matter that will be central to the Inquiry's work, informed by the Chair and her Team's overarching knowledge and management of its own work. We respectfully invite the Inquiry to place the Manston victims at the centre of its thinking on disclosure. Such disclosure is key to our clients' effective participation and their ability to assist the Chair and her Team. That applies both to the breadth of material that is provided, and the timing of disclosure. As to timing, we invite the Inquiry to provide disclosure to our clients as quickly as possible, and to seek – so far as possible, while recognising realities – to avoid last-minute and ongoing disclosure prior to and during the Inquiry's hearings.
7. As the Chair will be aware, the Home Office Inquiry Response Team confirmed during the judicial review proceedings that led to this Inquiry that a detailed chronology has been prepared identifying 530 events relating to Manston during the relevant period. We invite the Chair to disclose this detailed document to all IPs as soon as possible. Doing so is likely to assist the Inquiry in formulating the list of issues and will assist IPs in their understanding of the relevant events, so as to make informed and constructive further representations.

Disclosure requests sent to Material Providers

8. We are grateful for CTI's Note and look forward to CTI's further update at the 15 January hearing. We recognise that the Inquiry is responsible for identifying who to ask for material, and what to request; that is a central plank of its work. We would welcome the opportunity to assist with that work, including identifying Material Providers ("MPs") who should be approached for material and enumerating disclosure requests that should be made where they have not been. To that end, we

respectfully invite the Chair to (1) disclose to IPs the list of MPs who have been approached, (2) provide IPs with the disclosure requests that have been made to each MP, and (3) allow a reasonable period of time for IPs to make focused, targeted proposals for additional MPs to be approached, and for additional disclosure requests to be made. Such a process will assist the Inquiry's work, there is sufficient time for it to be done (given the relatively early and ongoing nature of the disclosure process to date), and it can be done in a proportionate way.

9. We anticipate that the Inquiry is already in the process of seeking witness statements from relevant Government Ministers and officials (not merely those formally designated as IPs). We raise the issue at this stage to ensure that early steps are taken to obtain relevant, best evidence from such witnesses.

Public hearings

10. We welcome the Chair's intention to hold hearings in Autumn 2026. That will focus minds and avoid unnecessary delay. Promptness is also an important part of the Article 3 duty which this Inquiry has been established to meet. However, it is imperative that prompt hearings are effective; the Inquiry's hearings should not be rushed at the expense of rigour. We therefore consider that a start date in Autumn 2026 should be set now and kept under review at this stage. The precise date that is feasible is likely to depend on the speed of disclosure, and ensuring that appropriate and sufficient evidence has been sought from all relevant MPs and witnesses.
11. We also note that a start date in early September, with – as is very likely – substantial disclosure review, preparation and IP questioning pro formas (what would be Rule 10 pro formas in a statutory inquiry) required throughout August, may pose difficulties given the Summer break and childcare commitments. We therefore invite the Chair to keep the start date under review, and to consider whether the start of October may be preferable.
12. We note that the Chair anticipates that questions on behalf of IPs will be permitted (subject to her discretion), following CTI's questioning: CTI §45. We are grateful for that indication. We consider that the opportunity to ask questions will be important in this Inquiry, given its particular features. We also recognise that questioning must be relevant, appropriate and not open-ended. For our part, it will be, and we will seek to ensure that duplication and repetition is avoided.

LAURA DUBINSKY KC
Doughty Street Chambers
JESSE NICHOLLS
Matrix
LEWIS KETT
Duncan Lewis

13th January 2026

THE MANSTON INQUIRY

DUNCAN LEWIS INQUIRY PARTICIPANTS - ANNEX A TO SUBMISSIONS FOR PRELIMINARY HEARING: PROVISIONAL LIST OF ISSUES 15 January 2026

To assist the Inquiry, we have identified some additional and supplementary issues to frame and assist the Inquiry's work; the additions to the Inquiry's existing list of issues are marked in red.

I. Pre-disembarkation

1. The physical and mental condition of people upon disembarkation in the UK.

II. Legal Framework.

2. The legal framework which applied to people who arrived by boat spanning the point of their arrival to the point at which they left Manston **and whether it offered adequate safeguards against the situation which arose.**

III. Initial entry

3. The treatment and processing of people at Western Jet Foil ('WJF') prior to transfer to Manston.
4. The screening (including the use of age assessments **and to identify vulnerabilities**) of people at WJF.
5. **The Home Office-contracted pilot project of the British Red Cross at WJF (but also Manston) between August and December 2022, and their findings on safeguarding, welfare and well-being needs for those arriving by small boat.**
6. **The initial decisions to detain and the subsequent reviews of detention and how the Home Office approached these decisions, including:**
 - a. **The basis in which initial decisions to detain were made, what information was taken into account and whether decisions were taken on an individual or blanket basis;**
 - b. **Whether legal safeguards, including statutory provisions and published policy were adhered to, including specific protections for vulnerable persons**

including mental illness, victims of torture, pregnant women and age-disputed minors.

- c. Whether detention documentation was both adequate and provided to detainees.

IV. The operation of Manston

7. The background to the establishment of Manston as a Short-Term Holding Facility.
8. The framework which governed the establishment, operation and governance of the Manston Short-Term Holding Facility and the detention of people; **whether it offered adequate safeguards against the situation which arose; and whether it was adhered to.**
9. Manston's maximum capacity (in respect of different categories of people) **and what duration of detention (if any) Manston was equipped to manage.**
10. The facilities and services provided to people at Manston.
11. Identification of those who provided those services or carried out key functions.
12. Responsibility and, or accountability for:
 - The strategic operation of Manston.
 - The operational aspects of Manston.
 - The provision of different services
 - The oversight of different services.
 - **The delineation and overlap of these responsibilities between the Home Office and Ministry of Defence and the reasons behind the latter's involvement from April 2022, and how that impacted the running of Manston.**
13. The key processes undertaken at Manston in respect of people who arrived by small boats and how effectively **and quickly** those processes were carried out.
14. How those processes ought to have been documented or recorded.
15. The processes and associated decision making in relation to accommodating people leaving Manston.
16. Any impediments which existed in accommodating people who had been processed at Manston (and how these contributed to the deterioration in conditions at Manston).

17. Processes at Manston to screen for vulnerability, illness, a history of torture or trafficking, and risks of self-harm or other harm through detention; whether these offered adequate safeguards and whether these were adhered to.
18. Access to interpreting and translation services for detainees and whether in practical terms these services were properly deployed throughout all operational processes.
19. The effectiveness, adequacy and access of oversight bodies, such as the ICIBI and the HMCIP, on Manston and the extent to which any concerns raised by such bodies were raised and how (or if) they were addressed.

V. Staffing

20. How Manston was staffed (including by staff provided by contractors) and what background checks were performed on staff, including by contractors.
21. Staffing levels, including contractual agreements on staffing levels and the effectiveness of the contract in ensuring adequate staffing levels, including by reference to key performance indicators and penalties. Whether the contractually-agreed staffing levels were based on assumed or maximum detainee capacity at Manston. Whether staffing levels adequately increased to reflect the increased numbers detained and if not, why not.
22. Training provided to staff (including staff provided by contractors) in relation to key aspects of their functions, including whether they had proper certification and accreditation to carry out certain functions, such as use of force.
23. The working conditions and support provided to staff (including staff provided by contractors).
24. How staff from different organisations or contractors worked together at Manston and how each organisations' process and oversight might have differed.

VI. Conditions at Manston and the treatment of people.

25. The physical conditions at Manston during the relevant period for people who arrived by small boats, and whether they were particularly suitable or safe for single women or children.
26. How those at Manston were treated. For example:

- a. How the physical and welfare needs of people were met during the relevant period.
 - b. The adequacy of healthcare provision (in relation to physical and mental health needs), both on-site but also processes to seek off-site hospital or ambulance access, and the processes to obtain prescription medication.
 - c. The adequacy of safeguarding systems at Manston.
 - d. How people who were detained or worked in Manston were kept physically safe.
 - e. The use of force against people, including the processes for properly recording these incidents and their oversight.
 - f. The use of segregation and / or isolation and whether safeguards and recording requirements were adhered to.
 - g. The handling and protection of people's property.
 - h. Allegations of staff misconduct and the response to it, including the factual circumstances that led to Home Office staff being arrested on suspicion of misconduct in public office and conspiracy to steal.
 - i. Any inappropriate language, attitudes and actions of staff towards detainees;
 - j. Any other potential dehumanising practices such as the reference to detainees by the boat/person number;
 - k. What systems were in place to deal with complaints and were these communicated to detainees.
27. Access to justice. Were mechanisms available and effective to enable detainees access to:
- a. Legal advice (including on-site access for lawyers and being provided with information on how to access legal advice and where);
 - b. Telephone and internet;
 - c. Support from NGO services;
 - d. Information about their rights to seek bail, habeas corpus or judicial review and whether these rights were ever used in practice.

28. The detention of people at Manston and their release, including the duration of detention and compliance with the legal framework for detention.
29. Steps taken to keep conditions at Manston sanitary and to control infections, **what public health risks the conditions (and its response or lack of) caused.**
30. **Compliance of Manston with health, safety, planning, fire, food and other regulations.**
31. Measures taken to improve conditions at Manston **or if not taken, the reasons why.**
32. To the extent not covered by the issues set out at 10 above, responsibility and accountability for the conditions at Manston and how people were treated
33. **What was known and when by persons in positions of responsibility and leadership concerning the conditions and treatment of detainees, and what was the response.**

VII. Manston's capacity and resources during the relevant period.

34. Forecasting and planning for the numbers of people who might arrive by small boats (during the relevant period) and need to be processed through Manston.
35. Reasons for the increasing numbers of people passing through Manston during the relevant period and whether these increases were foreseeable.
36. Causes of significant delays in processing people out of Manston.
37. Decision making and the response to increased numbers of people needing to be processed at Manston.
38. The steps taken to reduce the numbers of people in Manston.
39. The steps taken to shorten periods of detention at Manston.
40. **If Manston was operating beyond its capacity or detention was unlawfully prolonged at Manston or Manston was otherwise operating unlawfully, whether this was known and if so when and by whom and what remedial steps were taken.**

VIII. The death of Mr Hussein Ahmed in November 2022

41. Mr Ahmed's background and status in Manston.
42. To the extent not covered by the issue VI above, disease prevention and infection control at Manston.
43. The circumstances surrounding Mr Ahmed becoming ill.

44. The treatment of Mr Ahmed at Manston (encompassing his contacts with staff and the management of his medication including antibiotic therapy).
45. The healthcare afforded to Mr Ahmed (including that provided by the NHS and liaison between the NHS and Manston).
46. How and in what circumstances Mr Ahmed came to die on 19 November 2022.

IX. Manston's closure on 22 November

47. The main factors leading to the decision to close Manston on 22 November 2022 (and the decision to re-open Manston).
48. The main changes (if any) implemented at Manston upon its reopening (to the extent required to inform recommendations).
49. **The reasons for, and impact of, the amendment of the Short Term Holding Facility Rules in SI 2022/1345.**

X. Leadership in relation to Manston

50. To the extent not captured by the issues above:
 - a. The broader context which informed the use of and decision making about Manston as a Short-Term Holding Facility.
 - b. Ministerial decision making and/ or senior civil servant decision making about Manston.
 - c. Ministerial and/ or senior civil servant decision oversight of Manston.

XI. Recommendations/lessons learned from the events at Manston during the relevant period

51. **An analysis of previous recommendations relating to Manston from oversight bodies and whether they were implemented and if not, why not.**
52. The key conclusions about the treatment of people at Manston.
53. Recommendations in response to these findings.