Manston Inquiry

List of Issues

The Inquiry's work is continuing. This List of Issues will be kept under review and may be revised at a later stage of the Inquiry's work.

I. Pre-disembarkation

1. The background of people (including their physical and mental condition) arriving by small boat.

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.

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) of people at WJF.

5. Whether or to what extent there was any other assessment of people as to the appropriateness of detaining them at Manston.

6. Detention at WJF.

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.

9. To the extent that it differs, the significant aspects of the health and safety framework which applied at Manston.

10. Manston's maximum capacity (in respect of different categories of people).

11. The facilities and services provided to people at Manston including:
    - Whether the arrangements between the Home Office and its contractors (or contractors and their sub- contractors) impacted upon the safe and effective operation of Manston.
    - Home Office oversight of contractors.

12. Identification of those who provided those services or carried out key functions.
13. Responsibility and, or accountability for (across HM Government):
    - The strategic operation of Manston.
    - The operational aspects of Manston.
    - The provision of different services
    - The oversight of different services.

14. The key processes undertaken at Manston in respect of people who arrived by small boats and how effectively those processes were carried out.

15. Whether or what processes were in place in relation to the detention of people.

16. How these processes (in relation to detention) ought to have been documented or recorded.

17. The processes and associated decision making in relation to accommodating people leaving Manston.

18. Any impediments which existed in accommodating people who had been processed at Manston (and how these contributed to the deterioration in conditions at Manston).

V. Staffing

19. How Manston was staffed (including by staff provided by contractors[1]).

20. Staffing levels.

21. Screening of staff and training provided to staff (including staff provided by contractors) in relation to key aspects of their functions, including whether staff had the requisite screening, skills, qualifications or training in order to undertake their functions.

22. The working conditions and support provided to staff (including staff provided by contractors).

[1] This includes sub-contractors.

23. How staff from different organisations or contractors worked together at Manston.

VI. Conditions at Manston and the treatment of people.

24. The physical conditions at Manston during the relevant period for people who arrived by small boats.

25. How those at Manston were treated. For example:
    a. Whether they were treated humanely, with dignity and respect (including their treatment by staff).
    b. Whether and how the physical and welfare needs of people were met during the relevant period.
    c. Assessment of people who might be "at risk" in Manston.
    d. The adequacy of safeguarding systems at Manston (including, where appropriate, information sharing).
    e. Whether and how people who were detained or worked in Manston were kept physically safe.
    f. The use of force against people.
    g. The use of segregation and / or isolation.
    h. The handling and protection of people's property.
    i. Allegations of staff misconduct and the response to it.

26. Whether or to what extent people detained at Manston had access to information, advice and/or were able to communicate with anyone outside Manston.

27. The detention of people at Manston and their release, including the duration of detention and compliance with the legal framework for detention.

28. Measures taken to improve conditions at Manston.

29. To the extent not covered by the issues set out at 12 above, responsibility and accountability for the conditions at Manston and how people were treated.

30. Regulatory oversight and inspection of Manston.

31. Impact of the conditions at Manston on people.

VII. Health and healthcare at Manston.

32. Screening or assessment for infectious diseases.

33. Steps taken to keep conditions at Manston sanitary and to control infectious diseases.

34. Access to and the adequacy of healthcare provision (in relation to physical and mental health needs) in Manston.

35. How health services were configured within Manston.

36. Access to external clinical care.

37. How and where ill people (or those with additional physical or mental health needs) were cared for at Manston.

38. How medication was provided.

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

39. 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.

40. Reasons for the increasing numbers of people passing through Manston during the relevant period and whether these increases were foreseeable.

41. Causes of significant delays in processing people out of Manston.

42. Decision making and the response to increased numbers of people needing to be processed at Manston.

43. The steps taken to reduce the numbers of people in Manston.

44. The steps taken to shorten periods of detention at Manston.

VIII. The death of Mr Hussein Ahmed in November 2022

45. Mr Ahmed's background and status in Manston.

46. To the extent not covered by the issue VI above, disease prevention and infection control at Manston.

47. The circumstances surrounding Mr Ahmed becoming ill.

48. The treatment of Mr Ahmed at Manston (encompassing his contacts with staff and the management of his medication). Including:
    a. His treatment on 13 November; any working or provisional diagnosis that he had diphtheria and his being prescribed (antibiotics) clarithromycin and co-trimoxazole.
    b. His being tested for Diphtheria.

c. His care upon return from the William Harvey Hospital on 14 November 2022 until he attended the Queen Elizabeth, Queen Mother Hospital on 18 November 2022.

49. The healthcare afforded to Mr Ahmed (including that provided by the NHS and liaison between the NHS and Manston). Including:
    a. His attendance at William Harvey Hospital in Ashford, on 14 November 2022; his diagnosis of tonsilitis; the prescription of co-amoxiclav (an antibiotic) and whether this meant that Mr Ahmed stopped being provided with clarithromycin and co-trimoxazole after this point.
    b. His attendance at the Queen Elizabeth, Queen Mother Hospital on 18 November 2022 until his death.

50. How and in what circumstances Mr Ahmed came to die on 19 November 2022.

IX. Events at Manston in or around 22 November 2022

51. The reduction in the population of Manston at this point in time.

52. The main changes (if any) implemented at Manston in or around this point in time (to the extent required to inform recommendations).

X. Leadership in relation to Manston

53. 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

54. The key conclusions about the treatment of people at Manston.

55. Recommendations in response to these findings.