

THE MANSTON INQUIRY

DEIGHTON PIERCE GLYNN & DUNCAN LEWIS INQUIRY PARTICIPANTS SUBMISSIONS FOR SECOND PRELIMINARY HEARING

25 September 2026

INTRODUCTION

1. These written submissions, made in advance of the second Preliminary Hearing on 25 September 2026 in accordance with §5 of the Note of Counsel to the Inquiry dated 28 August 2026 (“**CTI’s Note**”), are made jointly on behalf of the 20 Inquiry Participants (“**IPs**”) represented by Deighton Pierce Glynn (“**DPG**”) and the 75 IPs represented by Duncan Lewis (“**DL**”). These are 95 IPs who were detained at and subjected to the conditions and mistreatment at Manston under investigation by the Inquiry.
2. Our clients recognise and are grateful for the extensive efforts of the Inquiry Team in progressing the Inquiry’s work (as evident from CTI’s Note). They are also deeply concerned that, through no fault of the Inquiry and its team, very substantial work remains before the Inquiry is ready to begin substantive hearings: approximately half of the anticipated disclosure and more than half of the witness statements have not yet been disclosed to IPs. It appears that the principal threats to the progress and readiness of the Inquiry, and its important work, arise not from the Inquiry but from the unacceptable conduct of others. This is addressed in more detail later in these submissions.
3. Below we address the issues identified at §4 of CTI’s Note and also the new information that the Inquiry has helpfully provided regarding the film footage from Mitie Officers and Kent Police, and the update regarding the progress of our clients’ request for an undertaking from the Home Office (CTI’s Note §20-21). Since a significant volume of material is yet to be disclosed, the below is necessarily provisional, subject to our clients’ entitlement, and intention, to make further submissions as outstanding documents are provided and reviewed.
4. In accordance with §5 of CTI’s Note, we confirm that the DPG and DL IP cohorts each request the opportunity to address the Chair orally at the hearing. The two legal teams will ensure, in coordination with those representing the other detained persons IPs (“**DPIPs**”), that oral submissions are divided up appropriately and proportionately in order to assist the Chair.

WHETHER TO SEEK FURTHER WITNESS STATEMENTS

5. We thank the Inquiry for its work in securing those statements already obtained (listed at Annex B of the Note) and respectfully endorse the list of 17 further statements sought (or soon to be sought) foreshadowed at §9-12 of CTI's Note.
6. Based on our continuing review of the disclosure and witness statements, we identify at **Annex A** to these submissions a number of further individuals or organisations from whom we invite the Inquiry to seek statements to assist the investigation and meet the Terms of Reference. The list at Annex A is jointly advanced by the DPG and DL teams, alongside the Wilsons, Bindmans and Gold Jennings DPIP teams.
7. We have set out in Annex A the reasons for our requests. Those requests include (i) senior political decision-makers whose evidence will be integral to understanding how and why the widespread unlawful detention and deteriorating conditions at Manston came about (including the two principal Prime Ministers in place during the relevant period, two Chancellors of the Duchy of Lancaster, and officials at No.10 and in the Cabinet Office); (ii) staff at the Home Office who were responsible for detainee welfare and safety, and who were aware that ministerial decision-making was resulting in endemic unlawful detention and a range of serious and life-threatening health risks posed to detainees at Manston, (iii) a Home Office official who provided evidence to the Home Affairs Select Committee, an important oversight mechanism, indicating that "*any period of detention is as brief as possible*" at a time when 2,920 people at the site had been recorded as held in excess of the 24-hour legal limit (Ridley §989), (iv) evidence from legal advisors¹ or legal advice institutions relating to the lack of legal advice accessed or accessible for detainees at Manston in the relevant period, and (v) a Director at the British Red Cross ("**BRC**") who authored the BRC's formal escalation letter of 13 October 2022 to the Home Office's Director General for Asylum and Protection warning that conditions at Western Jet Foil and Manston "*constitute inhuman and degrading treatment*" and identifying a "*real risk*" of violations of Articles 3 and 5 ECHR.
8. For the reasons summarised above, and in Annex A, the focused requests will assist in meeting multiple aspects of the Inquiry's Terms of Reference and the List of Issues.
9. We wish to record our overarching concern that the list of those from whom statements has been sought, and the provisional witness list, are presently heavily weighted towards senior, corporate and directorial witnesses. The Inquiry's wish to

¹ In particular, the DL RLR is in contact with a solicitor formerly of DL who organised the only legal advice known to have been accessed by a detainee while held at Manston in the relevant period (that solicitor has since moved to another firm) and intend to confirm by next week their position concerning ability to give evidence.

obtain statements from senior witnesses is entirely proper; we agree with such requests. However, with the Inquiry hearings now nearer, it remains the position that few of the proposed witnesses worked on the ground at Manston during the relevant period.

10. The central issues in Section VI of the List of Issues – the physical conditions, the treatment of detained people, safeguarding, the use of force, and staff misconduct and the response to it – cannot adequately, fairly or effectively be investigated primarily through the evidence of senior managers and corporate witnesses. Currently that is the unintended but highly detrimental effect of the Inquiry’s proposal.
11. We therefore invite the Chair to consider making requests to an appropriate number of witnesses (including contractor and sub-contractor staff) who worked day-to-day in the marquees and other facilities in which our clients were detained. In particular, as listed in Annex A, we recommend that the Inquiry ensure sufficient statements from staff in the following roles:
 - a) **Detention Custody Officers and guarding staff** (including Interforce and Mitie Security staff) who worked shifts in the marquees and barrack blocks. The treatment issues at the heart of Section VI of the List of Issues (Issues 24–25) – including the alleged use of force, threats to withhold food, threats of removal to Rwanda and the use of isolation buses as punishment (Ridley §§588, 601, 633, 930) – occurred in their presence, at a guarding ratio recorded on one occasion as two guards to 120 people (Ridley §555). Only three Mitie Detention Custody Officers appear on the provisional list, and, notably, there are no Interforce ground staff at all (Mr Boswell being a corporate witness).
 - b) **Mitie site managers/directors** who worked on the ground at Manston. These officers were involved in the day-to-day management of Detention Custody Officers and were responsible for liaising with Home Office and Border Force officials and healthcare contractors. For example, see the statement from Andy Baxter indicating that Paul Morris, the Mitie Site Operations Manager, played a key role in managing the site, including in respect of public health issues and the death of Mr Ahmed (Baxter §§17-20, 48, 57).
 - c) **Officers who conducted asylum screening interviews and age assessments** on the ground (including GSA Global staff). Issues 4, 14 and 25(c)–(d) cannot properly be investigated without evidence from those who carried out screening and age assessments in practice: His Majesty’s Inspectorate of Prisons found the average detention of unaccompanied children was 27 hours (Ridley §569); and the mocking of young people who gave their age as under 18 is documented in the Home Office corporate statement (Ridley §755).

- d) **Border Force officers deployed to front-line duties at Western Jet Foil and Manston**, who received arrivals, escorted people between sites and witnessed contractor conduct at first hand (see, for example, the officer instructed not to travel on coaches on which Interforce escorts were not carrying handcuffs: Ridley §601).
 - e) **Members of the Manston Detention Monitoring Team** and other on-site welfare and safeguarding staff, whose reports documented vulnerability, self-harm and the conditions in which families and children were held (e.g. see Ridley §§740, 825). The Head of that team (Mr Butler) appears on the list; those who monitored welfare in the marquees day-to-day do not.
12. Finally, and respectfully, we caution against the Inquiry's expressed intention that all requests for statements will have been made by the date of the Preliminary Hearing (CTI's Note §12). There is a risk that such a cut-off will harden into a blanket rule against further requests, to the Inquiry's detriment, and in a manner that is unfair to the DPIPs. As set out above, approximately half of the anticipated disclosure and more than half of the witness statements remain outstanding. In those circumstances, it would not be fair to preclude IPs from making further focused requests for additional statements where material yet to be disclosed or reviewed justifies them. We welcome that CTI's Note recognises the need for flexibility where new information or evidence comes to light, or where fairness requires that a matter be put to a witness (CTI's Note, §12). We invite the Chair to confirm that any further requests for statements proposed by IPs will be considered on their merits.

THE PROVISIONAL WITNESS LIST

13. We are grateful for the circulation of the provisional witness list. We note its expressly provisional character and the intention to circulate a further version later in the autumn (CTI's Note §73). 18 of the witnesses omitted from the list have provided statements which have not yet been disclosed to IPs. Further, as the Inquiry has recognised, we are not yet in a position to have reviewed all statements disclosed to IPs to date; and there are 17 other statements which have been (or are being) requested but are yet to be received by the Inquiry. Our clients' position on the composition of the list is accordingly only partially equipped by the necessary information, pending our review. We make the following preliminary observations.
14. A number of individuals whose statements the Inquiry holds, and whose roles are central to the List of Issues, do not presently appear on the provisional list. At **Annex B** to these submissions, we identify witnesses that we respectfully invite the Chair to add to the provisional witness list. The list at Annex B is jointly advanced by the DPG and DL teams, alongside the Wilsons, Bindmans and Gold Jennings DPIP teams. For

the reasons set out in Annex B, this limited further pool consists of witnesses whose evidence bears on a number of the issues the Inquiry is tasked with examining.

15. In relation to Annex A, those individuals from whom we invite the Inquiry to seek statements, we reserve our position as to whether these witnesses should also give oral evidence, pending the Inquiry's decision on these requests and, if granted, pending our evaluation of their evidence. Subject to that, our preliminary view, based on what is already evident from the disclosure and the statements disclosed to date, is that it will be necessary and appropriate to call, at a minimum, the former Prime Minister, Mr Sunak, relevant witnesses from the Prime Minister's Office, a number of the Home Office officials identified in Annex A, the Independent Chief Inspector of Borders and Immigration during the relevant period, Mr Neal, and Mr Fraser, the UK Director of Refugee Support and Restoring Family Links at BRC. We also consider that the Inquiry should hear oral evidence from at least one "on the ground" witness in each of the categories listed at §11 above (quite possibly more than one), as well as from those who can address the difficulties of access to legal advice on the ground.

UNDERTAKING FROM THE HOME SECRETARY

16. We are grateful for the update at §20 of CTI's Note. We emphasise, as we have previously (including in the request for the undertaking in our letter of 4 June 2026), that the undertaking from the Home Secretary bears directly on the ability of our clients to participate effectively in this Inquiry; it is a vital form of necessary protection and assurance. Without it, many DPIPs may feel unable to provide statements or give oral evidence to the Inquiry, undermining effective victim participation and the rigour and effectiveness of the Inquiry.
17. Our clients are understandably very concerned at the Home Office's unexplained delay in confirming that the undertaking will be provided. Ongoing delay in confirming the undertaking risks further delaying the start of the Inquiry's hearings, as well as causing our clients anxiety and distress.
18. We therefore invite the Chair to direct the Home Office to confirm its position in writing before the forthcoming Preliminary Hearing, and welcome that time will be set aside at the hearing to address the issue.

SPECIAL MEASURES

19. We welcome the constructive approach taken to outlining available special measures at §76-90 of CTI's Note. We agree that the following measures ought to be generally available to witnesses who were detained at Manston: §81 (questioning by CTI only), §82-83 (the option of giving evidence via live link), §84 (a reduced number of IP representatives present in the room for those giving evidence in person), §85 (not

filming or broadcasting faces) and §86 (the presence of up to two nominated supporters). We also welcome the approach at §87 to reasoned applications concerning the gender of the examining member of the CTI team and confirm that we will make them in a timely manner.

20. Part of the value of special measures to a witness is, of course, in enabling the witness to decide whether they are able to give oral evidence, and if so, facilitating their best evidence. That requires certainty being afforded to the witness in advance. That principle is well established: as the Chair will be very familiar, in criminal proceedings the Court of Appeal has held that a ground rules hearing is expected “*in every case involving a vulnerable witness, save in very exceptional circumstances*”²; the Civil Procedure Rules and the Family Procedure Rules make equivalent provision for ‘ground rules’ to be considered and set in advance³; and in the immigration and asylum jurisdiction the Court of Appeal has confirmed that tribunals must apply Joint Presidential Guidance which provides for the consideration of adjustments at an early stage in the process⁴.

21. We therefore invite the Chair:

- a) Consistently with the four-week application window in §28 of the Inquiry’s Phase 2 Witness Handling and Questioning Protocol (23 April 2026) (the “**Protocol**”), to direct that special measures applications will ordinarily be determined not less than two weeks before the relevant witness gives evidence, for reasons of certainty; and
- b) To confirm that, where an application for special measures is granted, a detained witness will be told in advance of the hearing what the special measures will be rather than that matter being left to be resolved at or shortly before the hearing itself. That certainty is likely to make a material difference to the willingness and ability of vulnerable witnesses to give their best evidence.

22. Having considered CTI’s Note and revisited the terms of the Protocol, in particular §27–31, we make some further proposals to address the position of DPIP’s below. The DPIP’s are the cohort principally affected by the conditions and treatment under investigation by the Inquiry and are particularly likely to perceive (whether or not correctly) State and contractor IP’s as responsible for those conditions and treatment, and indeed as antagonistic to their welfare and interests. DPIP’s are likely to be particularly inhibited or fearful in that their future status and rights, including

² *R v Lubemba; R v JP* [2015] Crim LR 237, per Hallett LJ (Vice-President) at §42–45, referring to the Court’s duty to take “*every reasonable step to encourage and facilitate the attendance of vulnerable witnesses*”.

³ CPR Practice Direction 1A and FPR Practice Direction 3AA.

⁴ *AM (Afghanistan) v SSHD* [2018] 4 WLR 78.

entitlement to remain in the United Kingdom and to accommodation and subsistence support, will be to a substantial degree dependent on the decisions of institutions and officials represented among other IP cohorts. Many DPIP's will be inherently vulnerable as refugees or asylum seekers and particularly likely to have specific further vulnerabilities including unfamiliarity with English legal processes; young age; mental ill-health; prior trauma generally; and fear of persons in positions of authority owing to previous experiences (in the country of nationality, during transit, or in detention in the UK).⁵ Against that context, we set out our further proposals.

23. First, while we note what is said at §88 and §90 of CTI's Note about interpreters, we emphasise that some of our clients are vulnerable witnesses with trauma attributable to a history of gender-based violence. Whilst we understand that, in general, the Inquiry has little control over interpreter availability, we hope that the Inquiry will make a specific exception and secure such arrangements for vulnerable witnesses falling into this category. Refusal to commit to doing so risks such witnesses being rendered unable to give oral evidence at all, their voices going unheard.
24. This request is consistent with practice in related fields, e.g. in the asylum context, the Home Office's policy is that requests for an interviewer and an interpreter of a particular sex should be accommodated "*as far as operationally possible*" where an asylum claim involves gender-based violence, and the guidance of the United Nations High Commissioner for Refugees is to the same effect.⁶ Given the Inquiry's specific focus on the conditions in which different categories of people, including women, were held, on the assessment of those who might have been "*at risk*", as well as on the impact of the conditions on those detained (Issues 10, 24, 25(c) and 31), failure to secure this accommodation where needed would risk a significant gap in the evidence available to the Chair.
25. We also invite the Inquiry to confirm that a short introduction between the witness and the interpreter in advance of their evidence will be facilitated, as well as the meeting with the member of the Inquiry team conducting the questioning that CTI have identified (CTI's Note §89). These are modest steps which would substantially

⁵ See further *MSS v Belgium and Greece* (App no 30696/09), Grand Chamber, 21 January 2011; (2011) 53 EHRR 2, at §251: asylum seekers are a "*particularly underprivileged and vulnerable*" population group in need of "*special protection*"; and e.g. *Tarakhel v Switzerland* (App no 29217/12), Grand Chamber, 4 November 2014; (2015) 60 EHRR 28, §118–119 (applying MSS).

⁶ Home Office, *Gender issues in the asylum claim (asylum policy guidance)*, 29 September 2010, p30; UNHCR, Guidelines on International Protection No. 1: Gender-Related Persecution (HCR/GIP/02/01, 7 May 2002), §36(iii) (interviewers and interpreters of the same sex as the claimant should be provided where the claimant so wishes).

reduce the risk of evidence being lost to interpretation difficulties, and which need not entail the logistics and cost with which §90 of CTI's Note is concerned.

26. Second, while we endorse the proposals at §82-83 of CTI's Note, for acutely vulnerable witnesses, those arrangements for giving evidence by live link (from a separate room at the hearing centre) may not be sufficient. Acutely vulnerable witnesses may be intimidated and distressed by the travel to and attendance at the hearing; and may need instead to give live link evidence from a more familiar location, such as the offices of their instructing solicitor. We are taking instructions and shall indicate in any required applications if this is applicable.
27. Third, whilst welcoming the indication that all members of the Inquiry team will be trained in vulnerable witness handling, we seek confirmation, for the reasons given at §20 above (willingness to participate and ability to provide best evidence) and §22 above (inherent vulnerability and imbalance of power), that detainee witnesses giving oral evidence will be questioned only by CTI or by their own counsel. That does not, of course, inhibit the discretion of the Chair to enable CTI to put questions to these witnesses which have been advanced by other IPs.
28. Fourth, we also invite express confirmation that trauma-informed adaptations to questioning – including (where necessary) regular breaks, shorter sitting periods, questions structured simply, and the avoidance of unnecessarily re-traumatising material where a fact is not in dispute – will be available as special measures under §30 of the Protocol. Further, in addition to the advance indication of the “topics” to be addressed (CTI's Note §80), we strongly recommend that any “no go areas” of questioning should be agreed in advance. This will help to achieve certainty. Agreeing limits of questioning in advance is precisely the function of the ground rules hearing, where questions may be required in writing in advance (see *R v Lubemba* above). The same discipline applies to the participation directions settled in advance under FPR Practice Direction 3AA, and underpins the Joint Presidential Guidance applied in the immigration and asylum jurisdiction (see *AM (Afghanistan)* above).
29. Finally, we invite the Chair to confirm that: (i) detained witnesses will be offered a familiarisation visit to the hearing room (or, for those giving evidence by live link, a technical test) in advance of their evidence, in line with established practice; (ii) an appropriately qualified emotional support service will be available at the hearing centre on the days on which former detainees give evidence; (iii) the evidence of detained witnesses will be listed realistically, with an agreed means by which the witness can indicate that they need a break, and without their evidence being compressed at the end of a sitting day; and (iv) it will be made clear to them when

communicating any decision on special measures that no adverse inference of any kind will be drawn from a witness's use of special measures.

CRIMINAL PROCEEDINGS AND ALLEGATIONS OF SERIOUS MISCONDUCT

30. We note §92-99 of CTI's Note and will file full submissions on this issue in the autumn, as invited by CTI. At this preliminary stage we make three points.
31. First, the matters summarised at §97 are disgraceful and of the utmost public concern; they fall squarely within the Terms of Reference and the List of Issues (in particular Issues 25(h)-(i)); and it is essential that they are fully investigated by this Inquiry.
32. Second, the broader picture summarised at §97 of CTI's Note strongly reinforces the need for an expert to address issues of institutional racism and institutional culture, including institutional toleration of law-breaking.
33. Third, with the criminal trials not anticipated until January 2028, the existence of the prosecutions must not become a reason to defer, narrow or dilute the Inquiry's investigation of these matters. We are confident that appropriate case management can protect the defendants' right to a fair trial without sacrificing the effectiveness of the Inquiry.

OUTSTANDING DISCLOSURE

34. Whilst we are keen to emphasise our clients' gratitude at the progress described at §31-34 of CTI's Note and the work from the Inquiry that this has entailed, we remain concerned at the overall pace of disclosure. As set out above and confirmed in CTI's Note, half of the anticipated disclosure, and the significant majority of witness statements provided to the Inquiry have not been disclosed to IPs.
35. As CTI's Note indicates at §24-31, there have been a number of "*hurdles*" which have impeded onward disclosure by the Inquiry. In substance, it appears that the conduct of a number of State IPs, whose obligation is to assist this Inquiry, has frustrated its work and delayed disclosure to IPs. In particular, (i) multiple central Government IPs – the Ministry of Defence ("**MoD**"), the Met Office, the Cabinet Office – have made late or very late applications for redactions which have "*had a significant impact on the Inquiry's work*" (CTI's Note §30); (ii) no proper explanation has been given to our clients for the significant delays in making those applications; (iii) other central Government IPs – the Home Office, the MoD – have conducted the Inquiry's Material Provider Review ("**MPR**") process at such a slow pace that disclosure has taken a significant period (in the case of the Home Office) or is still awaited (in the case of the MoD and other material providers: CTI's Note §30-31); and (iv) even now, central Government IPs – HM Treasury, the Home Office – are intimating, but not advancing,

further applications which are impacting the progress of the Inquiry's disclosure (Note §26-27).

36. This is not acceptable, it is unfair to our clients, and it undermines the work of the Inquiry.
37. Set against that context, we attach real importance to the Inquiry's commitment to disclose a further tranche of approximately 2,000 documents in September 2026. We also invite the Inquiry to publish a timetable for the disclosure of the balance of approximately 6,500 documents, so that IPs can plan their preparation for the hearings accordingly and to ensure that material providers are focused.
38. As to the MPR process, we support the Inquiry's stated intention (§31) to require that tranches of documents which have been held far in excess of the Inquiry's three-day limit (in some instances, for months) be cleared for disclosure. This should happen as quickly as possible.
39. In light of the concern expressed in CTI's Note regarding the conduct of a number of material providers, we invite the Chair to make the following directions:
 - a) That the Home Office's anonymity application be made by a fixed (and short) deadline, failing which the provisional redactions applied pending that application be lifted; and
 - b) Any further application for redaction or anonymity in respect of material already provided to the Inquiry be made by a fixed deadline, after which such applications will be entertained only in exceptional circumstances.
40. Finally, our own review of the disclosure that has been provided to date is identifying apparent gaps: for example, emails disclosed without their attachments, and meetings referred to for which no minutes have been disclosed. It may well be that some of these gaps reflect documents which are yet to be disclosed, but IPs have no present means of knowing. We intend to provide the Inquiry with schedules of such gaps for consideration. We consider that it would be sensible for such schedules to be provided in periodic batches, rather than waiting for disclosure to be substantially complete. We would be grateful for an indication if the Inquiry has an alternative preference.

FILM FOOTAGE

41. Our clients had not previously been made aware that footage from Kent Police and Mitie Care and Custody and Management and Training Corporation ("**MTC**") existed. We were surprised to learn of it for the first time from CTI's Note (§36-37). The existence of this footage is potentially of real significance to the issues the Inquiry must investigate. We welcome the indication that it has been reviewed and is being

prepared for disclosure. We ask that the footage be disclosed to IPs as soon as possible and, in the interim, we invite the Inquiry to provide, in advance of the hearing:

- a) A description of the footage, including the periods it covers and a broad description of the nature of the events recorded (including whether it records uses of force or, for example, events surrounding Mr Ahmed's illness, death and the investigations that followed);
- b) An explanation of when the footage was identified and why its existence has only now been indicated to IPs; and
- c) Confirmation that all reasonable steps have been taken to identify and secure all other potentially relevant footage, including any further body-worn, CCTV or mobile telephone footage held by the police, the Home Office, its contractors or other agencies.

42. We also note that §37 of CTI's Note indicates that the footage is being pixelated by the Inquiry. It is suggested that this is to enable it to be disclosed to IPs. Save where pixelation is of detained persons (which would be appropriate and consistent with the Inquiry's approach to date) or of an individual who has been granted anonymity by the Inquiry (and we are not aware of any such at this stage), we do not see why pixelation would be justified or required to allow disclosure. Indeed, there are cogent reasons why such footage should be disclosed un-pixelated: the conduct of staff is a central issue in the Inquiry (List of Issues, Issue 25); the ability to identify which member of staff is shown acting in a particular way may be significant both to the Inquiry's investigation and to the fairness of any use of the footage; and pixelation can significantly hinder the quality of the evidence, restricting the ability to see, follow and understand the events and conditions being shown.

43. We therefore invite the Inquiry to provide further detail as to the Inquiry's proposed approach in light of the above.

44. Finally, and subject to our review of the disclosed footage, we confirm that our clients do not object in principle to the use of appropriately selected footage in opening the Inquiry. We also welcome CTI's indication that IPs will be informed in advance of any footage selected.

EXPERT EVIDENCE

(i) The legal framework

45. We agree that the three-stage approach in *British Airways Plc v Spencer* [2015] PLR 519, per Warren J at §68, adapted as CTI proposes (CTI's Note §48), can provide a starting point. We make four observations about its application to the Inquiry context.

46. First, in civil proceedings the issue is whether expert evidence is *necessary to resolve* an issue. That is not the case in an inquiry: an inquiry is not litigation, and issues do not require ‘resolution’ in the same way. This Inquiry is a search for the truth, and for the identification of measures to be taken to prevent repetition, in the public interest. Those are points of fundamental difference.
47. Second, in the context of civil proceedings, where expert evidence is necessary to resolve an issue, it “*must be admitted*” (§68(a)). However (even in civil proceedings) where it is not strictly necessary but would be of assistance (§68(b)-(c)), the question is whether it is reasonably required in the context of the proceedings as a whole, weighing the factors identified at §63 (or analogous ones more appropriate to the Inquiry context, identified below). Warren J was careful to caution that the court “*should not be over-zealous in excluding evidence in order to save time and cost*”: §25. We invite the Chair to bear that caution firmly in mind: the test is not one of strict necessity across the board, and the purposes of this Inquiry – including to ensure a thorough and effective investigation, to allay public concern, to assess what went wrong, and to make recommendations – lend themselves to a broader, not a narrower approach.
48. Third, legal and factual context matters. The direction in the Terms of Reference that the Inquiry should consider no more evidence than is reasonably necessary falls to be applied by an inquiry discharging functions which, vitally, include the investigative obligation under Article 3 ECHR and, in relation to Mr Ahmed, the investigative duty under Article 2 ECHR and the examination of matters that would otherwise be the subject of a coronial investigation and inquest. What is “*reasonably necessary*” in an Inquiry context (§68(b)-(c)) must be informed by the gravity of the issues, the vulnerability of those affected, the need, mandated by Article 3 ECHR in particular, for a thorough and effective investigation involving the effective participation of victims, and the need for the Inquiry’s conclusions to command public confidence. It is also, importantly, informed by the Inquiry’s function to make recommendations for the future (List of Issues, Issues 54-55). As indicated above, an Inquiry’s task extends beyond resolving disputed questions of primary fact, so that expert evidence directed to impact, lesson-learning and recommendations may be reasonably necessary even where primary facts could be found without it.
49. Fourth, as to whether each proposed area is properly the subject of expert evidence: skilled evidence embraces both opinion evidence and skilled evidence of fact, where the witness draws on the knowledge and experience of others (*Kennedy v Cordia (Services) LLP* [2016] 1 WLR 597, per Lords Reed and Hodge JSC at §43-44). Admissibility is governed by the four familiar considerations, including whether there is a reliable body of knowledge or experience underpinning the evidence. Each of the

areas proposed by those representing detained people is a recognised field of expertise governed by professional standards.

50. We also note the practice of other recent inquiries. The Brook House Inquiry instructed a use of force expert (Mr Jonathan Collier) to consider not only individual incidents but general themes, including the adequacy of recording and review. The Manchester Arena Inquiry instructed a range of independent experts to assist the Chair in evaluating the preparedness and response of the emergency services; these were operational and quasi-factual matters on which expert assistance was nonetheless found to be of real value. The Cranston Inquiry – like this Inquiry, a non-statutory inquiry concerning those who sought to reach the United Kingdom by small boat – instructed an expert in thermal physiology (Professor Michael Tipton MBE) to report on the survivability of those who entered the water on 23-24 November 2021, evidence which underpinned its conclusion that the loss of life was avoidable. The proposals we have made on behalf of those detained at Manston during the relevant period are not outliers.
51. Finally, as to timing: we welcome the Chair’s indication that she will determine the expert requests promptly. Provided the scope of any instruction is tightly defined, reports can be prepared in parallel with the completion of disclosure and witness statement gathering, and the instruction of further experts need not delay the commencement of hearings.
52. In the sections that follow, we address three of the four expert disciplines proposed by the detained persons IPs in our joint letter of 7 July 2026. We endorse the written submissions on behalf of the Wilsons, Gold Jennings and Bindmans IPs on the need for an expert institutional racism and institutional culture.

(ii) The provision of clinical care to women and children

53. We note the proposal (CTI’s Note §52) that this area be included within the instruction to Dr Hard, and that Dr Hard is considering whether the different health needs of detained women and children, the provision required to meet those needs in a detained setting, and the adequacy of what was provided at Manston, fall within his expertise. That is a sensible course if Dr Hard confirms that these matters are in fact within his expertise. As the joint letter of 7 July 2026 noted, his experience is understood to lie primarily in healthcare for men in custodial settings. We await the further update and reserve our position. If Dr Hard is unable to cover these matters, an expert in women’s health and/or paediatric healthcare in detention should be instructed, for the reasons given in the joint letter.

(iii) The impact of detention at Manston on children

54. We respectfully submit that CTI's framing at §53-61 of CTI's Note understates the meaningful contribution that expert evidence in this area would offer. The question is not whether the Chair needs an expert to tell her that the conditions at Manston would have been distressing for children. The proper question is whether she would be assisted by and could safely make findings, without expert assistance, on the nature, severity, likely duration and reversibility of the harm caused to children by their detention, findings which the List of Issues requires (Issue 31: the impact of the conditions on people) and on which any meaningful recommendations (Issues 54-55) must rest.
55. Children represented a significant proportion of those detained at Manston (and of the DPIP's), and the nature and extent of the harm done to them bears directly on whether their treatment was inhuman or degrading. Responding directly to the invitation at §61, expert evidence of the kind proposed would address matters including:
- a) The psychological and developmental impact of detention on infants and very young children – including effects on attachment, developmental milestones and regression – which is a matter of specialised clinical knowledge. This is of particular importance because such children cannot describe their own experiences and will not give evidence to the Inquiry.
 - b) How the particular features of the conditions the Chair identifies (for example, babies sleeping on floors, inadequate nutrition, the absence of outdoor space and play, and exposure to violent incidents) bear upon children of different ages, backgrounds and family compositions, i.e. translating findings about conditions (which the Inquiry may make without assistance) into findings about impact (which it cannot).
 - c) The significance of the duration of detention, including detention far beyond the 24-hour limits, for a cohort of children who (it is acknowledged) had already experienced multiple traumas.
 - d) The short and foreseeable long-term psychological and developmental consequences on children, their potential reversibility, and the support required. These matters are directly material to recommendations and to the lessons to be learned under the fifth limb of the Inquiry's Terms of Reference.
56. These are quintessentially matters "*outside the judge's expertise*". Indeed, on the first of the adapted *BA v Spencer* questions, the Chair could not safely determine the impact issues in relation to children without such evidence. Further, such evidence would,

we submit, plainly assist the Chair and is reasonably required in the context of the Inquiry as a whole. The reports of Dr Fairweather and Dr Given-Wilson and of Dr Hughes (**Annex D**) demonstrate both that a reliable body of knowledge and experience underpins this field and the nature of the assistance available. The unprecedented nature and duration of the detention of children at Manston, rightly emphasised at §59 of CTI's Note, heightens rather than diminishes the need for the Chair to have the best available assistance in assessing its impact.

57. In light of above, it is no answer to suggest that expert evidence in this area is not required because the Inquiry is assembling evidence about the conditions at Manston, and whether children were exposed to them (CTI's Note §53) – they were – and the lack of basic facilities for children at Manston (CTI's Note §60). Those are not the issues for expert evidence that we have identified in our request and above. Similarly, the fact that CTI considers (CTI's Note §54) that IPs are unlikely to dispute that "*children, detained in Manston, are likely to have experienced multiple traumas*" from a range of experiences (which do not include their detention at Manston) is not an answer to our request for expert evidence. The expert evidence we have invited the Inquiry to seek concerns the impact of detention on children at Manston in the ways summarised above. That is not covered by whether those children had 'experienced traumas' because of other matters.

(iv) Use of force, discipline and punitive measures

58. Expert evidence in this area is reasonably required, and will assist the Chair, for a number of reasons.
59. First, the issues are not confined to individual incidents. They include whether the frameworks governing the use of force at Manston – the standard operating procedures, training, recording, auditing and oversight arrangements applying across multiple organisations with differing regimes – were adequate when measured against accepted standards of custodial practice; and risks arising if they were not. That is a recognised field, underpinned by an established body of professional knowledge and standards. It is also common in the context of coronial inquests and civil litigation for specialist expertise to be obtained upon it.
60. Second, unlike the position in Brook House, where extensive footage existed, the Chair of this Inquiry faces a more difficult task: the use of force forms completed by Interforce staff during the relevant period have been destroyed (CTI's Note §63), and the Home Office and Mitie forms that do exist vary significantly in quality and detail. An expert in custodial practice can assist the Chair as to what a proper system of recording, reviewing and auditing would have produced, and the significance of the gaps in what has survived.

61. Third, whether particular techniques and practices – including the use of force on or in the presence of children and vulnerable adults, and the handcuffing of Mr Ahmed to a hospital bed until shortly before his death – were consistent with professional standards is not a matter of common knowledge, nor are the physical risks which such restraint posed to a gravely ill man. Such evidence is expert in nature and will assist.
62. Fourth, the issues for this proposed expert extend beyond formal uses of force to segregation, isolation and *de facto* punitive measures (List of Issues, Issues 25(f)-(g)). For example, the disclosure to date indicates that detainees were taken to vans and cars to be isolated after use of force incidents. The assessment of such treatment likewise requires familiarity with lawful and appropriate custodial practice and safeguards recognised as best practice. This is particularly important in the context of a highly vulnerable cohort of detained persons: the resort to the use of force, de-escalation techniques, and the appropriateness of other punitive measures should be seen against the particular, known vulnerabilities of the cohort. These are matters which require expert input from an appropriate expert.
63. Finally, the questions formulated at §65 of CTI’s Note – whether there were adequate processes; whether risks to detained people were recognised and mitigated; whether complaints were meaningfully investigated; whether force was being used inappropriately – are precisely the questions which an expert in the use of force in custodial settings is well placed to help answer, as the instruction of Mr Collier in Brook House (which extended to general themes including the adequacy of recording and review) demonstrates. The Brook House Inquiry recorded that Mr Collier’s evidence and opinions “*were of great assistance in evaluating the evidence collected and heard throughout this Inquiry, particularly those concerning technical matters, such as techniques used by officers during use of force incidents*” (Report, Volume 1, p32, §31).

READINESS AND PREPARATION FOR HEARINGS

64. CTI’s Note confirms that IPs have to date received approximately half of the anticipated disclosure (8,310 of some 16,500 documents) and fewer than half of the witness statements provided to the Inquiry (69 of 164) (CTI’s Note §9-10 and §33), with 17 further witness statements having been, or about to be requested. The Home Office’s undertaking – which our clients requested on 4 June 2026 – remains outstanding.
65. As already noted, the principal threats to readiness arise not from the Inquiry’s own work but from the conduct of others:
- a) We share the concerns expressed at §24-30 of CTI’s Note regarding the conduct of certain material providers. The belated applications for redactions or anonymity

have generated substantial additional work, delayed disclosure to IPs, and now represent one of the principal risks to the timetable. Our clients are surprised and disappointed that the reasons for the lateness of these applications remain unexplained.

- b) The Chair wrote to the Home Secretary on 7 July 2026 concerning the undertaking; an undertaking in the same terms was given in the Brook House Inquiry; and yet, more than two months later, the Home Office's response remains outstanding, with a meeting then fixed only on 8 September 2026 between the Inquiry Legal Team and the Home Office. In circumstances where the undertaking being sought is modelled on an undertaking given by the Home Secretary in another Inquiry, the answer ought to be straightforward to give.
66. The need to facilitate our clients' participation in the Inquiry, and the imperative of momentum can hardly be overstated. The events under investigation will soon be four years old. Memories fade. Our clients continue to live with the effects of their detention and their well-being and willingness to participate are affected by uncertainty about the Inquiry's timetable and the Home Secretary's undertaking. The Article 3 investigative obligation carries with it a requirement of reasonable expedition and we have no doubt that the Inquiry will agree that it is vital for that requirement to be given effect.

DATES FOR SUBSTANTIVE HEARINGS

67. Given the pressing need to avoid further delay, we invite the Chair to announce, at or as soon as possible after the Preliminary Hearing:
- a) A listing window for the substantive hearings, commencing as soon as possible in the New Year; and
 - b) The Inquiry's best estimate of the overall length and phasing of the hearings.
68. Early certainty is required to ensure progress and so that our legal teams can plan their work. The well-being and effective participation of those we represent, the efficient review of disclosed material, the availability of witnesses and of counsel, and the arrangements for special measures all depend upon it.

CONCLUSION

69. Our clients remain committed to working constructively with the Inquiry Team so that the substantive hearings can commence at the earliest realistic opportunity, and to that end, we invite the Chair to take the steps identified above. For ease of reference, a consolidated list of those requests is annexed to these submissions as **Annex C**.

**Jesse Nicholls
Zoe McCallum**

**Emily Soothill
Nkiru Okafor
Tabatha Pinto**

For the DPG IPs

**Laura Dubinsky KC
Jesse Nicholls
Agata Patyna**

Lewis Kett

*For the Duncan Lewis
IPs*

11th September 2026

ANNEX A - Further individuals or organisations to obtain witness statements from

	Individual	Role/ Department	Reasons	Relevant Refs
1.	Boris Johnson	Prime Minister until 6/9/22	- Mr Johnson was the Prime Minister ("PM") with overall responsibility for the actions of the government during most of the relevant period. He established and chaired the Small Boats/Illegal Migration Taskforce to tackle the small boats issue and the cross-governmental approach. - Mr Johnson, alongside the Chancellor, provided a financial package for the small boat response on 9/3/22. It is clear that the funding decisions by the PM impacted the Home Office's response to small boats crisis and the resources they had to tackle it. The PM's evidence would assist the Inquiry to understand the decision-making at the top level of government (see e.g. Ms Patel's statement raising concerns about available funding at §127-8, Mr Ridley's statement at §389-39). - The PM took the decision and publicly announced on 14/4/22 that the MoD was taking operational command of responding to small boats crisis, announced the MEDP scheme with Rwanda and made announcements on Manston (Patel §153). He is in the position to assist the Inquiry with evidence as to the basis for these wider policies and how they impacted the establishment of Manston and provision of onward hotel accommodation, particularly given the funding concerns summarised above. He is also likely to assist the Inquiry as to the MoD's role at Manston, and how the interactions between the Home Office and MoD were managed at government level. - Ms Patel's evidence further states that the reduction of hotel usage and focus on reception centres, in line with Ms Patel's decision to "<i>pause further procurement of hotels at the end of June 2022</i>", was "<i>in line with 'the position of the Prime Minister'</i>" (Patel §184). Mr Johnson is likely to be able to provide the Inquiry with evidence relevant to key decision-making concerning the alternatives to detention at Manston. - Ms Patel's evidence is that Mr Johnson's resignation and the extensive leadership contest that followed had a big impact on the work to tackle small boats (see e.g. §190-191 and §243). Mr Johnson will be able further to comment on these issues.	Priti Patel's witness statement ("WS") [mans001:000769 78]; Simon Ridley's WS [mans001:000735 89]

	Individual	Role/ Department	Reasons	Relevant Refs
2.	Rishi Sunak	Chancellor until 5/7/22 Prime Minister from 25/10/22	- There is currently a lack of evidence at Ministerial level from the Treasury as to how Manston was funded and whether the funding was sufficient. There is currently only a brief statement from a civil servant (Conrad Smewing). As Chancellor, Mr Sunak was responsible for signing off the small boats response package of financial support on 9/3/22 described above. - Further, Mr Sunak became Prime Minister at height of the relevant period. He was responsible for much of the public response to Manston including answering questions at PMQs on 2/11/22 (Ridley §1089). Ms Braverman's statement further states that Mr Sunak was very involved in the creation of a non-detained site at Manston (§82-83) and notes they had regular meetings concerning Manston (§103). Mr Sunak is likely to be able to provide evidence on the briefings he received, and decisions taken at the government level. - The statements from Ms Patel (§191, 214-215) and Mr Jenrick (§32viii) refer to Mr Sunak withdrawing support for using RAF Linton as an alternative asylum accommodation centre, which in their view would have relieved pressure on Manston, and for reasons they assert were overtly political relating to the Conservative leadership election. Mr Sunak's evidence would be able to respond to the criticism and explain the rationale for the decision. - The evidence further records Mr Sunak taking part in relevant decision-making in November 2022 about the option of bailing those detained to no fixed abode (Ridley §1090-1091, §1140-1141, §1154; Eastaugh §102). Mr Sunak's account is necessary for the Inquiry fairly to address the developments in the final month of the relevant period and responsibility for decision-making during that time.	Priti Patel's WS [mans001:000769 78]; Simon Ridley's WS [mans001:000735 89]; Suella Braverman's WS [mans001:000769 79]; Conrad Smewing's WS [mans001:000769 77]; Robert Jenrick's WS [mans001:000775 81]; Anthony Eastaugh's WS [mans001.000761 17]
3.	Simon Clarke (and/or those who followed him in role)	Chief Secretary to the Treasury ("CST") up to 6/9/22	As stated above, there is limited witness evidence from the Treasury as to funding arrangements for Manston. Conrad Smewing's WS (§12) refers to the CST as being "<i>responsible for public expenditure including spending reviews and in-year spending control</i>". On 11/4/22 CST confirmed additional £1.25billion in reserve funding over three years for policy programme on Illegal Migration Task Force, which involved work on developing Manston and related policies/centres it is noted that funding was relaxed for hotel accommodation: Smewing §44-45. Mr Clarke's evidence is likely to help the Inquiry understand the background to the key funding decisions.	Conrad Smewing's WS [mans001:000769 77]

	Individual	Role/ Department	Reasons	Relevant Refs
4.	Witnesses from the Prime Minister's Office	Various	- No Downing Street official appears among those from whom statements have been sought, yet No.10 had a key role in decision-making over the relevant period: (i) the December 2021 site-selection was driven by "<i>an urgent request from Number 10 and the Cabinet Office's Illegal Migration Taskforce</i>" (Ridley §163); (ii) the No.10 Private Secretary for Home Affairs conveyed the Prime Minister's requirement for "<i>a step change of ambition</i>" (2,500 detention places by February 2022 scaling to 30,000 by June) (Ibid, §211-212) – the pressure under which it appears lawful design of Manston was abandoned; (iii) No.10 and the Chancellor of the Duchy of Lancaster ("CDL") determined "<i>only MOD sites could be used</i>" (§161); (iv) the Prime Minister received small boats briefings from December 2021 (Eastaugh §28) and a "<i>show and tell</i>" at Lydd (Eastaugh §45); and (v) in November 2022 the Home Secretary's position on the non-detained area was "<i>comfortable ... subject to No 10</i>" (Ridley §1156). - A statement from the Private Secretary for Home Affairs would assist the Inquiry understand the relevant discussions and decisions by No. 10.	Simon Ridley's WS [mans001:000735 89]; Anthony Eastaugh WS [mans001.000761 17]
5.	Hannah Guerin	Priti Patel's Special Advisor	- Ms Guerin was Priti Patel's special advisor throughout relevant period that she was Home Secretary. She facilitated and attended meetings on key issues related to Manston and fed into the discussions and decisions (Patel §85, 127, 167, 171, 193). She was copied into almost all emails going to the Home Secretary and attended Small Boats Strategy Meetings (e.g. mans001:00000048). The evidence suggests that Ms Guerin's advice was key to Ms Patel's decision-making, including when she overruled Ministers on relevant decisions (in particular in relation to bailing individuals from Manston) (mans001:00004222). Ms Guerin briefly stayed on to transition Ms Braverman when she became Home Secretary (Braverman §15) and is likely to be able to comment on how the transition impacted the situation in Manston. - More generally, we invite the Inquiry to consider the role of Special Advisors in decision-making related to Manston and whether others should be identified as needing to give evidence; see e.g. email chain 24/10/22 which suggests Special Advisors were making decisions on what additional asylum hotels could be approved (mans001:00004373).	Priti Patel's WS [mans001:000769 78]; Suella Braverman's WS [mans001:000769 79]; mans001:0000004 8; mans001:0000422 2; mans001:0000437 3

	Individual	Role/ Department	Reasons	Relevant Refs
6.	Nadhim Zahawi MP	CDL, 6/9/22 to 25/10/22	- The Inquiry has indicated that it recently sought (or is about to seek) statements from Kit Malthouse MP and Steve Barclay MP (CTI's Note, §11(d)-(e)), each of whom held the office of CDL during the relevant period (Mr Malthouse: 5/7/22 to /6/9/22, Mr Barclay: 15/9/21 to 5/7/22). Two further holders of that office during the relevant period – Nadhim Zahawi (6 September to 25 October 2022) and Sir Oliver Dowden (from 25 October 2022) – do not appear to have received requests but are able to provide relevant evidence covering periods of their tenure. Given the Cabinet Office's significant role in relation to Manston (reflected in its designation as an IP), we invite CTI to make requests of Mr Zahawi and Sir Dowden. - In particular, Mr Zahawi held the office throughout the period in which (i) officials reported being "<i>consistently in breach</i>" of the 24-hour limit (Ridley §720); (ii) His Majesty's Prison and Probation Service ("HMPPS") reported that "<i>the operation of Manston was unlawful</i>" (Ibid §863), (iii) 2,920 people were recorded as held in excess of 24 hours (Ibid §989), and (iv) the risk of unlawful detention at Manston featured on Cabinet Office stocktake agendas (Ibid §§441, 445, 1061). A statement is required from Mr Zahawi as to the operation of the CDL-chaired machinery between 6 September and 25 October 2022, what it was told about unlawful detention at Manston, and what decisions or interventions it made (or declined to make) to address conditions and unlawful detention of people in Manston.	Simon Ridley's WS [mans001:000735 89]
7.	Sir Oliver Dowden MP	CDL, 25/10/22 to 5/7/24	- Sir Dowden's tenure covers (i) the Western Jet Foil ("WJF") attack and evacuation to Manston (Ridley §§1053, 1059), (ii) the site's peak of over 4,000 people, (iii) the Cabinet meeting of 1/11/2022 at which the Home Secretary's speaking notes recorded "<i>we are detaining individuals for far longer than our statutory powers permit</i>" (§1076), (iv) the Prime Minister's 11/11/22 refusal to bail individuals to no fixed abode (§1140), (v) the Cabinet Secretary's 18/11/22 site visit (§1176), and (vi) the Cabinet Office-facilitated recovery under Lt Gen Skeates, who had worked in the Cabinet Office on small boats since January 2022 (§909 fn 1097; fn 500). - As the minister responsible for the Cabinet Office and the cross-government coordination machinery during the recovery and emptying of the site Sir Dowden should be asked to address the government's decisions relating to detention at Manston from 25 October 2022 onward.	Simon Ridley's WS [mans001:000735 89]

	Individual	Role/ Department	Reasons	Relevant Refs
8.	Gareth Hills	Home Office Senior Director for Returns and Detention Operations	- Mr Hills was the Home Office’s “<i>recognised Subject Matter Expert</i>” on what was required to operate a Short-Term Holding Facility (“STHF”), contributing on detainee welfare and the practicalities of minimising harm and risk (Eastaugh §15). - The Home Office’s corporate statement shows that expertise of this kind was repeatedly sought and overridden: (i) Detention and Escorting Services (“D&ES”) officials warned that Manston’s processes were “<i>not compliant with the Short Term-Holding Facility Rules and the Immigration Act 1971</i>” (Ridley §425); (ii) the Director of D&ES insisted in May 2022 on compliance with the STHF Rules and on Ministers being informed of detention beyond 24 hours (Ridley §413); (iii) D&ES produced the July 2022 pre-inspection report (Ridley §541); and (iv) a senior Returns and Detention official refused to recommend to Ministers “<i>a course of action that we know would lead us to act unlawfully</i>” (Ridley §517). - A statement from Mr Hills would speak to the timing and content of the advice given by the government’s own expert, and any the government’s responses to it.	Simon Ridley’s WS [mans001:000735 89]; Anthony Eastaugh WS [mans001.000761 17]
9.	Jonathan Baker	Assistant Director, Health and Safety Manager, Clandestine Channel Threat Command (“ CCTC ”), Home Office	- Mr Baker was the “<i>the site Health and Safety Manager</i>”, and a recurring actor in the Home Office corporate witness statement who received the vast majority of the safety warnings the Inquiry will examine. - These include: (i) the fire-safety concerns of the Crown Premises Fire Safety Inspectorate (“CPFSI”) of 5/1/22 were addressed jointly to him (Ridley §217); (ii) he was the Manston contact for Medevent escalations (Ibid §537); (iii) he responded to the August 2022 coach-restraint incident (§§588, 601); and (iv) he was the recipient of, and respondent to, the CPFSI’s 8/9/22 warning that the Officers’ Mess would “<i>not be safe to house anyone</i>” sleeping (§§698–699). - He is likely to be able to provide further information about what risk assessments existed, if and how warnings were escalated, and why documented fire and safety risks persisted to the November 2022 audits (§§1204–1205).	Simon Ridley’s WS [mans001:000735 89]

	Individual	Role/ Department	Reasons	Relevant Refs
10.	Dr Neil Honeyman	Director and Chief Technology Officer (“CTO”) within the CCTC	- The Home Office corporate statement describes systemic technology failures within the command’s remit: (i) site WiFi that “<i>could only support 15 laptops whereas 60</i>” were needed (Ridley §317), (ii) a shortage of biometric capture machines (Ibid, §§296–298), (iii) the absence of any “<i>method for tracking the duration of individuals on site</i>” as late as March 2022 (§331), (iv) the Pronto-based detention clock whose start point was moved on legal advice (§§421–422, 450), and (v) more generally, data systems the Skeates Review found “<i>not fit for purpose</i>” (§1196). - The CTO is likely to assist the Inquiry to understand the procedures for record keeping, reasons why appropriate systems were not delivered, and why the true scale of detention at Manston cannot be reconstructed from Home Office records.	Simon Ridley’s WS [mans001:000735 89]
11.	Dan Hobbs	Director, Asylum, Protection and Enforcement, Home Office	- Mr Hobbs gave evidence on Manston to the Home Affairs Select Committee on 26/10/22, alongside the Manston Senior Responsible Officer (“SRO”) and Director General for Customer Services (Ridley §1028). The briefing prepared for that session stated the site was “<i>neither overwhelmed nor under resourced</i>” and “<i>any period of detention is as brief as possible</i>” at a time when 2,920 people at the site had been recorded as held in excess of the 24-hour legal limit (Ibid, §989) and its own Permanent Secretary was seeking advice on “<i>how to make Manston lawful</i>” (§995). - A statement from Mr Hobbs should address who settled the briefing line, what he knew of the true position when the Committee was briefed, and if and how it was reconciled with the internal record.	Simon Ridley’s WS [mans001:000735 89]
12.	Ailish King-Fisher and Joy Johnston	Deputy Directors, Resettlement, Asylum Support and Integration, Home Office	- The 18/7/22 briefing to the Home Secretary’s Private Office from the directorate set out the impacts of the June 2022 decision to pause hotel procurement (Ridley §543(vi)). A Deputy Director responded on 5/9/22 to the Crown Commercial Services costings for cruise ships and holiday parks, confirming Asylum and Protection’s lead on accommodation solutions (§676). The Home Office’s evidence attributes Manston’s blocked outflow to “<i>a ministerial decision</i>” on hotel bookings (§734). - The officials who documented the impact of that decision in real time can provide material evidence as to ministerial knowledge and the practicability of alternatives to hotels.	Simon Ridley’s WS [mans001:000735 89]

	Individual	Role/ Department	Reasons	Relevant Refs
13.	Alex Fraser	British Red Cross, UK Director of Refugee Support and Restoring Family Links	- The Inquiry has received a statement from the British Red Cross's ("BRC") Eleanor Shepard, whose fortnightly pilot reports documented conditions on the ground (Ridley §755). It has not, however, requested a statement from Mr Fraser, the author of the BRC's formal escalation letter of 13 October 2022 to the Director General for Asylum and Protection. - That letter may well be among the most significant contemporaneous documents before the Inquiry. According to the Home Office corporate statement, it (i) warned that conditions at WJF and Manston "constitute inhuman and degrading treatment", (ii) identified a "real risk" of violations of Articles 3 and 5 ECHR (Ridley §§929-932), and (iii) it recorded the BRC's assessment that arrivals were not "in excess of what you expected and therefore could have planned for" (§932). The Home Office's documented response was that the letter "needed careful handling", copying in the Press Office (§933). - A statement from Mr Fraser would assist the Inquiry in establishing the evidential basis on which the BRC reached its Article 3 assessment, what concerns the organisation had escalated to the Home Office before resorting to a formal letter and any actions taken by the Home Office in response. This goes directly to the Home Office's knowledge of the Article 3 threshold being engaged.	Simon Ridley's WS [mans001:000735 89]
14.	Pierre Makhoul	Former Director of Bail for Immigration Detainees ("BID")	Mr Makhoul was at the relevant time the Legal Director at BID, the largest charity in the UK assisting immigration detainees applying for bail. He gave oral evidence to the Joint Committee on Human Rights on 16/11/22 in which he discussed how despite the number of individuals detained at Manston and the lengthy periods for which they were held, BID were never contacted by a detainee to assist with applying for bail. He would be able to give important evidence concerning the absence of legal advice at Manston or of information to detainees concerning their entitlements and how to access legal advice, and the contrast with provision made at other places of immigration detention, as relevant to Issue VI(27).	https://committees.parliament.uk/oralevidence/11569/pdf/

	Individual	Role/ Department	Reasons	Relevant Refs
15.	Detention Custody Officers and guarding staff (inc. Mitie, Interforce and Security staff), to include Site Managers/Directors	Mitie and Interforce	- We recommend that the Inquiry ensures that it has sufficient statements from individuals who worked shifts in the marquees and barrack blocks. The treatment issues at the heart of Section VI of the List of Issues (Issues 24–25) – including the alleged use of force, threats to withhold food, threats of removal to Rwanda and the use of isolation buses as punishment (Ridley §§588, 601, 633, 930) – occurred in their presence, at a guarding ratio recorded on one occasion as two guards to 120 people (Ridley §555). So far, only three Mitie Detention Custody Officers appear on the provisional list, and no Interforce ground staff (Mr Boswell being a corporate witness). - We also recommend that statements be obtained from relevant site managers/directors who worked on the ground at Mitie and were involved in day-to-day management of these officers and who would liaise with Home Office/Border Force officials and the healthcare contractors. The Site Operations Manager, Paul Morris of Mitie, is a key example. Mr Baxter’s statement (§17-20, 48, 57) confirms the key role Mr Morris played in managing the site, and actions of relevance to public health issues and the death of Mr Ahmed. We note that Mr Morris is listed on each monthly update as someone who the Inquiry is keeping under review as a potential witness.	Simon Ridley’s WS [mans001:000735 89]; Andy Baxter's WS [mans001:000501 72]
16.	Officers who conducted asylum screening interviews and age assessments on the ground (inc. GSA Global Staff)		His Majesty’s Inspectorate of Prisons (“HMIP”) found the average detention of unaccompanied children was 27 hours (Ridley §569), and the mocking of young people who gave their age as under 18 is documented in the Home Office corporate statement (Ridley §755). Issues 4, 14 and 25(c)–(d) cannot fairly be investigated without evidence from those who carried out screening and age assessments in practice.	Simon Ridley’s WS [mans001:000735 89]

	Individual	Role/ Department	Reasons	Relevant Refs
17.	Border Force officers deployed to front-line duties at WJF and Manston, including site managers for Border Force		We recommend that the Inquiry ensures that it has sufficient statements from individuals who received arrivals, escorted people between sites and witnessed contractor conduct at first hand (see, for example, the officer instructed not to travel on coaches on which Interforce escorts were not carrying handcuffs, Ridley §601). This should include relevant site managers.	Simon Ridley's WS [mans001:000735 89]
18.	Members of Manston Detention Monitoring Team; on-site welfare & safeguarding staff		We recommend that the Inquiry ensures that it has sufficient statements from individuals whose reports documented vulnerability, self-harm and the conditions in which families and children were held (e.g. Ridley §§740, 825). The Head of that team (Mr Butler) appears on the list; but those who monitored welfare in the marquees day-to-day and are likely to provide relevant evidence are not.	Simon Ridley's WS [mans001:000735 89]
19.	Reinette Martin	Social worker manager, Home Office	- Eleanor Shepard's statement (§78) describes there being social workers at WJF and refers to Ms Martin. - Evidence from the manager about the team's remit, roles and responsibilities is required to understand the safeguarding available to those detained. This evidence is relevant to the Inquiry's list of Issues 25(b)-(d (safeguarding)); and 3-5 (Initial entry).	Eleanor Shepard's WS [mans001:000736 70]
20.	Dr Gayatri Amirthalingam & Dr Rebecca Cordery	UKHSA Diphtheria Incident	The UKHSA Diphtheria Incident Directors were directly involved in the assessments and recommendation for the management of Diphtheria, including the implementation of the UKHSA recommendation to deliver mass antibiotic prophylaxis and vaccination for unaccompanied asylum-seeking minors arriving in the UK [mans001:00013167]. Their evidence is relevant to the Inquiry's List of Issues 33 (control of infectious diseases) and 46 (disease and infection control, Mr Ahmed).	mans001:00013167; others include: mans001:00034227; mans001:00011132; mans001:00013174

ANNEX B – Witnesses who should be on provisional list for oral evidence.

We reserve our position on those whose witness statements we have not seen yet (including those listed above) pending a review of their evidence, but of those who have provided witness statements, we believe the following should also give oral evidence:

	Individual	Role/ Department	Reasons	Relevant Refs
1.	David Neal	Independent Chief Inspector of Borders and Immigration (“ICIBI”) during Relevant Period	- David Neal was the ICIBI during the Relevant Period. It is clear that the ICIBI was the most evidentially important inspectorate and will be crucial to giving evidence on point VI(30) on the List of Issues relating to the regulatory oversight and inspection of Manston. The ICIBI has a statutory role under Section 50 UK Borders Act 2007 to inspect specific matters requested by the Home Secretary and that was the basis of their inspections into Manston, WJF and Tug Haven during the relevant period. - We note the Independent Monitoring Board (“IMB”) and HMIP are due to give oral evidence. We note we have not yet seen Mr Neal’s evidence, but his evidence is of such importance we believe we are in a position now to say he should be called to give live evidence. - Mr Neal in his role inspected Tug Haven and WJF in January 2022 and therefore is well placed to assist the Chair in considering evidence under III of the List of Issues relating to initial entry and how people were processed at WJF. He is well placed to comment on various stages of how Manston ran in terms of conditions and management of the site: he visited Manston in January 2022 and raised concerns about its capacity and ability to handle large arrivals and manage vulnerabilities (Ridley §230, 241); returned on 20/4/22 and raised concerns about management and resources of the site (Ridley, §405); returned again in October 2022 where he made a significantly critical report during the height of the crisis at Manston. - Mr Neal’s findings and views were not just confined to evidence that can be found in the ICIBI’s reports. Notably, his April 2022 visit did not lead to a report or formal inspection. It is clear he also met with Home Office and CCTC officials (Ridley § 241), Lieutenant Skeates and Dan O’Mahoney (Ridley §1015) to air his views. He also met with Ministers regarding his findings at Manston (Ridley §1099, and mans001:00001384), including meeting with Robert Jenrick on 10 November 2022 (Ridley § 1136 and mans001:00000933). The ICIBI reports are not a suitable substitute for his oral evidence.	Simon Ridley’s WS [mans001:00073589]; mans001:0000093; mans001:00001384 mans001:00001500 https://www.theguardian.com/uk-news/2024/feb/27/sacked-uk-borders-inspector-tells-mps-removed-doing-job-david-neal https://www.theguardian.com/uk-news/2024/mar/27/home-office-tried-cover-up-critical-reports-sacked-uk-border-chief-david-neal https://www.theguardian.com/co mmentisfree/2024/feb/29/james-

	Individual	Role/ Department	Reasons	Relevant Refs
			- Mr Neal's evidence is also important for two further aspects. Firstly, he was the person originally approached by the Home Secretary to discharge her Article 3 duty to investigate what happened at Manston. As the ICIBI, he conducted significant scoping of what was needed to conduct the investigation and met several HO officials and conducted further site visits into Manston into 2023 to gain an understanding of the key issues. His evidence will be important for the Inquiry to understand how the Home Office responded to events in Manston and assist the Inquiry with Issue IX(52) relating to the main changes implemented at Manston in November 2022. - Secondly, Mr Neal was dismissed from his role as the ICIBI in February 2024 after publicly sharing his concerns about the delay of an inspection report. He had earlier faced issues with delays in publishing an inspection report into Tug Haven (not published until July 2022, despite the inspection having taken place in Dec 2021-Jan 2022) and gave evidence to Parliament which was critical of Home Office leadership and transparency regarding the reports (mans001:00001500). Mr Neal's evidence is important for the Inquiry to scrutinise the Home Office response to the ICIBI's concerns and accountability for the failures identified in the reports.	cleverly-borders-inspector-migrant-strategy-home-secretary
2.	Emma Churchill	Director General ("DG") for Migration and Borders from January 2022	- Ms Churchill was the DG for Migration and Borders during the Relevant Period, and in turn the SRO for 'ODP 4' of the Home Office's outcome delivery plan for 2021-22, tackling illegal migration (Churchill §5). She co-chaired the Illegal Migration Board giving direct advice to Home Secretaries (Ridley §453) and attended Manston Delivery board meetings (Churchill §10). The SRO for delivering Manston (Dan O'Mahoney) would report directly to Ms Churchill (Ridley §124-125). It was therefore Ms Churchill's responsibility to deliver the Manston project. It is important for her to give live evidence to explain her operational oversight and be questioned about her leadership role in establishing Manston and its management and responding to challenges relating to outflow and accommodation issues. Ms Churchill's evidence is also vital to understand lines of management, oversight and responsibility (List of Issues at X(53)) see e.g. Churchill §116, mans001:00001789 and mans001:00001792. - Ms Churchill's evidence is further important to understand the response to the findings of HMIP's July 2022 report; the Home Office corporate statement refers to her stating	Emma Churchill's WS (mans001:00076116); Simon Ridley's WS [mans001:00073589]; mans001:00001789 ; mans001:00001792

	Individual	Role/ Department	Reasons	Relevant Refs
			that the “ <i>inspection report should be challenged</i> ” (Ridley §578). It will assist the Inquiry in respect of Issues 13, 30 and 53.	
3.	Anthony Eastaugh	DG for Immigration Enforcement	- Mr Eastaugh was the DG for Immigration Enforcement during the relevant period and was highly involved in the leadership team which set up and managed Manston. He was jointly responsible for defining operational objectives for Manston. His evidence bears directly on Issues 27, 42–44 and 53(b)–(c). He also had heavy involvement and Ministerial liaising the operational response to issues around people not claiming asylum at Manston (e.g. mans001:00073692). On his own account he: (i) authorised the use of Immigration Removal Centres, “<i>against policy and practice</i>”, to relieve pressure at the site (Eastaugh §59); (ii) supported bail from Manston as “<i>the correct professional and moral action</i>” (Ibid §79); (iii) consulted the Home Office’s Ethical Champion on how officials should navigate the ministerial refusal of bail “<i>from an ethical, moral and professional perspective</i>” (Ibid §80); and (iv) on 12/10/22 took “<i>the strategic decision</i>” to authorise releasing people from the site “<i>for safety and necessity reasons</i>” (countermanded within hours) (Ibid §§91–93). He can also speak to (v) the Ministry of Justice’s refusal to make prison estate capacity available (Ibid §18) and (vi) to the limits of military primacy (Ibid §119). His evidence is central to Issue 53. - Mr Eastaugh expressed in strong terms his concerns about the lack of structured planning in setting up Manston and the decision not to bail individuals from Manston (see emails of 23/2/22 and 28/9/22; Tierney §25-7). It is important that these are explored in live evidence to assist the Inquiry to understand the concerns of the civil service leadership team in relation to political decisions concerning detainees’ welfare.	Anthony Eastaugh’s WS [mans001.0007611 7]; Abigail Tierney’s WS [mans001:0007749 5]; mans001:00001184 ; mans001:00073692 ; mans001:00004305
4.	Abigail Tierney	DG for Customer Services until Oct 2022, then DG for Asylum and Protection thereafter	Dr Tierney was DG for Customer Services and took over the Asylum and Protection role from Emma Haddad on 17/10/22 whereby she was immediately responsible and played large role in procuring of hotels (WS §44 onwards). She played a hands-on role in responding to the public health concerns at Manston (WS §58 onwards). She took responsibility for those issues at the time Manston was acutely at crisis and had daily calls with the Home Secretary on accommodation. She then led Asylum and Protection through the emptying of the site and the immediate aftermath of Mr Ahmed’s death (Ibid §106). She is thus an important witness on key issues.	Abigail Tierney’s WS [mans001:0007749 5]; Anthony Eastaugh’s WS [mans001.0007611 7]

	Individual	Role/ Department	Reasons	Relevant Refs
			Dr Tierney is uniquely placed on the question of organisational ethos, which the CTI Note has indicated the Chair will address through the existing issues (Note §§66-71): Mr Eastaugh consulted her, as Ethical Champion, on how officials should proceed “<i>from an ethical, moral and professional perspective</i>” when ministers refused bail (Eastaugh §80).	
5.	Philip Douglas	DG for Border Force	Mr Douglas was appointed by Suella Braverman on 12/10/22 to be the DG responsible for Manston to “<i>establish clear lines of responsibility with a dedicated team with key operational experience.</i>” (Braverman §41). His witness statement confirms that during this period that Manston was treated as a critical incident with him being a Gold commander for the site and visiting at least once weekly (§91-92). Mr Douglas signed off the “<i>Manston Recovery – Plan for a Plan</i>” submission of 22 October 2022 (Eastaugh §96) and led the operational recovery and communications to staff (Ibid §§97, 99, 101). His evidence goes to Issues 42-44 and 51-52. His live evidence will be important to understand how the Home Office managed Manston on the ground during this period and how the critical conditions developed.	Suella Braverman’s WS; [mans001:0007697 9]; Philip Douglas’ WS [mans001:000774]; Anthony Eastaugh’s WS [mans001.0007611 7]
6.	Emma Porter	Director of Future, Planning and Capability, CCTC	- Ms Porter played a key role in the logistical planning and setting up of Manston after CCTC noted that WJF was struggling for capacity. She was involved in multiple Military Aid to Civil Authorities (“MACA”) requests for military support and as part of process of identifying Manston as a suitable site (Porter §14-22) and subsequently became responsible for setting up Manston as a STHF. Ms Porter was also responsible for ensuring accommodation compliance with health and safety provisions – e.g. listing with the CPFSI (Ridley §§209 and 217). She was also responsible for drafting the submission to Ministers on the need to revise the operational model at Manston, and bail options to deal with outflow, in April 2022 (mans001:00000371). She continued to deal with operational issues on site right throughout the relevant period. - Given her role, her live evidence will assist the Inquiry in understanding the decision-making processes involving HO/CCTC officials and ministers. Her statement (§101-3) further sets out concerns about Ministerial failures which ought to be explored in live evidence.	Emma Porter’s WS ([mans001:0007611 5]; Simon Ridley’s WS [mans001:0007358 9]; mans001:00000371

	Individual	Role/ Department	Reasons	Relevant Refs
7.	Stephen Kershaw	Home Office Pay Band 2 Director for Strategic Services and Transformation in Immigration Enforcement	Mr Kershaw reported to the DG and was originally Manston's de facto SRO. He led the Home Office's planning for Manston from early December 2021 until his sudden departure on 10/2/22 (Eastaugh §29). His evidence goes directly to Issues 7, 8, 13, 39 and 53. He can speak to the 15/12/21 decision that Manston would operate as a Holding Room under the Short-Term Holding Facility Rules 2018, with the 24-hour limit that decision entailed (Ridley §189); to the public commitments made about the site; and to the ministerial pressure under which it was established. His <i>"Manston Phase 3 Worry List"</i> of 8/2/22 identified, before Phase 3 began, the unresolved risks which later materialised, and he left without a formal handover to his successor (Kershaw §§35-§36). It is necessary for the Inquiry and in the interests of fairness to examine the founding decisions with the official involved in them, and not just his successors.	Stephen Kershaw's WS [mans001:00044050]; Anthony Eastaugh's WS [mans001.00076117]; Simon Ridley's WS [mans001:00073589]; mans00100001146
8.	Michelle Jarman-Howe CBE	HMPPS	The author of the 7/10/22 letter recording that <i>"The operation of Manston was unlawful"</i> and that it was <i>"unregulated and unsafe as a place of detention"</i> (Ridley §863), following the HMPPS site visit of 6/10/22 (Ibid §945). This is the starkest contemporaneous external assessment of the site's lawfulness. How that assessment came to be made, and the response to it, are matters for oral evidence (Issues 27, 29-30).	Simon Ridley's WS [mans001:00073589]
9.	Matthew Drinkwater	NHS Kent and Medway Integrated Care Board	NHS Kent and Medway Integrated Care Board made 13 recommendations to the Home Office as early as January 2022 (Ridley §248) and wrote on 4/11/22 that the manner in which children were being held <i>"contravened"</i> their rights under the United Nations Convention on the Rights of the Child, with children <i>"sleeping on roll mats in unheated"</i> and damp accommodation at risk of diphtheria (Ibid §§1112-1113). This evidence is central to Issues 25(b), 31 and 32-38, and to the treatment of children at Manston. Its importance and likely value justify it being explored in oral evidence.	Simon Ridley's WS [mans001:00073589]
10.	Penny Button	Thanet District Council	Thanet's environmental health inspection of 9/9/22 found the catering service unregistered and never inspected for food hygiene, toilets <i>"blocked with excrement on the internal and external areas"</i>, and medical centre staff <i>"unaware of the gastrointestinal illness outbreak"</i> (Ridley §700). This is direct, independent and contemporaneous evidence of conditions (Issues 24 and 33) and of the regulatory oversight of the site, including its efficacy (Issue 30). Its importance and likely value justify it being explored in oral evidence.	Simon Ridley's WS [mans001:00073589]

	Individual	Role/ Department	Reasons	Relevant Refs
11.	Ms Sarah Hammond	Interim Corporate Director for Adult Social Care and Health (since October 2025) Corporate Director for Children, Young People and Education (since June 2022)	Ms Hammond was the statutory Director of Children's Services during Relevant Period. Ms Hammond's witness statement addresses: (i) the refusal of Kent County Council ("KCC") to accept unaccompanied asylum-seeking children during the Relevant Period including placing 16- and 17-year-olds at Manston; (Issues 18, 39-42) concerning capacity at Manston; (ii) safeguarding referrals to KCC; (Issues 4, 25) and (iii) children referred following age assessments (Issues 4). Its importance and likely value justify it being explored in oral evidence.	Sarah Hammond's WS [mans001:0007358 6]

ANNEX C

CONSOLIDATED LIST OF REQUESTS

For ease of reference, the requests and invitations made in these submissions are as follows:

Witness statements

1. To confirm the Inquiry will seek statements from the further individuals and organisations identified at Annex A.
2. To confirm that further focused requests for statements proposed by IPs after the Preliminary Hearing will be considered on their merits.

The provisional witness list

3. To confirm that the Inquiry will include in the provisional list the witnesses identified in Annex B.

The undertaking

4. To direct the Home Office to confirm its position on the undertaking in writing before the Preliminary Hearing.

Special measures

5. To facilitate, in advance of a detained witness's evidence: (i) a short introduction between detained witness and interpreter, and (ii) a familiarisation visit to the hearing room (or, for those giving evidence by live link, a technical test).
6. To indicate that the Inquiry will permit acutely vulnerable witnesses, where an application shows the need, to give live-link evidence from a familiar location such as the offices of their instructing solicitor (in place of a special room at the hearing centre).
7. To confirm:
 - a. That special measures applications will ordinarily be determined not less than two weeks before the relevant witness gives evidence;
 - b. That in advance of the hearing, (i) the Inquiry will inform a witness what special measures will be in place and (ii) it will be made clear to them that no adverse inference of any kind will be drawn from a witness' use of special measures;
 - c. That the evidence of detained witnesses will be listed realistically, with an agreed means by which the witness can indicate that they need a break, and without their evidence being compressed at the end of a sitting day;

- d. That detainee witnesses giving oral evidence will be questioned only by CTI or by their own counsel;
- e. For vulnerable witnesses whose trauma is attributable to gender-based violence, that the Inquiry will secure, upon reasoned application made in advance, an interpreter of the requested sex;
- f. That the following trauma-informed adaptations will also be available as special measures under §30 of the Protocol: (i) regular breaks, (ii) shorter sitting periods, (iii) questions structured simply, and (iv) the avoidance of unnecessarily re-traumatising material where a fact is not in dispute and “no go areas” of questioning agreed in advance; and
- g. That an appropriately qualified emotional support service will be available at the hearing centre on the days on which former detainees give evidence.

Disclosure

- 8. To confirm that the Inquiry will publish a timetable for the disclosure of the outstanding balance of approximately 6,500 documents.
- 9. To direct:
 - a. That the Home Office’s anonymity application be made by a fixed (and short) deadline, failing which the provisional redactions applied pending that application be lifted; and
 - b. Any further application for redaction or anonymity in respect of material already provided to the Inquiry be made by a fixed deadline, after which such applications will be entertained only in exceptional circumstances.

Film footage

- 10. To confirm when the footage will be disclosed to IPs.
- 11. To confirm that the Inquiry will provide, prior to the preliminary hearing:
 - a. A description of the footage, including the periods it covers and a broad description of the nature of the events recorded (including whether it records uses of force or, for example, events surrounding Mr Ahmed’s illness, death and the investigations that followed);
 - b. An explanation of when the footage was identified and why its existence has only now been indicated to IPs; and
 - c. An explanation as to the reasoning for the Inquiry’s proposed approach to pixelation of the footage (CTI’s Note, §37).

12. To confirm that all reasonable steps have been taken to identify and secure all other potentially relevant footage, including any further body-worn, CCTV or mobile telephone footage held by the police, the Home Office, its contractors or other agencies.

Expert evidence

13. To instruct an expert on the impact of detention at Manston on children.
14. To instruct an expert on the use of force, discipline and punitive measures.
15. To instruct an expert on institutional racism and institutional culture.

Hearing dates

16. To announce, at or as soon as possible after the Preliminary Hearing:
 - a. A listing window for the substantive hearings commencing as soon as possible in the New Year; and
 - b. The Inquiry's best estimate of their overall length and phasing.

Private and Confidential

Solicitor's ref: MPS

Our ref: SF.ZGW/MS - 09/2025

**Generic Report on Unaccompanied asylum seeking (UAS)
children: age disputed, detained in Western Jet Foil (WJF) and
Manston Short Term Holding Facility (STHF) and placed as
adults in Hotel Asylum Accommodation.
An overview of relevant research and analysis of findings and
direct clinical experience**

Date of report: 1st December 2025

This report has been prepared at the request of:
Bhatt Murphy Solicitors and Deighton Pierce Glynn

,

This report has been prepared by:

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Report of: Dr Susannah Fairweather and Dr Zoe Given-Wilson

Specialist field: Child and Adolescent Psychiatry and Psychology

Instructed by: Mr Mark Scott, solicitor on behalf of Bhatt Murphy Solicitors and Deighton Peirce Glynn.

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1.0 **INTRODUCTION**

- 1.1 This report has been prepared at the instruction of Mr Mark Scott of Bhatt Murphy solicitors in a letter via e-mail dated 1st August 2025. Bhatt Murphy Solicitors and Deighton Peirce Glynn are both acting for a number of Unaccompanied Asylum Seeking children (UAS) who are bringing civil claims for compensation relating to their treatment post arrival as asylum seekers on small boats in Kent, UK. They were age disputed, detained in immigration detention and placed in hotel accommodation as adults.
- 1.2 We have been requested to conduct a targeted literature review and together with consideration of our clinical expertise and assessments of individual young people, prepare a report for court which considers how a UAS child's mental health may have been affected dealing with issues of: mental trauma/psychiatric disorder on arrival to the UK, what factors increase/decrease the level of trauma/distress, the individual and cumulative impact of detention and age assessment, accommodation in adult facilities and not receiving child appropriate safeguards, support and assistance.
- 1.3 Our response to these instructions will appear in 8.0, the "OPINION" section.

2.0 **EXECUTIVE SUMMARY**

- 2.1 We reviewed key literature in respect to prevalence of trauma/psychiatric disorder in UAS children who have been detained in immigration centres, the impact of detention and age assessment on mental health of UAS children; and differential reactions depending on the specific conditions of detention and age assessment.
- 2.2 There is established consensus that those seeking asylum are at higher risk of developing psychiatric disorder. The most commonly diagnosed psychiatric disorders are Posttraumatic stress disorder, depression, anxiety and common reports

of somatic complaints and sleep disorders. UAS children are at even greater risk than their accompanied peers of developing psychiatric disorders

2.3 Unaccompanied asylum seeking children are exposed to cumulative adversity during displacement, during their journey, and resettlement which frequently results in psychiatric disorder and/or mental distress. There is evidence to suggest that this can be both a cumulative and distinct contribution of resettlement experiences.

2.4 The literature review provides strong and consistent evidence that detention is associated with poorer mental health and without adequate support deterioration in UAS children compared with those not detained. Age assessment has been found to have a detrimental impact on mental health. An ecological systems approach to understanding children's individual mental health highlights how these already vulnerable children can be profoundly and negatively impacted by detention, incorrect age assessment and accommodation without adequate support.

2.5 Based on the literature review evidence and our clinical experience, detention in WJF and Manston STHF, incorrect age assessment and accommodation in adult asylum accommodation hotels is likely to have had a highly deleterious impact on UAS children with the potential to cause the development of psychiatric disorder and symptoms, mental distress falling short of diagnosable psychiatric disorder and exacerbating symptoms of existing psychiatric disorder.

3.0 **QUALIFICATIONS**

3.1 **Dr Susannah Fairweather**

3.1.1 Dr Susannah Fairweather is a Consultant Psychiatrist. Since 2013, she has worked at the Tavistock and Portman NHS Foundation Trust. She is the Consultant Psychiatrist in the Children Looked After and Unaccompanied Asylum Seeking

Children CAMHS, which provides mental health care for children and young people up to 25 years old. From 2014 – 2023, she also worked in the integrated service for Children and Young People with Disability. From 2017 – 2020, she was the Consultant Psychiatrist for the Returning Families Unit, a national specialist mental health service commissioned by the Home Office for British national families returning from the Syrian conflict. From 2013 – 2016, She was the Consultant Psychiatrist for the Camden Complex Needs Outreach Service, a specialist mental health service for local young people placed in out of borough residential placements because local provisions could not meet their needs. Prior to this, she was a Consultant Psychiatrist at the North East London NHS Foundation Trust. In this service, she was Lead Clinician for the Emotional Disorders Pathway; Lead Child and Adolescent Psychiatrist for the Early Intervention Psychosis Service and the LAC mental health team.

- 3.1.2 She attended the University of Cambridge for her pre-clinical medical degree, completing her clinical training at Barts and the London Medical School, University of London in 2004. She completed her core training in Psychiatry on the University College London and Royal Free Hospital training rotations, gaining membership of the Royal College of Psychiatrists in 2008. She undertook her specialist training in Child and Adolescent Psychiatry on the Great Ormond Street Hospital and Royal London Higher Training scheme.
- 3.1.3 She has had further specialist training in assessing the mental health of refugee and asylum seekers of all ages. She is a member of the working party for asylum seeker and refugee mental health at the Royal College of Psychiatrists. She has presented at national conferences on the mental health of refugees and asylum seekers.
- 3.1.4 Dr Fairweather has extensive experience in the assessment and management of a wide range of emotional disorders, neurodevelopmental disorders and complex mental illness presentations in children, young people and adults, many who have

been severely traumatised and abused. This experience includes assessing and treating multi-problem families, multi-agency consultation and assessing risk.

3.1.5 She has published in the area of psychiatric assessment and prepared an Invited paper for the International Journal of Human Rights in Healthcare, on the mental health of young refugee and asylum seekers in the Calais Jungle, publication date December 2017.

3.1.6 She is a Clinical and Educational Supervisor in psychiatry for the London Deanery, providing training and supervision of junior psychiatrists in the assessment of the psychiatric consequences of trauma and in medico legal report writing.

3.1.7 She is regularly instructed as an expert witness in the civil courts and Asylum and Immigration Tribunals. She has undertaken expert witness assessments in the UK and internationally.

3.2 **Dr Zoe Given Wilson**

3.2.1 Dr Zoe Given-Wilson is a Clinical Psychologist. Currently Dr Given-Wilson is employed by Trauma Treatment International, The Anna Freud Children and Young People's Mental Health charity and Royal Holloway University of London. These roles share a common thread of working with people who have experienced trauma, the context of asylum and maintaining the quality of academic teaching in the areas of forensic and child and adolescent mental health.

3.2.2 Previously in her role at the Tavistock and Portman NHS Foundation Trust, Dr Given-Wilson worked as the trauma-specialist and lead psychologist in the Children Looked After Children's (CLA) and Unaccompanied Asylum Seeking Child and Adolescent Mental Health Service (CLA/UAS CAMHS). She worked in this role between 2019 and 2025. Prior to this Dr Given-Wilson was employed by NELFT NHS Foundation

Trust and worked as the Care Pathway Lead for Psychological Therapies within Tier 4 acute adolescent services.

3.2.3 In her role at Royal Holloway University of London, Dr Given-Wilson works as a postdoctoral researcher for the Centre for the Study of Emotion and Law. She has worked at the research centre since 2013.

3.2.4 Dr Given-Wilson attended University College London to complete her Doctorate in Clinical Psychology between 2010-2013. This course is recognised by the British Psychological Society and Health and Care Professions Council. Dr Given-Wilson is registered as a practitioner psychologist with the Health and Care Professions Council.

3.2.5 Dr Given-Wilson has further specialist training in working with traumatised children and young people. This training includes Trauma Focused Cognitive Behavioural Therapy for Children and Young People (Anna Freud Centre 2016); Eye-Movement Desensitization Reprocessing (EMDR; Alexandra Richman, 2019-2020), Narrative Exposure Therapy for children (NET; Dr Robjant, 2019), Teaching Recovery Techniques for Trauma (TRT, Children of War Foundation, 2019). For complex trauma Dr Given-Wilson has also trained in Mentalisation Based Treatment for Children and Adolescents and supervision (MBT-A; Anna Freud Centre, 2013 and 2016) and advanced EMDR (Alexandra Richman, 2021).

3.2.6 Dr Given-Wilson has extensive experience in the assessment and management of a wide range of emotional disorders, neurodevelopmental disorders and complex mental illness presentations in children and young people many who have been severely traumatised and abused. This experience includes assessing and treating multi-problem families, multi-agency consultation and assessing risk.

3.2.7 Dr Given-Wilson has published in the area of children and young people's emotional difficulties and trauma including impact on legal processes of traumatised asylum-

seeking minors. She has completed several systematic literature reviews and published these in peer reviewed journals.

3.2.8 Dr Given-Wilson is a clinical and research supervisor for doctoral students training in Clinical Psychology. This includes overseeing original research and systematic literature reviews as part of doctoral thesis and developing clinical assessment and treatment skills in developing clinicians.

4.0 **BACKGROUND**

4.1 In brief, we understand from our letter of instruction that Bhatt Murphy and Deighton Peirce Glynn represent a number of UAS children and young people who present with common features in their histories including: arduous journeys to reach the UK with the last phase of the journey via small boat from France to Kent, UK; are either from sub Saharan Africa (mainly Sudan and South Sudan) or are Kurdish Iranian; were detained and age disputed following arrival at Western Jet Foil (WJF), assigned an adult date of birth and thereafter treated as an adult and not provided with support that local authorities are obliged to provide to UAS children under the Children Act 1989; were transferred from WJF to Manston Short Term Holding Facility (STHF) and detained there in summer/autumn 2022 when the majority of the cohort arrived in the UK (with poor conditions being widely documented); were in some cases subjected to further detention in other immigration detention centres (IRCS); were transferred into adult hotels and were subsequently accepted by local authorities as children and thereafter treated as children by the Home Office.

5.0 **SOURCES OF INFORMATION**

A. Documentation

(See Appendix 1 for the documentation reviewed.)

B. Literature Review

6.0 **DOCUMENTATION**

6.1 We have been provided with background documentation to consider from our instructing solicitors into these matters (see Appendix 1). We have reviewed each document chosen to summarise the relevant information gained from specific documents in respect of issues relevant to our instructions, rather than provide a summary of all the information provided. We will comment on the relevance and psychiatric/psychological interpretation of any information presented in this summary in section 8.0 Opinion.

CONDITIONS	
Issue/concern/harm identified	Source
"5. Western Jet Foil was not equipped for the increased number of arrivals, delays in transferring detainees led to no floor space, overcrowding with detainees sleeping in close proximity. The area where the detained individuals were held often seemed to lack fresh air. There was often a stale, almost unpleasant atmosphere."	Conditions at Western Jet Foil
"6. Upon arrival to Western Jet Foil detainees were left confused as interpreters were not utilised effectively, by staff. Those detained for prolonged periods of time were unclear of what was happening..."	Conditions at Western Jet Foil
"9. Isolation units which were used to isolate cases with scabies/diphtheria	Conditions at Western Jet Foil

Report of: Dr Susannah Fairweather and Dr Zoe Given-Wilson

Specialist field: Child and Adolescent Psychiatry and Psychology

Instructed by: Mr Mark Scott, solicitor on behalf of Bhatt Murphy Solicitors and Deighton Peirce Glynn.

have been considered inadequate and inappropriate to be used for more than a few hours...”	
“10. There was no dedicated prayer room at Western Jet Foil, and no religious items were provided to detainees	Conditions at Western Jet Foil
“2. From 25-28 July 2022, HM Inspector of Prisons (‘HMIP’) made an unannounced inspection of short-term holding facilities including Manston the report raised concerns including about the lack of information to identify vulnerable detainees, the lack of access to fresh air, detainees being prevented from using toilets in private, and unhealthy food. The report also expressed concern at the length of time for which detainees were held at Manston...”	Conditions at Manston House
“3. On 6 October 2022 the Prison Officers Association (‘POA’) issued a public statement expressing concerns about individuals being detained at Manston for up to a week, the facility running out of drinking water and food for days, inadequate bedding and laundry, cleaning regimes not being	Conditions at Manston House

Generic Report

1st December 2025

Civil claim for compensation against the Home Office for Unaccompanied asylum seeking (UAS) children:
age disputed, detained and placed as adults in hotels post arrival in the UK

Report of: Dr Susannah Fairweather and Dr Zoe Given-Wilson

Specialist field: Child and Adolescent Psychiatry and Psychology

Instructed by: Mr Mark Scott, solicitor on behalf of Bhatt Murphy Solicitors and Deighton Peirce Glynn.

adhered to, resulting mould and bacteria developing in the marquees.”	
“4. On 21 October 2022 a Diphtheria outbreak was confirmed at Manston. Following the outbreak a case of MRSA was reported. As a result those detained in Manston began to receive vaccinations, it was later reported on 19 November that a man being held at Manston has died after falling ill. It was subsequently confirmed that he had contracted diphtheria...”	Conditions at Manston House
“8. Those being held at Manston describe being forced to sleep on the floor with bedding limited to a thin blanket. Each tent held up to several hundred detainees, sleeping in close proximity leading to the spread of contagious infections. A GP was only stationed at the centre from early November 2022 despite the risk of disease spreading.	Conditions at Manston House
“9. Detainees were preventing from going to the toilet, taking a shower or going outside for a walk. Those detained had their phones taken were prevented from contacting their families. Officers referred to detainees to a number based on the boat that they had arrived on.”	Conditions at Manston House

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“10. Appropriate care or consideration was not given to vulnerable groups such as those with mental health conditions, victims of trafficking... It was reported that Detainees who were Muslim had to eat non-Halal meat due to the food available...”	Conditions at Manston House
“5. Fair and humane treatment. 5.1 Accommodation, clothing, food... Manston: ... during monitoring visits in November, the Board noticed that blankets had been stuffed into the gaps between the joints of the marquees and the sodden cloth to keep out the wind and the rain...”	Independent Monitoring Boards - Annual Report of the Kent Coast Short-Term Holding Facilities For reporting year: 1 January 2022 – 31 December 2022 dated October 2023
INTER-PERSONAL	
Issue/concern/harm identified	Source
“11. The conditions at Manston led tension among detainees, documents reveal that there were fights over food and overcrowding, a Border Force Staff official stated, “All of that comes from and is driven by being restrained in conditions which are not designed to meet basic human needs.”	Conditions at Manston House
“12. Those working at Manston dealt with fights by handcuffing and restraining detainees in one incident a man was pinned to the ground, hit with	Conditions at Manston House

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an “elbow strike” and put in leg restraints. One detainee claims to have been racially abused and assaulted by guards who punched him and dragged across the floor. Staff would lock detainees in ‘cell vans’ where some detainees began to self-harm...”	
“4. Detainees’ vulnerability was not always recorded to inform subsequent assessments. Detainees with disabilities and trafficking victims were held at Manston...”	HM Chief Inspector of Prisons Report on an unannounced inspection of the short-term holding facilities at Western Jet Foil, Lydd Airport and Manston 25–28 July 2022
“6. The governance of security clearances and training of staff at Western Jet Foil and Manston sites was weak... it was not possible to determine if all staff had undergone relevant checks or appropriate training to work with children and vulnerable adults.”	HM Chief Inspector of Prisons Report on an unannounced inspection of the short-term holding facilities at Western Jet Foil, Lydd Airport and Manston 25–28 July 2022
“9. Detainees were searched too many times and not always with sufficient sensitivity by Home Office staff.”	HM Chief Inspector of Prisons Report on an unannounced inspection of the short-term holding facilities at Western Jet Foil, Lydd Airport and Manston 25–28 July 2022
“12. Detainees at the screening building were not allowed to use toilets in private.”	HM Chief Inspector of Prisons Report on an unannounced inspection of the short-term holding facilities at Western

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	Jet Foil, Lydd Airport and Manston 25–28 July 2022
“13. Detainees did not have adequate access to phones... some detainees’ request for a phone was refused with no explanation.”	HM Chief Inspector of Prisons Report on an unannounced inspection of the short-term holding facilities at Western Jet Foil, Lydd Airport and Manston 25–28 July 2022
“14. Detainees were given very little information about the next steps when leaving Manston.”	HM Chief Inspector of Prisons Report on an unannounced inspection of the short-term holding facilities at Western Jet Foil, Lydd Airport and Manston 25–28 July 2022
“43. The delegation learned that during the period of excessive occupancy rates, the situation at Manston STHF could become tense. The incidents logs examined by the delegation recorded several examples of unrest involving migrants such as fights, assaults on staff, collective protests, destruction of property, fabrication of makeshift weapons and episodes of self-harm...”	Report to the United Kingdom Government on the ad hoc visit to United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) dated 29th June 2023
“47. ... Further, it was not clear to the delegation how such elements of vulnerability would then be shared with the other institutional actors for the purposes of detention.”	Report to the United Kingdom Government on the ad hoc visit to United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or

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	Degrading Treatment or Punishment (CPT) dated 29th June 2023
"5. Fair and humane treatment. 5.2 Staff/detained person relationships ... At Manston, Mitie Security were on site during the period of increased occupancy in the autumn, but they were only allowed to stand in the middle of the quadrant of marquees, rather than have any interaction with the detained people...	Independent Monitoring Boards - Annual Report of the Kent Coast Short-Term Holding Facilities For reporting year: 1 January 2022 – 31 December 2022 dated October 2023
"... You asked for information relating to addressing the specific needs of vulnerable people being held at Manston, including children, potential victims of trafficking, and those with disabilities. The fundamental changes to our processes and the prioritisation of SOLAS management at the WJF ahead of formal processing at Manston means that our staff now have more capacity and opportunity to identify vulnerability. Vulnerability is now captured and recorded at the earliest opportunity and tracked and reviewed throughout the non-detained process and thereafter. In most cases it is recorded at the WJF – with beach landings being	Letter from Suella Braverman to Home Affairs Committee dated 28th November 2022

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triaged and recorded upon arrival at Manston. We continue to prioritise the welfare of UASCs, families and vulnerable adults at the initial point of arrival...”	
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7.0 **LITERATURE REVIEW**

7.1 **Literature review methodology**

7.1.1 To address the instructions, this review provides an overview of existing research published in peer-review journals addressing UAS children’s experiences of detention and age assessment.

7.1.2 A Rapid Evidence Assessment review methodology was adopted. This methodology allows for a rigorous and streamlined review of existing research published in peer-review journals. The methodology is transparent and could be replicated if required. It is conducted in a shorter timeframe than a full systematic review and is restricted to specific databases.

7.1.3 The articles included in this Rapid Evidence Assessment literature review were identified through two phases of database search. The first stage involved an initial scoping search on Google Scholar. The second stage involved a search on PsychINFO, a scholarly database.

7.1.4 The PsychINFO database was selected as it is the primary abstracting and indexing database for psychology, behavioural and social sciences.

7.1.5 Dr Zoe Given-Wilson completed the Rapid Evidence Assessment review.

7.1.6 Dr Zoe Given-Wilson and Dr Susannah Fairweather reviewed all the selected full-text articles included in this review of the current academic evidence to inform our opinion.

7.1.7 **Stage one: Initial scoping search on Google Scholar**

7.1.7.1 The initial scoping search through Google Scholar was conducted on the 28th August 2025. The purpose of this initial scoping search was to ascertain the breadth, scope and nature of the published literature on the areas relating to this report. Google Scholar was chosen for the initial scoping search due to the inclusive nature of its search outputs, meaning it has a wide coverage across various types of sources, including peer-reviewed scholarly journals, unpublished theses and book chapters (Martín-Martín et al., 2019).

7.1.8 **Stage two: Rapid Evidence Review on PsychINFO**

7.1.8.1 The PsychINFO database search was conducted on 3rd September 2025. A scholarly database was selected for the second search as it allows more focussed searching for articles containing specific key words and that are peer-reviewed (Martín-Martín et al., 2019).

7.1.8.2 Four searches were conducted using different search terms to identify articles that had the given search terms in the title, abstract or keyword list of the article.

1. Search One used the search term “detention” to capture articles related to detention. 5064 articles were identified.
2. Search Two aimed to capture articles related to children. The search terms “child* or you* or minor*” were used. 1,490,488 articles were identified.
3. Search Three aimed to capture articles exploring children’s threat processing and perception. The search combined terms were “asylum” or “refugee*” or “migrant*”. From this search 31150 articles were identified.

4. Search Four combined the papers identified in Search 1, 2 and 3 and produced articles which held the search terms from all three searches. This combined search identified 164 articles.

7.1.8.3 The 164 articles were reviewed by reading the title and abstract to determine if they were relevant. Following this review 138 articles were excluded due to not meeting inclusion criteria (see below). 26 articles were retained.

7.1.8.4 The full text version of these 26 articles were read and a further 14 papers were excluded due to poor methodology or lack of relevance to the instructions.

7.1.8.5 Following full text review to ensure relevant articles of acceptable methodology and quality 12 papers were retained for review. An additional 4 papers were identified through references and hand search which were also included in the review. (An asterix * demarks these papers in the reference list.)

7.1.8.6 Additional grey literature (e.g. reports) is referred to in the opinion section where we sought to triangulate understanding between the published peer-reviewed literature and clinical observation to inform our opinion.

7.1.9 Inclusion criteria

7.1.9.1 Across both the Google Scholar and PsychINFO searches, specific inclusion criteria were used to guide the decision making during the title and abstract screening of the articles. These included:

- Articles reporting on children (up to 18 years) and their psychological responses to their experiences of seeking asylum and included measure of impact of detention and age assessment.
- Articles reporting on empirical research of an acceptable quality.
- Peer-reviewed published literature of empirical research.

- Articles were published in English, reflecting language spoken by the authors of this report.

7.1.10 Quality assessment

7.1.10.1 A full quality assessment of each paper was beyond the scope of this review. However, the literature was assessed in relation to key quality criteria including:

- Were research questions clearly stated and the study population clearly defined?
- Was the sample size appropriate?
- Were measures used valid and reliable?
- Were there any confounding variables? If so, were these adjusted for?

7.2 Introduction to Findings

7.2.1 The following section provides a synthesised summary of the findings from the papers reviewed. It is organised into themes which reflect the literature as well as addressing the legal instructions. These themes are:

1. Prevalence of emotional distress and psychiatric disorder upon arrival
2. Impact of detention on mental health
3. Impact of age assessment on mental health
4. Risk and protective factors

7.2.2 Prevalence of emotional distress and mental illness upon arrival

7.2.2.1 There is established consensus that those seeking asylum are at higher risk of developing psychiatric disorder. The most commonly diagnosed psychiatric disorders are Posttraumatic stress disorder, depression, anxiety and somatic complaints and sleep disorders (e.g. Derluyn et al., 2023; Hayon & Oates, 2019).

For example, rates of PTSD among UAS children are found to be between 17% - 85% with a mean prevalence rate of 46% (Oberg & Sharma, 2023), significantly higher than 4% the mean prevalence found in the general comparator population.

- 7.2.2.2 UAS children are at even greater risk than their accompanied peers of developing psychiatric disorders (e.g. Mares, 2021, Ramel et al, 2015). As an example, Ramel et al (2015) found unaccompanied minors seeking asylum in Sweden had higher rates of post traumatic syndromes, anxiety, emotional and behavioural problems including self-harm and suicide attempts than those who arrived with an accompanying adult. The size of the difference depends on the populations studied and how distress is measured.
- 7.2.2.3 Exposure to traumatic events is considered central to contributing to UAS children's risk of psychiatric disorder. For example, Jakobsen et al (2017) found that 96% of the UAS children they assessed had experienced at least one serious and potentially traumatic life event (e.g. threat to life, physical abuse, loss of a close relative).
- 7.2.2.4 Those seeking asylum are at greater risk of exposure to traumatic events at pre-migration stage (e.g. exposure to war, corruption, persecution), during migration (e.g. trafficking, torture, sexual exploitation) and post-migration (e.g. detention, homelessness, racism) (Derluyn et al., 2023)
- 7.2.2.5 Events are recognised as traumatic if they cause threat and feelings of horror and/or helplessness, serious injury or threat of serious injury or death. For diagnostic purposes of post-traumatic stress disorder (PTSD) the current Diagnostic Statistical Manual - 5th Edition (DSM-5, American Psychiatric Association, 2013, p 271) defines a traumatic event as one where 'actual or threatened death, serious injury, or sexual violence' occurs. The International Classification of Diseases – 11th Edition (ICD-11) defines a traumatic event as

‘exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature or series of events. Such events include, but are not limited to, directly experiencing natural or human-made disasters, combat, serious accidents, torture, sexual violence, terrorism, assault or acute life-threatening illness (e.g., a heart attack); witnessing the threatened or actual injury or death of others in a sudden, unexpected, or violent manner; and learning about the sudden, unexpected or violent death of a loved one.’

7.2.2.6 It is important to note that there are individual and cultural variations in how potential traumatic events are experienced and whether they are considered traumatic (Vredevelde et al, 2023).

7.2.3 The impact of detention on mental health

7.2.3.1 This review focused on published studies where the impact of detention was evaluated.

7.2.3.2 There was clear consensus among the research reviewed that detention negatively affected asylum seeking children’s mental health. Robjant et al’s (2009) review on the impact of detention on asylum seekers mental health in children, adolescents and adults concluded that there were consistently higher rates of psychiatric disorder reported among detainees and that there is emerging evidence to suggest the adverse effect of detention has an independent negative impact on mental health over and above other factors such as pre-existing psychiatric disorder.

7.2.3.3 For example, Von Wethern et al.’s (2018) review of published studies on psychiatric disorder among detained children found that 85.7% of detained adolescent asylum seekers had severe psychiatric disorder. Prevalence rates were higher than those asylum seeking children who were not detained.

- 7.2.3.4 Priestly et al.'s (2025) more recent review of 21 studies goes further in its conclusions and states that any form of immigration detention is associated with adverse impact in children's mental health, physical health and development. The authors also outline three factors which when increased worsen outcomes; duration, level of containment and uncertainty on length of stay.
- 7.2.3.5 In Priestly et al.'s (2025) review, 15 of the 21 studies reported on prevalence of mental health symptoms and 2 on non-specific psychological distress. High rates of disorder and distress were reported and more prevalent difficulties were PTSD, anxiety/low mood, sleep difficulties and suicidal ideation and suicide attempts.
- 7.2.3.6 More restrictive detention conditions were also associated with significantly higher rates of psychiatric disorder (Mares, 2021).
- 7.2.3.7 The negative impact of detention on mental health was found by most studies to have a lasting effect. A UK based study found that 89% of UAS children who had been detained still had a diagnosis of psychiatric disorder 3 years after release (Ehnholt et al., 2018). Kronick et al (2015) also found continuing distress and preoccupation with detention experiences were reported by UAS who had been detained in Canada.
- 7.2.3.8 Longitudinal studies suggest that longer periods in detention worsen mental health (Ehnholt et al, 2018). One study Steel et al. (cited in Priestly et al.,2025) which retrospectively examined children who had been detained reported that there was a tenfold increase in psychiatric morbidity after entering detention.
- 7.2.3.9 Lorek et al (2009) noted that psychological problems emerged in children after they were held in British immigration detention centres and suggest this reflects the unique contribution of detention on psychological difficulties.

- 7.2.3.10 Zwi et al (2018) compared the mental health of children detained with those living in the community. They give the example of children detained for around 43-56 days in Canadian and British detention centres and had high rates of emotional distress, behavioural difficulties, depression, anxiety, sleep problems, somatic complaints and symptoms of PTSD, even if they did not report exposure to physical violence, deprivation and were detained under relatively 'safe' conditions such as access to regular meals, support services and safeguarded from adults.
- 7.2.3.11 Jakobsen et al. (2017) concluded their findings examining UASC detained in Norway are in line with published research which shows that high support accommodation with sufficient supervision is associated with lower levels of psychological symptoms.
- 7.2.3.12 Priestly et al (2025, p1) also state that "no period of detention can be deemed safe" and provide examples of children detained for less than one month who's mental health was affected by detention.
- 7.2.3.13 Von Wethern et al. (2018) found most studies reported worse outcomes in those who had been detained for long term with the exception of three studies. The authors question whether shorter stays in detention, small sample sizes, and possibility of ceiling effects may influence the conclusions.
- 7.2.3.14 One exception was Palacios et al's (2024) paper, which examined the lasting impact of detention on Latinx adolescents' mental health and found that detention was not associated with internalising symptoms (e.g. depression and anxiety) however exposure to trauma was and that trauma impacts migrant youth regardless of time of detainment. It is noteworthy that the children who participated in this study were detained for 4 weeks or less.

7.2.3.15 ***Post-traumatic stress disorder (PTSD)***

7.2.3.15.1 Posttraumatic Stress Disorder (PTSD) is a psychiatric diagnosis characterised by key symptoms of intrusion, avoidance, negative alterations to cognition and mood and hyperarousal. It is triggered by experiencing or witnessing traumatic event(s). It is recognised in both the Diagnostic Statistical Manual of Mental Disorder (DSM 5, American Psychiatric Association, 2013) and International Classification of Disease (ICD 11, World Health Organisation, 2022).

7.2.3.15.2 PTSD was reported to be more prevalent among detained UAS children than those living in the community.

7.2.3.15.3 Ehntholt et al. (2018) reported that the experience of detention resulted in 29% of UAS children developing a diagnosis of PTSD. Detention appeared to exacerbate PTSD symptoms in 51% of those who already had a diagnosis of PTSD. Many of the UAS children in this study also showed an exacerbation in their pre-existing PTSD symptoms related to being detained.

7.2.3.15.4 Priestly et al. (2025) reported that across 21 studies including 17 studies where children were separated from caregivers, at least 32% of detained children had a PTSD diagnosis. Of note, short-term detention (under 3 months) prevalence of PTSD ranged between 17-80% but averaged at 95% for children detained between 3-18 months.

7.2.3.16 ***Depression***

7.2.3.16.1 Depression is another psychiatric disorder that may develop post-trauma either in its own right or comorbid with PTSD (secondary to PTSD or preceding PTSD). Depression is characterised by core symptoms of feeling low, depressed, hopeless and/or of experience limited joy in life, as well as accompanying

symptoms, such as altered sleep and appetite, reduced energy and concentration and presence of suicidal thoughts (American Psychiatric Association, 2013).

7.2.3.16.2 Ehntholt et al. (2018) reported that the experience of detention resulted in 23% of UAS children developing a diagnosis of major depressive disorder. A high proportion of UAS children suffered an exacerbation in pre-existing mood disorder symptoms related to being detained.

7.2.3.16.3 Notably, Lorek et al (2009) found in their child population (some accompanied and some unaccompanied) 100% reported some presence of depression symptoms outside the normal range and 50% meeting the clinically significant threshold.

7.2.3.16.4 The majority of Vietnamese children detained in Hong Kong were 'depressed and anxious' and presented with sadness, lack of energy and disinterest in their surroundings (Mares, 2021).

7.2.3.16.5 Similarly, children detained in Australia presented with pervasive sadness and despair. All indicators of depression. (Mares, 2021).

7.2.3.16.6 Priestly et al. (2025) reported that across 21 studies that around 42.4% of children reported depression and this was more common on those children who remained in protracted or indefinite detention.

7.2.3.16.7 Indefinite detention is when people are detained with no time limit specified and is associated with widespread mental health difficulties and feelings of hopelessness and despair. Psychiatric symptoms were worse for those held indefinitely in closed facilities compared to definite time periods including both anxiety (30%-100% indefinite v 5% definite) and low mood (47%-100% indefinite v 2% definite).

7.2.3.16.8 Von Wethern et al (2018, p13) who reviewed 21 studies and separated findings by age, noted clinically high levels of depression and somatic expressions of sadness and distress in detained children.

7.2.3.17 **Anxiety**

7.2.3.17.1 Anxiety is a further psychiatric disorder that may develop in response to highly stressful or traumatic conditions. Anxiety is an umbrella term encompassing a wide range of anxiety presentations.

7.2.3.17.2 Derluyn et al (2023) reported that UAS children who were isolated from family in detention had more severe anxiety symptoms including worries about family (91%) and uncertainty about their future (80%).

7.2.3.17.3 Lorek et al (2009) found that 66% of children held in British immigration detention aged 7-17 years reported anxiety symptoms within the clinically significant range.

7.2.3.17.4 Kronick et al (2015) compared response of detained children (both unaccompanied and with caregivers) in different ages and reported that older children and adolescents reported high levels of internalising anxiety and separation anxiety. They noted that emotional distress and separation anxiety persisted after children were released from detention.

7.2.3.18 **Other psychological/behavioural reactions.**

7.2.3.18.1 Some of the reviewed studies explored the prevalence of other psychological and behavioural reactions beyond these diagnostic categories. This is particularly helpful in the context of developmental and cross-cultural presentations where variation in reported and presenting symptoms is recognised.

7.2.3.18.2 Lorek et al. (2009) found that those children who were detained and separated from their mothers showed higher rates of emotional problems (49%) compared to those detained but remained with their mothers (29%),

7.2.3.18.3 Zwi et al (2018) found that detention had a negative impact on children's health as well as their developmental progression, with longer detainment resulting in worse outcomes.

7.2.3.18.4 Palacio et al (2024) found three quarters of their participants reported distress associated with detention and described detention being a time of fear and sadness.

7.2.3.18.5 Sleep difficulties are common among UAS children generally, but markedly worse in those in prolonged or indefinite detention. Around 38%-100% of those held in prolonged and indefinite detention had sleep difficulties compared with those who were detained for a short definite period (15%) (Priestly et al., 2025).

7.2.3.18.6 VonWethern et al (2019) reviewed 10 studies and found that the overwhelming majority of children (60%-100%) experienced sleep difficulties and eating problems (100%).

7.2.3.19 ***Suicidal thoughts and behaviours.***

7.2.3.19.1.1 Suicidal ideation, i.e. having thoughts of wanting to die, was reported to be significantly higher in those detained than those living in the community (vonWethern et al., 2018).

7.2.3.19.1.2 Gargiulo et al (2021) examined risk factors associated with increased risk of self-harm and suicide among asylum seekers and found the experience of

being detained as one of the highest risk environments. Furthermore, UAS children were identified as a particularly vulnerable group.

7.2.3.19.1.3 Deliberate self-harm prevalence ranged between 10-80% in Priestly et al (2025) review of 21 studies of detained children. Notably prevalence increases with length of time detained and 100% of children detained for 12-18 months reported suicidal ideation.

7.2.3.19.1.4 Factors associated with self-harm and detention included uncertainty, slow procedures and social isolation which were all associated with greater anxiety and depression and represented clear triggers to self-harm episodes (Garguilo et al, 2021).

7.2.4 Impact of Age Assessment on mental health

7.2.4.1 The experience of being age assessed was found to create distress (Derluyn et al., 2023). Some research found specific links between age assessment and worsening mental health (Jakobsen et al., 2017, Mares, 2021, Ehntholt et al., 2018).

7.2.4.2 The findings suggest that subjecting UAS children to the process of age assessment uniquely harmed their mental health. The UAS children in this cohort were all subject to age disputes (Ehntholt et al., 2018).

7.2.4.3 The consequences of not being believed to be a minor, being placed in adult accommodation, and facing additional legal difficulties are all associated with worsening emotional state (Ehntholt et al., 2018).

7.2.4.4 Similarly, Jakobsen et al (2017) and Mares (2021) both found that age assessment increased UASC vulnerability to developing emotional difficulties. If

the UASC was not believed and treated as an adult further harm was associated with exposure to more administrative processes, being inappropriately housed (or detained) with adults and lack of support in negotiating migration processes.

- 7.2.4.5 Being incorrectly placed in adult accommodation prevented UAS children from accessing mental health support, education and leisure suitable for their developmental stage (Jackobsen et al., 2017, Oberg & Sharma, 2023).
- 7.2.4.6 Being age disputed, assessed as adult and detained with adults also results in further exposure to traumatic events such as forced searches, aggression and violence from officers, violence between detainees and self-harm. Mares (2021) also reported that age dispute and detention were precipitating factors for PTSD symptoms such as intrusive memories.
- 7.2.4.7 Research has acknowledged the differing nature of reactions depending on age (Fremont, 2004; Wooding & Raphael, 2004). Developmental timing will also affect the child's response as there are certain 'critical' timeframes for development in certain domains which may mean the child's affect, appraisal or emotional and physiological regulation will be affected.
- 7.2.4.8 Jakobsen et al.'s (2017) is useful due to its prospective nature. They tracked mental health of UAS children from arrival to Norway and followed up to 26 months. Of the fifty-six percent who were age assessed as adults, half of those were placed in adult accommodation and fared worse in the long term, showing similar levels of distress at 4 months but significantly higher levels of symptoms which persisted between 15 to 26 months.

7.2.5 Risk and Protective factors

7.2.5.1 Trauma responses cannot be understood through a narrow lens of the traumatic incident in isolation. Peer reviewed literature has identified a number of factors which may influence the trajectory of children who have been exposed to a traumatic event. These factors can be broadly understood as either increasing risk (risk factors) or preventing risk (protective factors).

7.2.5.2 To help conceptualise this, it is useful to draw on Bronfenbrenner's bio-ecological systems theory (2001) (See Figure One in Appendix 3) which views a child and their development as a complex system of relationships in their ecology. Bronfenbrenner divides the environment into five systems; at the heart is the child, surrounded by the microsystem (e.g. family, school, health services, neighbourhood) which is thought to be the most influential on the child. This is followed by the mesosystem (interactions of the child's microsystem with wider systems), exosystem (formal and informal structures which do not include the child but directly influence them e.g. parents' economic situation, school operations, governmental policy, extended family and neighbours) macrosystem (attitudes and ideologies of the culture) and chronosystem (environmental changes that occur of life-course).

7.2.5.3 ***Risk and Protective factors at the individual level.***

7.2.5.3.1 It is clear that being unaccompanied significantly increases risk of developing psychiatric disorder and/or distress (Lorek et al., 2009, Mares, 2021)

7.2.5.3.2 The factors which have been found to increase risk of psychopathology in UAS children who are detained include those with higher social needs such as communication difficulties including language differences, difficulties making

friends, feeling bored and feeling they have been treated unfairly (Derluyn et al., 2023) and social isolation (Gargiulo et al., 2021).

7.2.5.3.3 Prior exposure to violence, loss and traumatic events all increase UAS children's risk of developing mental distress or psychiatric disorder including PTSD (Mares, 2021) and depression (Derluyn et al., 2023).

7.2.5.3.4 Improvement in asylum seekers mental health in the long term is associated with positive connection to social life and improved living conditions (Jackobsen et al, 2017) and perhaps relatedly those held in particularly restrictive detention fared worse.

7.2.5.3.5 UAS children who had previously been exposed to violence and loss were more vulnerable to developing psychological disorder when detained than those who had not (Mares, 2021). It is important to note that UAS children have very high rates of exposure to adversity and therefore the majority of UAS children will be at increased vulnerability for any or all of the reasons described above.

7.2.5.4 ***Risk and Protective factors at the system level***

7.2.5.4.1 Children are embedded in systems and relationships which may buffer or exacerbate effects of exposure to traumatic events, as their development is contingent on optimal support from supportive structures and caregivers.

7.2.5.4.2 vonWethern et al. (2018) state that detention is its own risk factor and increases asylum seekers vulnerability to psychiatric disorder and distress due to the associated deprivation of liberty and isolation.

7.2.5.4.3 Detention also increases risk of developing or worsening psychiatric distress by virtue of the fact it often prevents UAS children from accessing appropriate and

adequate mental health assessment and treatment (Lorek et al., 2009). For example, detained adolescents reported that worry was associated with a lack of information and inability to anticipate next steps (Palacios et al., 2024).

7.2.5.4.4 Negative outcome of an asylum claim is associated with poorer mental health. Interestingly the prospective study by Jakobsen et al (2017) found that those who were age assessed as adults, placed in adult accommodation were more likely to have negative asylum claims. An interplay between not receiving age appropriate mental health and legal support could possibly influence asylum decisions, which in turn worsens mental health (Ehnholt et al., 2018, Jakobsen et al., 2017).

7.2.5.4.5 Longer periods of time in detention are associated with worse mental health outcomes (e.g. Priestley et al., 2025).

7.2.5.4.6 It is consistent in the reviewed literature that a lack of appropriate access is associated with poorer outcomes (e.g. Mares, 2021, Lorek et al., 2009). Palacios et al (2024) also reported adolescents view on what made their experience of short term detention better and they identified having food security, social support and healthcare access were positive

8.0 **OPINION**

8.1 The opinions expressed below are based on: our reading of the documentation provided to us; the findings of the literature review; our experience of conducting medico legal reports on a number of children impacted by detention and age assessment upon arrival in Kent, UK and our extensive clinical experience of assessing and managing children and young people who have experienced multiple forms of trauma and post-migration stressors, including age assessment.

8.2 In so far as you are able to opine, are individuals in the cohort likely to have been suffering from mental trauma/psychiatric disorder when they arrived in the UK as a result of their:

- a. Experiences as a child in their host country;**
- b. Separation from family and friends;**
- c. The events of their journey from their host country to France and thereafter the crossing of the channel by small boat to Kent, UK;**
- d. Any other factors.**

8.2.1 In our opinion, it is clearly established that pre, peri and post migration adverse experience and trauma exposure are much higher in asylum seeking populations and even higher in UAS children. Therefore, UAS children are the most vulnerable group for developing psychiatric disorder, psychiatric symptoms falling short of fulfilling diagnostic criteria and other psychological and behavioural reactions. This is likely to be due to the high number of trauma exposures and ongoing increased risk of exposure due to arduous and dangerous journeys without adult guardian protection.

8.2.2 We note the particular nationalities of the cohort (being from sub Saharan African countries, mainly Sudan and South Sudan and Kurdish Iranian). We understand both regions are characterised by political instability, ethnic clashes and high levels of community or state violence and ill-treatment that have persisted over many years. Therefore, the majority, if not all of the cohort, are likely to have been exposed to trauma, associated adverse events and atmosphere of threat due to this context over their childhoods.

8.2.3 Additional to the community based adverse experiences and traumas the cohort are likely to have suffered, based on our clinical experience, it is possible a number of the children also experienced traumas or adverse childhood experiences within their close community/family context. These could include but are not limited to, direct physical, emotional and/or sexual abuse and neglect, exposure to domestic violence,

exposure to parental substance use and/or exposure to parental mental illness, disappearance and death. In our clinical experience, disclosure of these types of experiences is more likely to be delayed and to occur in a context where the child is offered the opportunity to develop a trusting relationship with an adult.

8.2.4 All of these experiences in their country of origin, community and intra-familial, increase their vulnerability to developing psychiatric disorder.

8.2.5 The children in the cohort separated from their family, friends and community at the developmentally sensitive time of adolescence. During this period between childhood and adulthood significant biological, cognitive and emotional development occurs alongside identity formation. Forced migration, causes precipitous independence with the loss of direct family and community support for negotiating these developmental changes. Based on our clinical experience, the children had often not left their countries/culture of origin prior to their forced migration and had limited direct exposure of other cultures. This, alongside their developmental changes, made them additionally vulnerable to experience uneven development and to be influenced by others.

8.2.6 The long and perilous journeys all the children undertook exposed them to significant risks. Most describe contact with agents or people smugglers who controlled aspect of their journeys in poor conditions, some which can be understood as life-threatening, for example due to inadequate food and hydration (especially travelling to northern Africa) or inadequate unsafe boats for the crossings to be made. The particular routes of travelling in Africa, especially through Libya put children at high risk of detention, often for prolonged periods. During detention, conditions are often very poor with lack of food, crowded conditions, direct maltreatment and witnessing others being physically and sexually abused. Other risks include human trafficking, forced labour and exploitation. In our clinical experience the cumulation of these further traumas without direct family support and consistent adult care-givers means

the children are very vulnerable to develop psychiatric symptoms and disorders as a consequence.

8.3 If individuals in the cohort are likely to be suffering from trauma on arrival in the UK can this trauma be described as a recognised psychiatric disorder and if so, what kind of disorder? Please describe the symptoms of any such disorder and the impact of these symptoms on the individual.

8.3.1 The research evidence indicates that the most commonly diagnosed disorders in UAS children are PTSD, Depression, Anxiety and Sleep disorders. Cultural variations may affect accurate diagnosis. Complex PTSD, though recognised clinically for many years, has only recently become a formal diagnosis within ICD-11 in 2022. Due to the lag between research to publication, it means we currently have a lack of evidence on the prevalence of Complex PTSD in this population. However given the high exposure to traumatic events and early developmental stage that the traumas are being experienced, it seems likely that Complex PTSD will be prevalent. This is consistent with our clinical experience.

8.3.2 Posttraumatic Stress Disorder (PTSD) is a psychiatric disorder characterised by key symptoms of intrusion, avoidance, negative alterations to cognition and mood and hyperarousal. Complex PTSD requires the diagnostic criteria for PTSD to be met. In addition, Complex PTSD is characterised by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others.

8.3.3 Depressive disorders are characterised by depressive mood (e.g., sad, irritable, empty) or loss of pleasure accompanied by other cognitive, behavioural, or neurovegetative symptoms that significantly affect the individual's ability to function.

- 8.3.4 Anxiety Disorders vary in their type depending on the focus of anxiety and are characterised by excessive fear and anxiety and related behavioural disturbances, with symptoms that are severe enough to result in significant distress or significant impairment in important areas of functioning. Fear and anxiety are closely related phenomena; fear represents a reaction to perceived imminent threat in the present, whereas anxiety is more future-oriented, referring to perceived anticipated threat.
- 8.3.5 Sleep-wake disorders are characterised by difficulty initiating or maintaining sleep (insomnia disorders), excessive sleepiness (hypersomnolence disorders), respiratory disturbance during sleep (sleep-related breathing disorders), disorders of the sleep-wake schedule (circadian rhythm sleep-wake disorders), abnormal movements during sleep (sleep-related movement disorders), or problematic behavioural or physiological events that occur while falling asleep, during sleep, or upon arousal from sleep (parasomnia disorders). In our clinical experience, children's sleep symptoms are often a symptom of another psychiatric disorder such as PTSD and depressive disorder than a separately diagnosable sleep disorder.
- 8.3.6 All of the above psychiatric disorders cause significant impairment in multiple domains of functioning for a child. Psychiatric disorders are by definition impairing. Due to the nature of the specific disorders identified that UAS children are more likely to suffer from they affect a child's day to day ability to care for themselves and meet their needs. They reduce a child's ability to manage social interactions and relationships. This is particularly relevant when a child is alone and without a care-giving adult. In our clinical experience this increases their risk of exploitation and abuse. They are more likely to acquiesce to demands of adults, particular those in positions of authority due to fear of further abuses or to avoid conflict. The systemic context that these social interactions occur will further shape their ability to respond, dependent on the nature of perceived threat or conversely the opportunity for support offered. The presence of psychiatric disorder means the children are inherently less resilient to external and environmental stressors posed to them and more likely to

experience increased symptom manifestation and deterioration in their state as a result.

8.4 If individuals in the cohort are likely not to have a mental disorder but are experiencing distress falling short of a recognised psychiatric disorder, please describe any symptoms of distress and the likely impact this will have had.

8.4.1 The reviewed literature used a wide range of measures, many which are developed in Western cultural contexts, which affects the outcomes reported. In addition to the common psychiatric diagnoses described above at 8.3, other symptoms were identified including externalising, internalising and somatic symptoms. High rates of self-harm and suicidality were also identified. This is consistent with our clinical experience. It is important to understand that children presenting with such symptoms are also likely to suffer functional impairment in multiple domains of functioning. They are highly vulnerable and at risk of their presentations and/or symptoms escalating, with the potential of becoming diagnosable for formal psychiatric disorder and experiencing further impairment. Our comments above at 8.3.5 are relevant to the impact this will have on them. Given the multiple needs of developing children, in our view it is important to formulate a child's mental health presentation and consequent needs considering all aspects of their history, rather than focus on presence or absence of diagnosable formal psychiatric disorder. This is consistent with the clinical practice of services that we have worked/work in that provide specialist provision for UAS children and young people.

8.4.2 The published guidance on the assessment and treatment of UAS children's health in the UK including psychiatric disorder and mental distress is limited and can lack specificity. However, the existing guidance including National Institute for Health and Social Care Excellence (NICE) Guidance for Looked-after children and young people (with specific reference to UAS children), Royal College of Paediatrics and Child Health (RCPCH) for Children and young people seeking asylum and refugees and a

synthesis review by Yim et al. (2025) do commonly recognise the clinical complexity of UAS children's needs which must be met alongside high social and health needs. Mental health treatment must be delivered in a context of established sense of safety, cultural adaptation alongside wider systemic professional partnership around the child.

8.5 If you are able to say what factors are likely to increase or decrease the level of distress or trauma?

- 8.5.1 Consistent with the above explanations, one can consider factors likely to increase or decrease the level of distress or trauma as risk and protective factors for psychiatric disorder/symptoms. These can be considered utilising Bronfenbrenner's bio-ecological systems theory considering individual and systemic factors of the pre and peri-migration experiences as described above at 7.2.5.2.
- 8.5.2 Children may present with individual inherent vulnerabilities including presence of neurodevelopmental or learning disorders or difficulties. They may have genetic vulnerability to developing psychiatric disorder due to family history. In our clinical experience these factors may not have been identified pre-migration due to cultural/practice in country of origin and differences in education and health systems. These factors would be present prior to forced migration and increase a child's vulnerability to adverse experiences and reduce their ability to manage these.
- 8.5.3 It is well established that the impact of traumatic experiences has a cumulative effect with increased number of traumatic events of differing types increasing the risk that a child will present with psychiatric disorder or exacerbation of existing disorder and severity of symptoms as a result. Therefore, considering the extent of a child's history including that in their host country and the experiences within their journey will provide some indication of their vulnerability to developing psychiatric disorder and symptoms. In our clinical experience early exposure to intra-familial trauma, such as

physical abuse or exposure to domestic violence and the loss of close family members, including witnessing the traumatic deaths directly has a particularly pernicious impact on children's mental health, especially in the context of having to flee as a result. Detention and torture experiences pre or post migration are impactful. Experiences of sexual abuse/assault bring about specific issues around shame, humiliation and distress, especially related to cultural views around sexual contact between males and at a time when psychosexual development is occurring.

8.5.4 In our clinical experience, individual protective factors include inherent abilities and character including an ability to elicit adult support even when unfamiliar to them. Some children had close relatives or family friends travelling with them for periods of time and this provided them with the required adult support and protection. This supported their mental health in threatening environments. Supportive peer relationships are also important in promoting resilience with the collective ability to respond to the stressors they faced.

8.5.5 Ongoing family contact is mainly supportive to mental health both through the direct support this provides but also by providing knowledge that family members are safe. However, some young people seek to protect their family members from the hardship and traumas they face so are not able to seek the support they require. Alternatively, if they hear distressing news about their families, this can provoke severe deteriorations in their mental health.

8.6 **What is the likely impact either individually or cumulatively on individuals in the cohort of:**

- a. Detention and being age disputed following arrival at WJF, assigned an adult date of birth and thereafter treated as an adult and not provided with support that local authorities are obliged to provide UAS children under the Children Act 1989;**
- b. Being transferred from WJF to Manston STHF and detained there;**

- c. Having their belongings, including their phones, seized and damaged / not returned, resulting in some case in loss of communication with their families;**
- d. Being subjected to further detention in other immigration detention centres;**
- e. Being transferred into adult hotels;**
- f. Not being provided with child appropriate support and assistance.**

8.6.1 The research literature provides compelling evidence for the detrimental impact of detention on UAS children with sufficient evidential basis to suggest detention of any duration is harmful.

8.6.2 von Wethern et al.'s (2018) review of published studies on detained children found that 85.7% of detained adolescent asylum seekers had severe psychiatric disorder. Prevalence rates were higher than those asylum seeking children who were not detained. Priestly et al.'s (2025) recent review went further in its conclusions and states that any form of detention is associated with adverse impact in children's mental health, physical health and development. Zwi et al (2018) compared the mental health of children detained with those living in the community and argued that even short periods of detention may be harmful even if they did not report exposure to physical violence, deprivation and were detained under relatively 'safe' conditions. The negative impact of detention on mental health was found by most studies to have a lasting effect. Longitudinal studies suggest that longer periods in detention worsen mental health (Ehnholt et al, 2018). This is relevant to consider for the UAS children who experienced further immigration detention post Manston STHF.

8.6.3 Our clinical experience is consistent with the findings within the literature. Therefore, it is reasonable to conclude that the cohort of UAS children detained in WJF then Manston STHF are likely to have experienced psychiatric disorder and/or other behavioural and distress symptoms. It is difficult to differentiate the separate contribution of impact of detention in WJF and Manston STHF. In our experience the

UAS children found it difficult to differentiate the two and experienced both as part of the same detrimental detention process and situation. Their detention experience was characterised by uncertainty and confusion due to poor communication, lack of interpreters and unclear information about the duration and process of detention. In our experience this contributed to the difficulties in differentiating their experiences and responses to WJF and Manston STHF. This is consistent with our clinical experience which recognises the limitations of autobiographical memory in general and particularly in those experiencing depression and/or PTSD.

8.6.4 In addition to the above, it is important to consider specific aspects of the detention experience at WJF and Manston STHF as described in the available documentation. In our view these would have exacerbated the negative impact of detention on psychiatric disorder and/or mental distress. The descriptions of overcrowding, with lack of privacy for all activities but particularly in respect of toilets and washing would have been highly distressing for adolescents, particularly those who had suffered inter-personal traumas. Given that reminders of traumatic events can trigger re-traumatisation the requirement to sleep in close proximity to unknown adults would have been likely to have been highly distressing for any adolescent but particularly for those previously traumatised where sleep is often difficult and a heightened sense of threat is apparent. It would have been particularly detrimental for those that had a history of sexual assault and abuse. There was an omnipresent threat of illness/infectious disease, through various infective causes. This threat to physical integrity without adequate medical care would have been likely to have provoked significant anxiety further exacerbating mental health likely worsened if the UAS child developed illness or disease. We note the descriptions of lack of trained staff to support children or identify vulnerability. This meant that the UAS children's vulnerability was very likely to only have been identified post detention. The description of how the staff were ordered to interact with the detainees, i.e. remain in the centre quadrant of the marquee, would not have created an environment where relationships that offered the potential for support were present. The UAS children

were subjected to significant dehumanisation through the use of numbers to identify them and decision making that was not individualised to their needs but made on a collective basis.

8.6.5 The literature in respect of UAS children undergoing an age assessment process indicates a detrimental impact. The experience of being age assessed was found to create distress. For example, Derluyn et al.(2023) found that 35% of the detained UAS Children reported age assessment to be a key stressor. Three studies found specific links with worsening mental health (Jakobsen et al., 2017, Mares, 2021, Ehntholt et al., 2018). The findings suggest that subjecting UAS children to age assessment uniquely harmed their mental health with the consequences of not being believed to be a child, being placed in adult detention and accommodation, and facing additional legal difficulties were all associated with worsening emotional state (Ehntholt et al., 2018).

8.6.6 Ehntholt et al (2018) conducted in depth clinical interviews with UAS children who were detained and concluded that the experience of being age disputed caused significant harm.

8.6.7 Jakobsen et al (2017) and Mares (2021) both found that age assessment increased UASC vulnerability to developing emotional difficulties. If the UAS child was treated as an adult further harm was associated with exposure to more administrative processes, being inappropriately housed (or detained) with adults and lack of support in negotiating migration processes. Incorrectly placed in adult accommodation prevented UAS children from accessing mental health support, education and leisure suitable for their developmental stage (Jackobsen et al., 2017).

8.6.8 Being age assessed as adult and detained with adults also results in further exposure to traumatic events such as searches, use of force, aggression and violence from officers, violence between detainees and self-harm. Mares (2021) also reported that

age dispute and detention were precipitating factors for PTSD symptoms such as intrusive memories.

8.6.9 A recent research project conducted by the Helen Bamber Foundation identified the deleterious impact of age assessment conducted by Local Authorities on UAS children's mental health. A focus group identified various themes related to the age dispute process and its consequences and linked with potential negative psychological impact of age assessments and disputes.

8.6.10 Our clinical experience includes assessing and treating UAS children undergoing age assessment processes and undertaking medico-legal reports related to age dispute. Our consistent experience is that the age assessment process has a negative impact on the mental health of those undergoing assessment. Our experience identifies various factors that lead to detrimental impact. The age assessment process itself is stressful, and can be intrusive, with repeated questioning of their history and contributes to ongoing uncertainty of their situation. We have found it results in a specific undermining of a young person's core identity when their age is challenged and/or disbelieved in the context of multiple other losses, including important aspects that contribute to a young person's identity formation such as family, community and culture. The experience of age dispute can further exacerbate problematic symptoms of hopelessness, distrust, persecution and hypervigilance. Our clinical experience of the additional mental health harm arising from being found to be an adult and treated as such is consistent with research findings, with the additional understanding that protracted legal /administrative processes to "correct" the age assignment results in additional distress, exacerbation of existing psychiatric disorder or development of psychiatric disorder.

8.6.11 Our clinical experience of the impact of the age assessment, which occurred at WJF indicates the harmful impact it had on the individual children both in itself and the consequences that arose from it. The UAS children in the main found the experience of their age being disbelieved through a cursory process of assessment shortly after

arrival in the context of their specific histories highly distressing and this distress continued until eventually resolved with further age assessment. We have understood this impact to arise because the UAS children experience a specific undermining of their core identity when they were assessed as an adult. This occurs within their history of forced migration and more likely than not past experiences of dehumanisation. They have lost so much of what would contribute to their identity formation as adolescents; family, home, community, culture, education etc. The dispute and alteration of their age, a core part of their identity is a further experience of dehumanisation and erosion of their sense of self.

8.6.12 Our clinical experience indicates that the UAS children were not fully aware of the long term implications of being assigned an adult age and this only became apparent as they experienced the consequences, which they then had to try and undo, which caused significant ongoing distress and worsened their mental health.

8.6.13 From our clinical experience we are aware of the adverse impact of belongings being removed from the UAS children, some of highly sentimental value and others with practical need such as phones and clothes. In our view this aggravated the UAS children's mental health. The loss of sentimental value items, especially when held since departure from their home context was highly distressing. The lack of return of these items or damage to them indicates the dehumanising, careless processes that could occur during this experience. The lack of access to phones seemed to have multiple impacts. It resulted in the UAS children being unable to access support systems such as family and friends. Also, they could not receive updates on their family who they may have left in precarious situations and is a considerable source of ongoing stress. Additionally, phones are not only communication means but provide activity such as games, watching films to distract and help manage psychiatric symptoms. They often store important photos or memories of family and culture, providing comfort when distress is high. The loss of this can further exacerbate mental health especially at times of stress.

8.6.14 Jakobsen et al (2017) tracked mental health of UAS children from arrival in Norway up to 26 months later. Of the fifty-six percent who were age assessed as adults, half were placed in adult accommodation. All involved in the study had high levels of trauma exposure and rates of mental health symptomology were similar across the whole population at 4 months. However by 15 months the group which were assessed as adults and placed in adult accommodation had higher levels of symptoms, which persisted until the end of the study at 26 months.

8.6.15 There is no peer reviewed research specific to the mental health of children in adult asylum seeker hotels. In our clinical experience the accommodation of UAS children in adult asylum hotels invariably had a detrimental impact due to their needs not being met in such environments, with hotel staff being ill equipped to identify and support their needs. In addition, a significant number experienced exposure to further harm, including an atmosphere of threat, exposure to substance use and physical and /or sexual assault. Dr Fairweather's specific experience of providing expert clinical consultation to the Respond Advice and Guidance multi-disciplinary meeting at University College Hospital, which was originally set up to meet the needs of asylum seekers in local hotels, including children both accompanied and separated (if incorrectly age assessed) further supports this opinion. <https://www.uclh.nhs.uk/our-services/find-service/tropical-and-infectious-diseases/htd-outpatient-services/specialist-services-hospital-tropical-diseases/respond-integrated-refugee-health-service>

8.6.16 In summary, we are of the clear view that being incorrectly treated as an adult was detrimental for the UAS children's mental health because it meant: their core identity was undermined; they were detained (with the detrimental impact of this discussed above); did not have timely social care assessments of their developmental needs as children, including a full understanding of their specific histories and vulnerabilities; were not provided appropriate accommodation for their age; were not provided relevant support; did not undergo health assessment as a child looked after (CLA)

through the Initial Health Assessment (IHA) process, a statutory requirement for CLA and had delayed access to activities to support their developmental needs such as education.

8.7 Is this likely to cause or precipitate any mental disorder or distress or exacerbate any pre-existing mental disorder or distress, if so to what extent?

8.7.1 In addition to what is described above at 8.6, from the reviewed literature some research looked at causality including Lorek et al (2009) which highlighted the unique contribution of detention to psychiatric disorder. Ehntholt et al (2018) also identified through clinical interview the isolated negative impact of detention. vonWethern et al (2018) reported higher risk of psychiatric disorder in detained traumatised individuals than if not traumatised.

8.7.2 Our clinical experience indicates that being detained as a UAS child, being age disputed and incorrectly assessed as an adult, denied appropriate safeguards and not receiving the support required results in significant likelihood of UAS children's mental health being detrimentally affected and this includes causing, precipitating psychiatric disorder and distress and exacerbating pre-existing psychiatric disorder and distress.

8.8 If you are able to say what factors are likely to increase or decrease the level of distress or trauma?

8.8.1 The reviewed literature indicates various risk and protective factors relevant to the cohort held in WJF and Manston House STHF. Being unaccompanied (and in detention) significantly increases risk of developing psychiatric disorder and/or mental distress (Lorek et al., 2009, Mares, 2021). Increased risk of psychopathology included those with higher social needs (Derluyn et al., 2023) and social isolation (Gargiulo et al., 2021). Prior exposure to violence, loss and traumatic events all

increase UAS children's risk of developing mental distress or psychiatric disorder (Mares, 2021). We note that UAS children have very high rates of exposure to adversity and therefore the majority of UAS children will be at increased vulnerability.

8.8.2 vonWethern et al. (2018) states detention in and of itself is its own risk factor and increases asylum seekers vulnerability to psychiatric disorder and distress due to the associated deprivation of liberty and isolation and being accommodated in a developmentally inappropriate environment in adult facilities. Lack of information and inability to anticipate next steps acts as a risk factor for worse mental health (Palacios et al., 2024). Longer periods of time in detention are associated with worse mental health outcomes. More restrictive detention conditions, i.e. conditions which resulted in extreme limitations of movement, autonomy and activity, were also associated with significantly higher rates of mental disorder (Mares, 2021).

8.8.3 Adolescents who experienced short term detention expressed that having food security, social support and healthcare access were positive aspects of their detention (Palacios et al., 2024) which is consistent with the findings that a lack of appropriate access is associated with poorer outcomes (Oberg & Sharma, 2023, Mares, 2021, Lorek et al., 2009).

8.8.4 In our clinical experience further risk factors that led to the development of psychiatric disorder, increased severity and exacerbation of existing psychiatric disorders and development of psychiatric symptoms falling short of meeting diagnostic threshold and including mental distress included expectation of a situation of safety in the UK, prior experiences of being held in detention or other forms of confinement acted as a risk factor for developing psychiatric disorder/ symptoms. UAS children who were exposed to specific traumatic events within detention/confinement, including exposure to fights or altercations and violence between detainees, use of force by staff and other detainees self-harming/ expressing distress seemed particularly vulnerable to worsening mental health and development of psychiatric disorder.

8.8.5 Age at which children are exposed to traumas can also impact their mental distress and psychiatric disorder. Studies reviewed indicate that distress may present in different symptoms depending on the child's age and developmental stage, for example young children are likely to show separation anxiety or selective mutism and adolescents more likely to report anxiety or deliberately self-harm (Kronick et al. 2015, Lorek et al., 2009). Furthermore, the specific impact of detention appears to be detrimental in the short- and long-term, so may have a cumulative negative impact on the child's mental health (Derluyn et al., 2025)

8.8.6 A further factor associated with detrimental impact on mental health included perception of discrimination due to their asylum seeker status, route of arrival and race. For example UAS children held in detention reported being 'treated like cattle' and were dehumanised through operational procedures (Mares, 2021)

8.8.7 WJF and Manston STHF would be understood to have been restrictive in nature given the severe restrictions on the UAS children's movement, autonomy and activity, which is particularly associated with higher rates of psychiatric disorder as described above. The detention was for an uncertain duration and this acted as an aggravating factor. Both facilities were not designed to act as detention centres. Manston House STHF was a disused military barracks. Our clinical experience indicates that for some of the UAS children, due to the military nature, this was further intimidating, re-traumatising and impacted their mental health detrimentally especially when they expected a situation of safety post-arrival.

8.9 Any further comments

8.9.1 We have no further comments.

9.0 **STATEMENT OF COMPLIANCE**

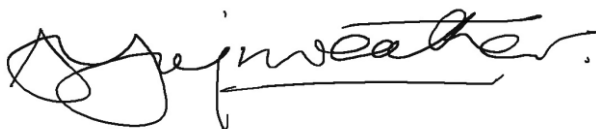
9.1 We understand that it is our duty to the court to provide an impartial professional opinion and to assist the court in reaching a decision. We have complied with that duty. This report includes all matters relevant to the issues on which our evidence is given. We have given details in this report of any matters, which may affect the validity of this report. We have addressed this report to the court.

9.2 We are aware of the requirements of the Civil Procedure Rules (CPR), part 35 and the related practice direction (PD35), including the guidance issued in August 2014.

10.0 **STATEMENT OF TRUTH**

10.1 We confirm that we have made clear which facts and matters referred to in this report are within our own knowledge and which are not. Those that are within our own knowledge we confirm to be true. The opinions we have expressed represent our true and complete professional opinions on the matters to which they refer.

10.2 We 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.



Signed:

Dated: 1st December 2025

Dr Susannah Fairweather, MA (Cantab), MBBS, MRCPsych, DHMSA, DPMSA
Consultant Child and Adolescent Psychiatrist

Generic Report

1st December 2025

Civil claim for compensation against the Home Office for Unaccompanied asylum seeking (UAS) children:
age disputed, detained and placed as adults in hotels post arrival in the UK

Report of: Dr Susannah Fairweather and Dr Zoe Given-Wilson

Specialist field: Child and Adolescent Psychiatry and Psychology

Instructed by: Mr Mark Scott, solicitor on behalf of Bhatt Murphy Solicitors and Deighton Peirce Glynn.

Signed:



Dated: 1st December 2025

Dr Zoe Given-Wilson, DCLinPsy, MSc, BPsych (Hons)

Clinical Psychologist and Postdoctoral Researcher

Generic Report

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11.0 **REFERENCES**

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). <https://doi:10.1176/appi.books.9780890423349>.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

Bronfenbrenner, U. (2001). The Bioecological Theory of Human Development (2001). In U. Bronfenbrenner (Ed.), *Making human beings human: Bioecological perspectives on human development* (pp. 3–15). Sage Publications Ltd.

*Derluyn, I., Orsini, G., Verhaeghe, F., Elhaj, R., Lietaert, I. & Pfeiffer, E. (2023). The impact of trauma and daily hardships on the mental health of unaccompanied refugee minors detained in Libya. *British Journal of Psychiatry*, 1-6, doi: 10.1192/bjo.2022.622

*Ehnholt, K., Trickey, D., Hendriks, J., Chambers, H., Scott, M. & Yule, W. (2018). Mental health of unaccompanied asylum-seeking adolescents previously held in British detention centres. *Clinical Child Psychology and Psychiatry*, 23(2), 238-257 doi.org/10.1177/1359104518758839

*Gargiulo, A., Tessitore, F., Le Grottaglie, F., Margherita, G. (2021). Self-harming behaviours of asylum seekers and refugees in Europe: A systematic review. *International Journal of Psychology*, 56(2), 189-198.

*Hayon, D. & Oates, J. (2019) The mental health service needs and experiences of unaccompanied asylum-seeking children in the UK: a literature review. *Mental Health Practice*. doi: 10.7748/mhp.2019.e1387

Helen Bamber Foundation (2024). The psychological impact of the age dispute process on unaccompanied children seeking asylum in the UK

*Jakobsen M, Meyer DeMott MA, Wentzel-Larsen T, *et al* (2017). The impact of the asylum process on mental health: a longitudinal study of unaccompanied refugee minors in Norway, *British Medical Journal Open* 7, doi; 10.1136/bmjopen-2016-015157

*Kronick, R., Rousseau, C. & Cleveland, J. (2015). Asylum-seeking children's experiences of detention in Canada: A qualitative study. *American Journal of Orthopsychiatry*, 85(3), 287-294.

*Lorek A, Ehnholt K, Nesbitt A, Wey E, Githinji C, Rossor E, & Wickramasighe, R. (2009). The mental and physical health difficulties of children held within a British immigration detention Centre: a pilot study. *Child Abuse and Neglect*. 33:573–85.

*Oberg, C. & Sharma, H. (2023). Post-Traumatic Stress Disorder in Unaccompanied Refugee Minors: Prevalence, Contributing and Protective Factors, and Effective Interventions: A Scoping Review. *Children*, 10, 941. <https://doi.org/10.3390/children10060941>

*Mares, S. (2021). Mental health consequences of detaining children and families who seek asylum: a scoping review. *European Child & Adolescent Psychiatry*, 30; 1615-1639. doi.org/10.1007/s00787-020-01629-x

Martín-Martín, A., Orduna-Malea, E., Thelwall, M., & Delgado-López-Cózar, E. (2019, December 3). *Google Scholar, Web of Science, and Scopus: Which is best for me?*. <https://blogs.lse.ac.uk/impactofsocialsciences/2019/12/03/google-scholar-web-of-science-and-scopus-which-is-best-for-me/>

National Institute Health and Care Excellence (NICE) guideline: Looked-after children and young people. Reference number: NG205. Published: 20 October 2021

Nowak M. The United Nations Global Study on Children Deprived of Liberty. United Nations, 2019 (https://childrendeprivedofliberty.info/wp-content/uploads/2020/09/Full-Global-Study_Revised-Version.pdf).

*Palacios, M., Patel, S., Martinez, W., Reed, D., Liu, K., & Mercado, A. (2024). “Estuvimos en una hielera”: Migration trauma and detainment among newcomer Latinx adolescents. *Psychological Trauma: Theory, Research, Practice, and Policy*, 16(2), 330-339. doi.org/10.1037/tra0001504

*Priestly, I, Cherian, S, Paxton, G, Steel, Z, Young, P, Gunasekera, H, & Hunt, C. (2025) The impact of immigration detention on children’s mental health: systematic review. *British Journal of Psychiatry*, doi.org/10.1192/bjp.2025.29.

*Ramel B, Täljemark J, Lindgren A, & Johansson BA. (2015) Overrepresentation of unaccompanied refugee minors in inpatient psychiatric care. *Springerplus*, 15(4):131. doi: 10.1186/s40064-015-0902-1.

*Robjant, K., Hassan, R., & Katona, C. (2009). Mental health implications of detaining asylum seekers: A systematic review. *The British Journal of Psychiatry*, 194: 306-312.

Royal College of Paediatrics and Child Health (RCPCH). Children and young people seeking asylum and refugees - guidance for paediatricians

*von Wethern, M., Robjant, K., Chui, Z., Schon, R., Ottisova, L, Mason, C., & Katona, C. (2018). The impact of immigration detention on mental health: a systematic review. *B&C Psychiatry*, <https://doi.org/10.1186/s12888-018-1945-y>

Report of: Dr Susannah Fairweather and Dr Zoe Given-Wilson

Specialist field: Child and Adolescent Psychiatry and Psychology

Instructed by: Mr Mark Scott, solicitor on behalf of Bhatt Murphy Solicitors and Deighton Peirce Glynn.

World Health Organization. (2022). *ICD-11: International classification of diseases* (11th revision). <https://icd.who.int/>

*Yim, S.H., Said, G., & King, D. (2025). Practical recommendations for addressing the psychological needs of unaccompanied asylum-seeking children in England: A literature and service review. *Special Issue: Difference and Intersectionality in Children and Young People's Mental Health and Services. Clinical, Child Psychology and Psychiatry*, 30(2), 245-263.

*Zwi, K., Mares, S., Nathanson, D., Tay, A., Silove, D. (2018). The impact of detention on the social-emotional wellbeing of children seeking asylum: a comparison with community-based children. *European Child & Adolescent Psychiatry*, 27, 411-422. <https://doi.org/10.1007/s00787-017-1082-z>

12.0 **APPENDICES**

12.1 **Appendix 1 – Documentation**

I. **Generic documentation**

1. Letter of Claim dated 12th May 2025
2. EPACT Witness Statement of Laura Duran & Josephine Schofield dated 8th June 2023
3. Refugee Council – Not A Minor Offence: Unaccompanied Children Locked Up as Part of the Asylum System dated May 2012
4. Coram Children’s Legal Centre – Happy Birthday? Dated May 2013
5. Kent Public Health Observatory - Health Needs Assessment: Unaccompanied Children Seeking Asylum dated March 2016
6. The Impact of the Asylum Process on Mental Health: A Longitudinal Study of Unaccompanied Refugee Minors in Norway dated May 2017
7. Mental Health of Unaccompanied Asylum-Seeking Adolescents Previously Held in British Detention Centres published 2018
8. The Mental Health and Wellbeing of Unaccompanied Refugee Minors dated December 2019
9. Detention of People with Mental Disorders in Immigration Removal Centres (IRCS) dated April 2021
10. Identity Crisis – How the Age Dispute Process Puts Refugee Children at Risk dated September 2019
11. Greater Manchester Immigration Aid Unit - "I'm Terrified": The Dangers of Home Office Age Assessments for Children in the North West dated September 2022
12. Mental Health of Unaccompanied Refugee Minors in Europe: A Systematic Review published 2022
13. Disbelieved and Denied: Children Seeking Asylum Wrongly Treated as Adults by the Home Office dated April 2023

14. Mental Health Problems in Unaccompanied Young Refugees and the Impact of Post-Flight Facts on PTSS, Depression and Anxiety dated June 2023
15. Forced Adulthood: The Home Office's Incorrect Determination of Age and How this Leaves Child Refugees at Risk dated January 2024
16. No Such Thing as Justice Here' - The Criminalisation of People Arriving to the UK on 'Small Boats' dated February 2024
17. The Psychological Impact of the Age Dispute Process on Unaccompanied Children Seeking Asylum in the UK dated May 2024
18. "They Made Me Feel Like Myself" – A Joint Young Roots and Helen Bamber Foundation Report on Age Disputes and Supporting Young People dated May 2024
19. Refugee and Migrant Children's Consortium – Age Disputes dated September 2024
20. "I Told Them The Truth" – An Update on the Criminalisation of People Arriving to the UK on 'Small Boats' dated May 2025
21. "This System Destroys You" – Children Trapped in Adult Asylum Hotels by the Home Office dated July 2025
22. Serious Safeguarding Scandal: New Data Shows That Hundreds of Child Refugees Continue to be Wrongly Treated as Adults dated 9th July 2025
23. The Impact of Hotel Accommodation on Asylum Seekers' Mental Health: A Mixed Methods Study dated July 2025
24. Refugee and Migrant Children's Consortium – Briefing on government's Rwanda scheme dated June 2022
25. UN CRC General Comment No 6 [para 20] 2005
26. Joint Committee on Human Rights – Human Rights of Unaccompanied Migrant Children and Young People in the UK Report [para 23] 2013
27. The Government Response to the First Report from the Joint Committee on Human Rights Session dated February 2014
28. An Inspection into the Handling of Asylum Applications Made by Unaccompanied Children dated October 2013

29. UN Committee on the Rights of the Child - Concluding observations on the fifth periodic report of the United Kingdom of Great Britain and Northern Ireland dated June 2016
30. Care of Unaccompanied Migrant Children and Child Victims of Modern Slavery Statutory guidance for Local Authorities dated November 2017
31. Literature Review on How the Home Office Ensures it Acts in the Best Interests of the Child When Conducting its Immigration, Asylum and Nationality Functions dated July 2017
32. An Inspection of How the Home Office Considers the 'Best Interests' of Unaccompanied Asylum Seeking Children dated March 2018
33. Second Annual Inspection of 'Adults at Risk in Immigration Detention' dated October 2020
34. Report on an Unannounced Inspection of the Detention of Migrants at Dover and Folkestone dated December 2021
35. An Inspection of the Initial Processing of Migrants Arriving via Small Boats at Tug Haven and Western Jet Foil dated July 2022
36. A Re-Inspection of the Initial Processing of Migrants Arriving via Small Boats, Including at Western Jet Foil and Manston dated June 2023
37. An Inspection of the Home Office's Use of Age Assessments dated July 2025
38. Government Response to an Inspection of the Home Office's Use of Age Assessments dated 22nd July 2025
39. Committee on the Rights of the Child Concluding Observations on the Combined Sixth and Seventh Periodic Reports of the United Kingdom of Great Britain and Northern Ireland dated June 2023
40. UN Special Rapporteurs and Working Group on Arbitrary Detention Letter to UK dated April 2024

II. **Documentation on the conditions at Manston STHF and Western Jet Foil**

1. Consent Order dated 14th January 2025
2. House of Commons Statement on Manston Inquiry by Dame Angela Eagle dated 12th February 2025

3. Manston Independent Inquiry: Terms of Reference dated 12th February 2025

4. Conditions at Western Jet Foil and Manston STHF

5. Reports

- i. Independent Chief Inspector of Borders and Immigration: An Inspection of the Initial Processing of Migrants Arriving via Small Boats at Tug Haven and Western Jet Foil December 2021 – January 2022
- ii. HM Chief Inspector of Prisons Report on an unannounced inspection of the short-term holding facilities at Western Jet Foil, Lydd Airport and Manston 25–28 July 2022
- iii. Report to the United Kingdom Government on the ad hoc visit to United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) dated 29th June 2023
- iv. Independent Monitoring Boards - Annual Report of the Kent Coast Short-Term Holding Facilities For reporting year: 1 January 2022 – 31 December 2022 dated October 2023
- v. Independent Monitoring Boards - Annual Report of the Kent Coast Short-Term Holding Facilities For reporting year: 1 January 2023 – 31 December 2023 dated July 2024
- vi. Home Affairs Committee Oral Evidence: Channel Crossings, HC 822 dated 26th October 2022
- vii. House of Commons debate, Cross-Channel Migrants Manston Facility dated 27th October 2022
- viii. Letter from Home Affairs Committee to Suella Braverman dated 2nd November 2022
- ix. Letter to Home Affairs Committee from Independent Monitoring Board dated 16th November 2022
- x. Home Affairs Committee Oral evidence: The work of the Home Secretary, HC 201 dated 23rd November 2022

xi. Letter from Suella Braverman to Home Affairs Committee dated 28th November 2022

xii. House of Commons statement on Manston by Minister Jenrick dated 28th November 2022

6. News Reports

- i. BBC News, Manston Migrant Centre Conditions Appalling and Inhumane, Charity Warns dated 14th October 2022
- ii. The Guardian, Diphtheria outbreak confirmed at asylum seeker centre in Kent dated 20th October 2022
- iii. The Isle of Thanet News, Diphtheria Outbreak Confirmed at Troubled Manston Processing Centre dated 21st October 2022
- iv. Prison Officers' Association Podcast, Transcript of Episode Immigration Crisis Special Edition dated 24th October 2022
- v. PR 238 - POA Concerns Around the Manston Immigration Short-Term Holding Facility in Kent
- vi. The Guardian, MRSA reported at Manston in migrant who tested positive for diphtheria dated 30th October 2022
- vii. The Times, Disease and despair at Manston migrant centre that left chief inspector speechless dated 1st November 2022
- viii. BBC News, Manston migrant centre like a zoo, says asylum seeker, dated 2nd November 2022
- ix. Sky News, Migrants moved from overcrowded Manston processing centre – as 1,322 children housed in hotels dated 2nd November 2022
- x. The Guardian, 'We need your help' young girl throws note over fence at Manston dated 3rd November 2022
- xi. The Guardian, Home Office contractors removed for trying to sell drugs at Manston asylum centre dated 4th November 2022
- xii. The Guardian, Asylum Seekers at Manston site to receive diphtheria jabs after cases rise dated 12th November 2022

- xiii. The Guardian, Man Being Processed at Manston Detention Centre in Kent Dies dated 19th November 2022
- xiv. The Guardian, Manston asylum centre now empty after weeks of controversy dated 22nd November 2022
- xv. Sky News, Man who died after staying at Manston migrant processing centre had diphtheria dated 26th November 2022
- xvi. BBC News, Manston Migrant Centre: What were the problems? dated 21st December 2022
- xvii. BBC News, Migrants detained illegally official email claims dated 21st December 2022
- xviii. Liberty Investigates, Asylum seekers at Manston were handcuffed, restrained and struck, internal docs show dated 4th February 2023
- xix. The Independent, Revealed Shocking accounts of migrants handcuffed and self-harming in UK's chaotic asylum system dated 5th February 2023
- xx. The Guardian, Manston Health Concerns Raised with Home Office weeks before outbreak dated 6th February 2023
- xxi. The Guardian, You Walked in, and your heart sank: the shocking inside story of Manston detention centre dated 25th March 2023
- xxii. BBC News, Migrants illegally held and humiliated, court told dated 2nd August 2024
- xxiii. The Guardian, Racial abuse, physical assaults and no beds: asylum seekers tell of brutal conditions at Manston migrant centre dated 23rd November 2024

7. Independent Social Work Report prepared by Ms Josephine Schofield dated 30th October 2025

12.2 Appendix 2

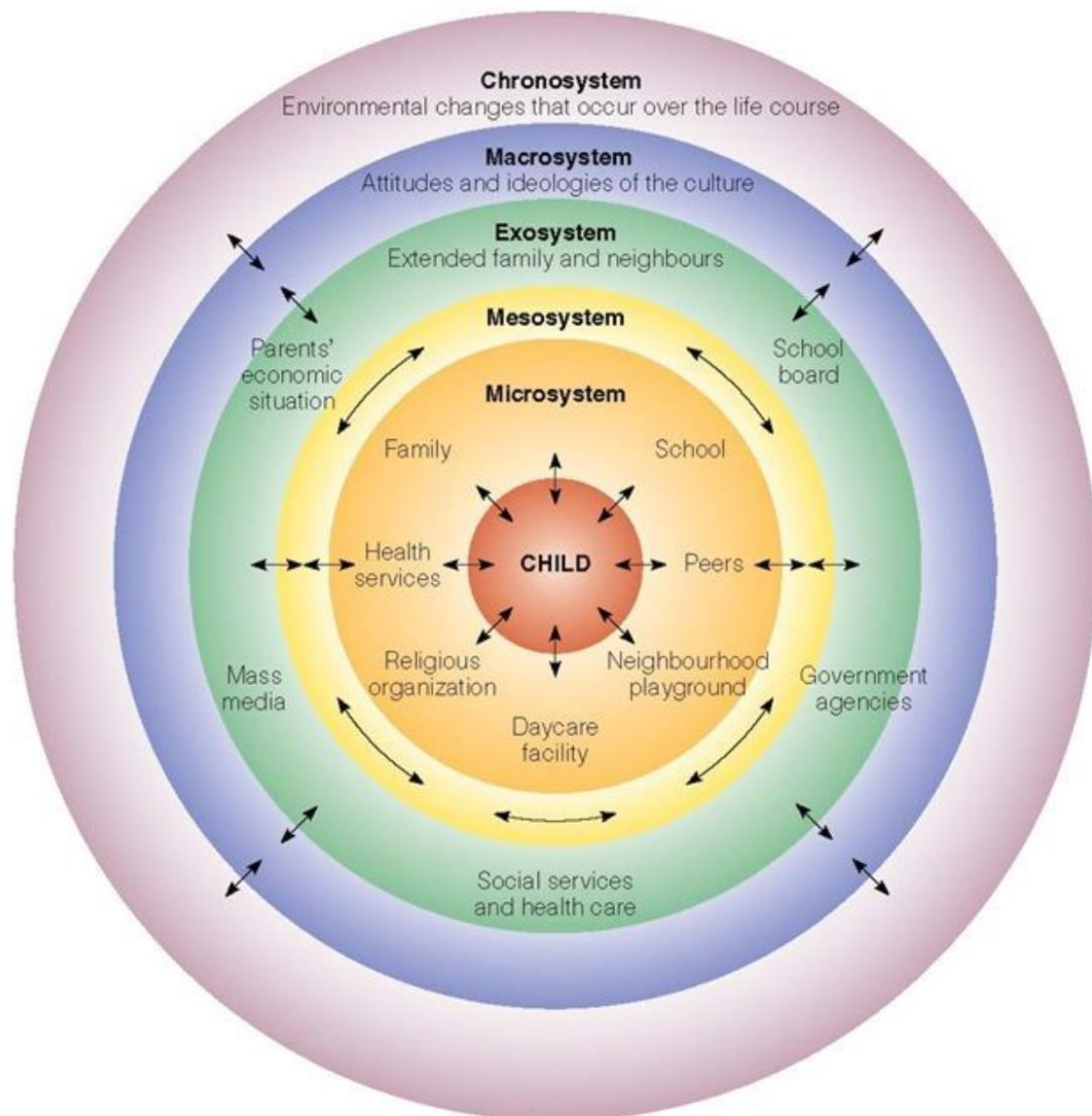


Figure one – Bronfenbrenner's Bio-ecological System Theory (2001)

12.3 **Appendix 3**

Brief Curriculum Vitae for Dr Susannah Fairweather

CURRICULUM VITAE

DR SUSANNAH FAIRWEATHER, MA (Cantab) MBBS MRCPsych DHMSA DPMSA

CONSULTANT PSYCHIATRIST

GMC No. 6105411

E-mail: sfairweather@doctors.org.uk

Qualifications and Education

Postgraduate Certificate (PG Cert)

Leadership and Management in CYP IAPT, University College London (2013)

Approved Clinician (AC)

Mental Health Act, 1983, amended 2007 (2011)

Completion of Certificate in Training (CCT)

Specialist registration in Child and Adolescent Psychiatry
General Medical Council (2011)

Diploma in the Philosophy and Ethics of Healthcare (DPMSA)

Worshipful Society of Apothecaries (2009)

Membership of the Royal College of Psychiatrists (MRCPsych)

Royal College of Psychiatrists (2008)

Diploma in the History of Medicine (DHMSA)

Worshipful Society of Apothecaries (2007)

Bachelor of Medicine and Surgery (M.B., B.S)

Barts and the London Medical School, University of London (2004)

Master of Arts (M.A.) (2:1)

Medical Sciences with History of Art Part II. Cambridge University (2001)

I have undertaken specialist training in being an expert witness at the Royal Society of Medicine, Royal College of Psychiatry and Great Ormond Street Hospital in association with City University.

Generic Report

1st December 2025

Civil claim for compensation against the Home Office for Unaccompanied asylum seeking (UAS) children:
age disputed, detained and placed as adults in hotels post arrival in the UK

Report of: Dr Susannah Fairweather and Dr Zoe Given-Wilson

Specialist field: Child and Adolescent Psychiatry and Psychology

Instructed by: Mr Mark Scott, solicitor on behalf of Bhatt Murphy Solicitors and Deighton Peirce Glynn.

I have had further specialist training in assessing the mental health of refugee and asylum seekers of all ages and participate in a regular CPD group within the Tavistock Immigration Legal Service.

Professional Experience

2013 – present: Consultant Psychiatrist

Tavistock and Portman NHS Foundation Trust: Looked After Children's (LAC) and Refugee CAMHS

- Assessing and treating the mental health of looked after children and refugee and asylum seeking children and young people, all of whom have experienced severe developmental disruption with maltreatment. My role includes significant multi-agency liaison and consultation, particularly with children's social care.

I regularly present at national conferences on the mental health of refugees and asylum seekers.

2011 – present: Expert witness in Psychiatry

- Asylum and Immigration Tribunals: provision of reports in the context of asylum and immigration claims, First Tier and Upper Tribunal, Court of Appeal and High Court.
- Civil court: assessing children and adults who are alleged to have suffered from the impact of physical, sexual and emotional abuse and neglect; including a multi-party action of claimants who suffered child sexual abuse, in countries outside of the UK.
- Organisation and supervision of pro-bono medico-legal assessments by psychiatrists and psychologists on children and vulnerable adults who have the legal right under Dublin III regulation ECHR to be re-united with their families in the UK. The majority of this occurred in the Calais informal migrant camp – the "Jungle" but now continue as needed across Europe. This work also included a number of adults

I provide training and supervision of junior psychiatrists in the assessment of the psychiatric consequences of trauma and in medico legal report writing.

2015 – present: Member

Royal College of Psychiatry working party in Asylum seekers and Refugee Mental Health care

2011 – present: Clinical and Educational Supervisor

London Deanery: supervising and training junior doctors in psychiatry and general practice and teaching under and postgraduates.

2014 – September 2023: Consultant Psychiatrist

Generic Report

1st December 2025

Civil claim for compensation against the Home Office for Unaccompanied asylum seeking (UAS) children: age disputed, detained and placed as adults in hotels post arrival in the UK

Tavistock and Portman NHS Foundation Trust: Camden MOSAIC (integrated service for Children and Young People with Disability) CAMHS

- Providing psychiatric assessment and management for children and young adults with disabilities. These include both physical and learning disability and neurodevelopmental disorders, such as autism. I undertake significant liaison with multi-agency networks, including paediatrics, social care and education.

2017 – 2020: **Consultant Psychiatrist**

Tavistock and Portman NHS Foundation Trust: Returning Families Unit

- The Returning Families Project is a national specialist service directly commissioned by the Home Office for families returning from the Syrian and Iraqi conflict zones. I was the Consultant Psychiatrist in the service.

2013 – 2016: **Consultant Psychiatrist**

Tavistock and Portman NHS Foundation Trust: Camden Complex Needs Outreach Team

- My responsibilities in the Complex Needs Outreach Team included providing psychiatric opinion on children and adolescents with complex presentations arising from one or more of the following: maltreatment, physical, emotional and sexual abuse, neuro-developmental disorders and learning disability.

2011 – 13: **Consultant Psychiatrist**

Waltham Forest Child and Family Consultation Team - North East London Foundation Trust

- Lead Psychiatrist for the Emotional Disorders Pathway and Early Intervention Psychosis Team.
- Provided training for foster carers, social workers and supervising social workers on mental health conditions related to Looked After Children.

2008 - 11: **Specialist Registrar in Child and Adolescent Psychiatry**

Great Ormond Street and Royal London Higher Training Scheme in Child and Adolescent Psychiatry

- Child Care Consultation Team at Great Ormond St Hospital (GOSH): provided an expert witness service for the family courts. (One year)
- Mildred Creak Inpatient Unit at GOSH, which specialises in the treatment of children with severe psychosomatic disorders who cannot be managed in the community, the Eating Disorders Team and the Neuropsychiatry team (Centre for Interventional Paediatric Psychopharmacology).
- Paediatric Liaison at Ealing CAMHS (one year)
- Adolescent Mental Health Team in Tower Hamlets (one year).

Report of: Dr Susannah Fairweather and Dr Zoe Given-Wilson

Specialist field: Child and Adolescent Psychiatry and Psychology

Instructed by: Mr Mark Scott, solicitor on behalf of Bhatt Murphy Solicitors and Deighton Peirce Glynn.

2005 – 7: **UCL and Royal Free Core Psychiatry Training**

- Specialities: Substance misuse, inpatient psychiatry (adult and adolescent), old age psychiatry, psychotherapy and adult community psychiatry.

Therapeutic Experience

- **Psychopharmacology:** Adults, adolescents and children
- **Psychoanalytic psychotherapy:** Adults and adolescents
- **Mentalisation Based Therapy (MBT):** Adults and adolescents.
- **CBT:** Eating Disorders, Panic Disorder, Anxiety (generalised and specific phobias), OCD and Depression.
- **Family Therapy:** Trauma presentations, eating disorders, psychosomatic disorders, anxiety, depression and psychosis.
- **Motivational Interviewing:** Substance misuse.

Relevant Publications

- Invited paper for the International Journal of Human Rights in Healthcare, publication date December 2017 on the mental health of young refugee and asylum seekers in the Calais Jungle.
- Oxford Assess and Progress: Psychiatry. Chapter author on psychiatric assessment and interviewing skills, 2014.

Report of: Dr Susannah Fairweather and Dr Zoe Given-Wilson

Specialist field: Child and Adolescent Psychiatry and Psychology

Instructed by: Mr Mark Scott, solicitor on behalf of Bhatt Murphy Solicitors and Deighton Peirce Glynn.

12.4 **Appendix 4**

Brief Curriculum Vitae for Dr Zoe Given-Wilson

(See attachment)

Expert Report Regarding Children Formerly Detained at Manston Short-Term Holding Facility

Claim No. KB-2023-003413

Prepared for the court by:

Dr. Gillian Hughes, Chartered Clinical Psychologist and Systemic Psychotherapist

Dated: 23rd October 2025

On the instructions of:

Duncan Lewis Solicitors
Sackville House
143-149 Fenchurch Street
London
EC3M 6BL
www.duncanlewis.com

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Introduction

I have been instructed to prepare a report on the impacts of detention on children with particular reference to the likely impacts of detention on a cohort of children detained with family members at Manston Short-Term Holding Facility (**Manston House**) between September and November 2022, in the context of the civil claim for false imprisonment, misfeasance in public office and breaches of human rights brought by the children and their family members.

Qualifications and relevant experience

I, Dr Gillian Hughes, am a Chartered Clinical Psychologist and Systemic Psychotherapist (professional registration with the Health and Care Professions Council (HCPC) and UK Council for Psychotherapy (UKCP)). I was a Consultant Clinical Psychologist at the Tavistock and Portman NHS Trust, from Nov 2009 – Oct 2018 in my capacity as Clinical Lead, Manager for the specialist Child and Family Refugee Service for 7 years, and then Manager of the Child and Adolescent Mental Health Service serving marginalised communities in a deprived inner-city area of London. From 2018 – 2021 was the London and South East Clinical Services Manager at Freedom from Torture, a charity to support survivors of torture. I currently work in the NHS in a mental health training institute (The Prudence Skynner Clinic). I have published widely about the mental health of asylum-seeking children and their families and the effect of trauma on their emotional development. I completed a PhD in 2024 on the psychological treatment of refugee children and families.

Comments on methodology

This report draws on a literature review of academic studies concerning the impact of immigration detention on children.

In preparing the report, I have also considered the Particulars of the Claim, including both the particulars common to all the claimants in the claim, and specifically concerning each of the families with children in the cohort of claimants.

I am aware from my instructions that Duncan Lewis have obtained (or are in the process of obtaining) medico-legal reports concerning the mental health of a substantial number of the children and parents in the cohort, and that, for many of them the reports show that they have suffered psychological injury as a result of their detention. I have not reviewed those reports as I do not consider it proportionate, and it would be difficult to identify a representative sample.

I have undertaken a general review of the literature but also focussed upon particular features addressed in it which, according to my instructions, the children encountered in Manston House.

I was not asked to meet with any of the children to do individual psychological assessments. Therefore, I could not directly assess the vulnerabilities of specific children or the impact of immigration detention on their mental health after being released from Manston House. Nonetheless, I felt able to reach the conclusions I did based on: the common features of and observations about the specific children set out in the pleadings; the conditions at Manston House as described in the particulars of claim (incorporating those available in the public domain); my review of the research literature about the impact of immigration detention on the mental health of children; and my clinical experience.

When citing research literature, I draw on studies done in different countries around the world. These vary in the ages and nationalities of children studied, the length of detention and conditions in detention facilities; I nonetheless consider those studies helpful in drawing conclusions in the current case. This is because the common features which impact on the mental health of children are similar across these different contexts and have parallels with the experience in Manston House described in this claim: for example, the loss of liberty, the lack of certainty about the length of detention or what this means for future safety, the overcrowded, noisy, stressful and inappropriate environment, the impact on parental mental health and insufficient/lack of physical and mental health services. Where I consider this is relevant, I have named the specifics of a study I am citing to contextualise any claims I am making.

I have, however, excluded studies where the conditions or periods of detention varied most significantly from the children's experiences of Manston House (such as Australian studies concerning children detained for months or years).

Documents considered in preparing the report

In preparing the report, I considered the following documents:

- Particulars of the Claim with schedule of claimant specific matters, set out in annexes 1-7 to the particulars.
 - Letter of instructions to prepare expert report, from Duncan Lewis, dated 12 September 2025.
 - Practice Direction 35 – Experts and Assessors – Civil Procedure Rules
 - 2014 Guidance for the Instruction of Experts in Civil Claims.
- The research literature referenced in the section at the end of this report entitled 'Research literature on which this report is based'.

Summary of instructions

Taking into consideration the Particulars of Claim, my professional experiences, and review of the relevant literature, I am instructed to provide an expert report addressing the following questions:

I. Psychological impacts of detention on children

- a. Based on your expertise and the relevant clinical and psychological literature, what are the typical psychological effects of detention for a period of days or weeks on children (detained with family members)?
- b. How, if at all, does the duration of detention influence the psychological impact on such children?
 - i. What differences, if any, would you expect between a detention period of, for example, 24 hours, 72 hours, one week, or longer?
 - ii. Is there any clinically recognised threshold after which detention is likely to result in measurable harm to children?
 - iii. If the duration of detention does affect psychological impact, what is the mechanism by which this may occur?
 - iv. If (an) adult family member(s) with whom a child is detained is/are unaware of the reasons for detention or the likely duration of detention, would this have any impact upon the child?
- c. Are there any particular vulnerabilities and/or developmental considerations for children in such settings?

II. Impacts of conditions at Manston House on children

- a. Please comment on any features of the conditions at Manston House during the relevant period that are likely to have been psychologically harmful to children (e.g. overcrowding, poor sanitation, lack of access to outdoor space, inadequate nutrition, exposure to distressed adults, but please also list any factors which you consider relevant).
- b. In your opinion, are these conditions likely to have caused or contributed to psychological harm in children? If so, in what ways? Are you able to comment on the degree of likelihood of such harm for this cohort?
- c. Are there particular developmental milestones and/or attachment processes that might have been disrupted for this cohort by the conditions at Manston House and/or the ongoing impact of detention at Manston House?

III. Family Impacts

- a. What psychological impact, if any, would there be upon a child if detained with a parent has experienced psychiatric harm?
- b. Would the presence of a parent and/or sibling have likely mitigated psychological harm in this setting? Would it alter your conclusions in section II?

IV. Short- and Long-Term Consequences

- a. What, if any, are the likely short-term psychological and/or developmental effects for children exposed to the conditions described at Manston House? How severe are any such effects likely to be?
- b. What longer-term psychological and/or developmental effects, if any, might arise as a result of detention in such conditions, even after the child is removed from the environment? How long would you expect such effects to endure, if untreated; and how severe are any such effects likely to be?

When discussing psychological effects and their severity, please refer to the categorisations and terms utilised in the Judicial College Guidelines, Chapter 4.

- c. Are any psychological impacts of detention upon children typically reversible? If so, what type of intervention or support is usually required and of what duration?

V. Other Matters

- a. Please address any further issues that you consider to be relevant.

Summary of my instructions about conditions at Manston House

The following is a summary of the information contained within the Schedule of Claimant Specific Matters which is relevant to an assessment of the psychological impact of detention on the child Claimants.

As set out in the letter of instructions from Duncan Lewis, at the time of the children's detention (all were detained between September to November 2022), Manston House was used to detain individuals, including children, upon their arrival in the UK. Manston House was ordinarily authorised to detain up to 1,600 individuals for periods of up to 24 hours. At the time of the children's detention, however, individuals were detained for significantly longer and in significantly higher numbers. By November 2022, up to 4,000 asylum seekers were being held at Manston House at any one time, some for periods of detention lasting several weeks.

The Claimants in this claim complain that conditions at Manston House during the relevant period were overcrowded, unsanitary, and unsafe (see Particulars of Claim at paragraphs 15-31 and 44-62). Save for a small number of families who were detained in separate rooms, there was no privacy. Families, including children, were held in large marquees or halls with no partitions and limited ventilation, sleeping on mats on the floor or thin mattresses, often without bedding. Female adult detainees and child detainees were forced to sleep in close proximity to unrelated adult men. There were no changing rooms, nor facilities for breast-feeding mothers. Children, including babies and toddlers, were confined in the marquees or other buildings with limited natural light, no or limited access to outdoor space, and no dedicated spaces for play or recreation.

The unhygienic and degrading conditions of which the Claimants complain included inadequate access to toilets and showers, limited changes of clothes, an absence of separate eating areas (such that detainees were required to eat in their living and sleeping area), and an absence of facilities to maintain infant hygiene (such as baby-changing stations or nappies). There were reports of infectious disease outbreaks—such as diphtheria and scabies—spreading through the facility due to the cramped conditions and insufficient healthcare provision.

The Claimants further claim that adult detainees were not provided with timely or accurate information about their situation, contributing to distress, disorientation, and anxiety among adults. This is likely to have affected children, as parental distress has been shown to impact the emotional wellbeing of children (see section III.a. paragraphs 31-37 for reference to research).

The Claimants also describe a volatile environment. Staff shouted at and used force against adult detainees in the presence of child detainees. Violent incidents also took place between adult detainees in communal areas, again in the presence of child detainees. The pleadings specific to the children describe child detainees crying for extended periods, regressing in developmental behaviour (e.g. bedwetting, loss of language), and exhibiting signs of acute emotional distress following their release from Manston House.

- All Claimants experienced the following features which are likely to have had a negative impact on their mental health: At Manston House, the Claimants, including children, were made to wear wristbands with ID numbers and were addressed by staff by their ID numbers, not their names for the duration of their detention. Many said they found this degrading.
- Neither the children nor their parents understood why they were being detained, where they were being taken or why they were being transferred to Manston House and what was going to happen to them. This led to families being terrified, anxious, bewildered and distressed.

- Many of the families did not have any member who understood or was able to speak English which would have compounded the difficulties of communicating their needs or understanding the circumstances of their detention. Some families relied on children to interpret for them, including during distressing events.
- Many Claimants complain that no clocks were available which was disorientating. Some Muslim Claimants were unable to keep up with daily prayers which must be performed at specific times of the day. They experienced humiliation and loss of dignity due to the inability to practice their religion.
- There was no child appropriate play area.
- The children were detained in a combination of severely dirty, unsanitary, poorly ventilated and overcrowded conditions as described above which would have significantly contributed to the stress of both parents and children.
- At night, the environment was noisy, cold and (for many claimants) severely overcrowded, with children, and unrelated men and women sleeping in close proximity. This contributed to poor sleep, exhaustion and stress for both children and parents which would have compromised children's and their parent's ability to cope.

I. Psychological impacts of detention on children

a. Based on your expertise and the relevant clinical and psychological literature, what are the typical psychological effects of detention for a period of days or weeks on children (detained with family members)?

1. Research consistently shows that immigration detention, even for relatively short periods of detention lasting days or a few weeks, has a significant adverse impact on the mental health and development of children, as highlighted by Lorek et al. (2009) in their study of UK immigration detention. Several systematic reviews of the impact on mental health of children of different forms of detention in a variety of countries show consistent results that immigration detention harms children and no period of detention can be deemed safe (Priestley et al., 2025; Verhulsdonk et al., 2021; von Werthern et al., 2018; Robjant et al, 2009a).
2. This finding has been reflected in my clinical experience over many years working with refugee children and families, where the trauma of detention can be one of the most challenging experiences for children for the reasons set out in Section II below.
3. Common symptoms of mental distress in children held in immigration detention are reported to be social emotional problems (manifest in conduct disorder or hyperactivity), depression, anxiety, post-traumatic stress disorder (PTSD), self-harm and suicidal ideation. Rates of mental ill health are often at the severe end of the spectrum. For example, in their systematic review on the impact of immigration detention on children, von Werthern et al. (2018) found that all children in three of the studies examined showed evidence of at least one psychiatric disorder, most commonly depression, anxiety, PTSD, and somatisation (the tendency to experience psychological distress in the form of bodily symptoms).
4. Reported physical symptoms associated with mental distress include sleep difficulties, enuresis (urinary incontinence or bedwetting), and headaches (von Werthern et al., 2018).
5. As noted across research reviews, the ways in which some studies have been designed can make it difficult to isolate the specific impact of the immigration detention experience from children's potential exposure to other traumatic events pre-detention. However, there is now a consistent body of academic literature which demonstrates the specific impact of immigration detention even on children who have experienced previous trauma. See, for example, Lorek et al., (2009) who studied children aged 3 months to 17 years in UK immigration detention; or Robjant et al., (2009b) whose systematic review included studies of children in immigration detention up to age 17 in the UK, USA and Australia. The systematic review of 26 studies from around the world carried out by von Werthern et al. (2018)

concluded that higher mental ill-health symptom scores were present in refugee children both during detention and following release than those who had not been detained, and further, these were consistently found to be at the severe end.

6. Immigration detention is increasingly recognised as an Adverse Childhood Experience (ACE) as detention can create immense stress, anxiety and fear in children, leading to mental health problems such as PTSD and depression (Barajas-Gonzales et al., 2021). It is well recognised that the presence of ACEs predisposes children towards poorer health and psychosocial outcomes in adulthood (Chapman et al., 2007).
7. Not all of the research on the impact of immigration detention specifies the age of children studied, other than stating a broad age range or average age. However, there is agreement amongst researchers that children of all ages are impacted negatively and that the ways this is exhibited is age dependent (see section II.c. below). Younger children are likely to be particularly vulnerable because they do not have the cognitive capacity or emotional maturity to make sense of events or modify their responses to traumatic experiences. Similarly, children with special needs are likely to be more vulnerable if they have limited cognitive and communication skills.
8. Research on trauma in children indicates that symptoms are likely to be more complex and severe if they experience accumulated exposure to multiple traumas (Hodges et al., 2013). In the context of Manston House, accumulated trauma is likely for children who: have arrived having experienced traumatic events (such as a dangerous small boat journey); and who are exposed to further traumatic incidents in detention such as witnessing adult violence and aggression, and/or adults in distress. This is likely to be compounded where there is parallel exposure to traumatic events affecting parents and caregivers impacting their ability to nurture and care for the child. All the children detained at Manston House were detained directly after a small boat crossing to the UK, which in my experience of listening to accounts is often a terrifying experience for children leaving them traumatised and needing to recover. For some of the Claimants, it was noted that the boat journey was particularly traumatising. When children have experienced a traumatising event such as this, they will urgently need to establish a sense of safety and predictability in their environment as an essential part of recovery (Daud et al, 2008). The stressful and uncertain environment of Manston House would be likely to compound the effects of any trauma experienced from the boat crossing to the UK.
9. The conclusion that immigration detention profoundly harms the mental and physical health of children is universal across studies, even where they differ in respect of each child's experiences pre-detention, their individual characteristics and parental care (Priestley et al., 2025).

b. How, if at all, does the duration of detention influence the psychological impact on such children?

10. A number of studies have shown that symptoms of poor mental health in children are more severe the longer they have been detained (see, for example, Mares & Jureidini, 2004; Nielsen et al., 2008; and von Werthern et al., 2018). However, the research on this shows a mixed picture and several studies have found no correlation between length of detention and mental health morbidity (von Werthern et al., 2018).

i. What differences, if any, would you expect between a detention period of, for example, 24 hours, 72 hours, one week, or longer?

11. In spite of the slightly mixed research findings, it is generally likely that the longer a child is detained, the more severe the impact will be on their mental health. However, the experience of detention at Manston House is highly likely to have had a negative impact on all the children, even for those with the shortest length of detention.

12. Childhood trauma occurs when a child is in a situation that induces intense fear and a sense of helplessness. Traumatic responses are best understood on a continuum, with mild to moderate responses generally occurring where the trauma is brief. A 24- or 72- hour detention is likely to fall into this category, although the impact on a child will depend on the severity of the traumatic event, their individual resilience and parental responses. As set out above, the children at Manston House had all arrived following a small boat crossing, often cold and wet, and held in a waiting room without dry clothes until they were transferred to Manston House. This is likely to have weakened their resilience and aggravated the impact of the children's experiences of detention. In addition, all the children's parents showed signs of distress and had varying degrees of personal trauma, which would have affected their ability to parent (see section III.a. for further details).

13. Repeated or prolonged exposure to traumatic events, lasting several days or weeks, will be likely to induce a more severe response, particularly where parental distress or mental ill health impairs the ability to support a child's recovery. For all the Claimants, the distress their parents were experiencing is highly likely to be an aggravating factor in their experience of distress (See section III.a.). Where the child is very young (0-5 years old) the effects are likely to be amplified as this is a particularly developmentally sensitive period where children rely intensely on parental figures for nurturing.

14. One-off traumatic events can have an impact on the mental health of children lasting months or even years, but this will depend on a number of variables. These include the nature of the trauma and the degree to which the child has

experienced fear, stress and lack of safety, which is likely to be exacerbated by a younger age where there is less understanding of the actual risks, or a child with cognitive or emotional impairment. Other variables include: the response of parents and their ability to restore a sense of safety in the child; previous traumas and whether detention experiences trigger earlier trauma responses; and individual characteristics and the general resilience of the child.

15. Further, periods of detention of less than one month have been found to be associated with significant harm to children's mental health (Priestley et al., 2025).

16. Therefore, a brief period of detention (e.g. as little as 8 or 9 days) can have a lasting, severe impact on a child or a moderate one, depending on the variables described in the previous paragraph. The information about the conditions at Manston House indicates an environment that is likely to be moderately to severely traumatising. This includes being severely overcrowded, poorly ventilated, noisy, insanitary and dirty, cold, families sleeping in close proximity to strangers in very uncomfortable conditions, limited access to outside space or play areas, limited or no access to medical attention, and, for the older children, no clocks to facilitate orientation in time and the dehumanising impact of having to wear an ID wristband and being referred to by ID number and not your name. The conditions at Manston House are likely to have been particularly traumatising where a child witnessed adult aggression or distress during detention, including violence between detainees or racist language. The traumatising effects are likely to be even more so where this is directly associated with a parent. This is supported across multiple research findings which conclude that detention of children is a severely traumatising experience, as described in Section I.a above.

ii. Is there any clinically recognised threshold after which detention is likely to result in measurable harm to children?

17. There is no clinically recognised threshold because the impact to each child will depend on the specific circumstances of each child and their detention experience. However, for the reasons set out in this report I would consider that the children's characteristics and the condition at Manston House are likely to have resulted in measurable harm to each of them.

iii. If the duration of detention does affect psychological impact, what is the mechanism by which this may occur?

18. Where a lack of safety or threat is perceived, stress hormones are released to prepare the body to respond in a protective manner. Where fear is intense, the rational, problem-solving part of the brain is bypassed so that subconscious protective behaviour is prioritised. Children have highly neuroplastic brains and

where there is multiple prolonged adversity, their brains will chronically adapt to functioning aimed at preserving and protecting life at the expense of learning and relationships (National Scientific Council on the Developing Child, 2005). The more intense or more prolonged the trauma is, the more likely it is that this brain adaptation will take place. In these cases, children develop complex patterns of protective responses, including hyper-arousal, agitation, and emotional reactivity, but also dissociative responses, such as emotional numbing, and poor cognitive functioning (Wood, 2018). These behavioural responses persist even once the threat has passed and interrupt normal emotional social and cognitive in a child, which can lead to failure to thrive. The consequences of this can be lasting and felt in adult life.

19. The fact that some of the children and their parents described ongoing distress and mental health problems after release from detention is likely to reflect a persisting negative impact of detention at Manston House following the children's' release.

iv. If (an) adult family member(s) with whom a child is detained is/are unaware of the reasons for detention or the likely duration of detention, would this have any impact upon the child?

20. The children's parents say that they were not given information about the reasons for their detention, nor how long they were likely to be detained or what was going to happen to them. This lack of clarity can create severe anxiety in parents (von Werthern et al., 2018). It has been found that the lack of control that parents feel when subjected to detention without clear time limits impacts parental mental health and indirectly also that of children (Newman and Steel, 2008). Where parents are unable to communicate adequately with staff because they do not speak or understand English, the uncertainty and lack of control over the situation and associated stress is likely to be further exacerbated. In my clinical experience of working with asylum seekers where their legal status is uncertain, the fear of being returned to an unsafe home country can create additional severe and overwhelming distress which can entirely block recovery from trauma. As stated in Section III. below, parental mental health has a direct impact on parenting.

c. Are there any particular vulnerabilities and/or developmental considerations in such settings?

21. Although children under the age of 5 are at a particularly developmentally sensitive age and are likely to have been particularly vulnerable, all children are vulnerable to the impact of trauma on their emotional, social and cognitive development as elaborated in section II.a. and section II.c. below.

22. Children are also likely to be particularly vulnerable if they have a learning difficulty.

23. I have identified the categories above (children under 5 and children with a learning difficulty) as particularly vulnerable because they will have more limited capacity to make sense of their experiences and less maturity to manage their emotional responses, as set out in II.c. below.

II. Impacts of conditions at Manston House on children

a. ***Please comment on any features of the conditions at Manston House during the relevant period that are likely to have been psychologically harmful to children (e.g. overcrowding, poor sanitation, lack of access to outdoor space, inadequate nutrition, exposure to distressed adults, but please also list any factors which you consider relevant).***

24. Research shows that the immigration detention environment is developmentally inappropriate for children for a number of reasons (Coffey et al, 2010; Puthooppambal et al., 2015; von Werthern et al, 2018). The severely limited opportunities for play and recreation, including severely restricted access to outside space, have been found to have a negative impact on child development (von Werthern et al. 2018) and even over a short period of time would be a significant factor contributing to a stressful environment. All the children at Manston House report that they had severely restricted access to outside space, or any appropriate play areas and no or very limited access to toys. The children described feeling bored and restless. Added to the fact of severe overcrowding, the requirement from stressed adults for children to be quiet and inactive would be likely to add further stress.

25. Witnessing violence and aggression and parental mental illness constitute major traumatising events for children (Tosif et al., 2023), a finding which is widely replicated in studies into the impact of Adverse Childhood Experiences (ACEs). In Manston House, the witnessing of adult aggression (including shouting, use of force and violent incidents from staff towards detainees), and arguments between those detained is likely to have induced intense fear and trauma in children.

26. Similarly, witnessing the distress of adults who themselves are suffering mental health distress can be both confusing and terrifying for young children, for example, hearing adults screaming in the night because they are experiencing

nightmares. For those sleeping in a shared sleeping space, this will intensify the fear response and trauma suffered by young children. Disrupted sleeping from noise at night is likely to further weaken the ability of children to cope. In the context of recent traumatic journeys, such as precarious boat journeys, and previous trauma, this is likely to have a highly damaging impact on mental health of children who instead need a calm and secure environment in which to recover.

27. Added to these considerations is the impact on parental mental health of the conditions at Manston House. The severe overcrowding with increased noise and lack of privacy, as well as extreme insanitary conditions, will contribute to stress and tension in adults. This environment will likely have fuelled conflict between adults, particularly where there are differences in cultural or religious practices, racism or mental illness. The culture of surveillance in immigration detention and removal of personal agency and dignity leave detainees feeling ashamed, disempowered and humiliated which impacts significantly on their mental health (Cleveland et al., 2018; Coffey et al., 2010). For example, with the removal of mobile phones and personal effects, having no access to the internet or to legal advice or support services, or the de-humanising effect of being made to wear wristbands and referred to by number not name. Where parents are themselves suffering from PTSD or other mental health problems, the impact of stress on the whole family will be compounded.

b. *In your opinion, are these conditions likely to have caused or contributed to psychological harm in such children? If so, in what ways? Are you able to comment on the degree of likelihood of such harm for this cohort?*

28. In my opinion, which is supported by research findings as set out in this (section II.), the conditions at Manston House are highly likely to have contributed to psychological harm in children held there – either through direct impact on them or indirectly through the stress and trauma experienced by parents. The conditions at Manston House are highly likely to have added further trauma at a time when children were likely to have been extremely vulnerable for the reasons I have already explained.

c. *Are there particular developmental milestones and/or attachment processes that might have been disrupted by the conditions at Manston House and/or the ongoing impact of detention at Manston House?*

29. Normal developmental processes in children are disrupted by exposure to trauma. Exposure to the unsafe and high-stress environment of Manston House which leads to mood disturbance in children is therefore likely to impact development. In addition, developmental processes of attachment for children are disrupted where parental responsiveness and nurturing is compromised over a sustained period so that the child learns that they cannot trust that they

will receive care when needed. These processes mostly take place during the age period 0-5 years. For example, parental stress and trauma may impact on the parent's capacity to notice, understand, and appropriately respond to a child's physical and emotional needs and impact on the child's development of self-regulation, problem solving, and managing interpersonal relationships which will persist into later life (Dobler and Nelki, 2022).

30. For older children, aged 5 and above, the developmental tasks are building independence and autonomy in relationship to parents, peers, and other adults. It is an important time for education, negotiating peer relationships and friendships, and becoming proficient in practical skills, while maintaining a safe base within the family. As with attachment processes, if parents are not able to offer adequate nurturing at this stage, these processes can become disrupted, and a child may experience neurocognitive and social delay in development. The impact of trauma on child development can be mitigated by psychological therapy, although this is unlikely to entirely address the effects of trauma. If left untreated, the resulting problems can over time have a profound effect on developmental processes. This is a risk for children of any age. In some of the Claimants evidence, there were clear signs of severe ongoing emotional disturbance in children post-detention.

III. Family Impacts

a. *To what extent and in what way was the distress of parents and/or carers who were also detained likely to have affected the psychological well-being of children?*

31. The impact of parental mental health on children is a widely studied area. Poor mental health means that a parent is less able to provide adequate nurturing of children, offer an emotionally stable and predictable environment and respond to the needs of their children. Daud et al. (2008) studied the impact on children of having parents who suffered from PTSD and found that children of traumatised parents scored lower on IQ tests, prosocial behaviour and emotionality.
32. When in detention, parenting is crucial to help children navigate the stresses of the environment including lack of familiarity, privacy, safety, opportunities to play – which are all crucial for development and are mediated by parental care. This is supported by research which shows that the detention environment has a negative impact on parental ability to provide nurturance and care for children, (von Werthern et al., 2018). In this case, all the parents of the children report being distressed by the circumstances of their detention. This is likely to have impacted their parenting.

33. The negative impact of immigration detention on the mental health of adults, including parents, has been well established and is consistent across a variety of ethnic groups and reception countries (Robjant et al, 2009a; Filges et al, 2024). This effect has been found to be independent of previous traumas (Steel et al. 2006; Momartin et al. 2006) although previous traumas can compound the effects, as described in paragraph 34. Parental distress can be connected to multiple aspects of detention (which have been identified at Manston House), including lack of privacy, unsanitary conditions, severe overcrowding, witnessing violence, uncertainty about reasons for and length of detention, prior vulnerability of those detained, concerns about children, inadequate medical attention, isolation from the outside world and no access to lawyers or any form of help. Each of these features are reported by the Claimants to have been present at Manston House. Further, immigration detention grossly undermines parental mental health and parenting capacity (Mares et al, 2002) owing to diminished parental responsiveness, and lower quality parent–child relationships at a time when a stable parental presence is critical (Coley, Lynch, & Kull, 2015; McCoy-Roth et al., 2012).
34. Where a parent has themselves been subjected to trauma pre-detention, they are likely to be particularly vulnerable to the stress of detention, and this will have a direct impact on their children. For example, Nielson et al (2019) in their study of 51,793 refugee parents in Denmark found that parental PTSD significantly increased risk of psychiatric disorders in children.
35. Mental ill health in parents is recognised as one of the core Adverse Childhood Experiences with far reaching consequences for a child’s psychological, cognitive and physical development (Quigg et al, 2018). This accords with my clinical experience that mental illness amongst refugee parents can have a devastating impact on their children’s ability to form good attachment relationships, to develop a sense of security and safety and to thrive.
36. In summary, parental distress at Manston House is highly likely to have a very significant impact on the mental health of children, both while in detention and during the months and possibly years following detention. If parental mental health problems persist after release from detention and parenting is affected over a longer period, this may be a significant risk affecting attachment patterns in their children.
37. The effects of this could be mitigated by parents and children both receiving psychological therapy. Where parents do not receive trauma focussed psychological therapy, the likelihood of this happening is greatly increased.

b. *Would the presence of a parent and/or sibling have likely mitigated psychological harm in this setting? Would it alter your conclusions in section II?*

38. The presence of a parent certainly has the potential to reduce the impact of psychological harm to a child if the parent is in a psychological state where they are responsive to the needs of the child and able to offer appropriate comfort and reassurance. However, this is likely to be severely compromised when a parent is themselves experiencing the effects of trauma or dealing with environmental stressors, as explained in section III.a. paragraphs 33 and 34.
39. Although the effect of being with siblings in immigration detention is a very poorly researched area, it is reasonable to assume that having other family members present will be a protective factor for the mental health of children. However, sibling distress will also act as a further stressor and take the attention of parents away from other siblings, making them less emotionally available. Therefore, the presence of siblings may also increase the emotional stress experienced by children. This is relevant for sibling groups where sibling distress was likely to act as a significant additional stressor.
40. Family separations are likely to lead to added stress within the whole family. Hanes et al (2017) found that the mental health of children in detention was affected by disruptions in family cohesion and functioning, for example where there are family separations. This accords with research showing that separation of children from close family members, particularly those with a caring role can be acutely stressful and in some cases traumatising, even when detention is brief (Ali-Naqvi et al. 2023).

IV. Short- and Long-Term Consequences

a. *What, if any, are the likely short-term psychological and/or developmental effects for children exposed to the conditions described at Manston House? How severe are any such effects likely to be?*

41. In the short term, distress and trauma in the children held in Manston House was exhibited in various ways including sleep disturbance, listlessness, excessive crying, headaches, anxiety, restlessness and fear/terror. These are all common responses to trauma indicative of moderate to severe distress. Particularly in pre-school children, regression in developmental behaviour is a common response to trauma, for example, clinging to parents with loss of independence, or urinary/ faecal incontinence.
42. The severity of these effects will depend on a number of factors as detailed above including: the specific experience of the child while in detention (for example if they witnessed adult violence or distress) – section II.a and b; the

mental health of parents and their ability to nurture the child – section III.a; age and developmental level of the child – section II.c.; the level of any pre-detention trauma, personal characteristics and resilience of the child – section I.c. However, it is worth noting that the research literature uniformly indicates the significantly damaging impact of detention on the mental health of children across ages, countries and detention settings. Therefore, it is a reasonable assumption that even with the relatively short-term detention of the Claimants at Manston House, the mental health impact on them is likely to be moderate to severe in the short term, and quite possibly also the long term.

- b. ***What longer-term psychological and/or developmental effects, if any, might arise as a result of detention in such conditions, even after the child is removed from the environment? How long would you expect such effects to endure, if untreated; and how severe are any such effects likely to be?***

43. The effects described in this section (section IV.) are likely to be long term and significant whatever the child's social circumstances on release but particularly pronounced if there are ongoing stressors such as multiple house moves, changes in schooling, ongoing parental mental health problems, family separation, and a family atmosphere of stress and uncertainty. The extent of long term impact will also depend on the individual characteristics of the child (for example whether they have any special needs) and what psychological support they receive.

44. To recover from trauma, children of all ages need a secure and stable environment with a parental presence which is predictable and responsive to their needs, as set out in section III.a. If this is not available, the risk that the effects of detention trauma will persist are highly likely and can have severe and lasting consequences. Even with these conditions being present, there will need to be a period of recovery for children suffering the effects of trauma, the length of which will depend on the severity of the response to trauma. As described in sections I.a. and II.c., developmental milestones can be interrupted and damaging attachment patterns embedded which can have consequences for the child reaching into adulthood. Given the emotional responses described in the children at Manston House (see section IV.a.), and what can be learnt from the research about the impact of immigration detention (see section I.a), developmental processes are highly likely to be interrupted and children to suffer lasting effects. The long-term consequences of detention for parents are also relevant for the emotional wellbeing of children as described in section III.a.

c. *Are any psychological impacts of detention upon children typically reversible? If so, what type of intervention or support is usually required and of what duration?*

45. Research into the post detention needs of asylum-seeking children is limited as systematic reviews of the literature identify (Uphoff et al, 2020), and long term follow up studies are lacking, which means that it is difficult to draw conclusions about whether the psychological impact of detention is reversible. However, looking to studies on treatments for trauma more generally in asylum seeking children, there is significant evidence for the benefits of a variety of psychological treatments on reducing trauma related symptoms, including anxiety, depression and cognitive symptoms (Tyrer and Fazel, 2014; Della Roca et al. 2024). There is agreement that a multimodal approach to treatment is required, which includes psychological support for the child as well as for parents in addition to community based and peer interventions which are culturally congruent and facilitate a supportive environment around the child.
46. The duration of treatment will depend on the specific needs of the child and their family and is also dictated by what mental health services are available.
47. Treatments studied are highly variable and range from brief interventions lasting approximately 6 weeks to several months, or up to 2 years.

V. Other Matters

a. *Please address any further issues that you consider to be relevant.*

48. For the research cited in this report, I have attempted to select high quality studies which conform to well established research standards. I have prioritised studies with large data sets where discrepancies in the data are less likely to affect the reliability of the findings. I have also drawn as much as possible on systematic reviews which look at the findings from across a number of papers which have all been screened to ensure that they are of high quality.
49. Where there is a lack of robust research answering the specific questions asked in this report, I have either relied more heavily on my clinical experience or have made inferences from research answering similar questions and made this clear in my report. For example, much of the research does not specify the exact ages of children sampled, but has given an age range, or has not specified the exact length of detention.

Conclusions

50. There is uniform agreement in the research literature across multiple countries, including the UK, that immigration detention for children of all ages is a psychologically damaging experience with long term consequences for their cognitive social and emotional development. Longer detention periods appear to be more damaging, but even brief detention such as that experienced by the children here can have a significant and lasting negative impact. For the children at Manston House, the pleadings and my instructions refer to circumstances and behavioural responses of specific children being represented which indicated that all Claimants, including the children, found their period of detention highly distressing and likely to have led to significant trauma, even for those children within the cohort detained for the shortest periods.
51. The impact of the highly stressful environment is likely to have been exacerbated by many families not being able to understand or speak English, compounding the difficulties of communicating their needs or understanding the circumstances of their detention. For families needing medical attention this would have created very significant additional stress for parents and consequently children.
52. The severity of the effects of detention on children at Manston House would have been compounded by children being exposed to adult violence and aggression, and/or adults in distress and more so where this has directly impacted a parent.
53. Similarly, parental mental ill health and distress will likely have exacerbated the negative impact of detention on mental health as this will have limited parental ability to nurture and care for their children. Parents who were classed as vulnerable adults or who had experienced trauma pre-detention are likely to have been more negatively affected by the conditions at Manston House, and more likely that their parenting will have been affected. The same applies to those who experienced particularly distressing or traumatising events whilst in detention. Traumatized parents are compromised in their ability to nurture their child which can affect child development in the long term.
54. Other factors likely to lead to greater severity of psychological disturbance in Claimants include separation from parents or family members while in detention, a longer detention period, or characteristics of specific children which increase their vulnerability which would limit the ability of these children to make sense of what was happening to them or have the emotional maturity to deal with it.

55. Given the above considerations, it is highly likely that the Claimants all suffered moderate to severe impacts on their mental health through their time at Manston House and that these are highly likely to persist well beyond the end of their detention period. The negative effects of detention are likely to be mitigated by the Claimants (parents and children) receiving specialist psychological therapy to facilitate their recovery. However, in my clinical experience, although therapy can make a significant difference, it cannot entirely address the negative impact that children are likely to experience. Parental mental health would also need addressing to reduce the negative effect of parental trauma on parenting ability in the longer term.

Statements of Truth

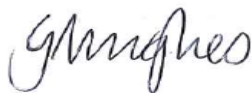
I confirm that I understand my duty to the court and have complied and will continue to comply with that duty.

I confirm that I am aware of the requirements of Part 35 of the Civil Procedure Rules, Practice Direction 35, and the Guidance for the Instruction of Experts to give Evidence in Civil Claims.

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinion on the matters to which they refer.

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.

Signed:

A handwritten signature in cursive script, appearing to read 'G Hughes'.

Gillian Hughes

Dated: 23rd October 2025

Sources on which the report is based

Ali-Naqvi, O., Alburak, T.A., Selvan, K. et al. (2023). Exploring the impact of separation on family mental health: A systematic review and meta-narrative analysis. *Psychiatr Q*, 94, 61-77.

Barajas-Gonzalez, R. G., Ayón, C., Brabeck, K., Rojas-Flores, L., & Valdez, C. R. (2021). An ecological expansion of the adverse childhood experiences (ACEs) framework to include threat and deprivation associated with US immigration policies and enforcement practices: An examination of the Latinx immigrant experience. *Social Science & Medicine*, 282, 114126.

Barry, T. J., Murray, L., Fearon, R. P., Moutsiana, C., Cooper, P., Goodyer, I. M., ... & Halligan, S. L. (2015). Maternal postnatal depression predicts altered offspring biological stress reactivity in adulthood. *Psychoneuroendocrinology*, 52, 251-260.

Bonnie D., Zhang, J et al (2015) Adverse Childhood Experiences and Mental Health, Chronic Medical Conditions, and Development in Young Children, *Academic Pediatrics*, 15, (5) 510-517.

Chapman, D. P., Dube, S. R., & Anda, R. F. (2007). Adverse childhood events as risk factors for negative mental health outcomes. *Psychiatric annals*, 37(5).

Cleveland, J., Kronick, R., Gros, H., & Rousseau, C. (2018). Symbolic violence and disempowerment as factors in the adverse impact of immigration detention on adult asylum seekers' mental health. *School of Public Health*, 63, 1001-1008. [https://doi.org/10.1007/s00038-018-1121-7\(0123456789\(\).-volIV\)\(0123456789\(\).-volIV\)](https://doi.org/10.1007/s00038-018-1121-7(0123456789().-volIV)(0123456789().-volIV))

Coffey, G. J., Kaplan, I., Sampson, R. C., & Tucci, M. M. (2010). The meaning and mental health consequences of long-term immigration detention for people seeking asylum. *Journal of Social Science & Medicine*, 70 (12), 2070-2079. <https://doi.org/10.1016/j.socscimed.2010.02.042>

Cole, E. K. (2003). *A few families too many: The detention of asylum-seeking families in the UK*. Bail for Immigration Detainees.

Coley, R. L., Lynch, A. D., & Kull, M. A. (2015). Early exposure to environmental chaos and children's physical and mental health. *Early Childhood Research Quarterly*, 32, 94–104.

Crawley, H., & Lester, T. (2005). No Place for a child. *Children in UK Immigration Detention: Impacts, Alternatives and Safeguards*. London: Save the Children England Programme.

Daud, A., af Klinteberg, B., & Rydelius, P. A. (2008). Resilience and vulnerability among refugee children of traumatized and non-traumatized parents. *Child and Adolescent Psychiatry and Mental Health*, 2, 1-11.

Della Rocca, B., Bello, R., Carbone, M., Pezzella, P., Toni, C., Sampogna, G., ... & Fiorillo, A. (2024). Promoting mental health and preventing mental health problems in

child and adolescent refugees and asylum seekers: A systematic review on psychosocial interventions. *International journal of social psychiatry*, 70(4), 653-666.

Dobler V; Nelki J (2022) Children, families & young people, chapter 11. In C Maloney; J Nelki; A Summers (Eds) *Seeking Asylum and Mental Health*, Cambridge University Press.

Ehnholt KA, Trickey D, Harris Hendriks J, Chambers H, Scott M, Yule W. (2018) Mental health of unaccompanied asylum-seeking adolescents previously held in British detention centres. *Clinical Child Psychology and Psychiatry*. 23(2):238-257

Filges, T., Montgomery, E., & Kastrup, M. (2018). The impact of detention on the health of asylum seekers: a systematic review. *Research on Social Work Practice*, 28(4), 399-414.

Hanes, G., Chee, J., Mutch, R., & Cherian, S. (2019). Paediatric asylum seekers in Western Australia: identification of adversity and complex needs through comprehensive refugee health assessment. *Journal of Paediatrics and Child Health*, 55(11), 1367-1373.

Hanes, G., Sung, L., Mutch, R., & Cherian, S. (2017). Adversity and resilience amongst resettling Western Australian paediatric refugees. *Journal of Paediatrics and Child Health*, 53(9), 882-888.

Hodges, M., Godbout, N., Briere, J., Lanktree, C., Gilbert, A., & Kletzka, N. T. (2013). Cumulative trauma and symptom complexity in children: A path analysis. *Child abuse & neglect*, 37(11), 891-898.

Kronick, R., Rousseau, C., & Cleveland, J. (2015). Asylum-seeking children's experiences of detention in Canada: A qualitative study. *American Journal of Orthopsychiatry*, 85(3), 287.

Lorek, A., Ehnholt, K., Nesbitt, A., Wey, E., Githinji, C., Rossor, E., & Wickramasinghe, R. (2009). The mental and physical health difficulties of children held within a British immigration detention centre: a pilot study. *Child abuse & neglect*, 33(9), 573-585.

Mares, S. (2021). Mental health consequences of detaining children and families who seek asylum: a scoping review. *Eur Child Adolesc Psychiatry* 30, 1615–1639

Mares, S., & Jureidini, J. (2004). Psychiatric assessment of children and families in immigration detention—clinical, administrative and ethical issues. *Australian and New Zealand journal of public health*, 28(6), 520-526.

Mares, S., Newman, L., Dudley, M., & Gale, F. (2002). Seeking refuge, losing hope: parents and children in immigration detention. *Australasian Psychiatry*, 10(2), 91-96.

McCoy-Roth, M., Mackintosh, B. B., & Murphey, D. (2012). When the bough breaks: The effects of homelessness on young children. *Early Childhood Highlights*, 3(1), 1–11.

Mensah, F.K., Kiernan, K.E. (2010) Parents' mental health and children's cognitive and social development. *Social Psychiatry and Psychiatric Epidemiology*, 45, 1023–1035.

Momartin, S., Steel, Z., Coello, M., Aroche, J., Silove, D. M., & Brooks, R. (2006). A comparison of the mental health of refugees with temporary versus permanent protection visas. *Medical Journal of Australia*, 185(7), 357-361.

Newman, L. K., & Steel, Z. (2008). The child asylum seeker: psychological and developmental impact of immigration detention. *Child and adolescent psychiatric clinics of North America*, 17(3), 665-683.

National Scientific Council on the Developing Child. (2005). Excessive stress disrupts the architecture of the developing brain. *Working Paper*, 3.

Nielsen, S. S., Norredam, M., Christiansen, K. L., Obel, C., Hilden, J., & Krasnik, A. (2008). Mental health among children seeking asylum in Denmark—the effect of length of stay and number of relocations: a cross-sectional study. *BMC Public health*, 8, 1-9.

Nielsen, M. B., Carlsson, J., Rinvall, M. K., Petersen, J. H., & Norredam, M. (2019). Risk of childhood psychiatric disorders in children of refugee parents with post-traumatic stress disorder: a nationwide, register-based, cohort study. *The Lancet Public Health*, 4(7), e353-e359.

Puthoopparambil, S. J., Bjerneld, M., & Källestål, C. (2015). Quality of life among immigrants in Swedish immigration detention centres: a cross-sectional questionnaire study. *Global health action*, 8(1), 28321.

Pourgourides, C. K., Bracken, P. J., & Sashidharan, S. P. (1996). *A second exile: The mental health implications of detention of asylum seekers in the United Kingdom*. Northern Birmingham.

Priestley, I., Cherian, S., Paxton, G., Steel, Z., Young, P., Gunasekera, H., & Hunt, C. (2025). The impact of immigration detention on children's mental health: systematic review. *The British Journal of Psychiatry*, 1-10.

Quigg, Z., Wallis, S., & Butler, N. (2018). Routine enquiry about adverse childhood experiences: implementation pack pilot evaluation. *Public Health Institute (PHI): Oakland, CA, USA*.

Radcliff, E., Crouch, E., Strompolis, M. *et al.* (2019) Homelessness in Childhood and Adverse Childhood Experiences (ACEs). *Journal of Maternal Child Health*, 23, 811–820.

Robjant, K., Hassan, R., & Katona, C. (2009a). Mental health implications of detaining asylum seekers: systematic review. *The British Journal of Psychiatry*, 194(4), 306-312.

Robjant, K., Robbins, I., & Senior, V. (2009b). Psychological distress amongst immigration detainees: A cross-sectional questionnaire study. *British journal of clinical psychology*, 48(3), 275-286.

Seifer, R., & Dickstein, S. (2000). Parental mental illness and infant development. In C. H. Zeanah, Jr. (Ed.), *Handbook of infant mental health* (pp. 145–160). The Guilford Press.

Smith, M (2004) Parental mental health: disruptions to parenting and outcomes for children. *Child and Family Social Work*, 9 (1), 3-11.

Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. N. A. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *The British Journal of Psychiatry*, 188(1), 58-64.

Tosif, S., Graham, H., Kiang, K., Laemmle-Ruff, I., Heenan, R., Smith, A., ... & Paxton, G. (2023). Health of children who experienced Australian immigration detention. *PLoS One*, 18(3), e0282798.

Tyrer, R. A., & Fazel, M. (2014). School and community-based interventions for refugee and asylum seeking children: a systematic review. *PloS one*, 9(2), e89359.

Uphoff, E., Robertson, L., Cabieses, B., Villalón, F. J., Purgato, M., Churchill, R., & Barbui, C. (2020). An overview of systematic reviews on mental health promotion, prevention, and treatment of common mental disorders for refugees, asylum seekers, and internally displaced persons. *Cochrane Database of Systematic Reviews*, (9).

Verhulsdonk, I., Shahab, M., & Molendijk, M. (2021). Prevalence of psychiatric disorders among refugees and migrants in immigration detention: systematic review with meta-analysis. *BJPsych Open*, 7(6), e204.

Von Werthern, M., Robjant, K., Chui, Z., Schon, R., Ottisova, L., Mason, C., & Katona, C. (2018). The impact of immigration detention on mental health: a systematic review. *BMC psychiatry*, 18, 1-19.

Webb, R., Ayers, S., & Rosan, C. (2018). A systematic review of measures of mental health and emotional wellbeing in parents of children aged 0–5. *Journal of Affective Disorders*, 225, 608-617.

Wood, L. C. (2018). Impact of punitive immigration policies, parent-child separation and child detention on the mental health and development of children. *BMJ paediatrics open*, 2(1), e000338.

Glossary

ACEs	Adverse Childhood Experiences. Traumatic events or situations that occur during childhood that can have a lasting negative impact on a child's wellbeing and development.
Attachment disorder	A mental health condition that affects a person's ability to form and maintain emotional bonds.
Enuresis	Urinary incontinence or bedwetting.
Encopresis	Faecal soiling
PTSD	Post Traumatic Stress Disorder
Systematic review	A review of a clearly formulated question that uses systematic and explicit methods to identify, select and critically appraise relevant research, and to collect and analyse data from the studies that are included in the review.