Wednesday, 8 December 2021
(9.30 am)
MS VICTORIA SILE REYNOLDS (affirmed)
Examination by MS SIMCOCK
MS SIMCOCK: Good morning. Could you give us your full name, please?
A. My name is Victoria Sile Reynolds.
Q. And what is your job title?
A. So I'm the head of asylum advocacy at Freedom from Torture.
Q. What does that role involve in particular?
A. So I work with clinical and legal colleagues across the organisation and across our five centres to pull together evidence and expert analysis of the experience that torture survivors within the UK have of the UK asylum system, their access to protection and any issues they may experience as torture survivors seeking asylum in the UK, and I make representations to the government and other influencers and decision makers to try and improve -- make improvements to the system for their benefit.
Q. So Freedom from Torture as an organisation, what exactly does it do? What are its aims and objectives?
A. So Freedom from Torture is a UK-based human rights organisation and one of the largest torture

rehabilitation centres in the world. We provide -- primarily, we provide clinical services to more than 1,000 torture survivors in the UK, as I said, the vast majority of whom are asylum seekers or have refugee status.
We also do campaigning work, so that includes the advocacy work that I'm responsible for, which involves working alongside government counterparts to try and improve the asylum system for their benefit.
We also do public campaigning work, so we work with our supporters and members of the public to campaign for better treatment of torture survivors as asylum seekers in the UK.
Q. Does Freedom from Torture provide medico-legal reports to formerly detained persons?
A. Yes. So one of the services that we provide is the forensic documentation service, so our medico-legal report service provides expert documentation of torture for people who are referred to us by their legal representatives. They may be referred to us from detention or from the community. We don't provide medico-legal reports -- we don't go into detention to document torture. So someone needs to be released from detention and then they can be referred in to our service and we can do a medico-legal report assessment

and produce a report for them if they meet our intake criteria.
Q. For what purpose do you provide medico-legal reports to those people?
A. So it's to inform the asylum decision, mainly. So we will be instructed by the legal representative where someone has an asylum claim ongoing and the -- documenting their experience of torture is an important element of their asylum claim or will contribute to helping the decision maker to make a decision on their asylum claim.
Q. You also mention in your statement that Freedom from Torture has safeguarding policies. What is a safeguarding policy and what's the purpose of those types of policies?
A. Our internal policies help us to deliver on our own safeguarding obligations towards our clients. So protecting our clients as at-risk individuals to ensure that we do no harm in our own service delivery and to enable them to live lives that are free from harm and neglect. They assist us to work together as an organisation, but with organisations, partner organisations, to prevent and stop the risks and actual experience of harm that our clients might have.
It is about managing our clinical risk so that, in

the work that we do, we do not do harm to our clients.
Q. Does Freedom from Torture also provide training for organisations?
A. Yes, we do. We provide narrative exposure therapy training to IAPT services and we do training on engaging with survivors of torture for voluntary sector organisations.
Q. Thank you. You mentioned that you don't have a particular role in going into immigration removal centres. Do you have any particular role in the detention in immigration removal centres at all, or is it only after people have been released?
A. So we -- I guess we interact with the detention estate. Sort of two key points. So we may be alerted that one of our therapy clients, so someone receiving therapy with us or being assessed for therapy with us, has been detained; or we might get a referral from a legal representative of someone who is in detention but hasn't previously been one of our therapy clients, and that's, in the circumstances I just described earlier, where we have been asked to produce some medico-legal reports. So, in those circumstances, we can do an assessment of the documents on the paper to see if the individual meets our remit and if we think there is something to document, and then we will advise the legal

representative to make a referral to us after release for us to do a medico-legal report.

In the context of a therapy client who has been detained, if we are alerted that someone has been detained, then we will usually write a letter from the treating clinician at Freedom from Torture to the clinical team at the IRC -- so a professional letter from one healthcare professional to another -- to alert them to the fact that that individual was a current client of Freedom from Torture who was receiving therapy with us, confirming that they are a torture survivor, and any details that we have, or concerns that we have, around the risk and the mental health needs of that individual. We will also often comment in that letter on our concerns around the risk of detention, especially if we think that being detained will increase the risk of harm to that individual.

Q. You have mentioned various different ways that you might be alerted to a victim from torture or a torture survivor. How do individuals who are torture survivors access your services? What's the referral process?

A. So we have an open referral process for our therapy services. We mostly -- someone can self-refer for therapy with us, but we mostly receive referrals from other healthcare professionals, usually from GPs.

Q. Moving on, then, Freedom from Torture submitted a document entitled "Freedom from Torture submissions to the Brook House Inquiry" to the inquiry. You prepared that document, I believe, with Zoe Cross. What's Zoe Cross's job title?

A. Zoe is the policy and administration assistant in the Policy & Advocacy Directorate of Freedom from Torture.

Q. What does that role involve?

A. She provides administrative support to the team and she provides additional policy analysis support to me on detention policy issues.

Q. In those submissions, you've come to some conclusions on the effect of immigration on victims of torture, and you have particularly looked at two case studies which have been anonymised, and we will come to those in a moment in more detail.

Those case studies are in relation to two former Freedom from Torture clients; is that right?

A. Yep. So one was a therapy client and one was referred to us from detention for a medico-legal report.

Q. Freedom from Torture has declined to provide the inquiry with their identities, those are anonymous case studies. Why is that?

A. When someone is referred to us, they provide consent at that early point. That's a generalised consent that

allows us to use anonymised data for nonidentifiable purposes for research and policy. So that is the level of consent that we had from these two individuals that allows us to use their data, to the extent that we have within the submissions to this inquiry.

Q. Thank you. You have also, in relation to those case studies, looked at various sources of information, and you set those out at paragraph 5 of your statement. You have looked at some rule 35 reports, the Home Office response to those reports -- is that right?

A. So we looked at the rule 35 and the Home Office response within the two case studies, but we have also previously done more generalised analysis of rule 35s and Home Office response to rule 35s for a wider case set that we submitted to the Independent Chief Inspector's inquiry into a second inspection of the adults at risk.

Q. Also, in relation to these two case studies, you looked at any other information, including any other clinical reports and, really, any other information that you held upon your system in relation to that?

A. That's right.

Q. Before we come to those case studies in more detail, you set out, at the bottom of page 1 of your submission:

"Clinically, it is well understood that torture survivors are particularly vulnerable to harm in

detention."

From where have you drawn that conclusion?

A. So there have been a number of systematic literature reviews that have been done over the years, looking at clinical and legal literature, including a mental health literature survey that was commissioned by Stephen Shaw for his initial inquiry into adults at risk in immigration detention, so we have relied on a number of those systematic reviews to form our opinions.

Q. What is it that renders torture survivors particularly vulnerable to detention, then, in your view?

A. So I'm going to restrict my comments to the clinical opinions that we provided in our witness submissions. I'm not a clinician myself. But, as we understand it, it is recognised within the literature consistently that immigration detention is harmful to mental health and that if you have -- for those who have a pre-existing mental health issue or experience of trauma, including torture, that detention can be -- that the impact of detention can be -- the harm can be even greater, the degeneration of mental health and the symptoms can be even more severe with a history of trauma such as torture.

Q. So it is Freedom from Torture's experience that, in particular, victims of torture are vulnerable to adverse

mental health outcomes, to deterioration in their mental health whilst in detention?

A. Yes. We have seen this, both in the two case studies that we put into our submission and, more generally, in work that we do -- that our clinicians do with survivors of torture, including those who have experienced detention, that the effects of detention on those -- detention can be extremely re-traumatising, it can result in intrusive recall of memories of previous detention and torture, it can lead to nightmares, depression, PTSD, anxiety, and that these effects worsen the longer that someone is in detention and that they endure after release.

Q. At the bottom of the first page of your submissions, you say that the two cases are illustrative of systematic problems faced by individuals, including survivors of torture, who have been held in immigration detention across various IRCs, and you say over a long period of time. Firstly, what do you mean by "a long period of time"?

A. So we have been working on this issue -- well, certainly myself -- since around 2015/2016 and looking at the failures of the safeguards to protect vulnerable people in order to feed into Stephen Shaw's first inquiry, which was in 2016. We have, since then, been monitoring

closely the effectiveness of the rule 35 process, how the Home Office responds to rule 35 reports, the Adults at Risk process, when it was set up, we have been closely monitoring, ever since, the way that the levels of risk have been used and the balancing immigration factors, and we have been engaging very closely with the Home Office on reforms to those processes as subsequent inquiries have highlighted failures in the implementation of those safeguards.

Q. So those are the types of systematic failings that you have just referred to that you talk about at the bottom of that page?

A. Yes.

Q. In relation to the liaison with the Home Office, has that been over the period since 2015/2016 to date?

A. Yes. So we have been engaged -- we are -- Freedom from Torture is a member of the National Asylum Stakeholder detention subgroup, which is the -- a regular meeting between the Home Office detention officials and NGO stakeholders. We are a member of that, so we engage with them at that level, but also on a bilateral level on particular issues to do with, for example, issues with rule 35, issues with healthcare screening, issues with the use of medico-legal reports to inform Adults at Risk decision making, and the reforms they wanted to

make to that, including on the introduction of quality standards for medical reports. Most recently, that's the engagement. And also on the enhanced screening tool.

Q. As part of that process, do you submit evidence or written submissions to them?

A. We do, yes.

Q. Do they respond?

A. Sometimes. Sometimes. Engagement with the Home Office on detention matters has not always been easy. For example, communication channels sometimes break down altogether. We have had periods of time where the detention subgroup has not met at all. We have found in our conversations with them through forums like that that they will put fairly tight constraints on what can and cannot be discussed. And particularly, when it comes to policy matters, there is a general sense that they are at one end of a spectrum and they believe us to be at the other end of the spectrum. It is difficult, therefore, to find common cause --

Q. Common ground?

A. Common ground on which we can make progress for the benefit of vulnerable detainees.

Q. Do you feel you are making progress?

A. I think that the Home Office has been on a bit of

a journey, certainly since Stephen Shaw's inquiry, and it has made a lot of effort certainly to learn about vulnerability and to learn about safeguarding. It's become very fluent, I think, in the language of vulnerability and safeguarding, and it has done a lot to build an infrastructure, both policy and operational, to try to implement that. My perception is that that is undermined by a preoccupation with abuse of the safeguards that have been put in place, which then has led to efforts to restrict access to those safeguards, which then renders them almost inaccessible to the people who really need them.

Q. Thank you. Let's look, then, at the case studies in a little more detail. You first deal with case study 1 on page 2 of your submissions. This relates to an individual whom you have referred to as "Alex" -- clearly not his real name. He was detained at Brook House for a 28-day period from early April 2017 to early May 2017, so at the beginning of the period with which the inquiry is concerned.

A. Mmm.

Q. Afterwards, he was detained at Harmondsworth; is that right?

A. That's right.

Q. You then set out that the asylum policy instruction on

the rule 35 process -- that's DSO09 of 2016. Perhaps we can show that on screen. It's <FFT000002>. That's the instruction that you're talking about. Can we turn to page 10, please. Perhaps just zoom in slightly.

This instruction explains that shortly after the arrival of detained persons at an IRC, all detainees are, as part of the admissions process, given a healthcare screening, which includes being asked whether they have been tortured and that this healthcare screening should happen within two hours of arriving in detention. Is that your understanding?

A. Yes, that's my understanding of how it should work, yes.

Q. Do you know whether the staff undertaking this screening have been given any definition of what constitutes torture?

A. No. We are not aware of what they have been provided by way of understanding the definition of torture.

Q. Presumably, in your view, they should be provided with a definition?

A. I would have thought so. If you are asking somebody whether they have been tortured, then you should be able to understand what you are asking them and the response they are providing you with.

Q. You say that any individual who discloses that they have experienced torture must be provided with a follow-up

appointment with a doctor as quickly as possible, during which the doctor will assess whether there are concerns that the individual is a victim of torture; is that right?

A. That's right.

Q. Perhaps we can just look on screen at <CJS000731>, please. This is the Detention Services Order 08 of 2016 which deals with the management of adults at risk in immigration detention. If we could. That's the DSO. If we could look at page 8, please. If we come down slightly in the page, there we find:

"All detainees must have a medical screening within two hours of their arrival", which we have just dealt with.

It goes on to say, five lines down:

"Every detainee identified as an adult at risk must be given an appointment with a GP within 24 hours of admission to an IRC, which should include consideration of any medical requirements to enable removal to take place as planned."

That paragraph doesn't mention rule 35 at all, does it?

A. No, but my understanding is that's the rule 34 appointment.

Q. Let's just look, then, at rule 34. If we show on screen

<CJS006120>, so these are the Detention Centre Rules. That's the first page. If we look at page 11, please, and zoom in on 34, rule 34(1) says:

"Every detained person shall be given a physical and mental examination by the medical practitioner (or another registered medical practitioner ...) within 24 hours of his admission to the detention centre."

Is that right?

A. Yes.

Q. So, in fact, what rule 34 requires is that every detained person should see the doctor within 24 hours of admission, not just those who disclose a history of being a victim of torture or those identified as an adult at risk in the screening; is that your understanding of that rule?

A. That's how I read it.

Q. The instruction, the asylum policy instructions, the two DSOs we have looked at, don't seem to reflect that, do they?

A. No.

Q. Rule 34 requiring a GP to examine within 24 hours, would you view that as key to the rule 35 process? Because it's only a GP who can make a rule 35 report?

A. Absolutely.

Q. So it is an important safeguard in identifying those who

are vulnerable early on in detention that have not been identified as that previously?

A. That's correct.

Q. The reason for undertaking that process, part of its purpose is that, whether someone is a victim of torture or not is intended to be factored into the decision by the Home Office of whether that person should be detained; is that right?

A. That's right.

Q. What is your experience, or Freedom from Torture's experience, of whether decisions to detain or maintain detention are properly informed by information from the detention centre about vulnerability?

A. So we have long had concerns about the quality of the rule 35 process and specifically of rule 35 reports themselves, but also access to rule 35 reports. So, additionally, within those rules, there is the requirement that the individual consents to that assessment, and I think there are issues around uptake of rule 34 assessments by individuals who are extremely vulnerable and least able to advocate for themselves. I think the people who -- I think that not everybody who needs a rule 34 assessment is getting one. I think they are having -- historically, had to wait a long time to get an assessment and then to get the report done.

I think the quality of reports has not always been to the standard that we would expect, and I think the reports within the case studies that we have submitted show how rule 35 doctors do not -- rule 35 report writers do not always comply with the requirements or the instructions for completing a report, including providing a comment on the impact of detention or the risk of harm caused by detention for the individual. That is frequently, in our experience, left out of the report. They often miss evidence of scarring that we later pick up in our medico-legal reports, and we can put some of that down to the length of time that they have to do the assessment, but also their level of skill in doing it. It's not -- a rule 35 is not a medico-legal report, I should be clear on that; it is a very, very -- it's a much lower evidential threshold that the rule 35 has to meet, but, even then, rule 35 doctors are often missing evidence of torture when they do them, particularly psychological.

Then, of course, in the response that the Home Office provides to the rule 35 report we have seen many flaws in the way the Home Office engages with those reports. We would expect a Home Office caseworker to identify the information that's missing. So if key information is missing from a rule 35 report, such as

the impact of detention on the individual, then the Home Office caseworker should return that report to the doctor and ask for it to be completed in such a way that they are in a position to make the best decision on the ongoing detention of that individual. We have not seen that happening in our experience consistently.

Then the way that the Home Office engages with the information in the rule 35 report in making its decision, and this is often around the extent to which -- or the way in which they use the evidence to establish the level of risk that the individual is exposed to, where that puts them within the Adults at Risk process. So we see the Home Office making judgments that clearly place far greater weight on the immigration factors that form part of the balancing process in the adults at risk than they do on the evidence that even -- even the barest evidence that's in the rule 35 report of an experience of trauma and, therefore, an indication of clear vulnerability. And we see people consistently being rated at levels lower than they should be, so put at level 2 on the Adults at Risk on the back of a rule 35 report, often because there is no declaration of impact of harm in detention because the doctor didn't include it and the Home Office caseworker didn't chase it and what should have put the

person at level 3 sees them being rated at level 2 instead, which we think is a significant failing within the rule 35 and Adults at Risk process.

Q. Thank you. We will come to some of those a little later in further detail. Just looking, then, at Freedom from Torture's experience of the rule 34 assessment with a view to a GP preparing a rule 35 report, has that become something that effectively a detained person has to proactively ask for, rather than it being an obligation under rule 34 for every detained person?

A. It does seem that there is an inappropriate level of sort of obligational onus on the individual to self-advocate in order to secure a rule 35 report, and this is even -- I suppose it is even more the case when they have already been through a process like rule 35 and either it hasn't been documented -- because, if it is purely self-declaration, then the rule 35 doctor is under no obligation to produce a rule 35 report. So unless they have something additional to an individual's self-declaration, then they don't have to produce one.

By our understanding, that -- even a self-declaration should provoke a duty of enquiry by that doctor. So whether or not they produce a rule 35 report, there should be a process by which that individual is monitored and reassessed so that, if their

condition changes, their level of vulnerability changes, that is picked up and they are routed back through a rule 35 process again and quite possibly would secure a rule 35 report at a later date and that should apply if that individual has a rule 35 and is rated as a level 1, that that should trigger, again, a process of review and monitoring so that the IRC healthcare can see whether that individual's level of vulnerability has changed. We don't see any of that process for returning to an individual and reassessing and monitoring to see if their level of vulnerability has changed. That's not built into the rule 35 process.

Q. So even where they have self-advocated and asked for a rule 34 assessment leading to a rule 35 report, contrary to the obligation under the rule, they are not routinely reassessed or monitored in any way to follow that process through?

A. That's right.

Q. That doesn't form part of the system?

A. Yes, not to my knowledge.

Q. What is your understanding of why there are delays in obtaining rule 34 assessments or rule 35 reports currently?

A. So my understanding is that it was a combination of a failure of earlier safeguards. So ideally, if the

system worked, the detention gatekeeper would be picking up on vulnerabilities and grounds for routing someone away from detention before they have even entered detention, or in earlier stages, and because earlier safeguards are not working, there is a much greater reliance on the safeguards within detention.

Q. So rule 34 and rule 35?

A. Yes, so that is effectively kind of the first in-detention safeguard that someone would encounter.

Q. In your view, that's not working either, in bringing to light vulnerabilities of detained persons who are victims of torture or otherwise at risk?

A. Yes, that's right.

Q. Let's look, then, a little further at the case study. "Alex", I think we are dealing with in number 1. When he was provided with a rule 35 report in Harmondsworth, so not in Brook House but afterwards, when he was transferred to Harmondsworth, that indicated that he was a level 2 in terms of categorisation of evidence of torture, and, again, so we are clear, level 2 indicates that there was some professional evidence that he was a victim of torture and it wasn't just a self-declaration from him; is that right?

A. That's right, yes.

Q. The Home Office response was, nevertheless, that he

would remain in detention; is that right?

A. That's right.

Q. The reasons the Home Office gave were that his immigration history clearly showed that he cannot be relied upon to comply with immigration requirements; is that right?

A. That's right.

Q. So is that an example of the balancing exercise that you referred to earlier, where immigration factors seem to outweigh the risk factors in relation to harm?

A. That's right.

Q. Prior to the Adults at Risk policy being brought in, and so the evidence levels approach that we have referred to -- level 1 being a self-declaration; level 2 some evidence from a professional of torture; and level 3 being also some evidence of likely harm -- there was a category-based approach in place, and so, if you fell, as a detained person, within a particular category, you were classed as an adult at risk. Is that right?

A. Yes, that's right, and there was a presumption that you wouldn't be detained except in exceptional circumstances.

Q. So under the old category-based approach, immigration factors would not outweigh the presumption against detention except in exceptional circumstances. What

effect does Freedom from Torture consider that the removal of reference to that high threshold has had on the presumption against detention for categories of vulnerable persons or adults at risk?

A. We think that this has significantly raised the evidential threshold at which someone can secure release from detention. It places a far greater emphasis on documentary evidence of vulnerability, as opposed to self-declaration or indications that someone might fall within a category that has already been accepted as being at risk of harm in detention.

Q. So the converse of that is it has effectively lowered the presumption, it's diluted the presumption?

A. Yes, and it's enabled the Home Office to place significantly more weight onto the immigration factors at the expense of an understanding of the level of risk that's been described.

Q. So, in Freedom from Torture's experience, has that effectively raised the number of people with mental illness or significant issues in relation to past trauma, in terms of being a victim of torture, who remain in detention?

A. We can only assume so. We don't go into detention, so we can't sort of speak for the numbers that are survivors of torture within detention. But we can look

at some of the statistics that have been produced, including the Home Office's own data on rule 35 and releases on the back of rule 35s and also the data that the Independent Chief Inspector produces in relation to the functioning of the rule 35 and what it means for -- the extent to which it provides a meaningful safeguard for vulnerable individuals, including torture survivors.

Q. In Alex's case, after his release, there was various clinical evidence available to you in the form of an independent psychiatric report, a letter from Freedom from Torture's own clinician, and a Freedom from Torture medico-legal report, all showing that detention had indeed had a negative effect upon him. Is that right?

A. That's correct.

Q. The report -- that evidence -- those reports don't distinguish between his detention at Brook House and Harmondsworth; is that right?

A. That's right.

Q. So it could be one or the other or a combination of the two?

A. That's right.

Q. Just dealing, then, with your conclusions as drawn from Alex's case, I believe at page 4 of your submission, what failures do you consider his case exemplifies?

A. So the fact that he was in detention for 42 days before

he was given a rule 35 report I think demonstrates the failures of the healthcare screening process and the rule 34 and rule 35 processes. I think the fact that his MLR doctor found considerable evidence of torture, both -- in the form of lesions across his body, there should have been -- it should have been possible to identify some indicators that this man fell within a vulnerable category much earlier in his time in detention, had the effort been made by people who understood how to identify vulnerability and indicators of torture.

Q. Given, it seems, there was clinical evidence, following his release, that detention had caused him some harm, he had deteriorated in his mental health, would that have put him at level 3 in the risk evidence?

A. If that had been documented, if that had been written into his rule 35 report, then it should have put him at level 3.

Q. Let's look, then, at case study 2, which starts at page 4 of your submission. This relates to an individual you referred to as "Alan" -- again, not his real name -- who was detained at Brook House for 46 days from late February 2017 to mid April 2017. So slightly before and into the early period of the relevant period with which this inquiry is concerned.

While he was detained at Brook House, Alan did undergo a rule 34 assessment that resulted in a rule 35 report. Is that right?

A. That's right.

Q. The doctor concluded that he may be a victim of torture and does present with physical and apparent psychological evidence of this; is that right?

A. That's right.

Q. The doctor then concluded that since he was due for removal, it was unnecessary for the doctor to comment on the impact of ongoing detention. That is something that you have referred to before, that that was often absent from the rule 35 report. Is that right?

A. That's right.

Q. Is that correct, in your view? Should the doctor have declined to comment because he was due for removal?

A. No.

Q. So the doctor should have filled that section in, in any event?

A. Yes.

Q. The Home Office response accepted that there was level 2 evidence of torture, but, again, in balancing the risk factors of continued detention against immigration control factors, the Home Office nevertheless determined, in common with Alex, that he should remain

in detention?

A. Yes.

Q. What does that indicate to you about the presumption against detention?

A. It shows how the Home Office is giving considerable weight, excessive weight, to immigration factors when doing the balancing exercise and relying very often on issues to do with compliance, with reporting conditions. Even when there has been a history of good compliance with reporting conditions from the same individual, they will still rely on that as a justification for not releasing on the basis that that individual now has removal directions and, therefore, will not be compliant.

Q. So even if they'd been compliant in the past, if their removal is imminent, the presumption is made that they will now not comply?

A. Yes.

Q. For level 3 risk evidence under the Adults at Risk policy to kick in, that requires additional specific evidence that detention is likely to cause harm. Here, the doctor had not commented upon that likelihood, as we have just discussed, and the Home Office relied upon that.

So does that additional requirement make it much

more difficult to secure the release of a vulnerable detained person?

A. Absolutely.

Q. In Alan's case, from his Freedom from Torture clinician, he had, in a letter, identified exactly that risk to the Home Office prior to the issue of their response. That clinician had also told Brook House three days after his detention, by writing to the duty medical officer, and had also written after a further 12 days. Is that right?

A. Yes, that's correct.

Q. So both the detention centre, the immigration removal centre, and the Home Office had been informed that there was, in fact, evidence by a clinician of that level 3 risk that detention was likely to cause harm?

A. Yes.

Q. The clinician stated that he was extremely concerned about the detrimental impact Alan's continued detention was having on his mental health?

A. Yes.

Q. Was any particular action taken by staff at Brook House as a result?

A. Not that we're aware.

Q. What do you believe should have happened as a result of those letters, either by action by Brook House or by the

Home Office?
A. I think the rule 35 doctor should have taken into consideration the representations that were made by the FFT clinician regarding the level of vulnerability of the individual, the fact that they were a confirmed Freedom from Torture client in treatment with us, and that the clinician had raised concerns that detention was impacting on the anxiety of the individual and so the risk of harm to which he was exposed. The doctor should have taken that into consideration when writing the rule 35 report, and the Home Office should have taken those representations into consideration when they were doing the Adults at Risk assessment.
Ideally, the Home Office should have sent the rule 35 report back to the doctor to get the missing information addressed and then returned to the Home Office team so that they could make an effective decision on that individual's ongoing detention.
Q. The current iteration of the Adults at Risk policy includes a section setting baseline requirements and standards for medico-legal reports and clinician letters from external bodies, such as Freedom from Torture, which seems to set a higher benchmark for when they can be accepted as risk evidence. Are you familiar with that?

A. Yes. We were informed by the Home Office in August 2020 that they were considering introducing these quality standards for medical reports submitted as part of the Adults at Risk process, so we had a short period of engagement with them before the reforms that they planned were paused. Our engagement continued up until the point at which those medical standards were taken forward and put into the latest draft of the Adults at Risk guidance.
Q. Does that concern you, particularly in the light of what happened in Alan's case, in that the Home Office didn't take into consideration Freedom from Torture's evidence submitted?
A. Yes. It concerns us hugely. These quality standards are specifically for reports that are commissioned by legal representatives to inform an Adults at Risk assessment. So, in theory, they shouldn't apply to all medical evidence that is submitted for consideration as part of an Adults at Risk assessment. But what I think these quality standards show -- well, the desire to introduce them -- is a level of suspicion around what they perceive as abuse of an essential safeguard for individuals, which is access to independent expert medical evidence of their vulnerabilities to inform an assessment of them, and what we see happening is, in

response to -- much as we saw back in the day with rule 35 reports, whenever one safeguard gets excessively -- excessive pressure placed on it, the Home Office becomes very anxious that that safeguard is being abused, rather than looking holistically at what else might be failing within the system that leads to an over-reliance on one part, on one safeguard within it, they sought to shut down access to it and so, from our perspective, the introduction of these quality standards was an attempt to raise the evidential threshold yet more, yet again, for access to medical evidence that could carry weight in an assessment and an effort by the Home Office to apply less weight to medical evidence when it comes in from external experts on the basis that it doesn't meet one or more of their safeguards -- of their quality standards which, when you look across the ten standards, some are quite reasonable and are probably being met quite easily by a lot of the report producers, but some of which are unreasonable expectations to place on a medical report writer.
Q. Such as?
A. So, for example, they require that the writer must consider -- must include consideration of the standard of care in the immigration removal centre, including the standard of mental health care, and the expectation that

every medical report writer has a full and up-to-date understanding both of the medical care that should be provided but, more importantly, the medical care that actually is being provided within every IRC is unrealistic.
Q. Thank you. At page 2 of your submissions, you effectively set out some overall conclusions that you have drawn from these two case studies under your heading "Reflections and recommendations". What were they?
A. So, in summary, we think that the safeguards that are in place to prevent the detention of vulnerable individuals, and particularly torture survivors, are not working, and we think that includes everything from healthcare screening, so the induction and intake process, through rule 34 assessments, rule 35s, the Adults at Risk policy and process, the detention gatekeeper, all the way through to the final decision that's made by the caseworker and the rule 35 team around continued detention, we think these safeguards -- we believe these safeguards are failing.
Q. In your view, are these failings likely to be considerably more widespread than just in relation to these two individual case studies?
A. Yes, absolutely.

Q. Let's look a little further, then, at the conclusions you draw, from page 7 onwards in your submissions. You comment, first, on the Home Office's proposed reform of the Adults at Risk guidance in response to the Shaw report in July 2018; is that right?

A. Yes.

Q. Was there any other response from the Home Office to the Shaw report, to your knowledge, in relation to the Adults at Risk guidance? Have there been any changes implemented since Shaw to date?

A. So there have been a number of changes made. The proposed reforms that we became aware of in August 2020 was a package. So we have talked about the MLR -- the medical report quality standards, which did -- have gone through and been implemented. Another part of the reforms that have been implemented involved bringing trafficking cases within the remit of the adults at risk process. That has also gone ahead. But other reforms that haven't been progressed concern changes to the Adults at Risk levels and changes to the rule 35 process and scope.

On the Adults at Risk levels, I can talk about those ...

Q. Pause there for a moment. Firstly, do you know why the reforms were paused in 2020?

A. So they were paused in anticipation of the new legislation, so the new plan for immigration was published in early 2021 and then the new -- the Nationality and Borders Bill followed and the Home Office wanted to make the necessary legislative changes and then reform and adapt the Adults at Risk and rule 35 process in line with that.

Q. So, to your understanding, are those reforms likely to be unpaused, as it were? Are they likely to continue from now?

A. Yes. Yes, I would expect so.

Q. You say in your submission that Freedom from Torture are concerned about the direction of travel of these reforms. What do you understand the direction of travel to be?

A. We believe that the Home Office intends to further raise the evidential burden on individuals within the adults at risk process.

Q. And the corresponding concern is that there will be a reduction in protection from harm for vulnerable individuals?

A. Yes.

Q. Dealing, then, with the Adults at Risk levels, the three levels, so that we understand, level 1 is a self-declaration of being an adult at risk, including being a survivor or a victim of torture?

A. (Witness nods).

Q. Level 2 involves some professional evidence either from a social worker, a medical practitioner or an NGO that the person is an individual or may be someone at risk, including a victim of torture?

A. Mmm.

Q. Is that right?

A. Yes.

Q. And level 3 involves not just that evidence involving the risk, but also professional evidence that detention would be likely to cause harm?

A. Yes.

Q. Is that right?

A. Yes.

Q. Under the new policy, then, the proposed policy, an individual would not be categorised as an adult at risk unless they had a professional assessment to support it; is that right?

A. Yes.

Q. So that would be what is currently level 2?

A. Yes.

Q. Does that effectively do away with level 1, the self-declaration?

A. Yes.

Q. Because, at present, you're classed at level 1 evidence as an adult at risk if you simply say, "I am an adult at risk", for whatever reason?

A. Yes.

Q. Just dealing with level 1 at present, then, what is your experience as to how much weight the Home Office accords level 1 evidence; in other words, a self-declaration, with nothing more?

A. Very, very little.

Q. What is the problem with that?

A. The problem is that we have already discussed, I think at length, how difficult it can be for individuals to access the professional documentary evidence that's required to get them into a higher level, both because of their own vulnerability, which makes them least able to self-advocate for things like a rule 35, or for a medico-legal report or other medical evidence from an external expert, but also because of the Home Office's best efforts to try and restrict access to those mechanisms, and also because there appears to be no mechanism built in to allow for a return to that individual for regular reassessment to see if their situation has changed. So once you have gone through a process and been categorised as level 1, it appears you are still sort of abandoned.

Q. That's the end of it?
A. Yes, you are left, that's your one bite of the cherry. So it's hugely problematic because I think it creates an enormous risk that the most vulnerable -- some of the most vulnerable people will not be being picked up by their safeguard and will remain in detention.
Q. They'll simply be missed. I think you mentioned earlier in your evidence that you think, as Freedom from Torture, that a self-declaration should, in fact, trigger an obligation on the Home Office or the detention centre, either healthcare or management, to enquire whether there is other evidence that the person is at risk. Is that right?
A. Yes.
Q. At present, there is no such obligation?
A. No.
Q. As you said, there is one bite at the cherry?
A. (Witness nods).
Q. Having such an obligation would reflect the objective of protecting those who are particularly vulnerable?
A. Yes.
Q. That deals with the level 1. Are those who previously have been assessed as having level 2 evidence also effectively been downgraded by the proposed reforms?
A. Yes, because it is placing a far greater emphasis on

this prediction of harm within the assessment.
Q. If one doesn't have that, level 2 has effectively become level 1 and level 3 has become level 2?
A. Yes.
Q. Is there a concern about a continuation of requiring a prediction of future harm in and of itself?
A. Yes, absolutely. In our opinion, it's incredibly difficult for an IRC healthcare doctor to predict the future harm of detention on an individual, and it effectively puts them in a position where they have to wait to see if there is harm before they're in a position to be able to say that harm -- you know, the risk of harm and a deterioration is likely to happen in detention. That is not preventative.
Q. No. So it effectively requires -- the best way to predict future harm is if harm has already been caused --
A. Yes.
Q. -- by which time the damage has been done?
A. Yes.
Q. In other words, in your view, a past history of ill-treatment in terms of torture or a past history of vulnerability and risk should be enough to trigger that higher level of evidence?
A. Yes.

Q. One shouldn't require a prediction of future harm?
A. Yes, a category-based approach that's informed by significant evidence that people within a certain category are already -- can be presumed to be at risk of harm in detention.
Q. So the classification becomes automatic?
A. Yes.
Q. That's your view in relation to torture survivors?
A. Yes.
Q. Is it also your view in relation to someone who has previously attempted suicide or has previously been assessed as a suicide risk?
A. I mean, that's -- that's going slightly outside the -- I guess, the competency of -- but I think the fact that someone has demonstrated indicators of serious distress, mental health issues, to the level that they would self-harm or show evidence of suicidal ideation or attempts at suicide should be enough to indicate that that individual is highly vulnerable, and then further enquiries and efforts to document that vulnerability should be made.
Q. Yes, and so the conclusion of Freedom from Torture, which was also Stephen Shaw's recommendation, was that a return to a category-based approach should happen?
A. Mmm-hmm, yes.

Q. Moving on, then, specifically to rule 35, and you have touched on this in various ways in your evidence, there is a planned expansion to the rule 35 process to take account of all vulnerabilities, I think, and that's presumably a welcome change?
A. We do, yes, we welcome the proposal to expand rule 35 to cover all the vulnerabilities, although I guess we would repeat our sort of persistent call for appropriate resourcing and training for the individuals who are responsible for identifying those indicators and documenting so that they are in a position to do so without relying too heavily on individuals self-advocating and proactively seeking assessment under rule 35 for all those vulnerabilities.
Q. Yes. Is there also a concern to ensure that the existing separate functions of rule 35(1), (2) and (3) continue to operate -- (1) being that detention is likely to be injurious to health; (2) being whether there are suicidal intentions; and (3) being the victim from torture category?
A. We are concerned that the capacity to identify each of those categories and provide them with access to a protected safeguard under rule 35 must be sustained.
Q. So why is it important to have those three separate categories or functions of the rule?

A. Well, from our point of view, it's important that torture is recognised as a distinct category of vulnerability. It's -- we have extensive evidence within the literature and within our own experience of working with torture survivors of the harmful impact of detention. From our point of view, there needs to be, within any protected safeguard, an acceptance and understanding and a presumption that torture survivors are not suitable for immigration detention, except in the most exceptional circumstances.

Q. Is it important to recognise the other two categories as well?

A. Yes.

Q. Do you have concerns about the role of the clinician undertaking those assessments and the rule 35 reports? It's currently a GP. What are the concerns about a GP undertaking that role?

A. I think it's -- our concerns are less around the level of qualification of the individual undertaking that role and more around their skills, their training, their capabilities and also the resourcing that's available to them, so the time they have and the environment in which those assessments are done. All of those factors should support an IRC healthcare professional to make the best -- to do the best rule 35 assessment they can do

and to be applying the correct evidentiary threshold for it.

Q. So, in your view, it's important that the clinician carrying out the assessment and writing the report is clearly appropriately qualified and trained. Do you consider a GP to fulfil those requirements?

A. I think so, yes. I don't see that it needs to be someone of a higher level of qualification. The risk of -- the risk of raising any sort of qualification threshold for completing rule 35 reports is that, again, it pushes the evidential threshold up further still. As I said earlier, the rule 35 reports are not an MLR, it does not have to be completed to the standards of a medico-legal report, it doesn't have to be a simple protocol compliant. This is a low threshold and this is a safeguard that needs to be accessible. So I think putting the qualifications of the writer at a level that allows it to be accessible is important.

Q. Would you have a concern if the level of qualification and experience or training was lower than a GP? Do you think it's important that it remains a clinician, as opposed to a nurse or a healthcare assistant?

A. I think we are -- I think we are more concerned about their ability or the training and their skills and abilities in being able to identify and perform the

tasks that the rule 35 process itself requires and, as long as those requirements are met, then, you know, I think it could be a GP, I think there could potentially be the involvement of other healthcare professionals within the IRC.

Q. Are you aware of a proposal that perhaps multi-disciplinary panels could carry out rule 35 assessments?

A. It's not something that I've looked into.

Q. Would there be any concern about that? Would delay be a concern if more people were involved in the system?

A. Yes, I can see how that might be an issue. We are already struggling with access to the rule 35 process and resourcing being the issue that I keep coming back to.

Q. It's important for the system not to be overly complicated?

A. Exactly.

Q. You have also touched upon, in your evidence, that there doesn't appear to be built into the current system a reassessment or monitoring of detained persons after they're initially detained and subject to this process. Are assessments carried out frequently enough, in your view?

A. As I said, we don't go into detention and our level of

knowledge of how the processes work within the healthcare system within detention is limited. But my understanding is that, yes, they don't -- reassessments and monitoring, particularly of vulnerability levels, does not happen consistently or systematically. The Home Office and the IRC healthcare teams don't seem to understand how vulnerability is dynamic and fluctuates and changes over time.

Q. And so there also isn't assessment or monitoring of whether detention is, in fact, causing harm?

A. Not from what we can see.

Q. Presumably, you think detainees should be assessed regularly. Do you have any particular views on how regularly or how that could work?

A. I don't.

Q. You have mentioned predetention screening. What are your concerns about how the current system of predetention screening works?

A. I'm not -- to be honest, I'm not really aware of much by way of predetention screening.

Q. In other words, it doesn't really exist?

A. Yes.

Q. So greater effort should be made to identify those who are vulnerable, including torture survivors, prior to detaining them, in your view?

A. Yes. The Home Office has piloted an enhanced screening tool which was supposed to fill that gap, as far as I'm aware, and enable, I imagine, immigration enforcement staff at the point at which they identify someone for detention to conduct a very quick assessment and make recommendations on the back of that. But we were alerted to this tool very late in the day. We submitted comments for the Home Office as part of their evaluation. As far as we understand, the enhanced screening tool has also been paused. From our point of view, our perspective, this enhanced screening tool was not a vulnerability screening tool, as we would expect it to be. It was an extensive document with a wide range of questions, not just limited to assessing vulnerability and level of risk, but including questions around voluntary return and preferred airport of return.

Q. So immigration factors as well as vulnerability assessment?

A. Yes.

Q. You mention in your submissions the UNHR vulnerability screening tool. In a nutshell, what is that?

A. So this is a tool that is designed to help decision makers to understand the relevance of vulnerability to detention decision making, and it equips decision makers with guidance to help them in that assessment of

vulnerability and it talks about vulnerability domains, which probably is the closest thing you can find to the categories approach to understanding vulnerability. So torture falls into one of those domains, as we would expect it to, but there are other domains, concerning things like gender and age, that immediately flag to the decision maker that certain categories of individuals are presumed to be more vulnerable and at harm, and it then equips them to make an assessment of the level of risk to which that individual is exposed and provides guidance to the individual on placement options, as the UNHR calls it, which basically means whether that individual goes into detention or some alternative to detention.

Q. Your view is that the Home Office should be developing their own specific screening tool using the UNHR one as a guide?

A. Yes.

Q. You make some key recommendations in your submissions. Firstly, at page 2. And you make three particular key recommendations. The first is that "no asylum seekers or refused asylum seekers should be detained for administrative purposes". That would require a wholesale policy change that's outside the terms of reference of this inquiry?

A. (Witness nods).

Q. The second, though, is:

"The Home Office should ensure that all healthcare staff at IRCs are familiar with and use the Faculty of Forensic and Legal Medicines Quality Standards for healthcare professionals working with victims of torture in detention."

Again, just briefly, in a nutshell, what do those standards seek to achieve?

A. So these standards aim to help healthcare professionals working in detention to identify torture survivors and to protect them from harm and to provide them with the appropriate treatment. Critically, they empower healthcare professionals working in detention to maintain their ethical obligations where those obligations come into conflict with the requirements of the authority. So the Home Office in our case.

Q. The third recommendation relates to the Adult at Risk framework that we have discussed, should detention of asylum seekers continue, contrary to your first recommendation. And you say:

"The level 3 requirement for evidence that detention will likely cause harm should be reduced."

A. Yes.

Q. "The Home Office should amend the Adults at Risk policy

so that anyone with professional evidence of torture, including a rule 35 report, should be designated as level 3", effectively?

A. Yes.

Q. So doing away with the requirement for a risk of future harm or an assessment of such?

A. Yes.

Q. You say that the Home Office should effectively accord rule 35 reports with their appropriate weight?

A. Yes.

Q. On page 9 of your submission, you deal a little further with some detail of recommendations. You say in relation to predetention screening, and we have touched on it just now, that, in your view, the Home Office should develop a mechanism for identifying vulnerability prior to detention, and that's the screening tool we have just discussed?

A. Yes. It could be in the form of a screening tool that's used, for example, at the point of contact in enforcement action, although with enormous caveats around the environment in which someone extremely vulnerable finds themself at the point at which they are identified by enforcement action, not being a very suitable environment in which disclosure of vulnerability can happen. Nonetheless, I think it's

important to equip immigration staff across the Home Office's functions with the ability to identify indicators of vulnerability.

Other parts of the system could be enhanced to do a better job of identifying vulnerability. For example, the screening process that asylum seekers go through when they first enter the asylum process.

Q. You also say that the evidentiary threshold to indicate risk must be low enough that someone at risk is likely -- unlikely to enter detention?

A. Absolutely.

Q. So it's about the threshold of that risk as well as the identification of it?

A. Yes. It needs to be a preventive safeguard.

Q. You have mentioned a number of times that those who are responsible for identifying vulnerability should be adequately trained. What sort of training do you think is necessary?

A. So we are not really aware -- we haven't been provided with the training materials that the Home Office is using to train its staff in vulnerability, but we have had them described to us and explained to us at great length. We have been reassured that they are quite capable of equipping their staff with the skills and tools they need. It's hard to say, therefore, what the

gap is between the level of training that's currently provided and the level that it needs to be at. But I would say, at the very least, it should be capable of giving all of their staff -- at least all of their staff who come into contact with individuals from the very first point of contact with immigration process, but all the way through to those who have no direct contact with individuals but are making critical decisions around the routing of that case into detention or elsewhere through the process, have a good and consistent understanding of what vulnerability is and what the indicators of vulnerability are and how to feel confident that the process that they have gone through is sufficient to be able to make good decisions around routing of those vulnerable individuals.

Q. Again, you've mentioned that there should be more regular assessment and monitoring of the welfare and well-being of those at risk. Is that once they are in detention?

A. Yes.

Q. Who do you consider would be best placed to do that monitoring and assessment?

A. I think the healthcare team within the immigration removal centre is really the best-placed entity to be doing an assessment of ongoing healthcare needs, mental

health care needs and vulnerability associated with those needs. Critically, other parties, other third parties, will be having contact with that individual, their legal representative, any wider support network, organisations like Freedom from Torture where we are able to sustain contact with that individual, we will be forming opinions of the level of vulnerability and deterioration in their mental health. Any representations -- we should be invited to make representations and any representations we make should be taken into consideration alongside any input that the IRC healthcare team are able to give.

Q. Are there any other recommendations which you consider to be particularly important that we haven't already covered?

A. We have talked about -- we talked about the key decision makers taking into consideration the full range of evidence available to them, and I think that's really important in the context of the detention gatekeeper, which, from our -- what we are aware of, is making a paper-based assessment of someone's appropriateness of -- for detention. Beyond that, we think it is essential for those individuals to have some form of direct contact with the individual that they are making a decision about. It shouldn't be purely a paper-based

exercise. The person who is making such a serious, important decision about exposing someone to the harm of detention should have some face-to-face, direct contact with the individual concerned.

I think I've talked about the resourcing that needs to go into the system. This is critical around rule 35. People need to be able to access them quickly. The process needs to happen. There needs to be a quick turnaround in terms of Home Office response. And we need to address the gaps within the documentation that's produced and the quality of the documentation that's produced in the rule 35 process.

Critically, allowing -- enabling detainees to be aware of the safeguards that are available to them, and this should be happening at the point of induction. They should be -- in a way that is sensitive to their ability to intake information at that point, they should be made aware of the Adults at Risk rule 35 processes and the safeguards available to them, because, while the system continues as it is now, there is the responsibility on them to self-advocate, so they must be made aware of the safeguards that are available.

Q. That should be at induction, but should it also be thereafter as well?

A. Yes.

MS SIMCOCK: Thank you very much. Chair, those are all the questions I have for Ms Reynolds. Do you have any questions for her?
THE CHAIR: Thank you, yes, just one, briefly, thank you, Ms Reynolds. In terms of -- you talked about the process and keeping the detained person informed and able to access the safeguards. Do you have any views about the need to inform the detainee of the result of a rule 35 report that has been completed?
A. Yes. I think detainees should be kept up to date with all developments in their case. I think communication with a detainee is critical, both to sort of a successful and efficient processing of their claim, but also to their health and well-being. I think one of the most damaging impacts of detention is the lack of communication and the sense of uncertainty and not knowing what is happening with your case and how it's progressing and what the prospect is of you ever being released from detention. That is extremely harmful to an individual. So I think it is really important that if they have gone through a process like a rule 35, which they will have been aware of at the time, that they be given information about how that case has been resolved.
THE CHAIR: Thank you. No more questions from me. Thank

you very much.
MS SIMCOCK: Chair, I'm conscious of the time. We have finished with this witness. This might be an appropriate moment for the break -- maybe slightly earlier than intended. So, if you are agreeable, I suggest 15 minutes, and we will start with the next witness after that, who will be Dominic Aitken.
THE CHAIR: Thank you very much.
Thank you very much for giving your evidence. I know it isn't necessarily an easy experience, but I have very much appreciated it.
A. Thank you very much.
(The witness withdrew)
THE CHAIR: See you at 11.00 o'clock.
(10.46 am)
(A short break)
(11.02 am)
DR DOMINIC EDWARD AITKEN (sworn)
Examination by MS MOORE
MS MOORE: Good morning, Dr Aitken. Could you confirm your full name to the inquiry?
A. My name is Dominic Edward Aitken.
Q. We have a witness statement to the inquiry signed and dated 25 November 2021.
That's INQ000094. Chair, it is your tab 1. Can you

confirm that that's your statement?
A. Yes, that's mine.
Q. Chair, I will ask for this statement to be adduced in full. Dr Aitken, that means we are not going to go through everything in your statement. That's already in evidence for you. But there are some topics that the inquiry would like to hear more from you on.
You were also interviewed by Verita on 8 January 2018, and you have had the chance to look over it again, and confirmed in your statement that, in general, that account is still accurate. I will ask for the transcript of that interview to be adduced too -- that's at <VER000257>. That's at your tab 3, chair.
THE CHAIR: Thank you.
MS MOORE: If I refer to that, I'll just call it your Verita interview.
You came to be in Brook House due to your academic research. At the time, you were doing your DPhil or PhD. In brief, what was your topic or title?
A. My research was about how places of custody, primarily prisons and immigration removal centres, how they deal with people who are at risk of suicide, whether that is self-harming, attempting suicide or completing suicide. I did some empirical research in Brook House and I interviewed a number of professionals who do death

investigations.
Q. You were at Brook House for about a month?
A. That's correct.
Q. Was that three to five days a week?
A. Yes.
Q. Particularly while you were at Brook House, what was the focus of your research while you were there?
A. One of the things that I really wanted to understand was how efforts to keep detainees safe and how efforts to manage risk fitted into the broader institutional context of running a secure environment like an immigration removal centre, so I wanted to understand not only how members of staff dealt with detainees who had been identified as being at risk of self-harm or suicide, but also to understand how that fitted into their broader working patterns.
Q. You describe your access around the centre as relatively unrestricted. You had, I think, a set of keys?
A. Yes, that's correct.
Q. Was there anywhere you weren't allowed to go?
A. To the best of my knowledge, I was allowed to go pretty much everywhere. I spent the vast majority of my time on the residential units, the recreation -- in the recreational facilities and in courtyards and staff offices, and so on. But I was given -- for an outside

researcher, I was given quite a lot of freedom, I thought, to go around the centre.
Q. Was there anywhere you could only go if you were accompanied?
A. I'm not sure, but, overwhelmingly, I went around on my own.
Q. You did spend some time on E wing?
A. Yes, that's correct.
Q. What about in the Care and Separation Unit, the CSU?
A. I spent a little bit of time in there, although I was usually in there for specific reasons. In one case, I was interviewing a member of staff in the Care and Separation Unit, the segregation unit.
Q. Did people know where you were when you were around? Did staff know where you would be?
A. In the main, no, I didn't really need to explain myself to anyone. I didn't need to sort of report to anyone during the time that I was there. There were some days when I would shadow a particular member of staff. So it's quite likely that I would have been with them most of the time. But I was given quite a lot of autonomy, so I was free to go around and go wherever I wanted to go.
Q. How were you introduced to staff on your first day or two? What did they know about your presence?

A. I think some members of staff had probably been briefed at a morning meeting that I would be there, although I think a lot of people weren't really aware of my presence until they actually saw me in person and I went up and introduced myself or they would see me around a wing speaking to detainees or other members of staff. So I would usually go and introduce myself and explain who I was the first time I saw anyone.
Q. Did you have an ID card or a picture name on anything?
A. I did, yes, I had some G4S-issued lanyards with my face and name on it.
Q. In relation to information gathering, you discuss at some length in the statement your methods of evidence gathering -- that's at paragraphs 20 to 21 and 23 -- which you say was qualitative and not quantitative. So it was immersive and based on interviews rather than data driven?
A. Yes, that's correct.
Q. You also recognise your research wouldn't be called typical ethnographic research because, rather than doing a long-term immersive project, you were there for a relatively short time?
A. Yes, that's right.
Q. So you got a snapshot but not an in-depth over a long duration?

A. Yes.
Q. You also did a series of interviews. I think 18 interviews with 19 people?
A. Yes, that's correct. So the vast majority of them were one-to-one interviews, but one of the final ones I did was with two members of staff. So 19 participants but 18 interviews.
Q. The people you interviewed, did they know the purpose of your research?
A. Yes, so they had to fill in a kind of consent form which included information about the research I was carrying out.
Q. They knew that you were taking notes or recording the interviews?
A. Yes.
Q. Can I ask you about your first day at Brook House. So you witnessed an incident that you describe in the statement at paragraphs 24 to 25, which you say you witnessed a man -- we will refer to them as D401 -- on E wing and you say that he was detoxing. In your statement, you say:
"It was ... clear that [he needed] help ... but custodial staff were obviously ill-equipped to deal with such a serious issue, which would have required medical and other expertise."

Did you know whether he got help from medical or other staff during this episode?
A. I can't recall whether or not he got medical help when I was there. I'm fairly sure that the staff would have been trying to achieve that, but I can't recall whether or not he got medical attention at the time that I was there.
Q. In a blog post that you wrote, which I won't take you to because you will remember it -- it is in the evidence, chair, at tab 2 -- you mention this incident and you say:
"I saw staff deal with a severely ill man who was detoxing, who they knew should not have been in detention."
That's the same event --
A. Yes.
Q. -- on the first day? Did the staff looking after him tell you that he should not be in detention?
A. I think it was -- if not made explicit, it was very clear that they thought they were not equipped to deal with him and that he was very, very poorly. I say that. I'm not a medical expert but I think it was fairly plain that he was very unwell.
Q. I want to ask you about staff's perceptions of other members of staff, which you deal with in your statement,

for example, at paragraph 41. You asked questions, "What makes a good member of staff?" and "What makes a bad member of staff?", to many people you interviewed. Did you ask detained people or just staff members about this?

A. I just asked staff members and this was during the formal interviews with staff members.

Q. In general, what impression did you get of how those at Brook House saw a good member of staff?

A. Primarily, when they were speaking about what a good member of staff was, they emphasised a number of important interpersonal skills, so the ability to communicate effectively, working hard as part of a team, somebody who did the right thing, who was conscientious. So they stressed a number of interpersonal skills, but they also emphasised the importance of being vigilant, of not being naive, of being cognisant of the fact that it's a secure environment, but at the same time kind of balancing security concerns with welfare concerns. I think that was the kind of thrust of what members of staff said made a good member of staff.

Q. If you are able to recall, were these qualities, such as the interpersonal skills, things that they thought could be, or had been, received during training or they were more of a natural skill?

A. I think it was probably a combination of both. Many staff members said that some people, especially early on when they first came into the job, couldn't really handle it, so they would often have people who were only employed for a short period of time when they realised how difficult an environment it was to work in. So it would be emphasised in training but also in everyday actions and also through their sort of socialisation. The idea was, you always want to resolve things with your voice as much as possible.

Q. What about when you asked them what makes a bad member of staff? What sort of things were you told then?

A. I suppose there were lots of things that people mentioned that could make a bad member of staff. One of the things was somebody who was lazy, who didn't work as part of a team, so the inverse of all the positive qualities that I mentioned earlier.

One thing that a number of staff alluded to -- I mean, it was somewhat vague, but they said members of staff who were in the job for the wrong reasons, and they would usually either explicitly say or suggest that what they meant by that was the people who were attracted to the sort of power and authority of the role, so the fact that they wore a uniform, wore boots, carried keys and a radio and were authorised, under certain circumstances, to use control and restraint, so to physically coerce people. There was always a suggestion -- any members of staff who mentioned that to me would never say that they themselves were like that nor that, you know, colleagues that they associated were with like that, but they sometimes would refer to, "Oh, there are some members of staff who are attracted to that aspect of the role", so they would usually say that they were in the job for the wrong reasons.

Q. Did you get an idea of what level of staff they were discussing? Was it DCO, DCM, senior, healthcare level?

A. I think it would primarily be speaking about DCOs, so the detainee custody officers, so those that are on the ground and dealing with the detainees on an interpersonal level from day to day and also who might be called upon during, for example, a planned removal or unlocking somebody from a room or cell. So it would primarily be the kind of lower-grade members of staff like DCOs.

Q. I want to ask you about staffing levels. You mention at paragraph 51, as you did when you were interviewed by Verita, that some DCOs said staffing could be a problem and that, even with four DCOs on a wing, if they had all had individual tasks, in reality it was one person looking after the wing. Did you personally see any effects of understaffing or get the impression that DCOs were under this sort of pressure?

A. I certainly recall a couple of occasions where I would see maybe one or two members of staff on a wing which was notionally staffed by, say, three or four people. So it may be that another member of staff was escorting someone elsewhere in the centre or they were going on -- being taken outside of the centre or they had to go to do a constant watch, meaning that they would -- they'd constantly have to stay with an individual detainee. So I certainly saw some occasions where there was maybe one or only two members of staff on a wing with maybe 100 people on it.

Q. For a short period of time, for minutes or hours or a whole shift?

A. I can't say for sure how long it would have been when I was observing it. It might have been relatively brief. So maybe for half an hour or something like that. But I was certainly told by members of staff that there could be periods where it would be longer than that.

Q. Did they discuss with you the sorts of difficulties or issues that could arise when they were left on their own for such periods?

A. They were generally aware, as staff were at all times, that at any given moment things could kick off and things could suddenly go wrong very quickly. So they would be concerned, for example, if they found someone who was attempting suicide or if a fight broke out or somebody had overdosed on drugs or something like that. If they were alone, as a member of staff, they would really struggle to cope with that because they would then need to attend to an individual person or a small number of people, but that would then leave the remainder of the wing unattended. I think those would be the kind of situations they had in mind.

Q. Did you personally see any circumstances where somebody's time pressure meant that somebody had to effectively leave a wing unattended?

A. I don't think I ever saw that, no.

Q. Can I ask what your impression, if any, was of Home Office presence on site? Did you see members of -- representatives of the Home Office at Brook House?

A. I think I saw them very occasionally, but ordinarily, no.

Q. Did you speak to staff or to detained persons about Home Office presence on the site?

A. When I had informal conversations with detainees in the first couple of weeks that I was there, many of them

spoke in fairly general terms about their unhappiness about lots of things to do with the Home Office. I didn't specifically discuss with them their presence on site. Some staff members did allude to the fact that Home Office caseworkers were located offsite and that that created a number of problems for them.

Q. What sort of problems?

A. It meant that the members of staff who dealt with detainees on a daily basis didn't really know a great deal about their case, they were often having to relay bad news to detainees and so sort of clearing up a mess that had been made by someone else outside of the centre. And it also meant that a lot of key information was just not shared. So staff were uncertain about lots of things, detainees were uncertain about lots of things and, unsurprisingly, there was a lot of frustration about that.

Q. What sort of things? Uncertain about what sort of things?

A. So the duration of detention, any prospect of release or removal, for instance, if there had been things like a flight might have been cancelled or something like that, all of these things would cause a great deal of frustration, obviously particularly to detained people.

Q. You say the Home Office staff were not on site. Do you

mean they were in a different part of the building away from the residential shared areas or they were completely in a different place?

A. They were more or less completely in a different place. You would sometimes see individual caseworkers come in because they might have a specific meeting or they might be going to meet managers or senior managers but, in the main, on a kind of daily basis, I don't recall seeing very many Home Office personnel.

Q. Did you see any visitors from the Independent Monitoring Board, the IMB, while you were at Brook House?

A. I can't remember if I did. Because I've spent some time in some other IRCs and I've spoken to people from the Independent Monitoring Board there, I'm not sure if I'm remembering the Brook House IMB or a different IMB, so I can't remember.

Q. Fine. What about the Gatwick Detainee Welfare Group GDWG?

A. I don't think I met any of them personally, no.

Q. Do you remember if you spoke to any of the staff about the kind of monitoring or visiting bodies?

A. As in, did I speak to Brook House staff?

Q. Yes.

A. I think occasionally members of staff would mention oversight bodies and I think typically -- from

recollection, when staff spoke about them, their impression was that oversight bodies were very sympathetic to detainees and were perhaps not very understanding of how difficult their working lives were. So that -- but that was fairly brief when I had conversations with staff about that.

Q. Just to be clear, I think I ran the two together. You said the impression was, perhaps, from the few you spoke to, they were overly sympathetic to detainees. I had mentioned both the IMB and Gatwick Detainee Welfare Group. Do you remember which, if either of those two, you're referring to?

A. It probably would have been the Gatwick Welfare Group but I think it's fair to say they might have been lumped together.

Q. Can I ask about the staff's perception of the detained population now. So you spoke to staff about the residents of Brook House, of course. Can you tell us about your impression of how staff saw the residents? So, first, you mention at paragraph 26 the staff's impression of people who had been there for a very long time. Did you get the sense that the long-term residents were treated differently in any way from other residents?

A. I'm not sure about them being treated differently. That

wasn't something that I necessarily observed. But I would say that members of staff, if they knew how long someone had been detained for, would often mention that to me or would identify a particular individual who they said had been detained for a long time, and would often express their sympathy for the fact that somebody had been detained for a very long time.

Q. What particular views did they express about either the length of detention or the fact that these people had been there for a long time? You say they expressed a sympathy about them.

A. Yes. I think, for people who had been detained for a long time, and I mean people who had been detained for maybe a year or more, which was a relatively small number of detainees, a handful of them, at any given time, but they would typically say they thought that was unfair and that -- if the Home Office or the government was unable to remove somebody, or deport somebody, within a more reasonable timeframe, that it didn't really seem fair to keep them in detention for such a prolonged and uncertain duration.

Q. Did you get the impression this caused any difficulty with the way these people were dealt with or they had to be approached in a different way to other residents or it was just an impression they expressed to you?

A. There were some individual detainees who I knew had been detained for a long time and whose behaviour was undoubtedly quite difficult for staff to deal with because they were acutely frustrated and angry about how long it was taking for them to be released or removed and there didn't seem to be very much progress on their case. So there were some cases where that was manifested in the behaviour of the detained people.

Q. You mention also detainees who had been perhaps raised in Britain or who had lived in Britain for a long time prior to their detention. What did staff say to you about that group of people?

A. When staff spoke about people who had been living in Britain for a very long time, so, for example, if their family had come from, say, Jamaica when they were, you know, three or four years old, staff would often say that they are, to all intents and purposes, British because they went to school here, they might have gone to college or university or worked here, all of their family and social connections are here, and often there were certain cultural markers, like they spoke with, for example, a London accent. And this would strongly suggest that they are, to all intents and purposes, British, even though they might have been born overseas. So staff, again, in some of those cases, would sometimes

express sympathy with those particular detainees.

Q. You also discussed with staff the men at Brook House who had served prison sentences and who were being held at Brook House prior to their removal. We have called them time-served foreign national offenders. Can you tell us, and you discuss it at 68 to 69 of your statement, what staff views were of this cohort of the detained population?

A. So Brook House was regarded informally as a higher security IRC, even though it doesn't have a sort of formal security classification like you have in the prison estate, but staff were aware of the fact that I think Brook House had maybe a slightly larger proportion of ex-foreign national offenders in their population than other centres, maybe similar to somewhere like Colnbrook at Heathrow. So, although it was less than half of the detainee staff were very aware that quite a lot of the detainees were ex-prisoners, and so I think that coloured their perception not just of the ex-prisoners but perhaps of the whole detention population, which was that they needed to be very vigilant, they needed to be aware that people might be trying to manipulate them -- the term they used was to "condition" members of staff, so to kind of slowly manipulate them over time, and it meant that they needed

to be -- needed to be vigilant at all times. I think that was the effect of having so many ex-prisoners.

Q. You just referred to the term "conditioning" as well as manipulation. So "conditioning" is a term that staff used to you, is it?

A. Yes, I had quite a few members of staff talk about the risks of being conditioned by detainees.

Q. If you are able to say, was this something you felt they had received training on or was it more of an informal use of the term?

A. I'm unsure if it would have been mentioned in training, but it was something that informally and through their sort of first-hand, practical experience they were very aware of and they mentioned to me.

Q. Just to reiterate, what did you understand them to be concerned about when they talked about the risk of conditioning or attempted conditioning?

A. Essentially, the idea was, because you spent a lot of time with detained people -- they are living in this environment and you're working there for perhaps 12 hours a day -- you spend a lot of time with them, so you can potentially get to know them quite well and you have to form interpersonal relationships with them of some kind. So one of the risks of that, members of staff claimed, was that some detainees would try to

manipulate members of staff. They often said to me that it would be impressionable members of staff, often younger members of staff, often women, and it would be to try to get -- the idea was that detainees would be trying to get favourable treatment by influencing a member of staff over a prolonged period of time. That was the idea of conditioning. I'm not saying that it was a valid concept necessarily, but that was what they said.

Q. Did anyone say that this had happened to them or anyone had tried to do it to them or was this something that happened to other people?

A. It always happens to other people.

Q. At paragraphs 43 to 44, you talk about staff's treatment and approaches to men of different nationalities in relation to use of force in those paragraphs. In summary, you say staff would say it's all down to the individual -- that's what they would report to you -- and that residents are not treated differently on the grounds of nationality, religion, race, but in reality, particularly when they spoke to you about control and restraint, that did not seem to be the case. How did that manifest -- how did you get that impression?

A. So I had some members of staff explicitly say to me that in certain circumstances they would send staff, of

a particular sex and gender and particular race or particular age, knowing information about a detainee. So the perception among some members of staff was that, for example, Caribbean men or Afro-Caribbean men were regarded as being chivalrous and, therefore, they would be more respectful of women, and so, if you were going to do a planned removal, you might want to have more women involved in the planned removal, or, similarly, if you were going to do an ACDT review, Assessment Care and Detention and Teamwork at risk for suicide review, you might want to have women do that rather than men.

By contrast, the perception was -- I think this was sometimes explicitly stated to me -- that Arabic or Muslim men were sexist or were "disrespectful" of females -- was a phrase that I'm sure a number of staff said -- and so, in those circumstances, you might want to have men do a planned removal or an unlock from someone's cell or an ACDT review or something like that.

Q. Was your perception that this would be arranged informally, so it wouldn't be clear to somebody perhaps looking at the documents that that decision had been made on the basis of a presumption about somebody's race or background?

A. Yes, that's correct. I should say, that probably wasn't the only consideration about who they would have doing

it, but that was certainly one of the things they might think about.

Q. Did you see any evidence of that yourself when you, for example, saw teams who had been despatched to deal with one thing or another?

A. I didn't observe it myself but, as I say, I think some members of staff mentioned it to me either in interviews or informally during conversation.

Q. Did you witness any control and restraint at all while you were there?

A. I witnessed certainly one control and restraint, but it was very brief. I was having a conversation with a detainee on E wing. Another detainee who I think was -- might have had a recognised mental illness, he threw a little bit of food at one or both of us, and then the man who I was speaking to reacted by going up and sort of slapping him. A member of staff came and restrained him, but it was -- so I had to fill out a security report. I can't remember what the official name for that report is. I certainly saw that use of force but that was a relatively unproblematic and brief one. I can't recall seeing another use of force.

Q. Not a planned use of force?

A. And not a planned use of force, no.

Q. Did you observe any of the meetings prior to planning

the use of force, the briefing or debriefing meetings?

A. On my first or second day, quite early on, I attended a meeting for managers about a charter flight that was due for that night. And so they were making lots of preparations about how they were going to get quite a large number of detainees -- it might have been as many as -- it might have been more than 20, some of whom would be arriving into Brook House that night, many of whom were already in Brook House. So there were kind of preparations for how they would do -- how they would kind of orchestrate the situation to get people into various parts of the centre that would make it easier to do the planned removal and the charter flight. So I did attend a meeting which was preparations for a charter flight.

Q. On to managing the behaviour of the detained population, and this is something you mention at paragraph 54 of your statement, you say that some staff felt that incentives and privileges should be introduced which would be similar to those in place in the prison system. The staff who mentioned this as an idea, or presumably you asked them about what could be changed, were they staff who had worked in the prison system generally?

A. Usually, no. So the people who desired greater formal or structured incentives and earned privileges system

like they have in the prison estate, quite often they were staff who themselves hadn't worked in a prison and, indeed, the staff I spoke to who had worked in prison typically said that IEP was not the kind of silver bullet solution that some people might think because it's more complicated than that and there are other factors at play.

Q. Can you tell us what IEP stands for?

A. Incentives and earned privileges.

Q. Why did the staff who say that would be a good idea seem to favour that as an approach? What did they think the benefits would be?

A. What they said to me was they lacked disciplinary tools to deal with bad behaviour in the centre. Sometimes they would say that in the sort of good old days, when Brook House first opened, so around 2010, there was, perhaps, a slightly more disciplinarian staff culture. That had been criticised by Her Majesty's Inspectorate of Prisons, amongst other people, but some staff said, "We used to be able to do this and now we are not able to", so it was specifically to punish bad behaviour, though I should say that, in principle, incentives and earned privileges is both about rewarding good behaviour as well as punishing bad behaviour, but it was always punishing bad behaviour people were interested in.

Q. Did they generally speak about punishing bad behaviour or did they give examples of the sorts of behaviours that would be liable to be punished?

A. They would usually speak in fairly general terms about punishing bad behaviour, but they might have had specific examples in mind. For instance, people, if they had -- if they were verbally abusive to members of staff or to other detainees, if they were being kind of generally difficult to manage, but then also more serious things like drug taking or drug dealing or violence or things like that.

Q. For those of us who don't have any experience within the prison system or know of IEPs, what sort of benefits or detriments might be offered out to punish or to discourage such behaviours or to encourage good behaviour?

A. So I don't know a massive amount about this, but if you were on a kind of -- I think it is called "enhanced level" in the prison estate, that would mean that you might have access to -- I don't know if you might have access to a slightly nicer room, but you also might have greater access to things like television, you might be permitted more visits, a number of kind of things like that. Don't quote me on that because that might not be exactly right, but the crucial thing and what would be

relevant here is that if you went to the basic level, so rather than the kind of standard level that you would enter prison at, if you went onto basic level, you would have certain privileges removed from you, so certain goods and services that you might want would be stripped from you or they would be harder to access or you could access them less frequently.

Q. Things like access to the shop or ...?

A. I think things like that, though I'm not 100 per cent sure.

Q. That's not because the people you spoke to didn't give specific examples of the sorts of privileges they would want to take away, or you can't remember if they did?

A. I can't remember if they specified particular privileges they would want taken away, but they generally thought they didn't have adequate disciplinary tools.

Q. You say, at paragraph 55, that an art teacher you spoke to, Sarah Walpole, had the impression that, even though she was not a DCO, she had to be vigilant, wary and distrustful of detainees. Do you know how she got that impression? Is it something she developed over time while at Brook House?

A. In this case, she mentioned to me that it was something that had been instilled in her during her training. She said that her impression from the training was the

overall sort of message that was sent -- this wouldn't have been stated explicitly, but her impression was to think of detainees as an enemy or a kind of "us and them" mentality.

Q. Did other people you spoke to have that similar -- give that similar impression to you, that they saw detainees as the enemy or saw an "us and them" approach was appropriate?

A. I certainly saw plenty of members of staff who spoke about detainees in a way that suggested that they were suspicious of them, that they were distrustful of them, or that they always needed to be aware of the possibility that they might be being misled or being manipulated, yes, I certainly saw that.

Q. When you saw interactions between staff and detainees, did you perceive that same "us and them" attitude?

A. Not necessarily during interpersonal interactions, the vast majority of which were perfectly kind of civil and respectful. So in the main, no, not from the kind of everyday interactions that I saw.

Q. From paragraphs 59 to 61, you summarise there your belief about staff's perception of violence. In summary -- and correct me if my summary is wrong -- you say that even infrequent violent incidents -- riots, protests, et cetera -- will tend to stick in the mind of

the person who sees them more than your day-to-day occurrence?
A. Yes. That was certainly the perception that I had speaking to members of staff, that even though there had been a riot in the early days at Brook House, which some members of staff did work there at the time and were still employed there, but many members of staff weren't there. But knowing that there had been a riot at Brook House and other detention centres or knowing that there were occasionally episodes of violence, they were very aware of that possibility, even if, in reality, on a day-to-day basis, it was relatively infrequent.
Q. Did they speak to you about events like that at other detention centres then?
A. I can't recall if they mentioned events like that at other detention centres, no.
Q. From what you were told, what was the effect of this knowledge, or this memory, on the way that staff perceived currently levels of risk?
A. I think, generally, it contributed to a kind of heightened suspicion or vigilance about the entire detainee population. I remember one member of staff saying to me, "Things can go wrong here very quickly" and that laconic observation captured what a lot of staff felt.

Q. So you said to Verita in a similar way there was a constant motif around how it could call kick off and suddenly the place would be up in flames?
A. Yes.
Q. But you added when you spoke to Verita:
"In some ways, my sense was that the biggest risks that they faced had nothing to do with that. The biggest risk they faced would be that someone would kill themselves."
A. Yes. I suppose I would maybe add to that that the bigger risks were all of these -- all of these different risks that were being stored up every day, so you have lots of different vulnerable people coming in that you don't necessarily know a great deal about or you're not very sure that you're equipped to treat them. So that might end up with somebody ending their life or attempting to end their life or any number of other serious risks you are storing up on a day-to-day basis?
Q. When you mention that that's the biggest risk, or one of the biggest risks, is that your view that that was one of the biggest risks or did you perceive that staff saw the possibility of someone killing themselves as a big risk as well?
A. Yes, I thought -- that was certainly my own perception but I think it was shared by members of staff. They

were aware of the possibility that somebody might die while held in Brook House. And in some cases they had dealt with so-called near misses where someone had very nearly died in custody. Or they had worked at other detention centres or other prisons where people had died when they were working there.
Q. The people who had had such experiences, did that change the way, in your view, they saw risk, or the nature of risk, they were likely to be faced with?
A. I think in plenty of cases, yes, it would have made them very aware of it and that would be something that they would try to impress upon their colleagues, how serious that was.
Q. You mention at paragraph 73 that DCOs have to deal with consequences of issues outside of their control, such as health problems or decisions around deportation. And you add that DCOs are aware of their responsibility to avoid major events such as a escapes, riots, a death in custody or other low-frequency, high-impact problems. When you mention that they are aware of their responsibility, do you mean moral responsibility, a legal responsibility, a contractual employment responsibility?
A. Probably all of the above. I think with respect to the risk that somebody might die in custody, staff would

have probably been aware of a kind of vague sense of legal responsibility though they might not know exactly what a coroner's inquest would entail or any other kind of formal legal process, but they would probably have been aware of a general sense of legal responsibility. But also a professional responsibility, and also, I'm sure, in many cases, a moral responsibility too.
Q. Under the focus of your research specifically, which is self-harm and suicide, and what you were looking at while you were at Brook House, in terms of staff's understanding of the risk of these events, at paragraph 33 of your statement, you say in summary that staff generally took self-harm and suicidal behaviour seriously. You mention the ACDT process as well as frequency of observations, speaking with detained people and listening to them as actions around these risks. When you discuss the lengths that staff would go to to assist people in crisis, is that something that people described to you, the lengths they would go to, or did you also observe staff going to lengths to help people in crisis?
A. I think I probably did observe one or two cases where staff were spending an awful lot of time with someone. It may not have been during a formal ACDT process but someone who was on an open ACDT form and would be

spending an awful lot of time with them patiently discussing their problems and trying to calm them down and trying to reassure them in various ways. So I sometimes -- occasionally would have directly seen it. But it also would have been staff would have spoken to me about how long they would often spend with at-risk detainees.

Q. Are you able to tell us who undertook ACDT observations? So when there was a formal process in place for somebody to be observed at whatever intervals, was it detention staff, was it healthcare, was it a mixture?

A. Primarily in the cases I saw, it would have been detention staff who would have been doing the observations, but when there was -- so if there were, for example, hourly observations, you would have had a detainee custody officer, a DCO, working on the wing, I think would write down various notes in a bright orange booklet, and then, when there was a more formal review, that would need to be a manager or a kind of qualified assessor. I think healthcare staff would be there. And you also might have somebody from the chaplaincy, for example, so you might have an imam on a priest or something like that or any other member of staff who might be relevant.

Q. When somebody was on those observations, from what you

saw or what you were told about, what was the nature of the observations? Was it looking and recording or verbal engagement or a mixture?

A. It would be a mixture of both. In principle or ideally, you would obviously want both physical observations or observations about someone's demeanour, but you would also want things that you had actually directly spoken to them about. In some cases somebody might, for instance, have been asleep during an observation so there's obviously a relatively limited amount you can say. But, ideally, it was supposed to be both. Some members of staff would say to me that sometimes the notes that they received weren't very detailed, or they wished that their colleagues would ask more questions or go into greater detail.

Q. By "notes they received", do you mean when the handover of one person taking care of somebody on an ACDT was handed over to another?

A. Yes.

Q. They would read those notes to get an idea of what happened?

A. Yes.

Q. When they said that they weren't very detailed, did they say -- were they able to do anything, speak to the person, ask them to make more detailed notes or was it

just a general gripe?

A. That was more a general gripe that I heard a couple of members of staff say they sometimes weren't as detailed as they would like them to be.

Q. You discussed the role of healthcare in ACDT which you think was perhaps when there was a more formal review rather than under regular observations. In general terms, did you form a view of whether healthcare and detention staff worked together well or closely to manage vulnerable people?

A. My impression was they didn't work especially closely. I should say I didn't spend very much time speaking with healthcare staff. I spent a little bit of time in the kind of healthcare units or speaking to individual members of staff. But the vast majority of time when I was with staff members, it was with custodial staff. But my impression, from both DCOs and then also from managers or people kind of higher up the chain, was that they felt they could -- they would benefit from more leadership from the healthcare team, perhaps more information about signs that they should be looking out for or symptoms that they should be aware of for particular conditions and then, occasionally, with particular case reviews, they felt that the healthcare team weren't sort of pushing them as much as they could

do.

Q. That's a sort of proactive role that they want healthcare to take, so given more leadership. What about the reactive role of healthcare? Were they there when they needed them in emergencies to escalate somebody to or do you not have an impression on that?

A. I don't have very much information about that, unfortunately.

Q. During your Verita interview, so this is just for the chair's note at page 10, but I'll read it to you, you said:

"... Brook House, as I understand it, uses constant watches for people on ACDT quite liberally, so at any one time, there was almost always at least one constant watch happening."

This was in the context when you were talking about levels of staffing, I think. With regard to the liberal use of constant supervision, are you intending to be critical of the liberal use, supportive or is it just the size of the population?

A. I'm not sure. It was just, as a matter of fact, it seemed that at Brook House they used constant watches quite a lot and I think, generally speaking, in detention centres, but also in prisons, people are quite wary about putting people on constant watch because it's

quite an extreme measure, but my impression was that staff themselves thought that constant watches were used quite a lot. And I think, comparatively, Brook House might have used them quite a lot.

Q. What do you mean by "quite an extreme measure"?

A. It's very invasive because there is somebody literally sitting and staring at you, including when you're asleep or in sort of arm's-length from you when you're using the bathroom. So it's not a particularly dignified process. It also doesn't have any ostensibly curative function. It is purely a way of watching somebody. So it is almost a bit more like surveillance, really, than it is anything that's helping somebody.

Q. Did staff express any view on whether they thought the numbers of surveillance -- sorry, monitoring ACDT supervisions was too high or not high enough?

A. I certainly heard a couple of members of staff say they thought they were used too often. So, for instance, I think, more or less automatically, somebody would be put on ACDT if they had refused food and fluid a number of times, which obviously -- maybe three times. That obviously sounds very serious, but they would say, in some cases, if they were aware they had food from the shop, for example, even though they hadn't had a particular hot meal on the wing, they knew that person

had eaten. If that then led to somebody being on a constant watch, they might have said they thought that was excessive. I think I remember people saying things like that.

Q. Did you speak to any contained people about their views of being on supervision?

A. I don't think I spoke to any detained people about their experiences of being on ACDT or being on a constant watch or anything like that.

Q. At paragraph 53, you sat in on an ACDT review -- paragraph 53 of your statement, you describe this -- which was conducted, in your view, in an inappropriate place. Can you tell us where it was held?

A. So in this case, I think it was held in the E wing staff office.

Q. Who was there at such a review? The detained person?

A. The detained person was there. I think possibly a member of the senior management team was there, who I might have been shadowing that day. Then possibly a couple of DCOs. But in that case, what was happening was other members of staff were going in and out of the room an awful lot because it was their office and they needed to go in to pick up things, or you would have detainees at the door kind of walking in or banging at the door, so it wasn't very private or very

confidential.

Q. For those of us who haven't seen an ACDT review, what sort of things, just in general terms, would you be discussing with the detained person at such a meeting?

A. In principle, I suppose they might be discussing anything. They would be discussing the sort of sources of their distress. In this particular case, the substance of the ACDT review or the substance of the person's distress was really to do with, I think, prolonged detention. And so, essentially, the ACDT review just became another vehicle for yet another discussion about their immigration case. So that was overwhelmingly what was being discussed at that review, as I recall.

Q. As far as you can recall, or if you know, was there any reason why it was being done there and not in a more private room?

A. I'm not sure why it was being done there. It might have been that they more or less made an improvised decision to kind of turn this into an ACDT review because the person had been very unhappy and was behaving in quite a difficult way for staff to deal with, and so I think they sort of said, "Right, we may as well turn this into a more formal ACDT review". That is what I think I recall happening, which is perhaps why it took place

in that setting.

Q. Did you see other ACDT reviews?

A. I think I saw maybe one or two other ACDT reviews and I think I had, previously -- another piece of research at another immigration detention centre -- also seen an ACDT review someone else.

Q. Do you know where they were generally held at Brook House or where they were meant to be held?

A. I'm not sure if there were any particular places. It would typically be somewhere quiet, somewhere private and somewhere kind of calm. Sometimes there would be parts of a wing that were like that, but it might have been you would take them to somewhere else, so you would maybe take them to the healthcare unit or somewhere like that.

Q. On to what staff told you about self-harm -- this is your paragraph 34. You say that a minority of staff you spoke to said self-harm was sometimes used as a form of manipulation. At 35, you form the view that some staff felt they had to evaluate the authenticity of a detained person's pain or question their motives. And you say at 36 that they were aware from training and policies that they had to take all self-harm seriously, but they felt that practical experience had taught them otherwise.

Regarding the use of self-harm as a form of manipulation, who held these views? What level of staff or was it across the board at different roles?

A. I should say it was a minority of the staff that I interviewed who expressed this to me. But I -- I heard it from DCOs but I also heard it from managers as well.

Q. What was, if they told you about it, the attempted goal in this manipulation?

A. So what -- the idea was that self-harm was being used as essentially a form of protest or in some cases they would say that it was just merely attention-seeking behaviour to get something that they wanted. So somebody would, for example, cut their arm or injure themselves in some way in order to get something that they wanted. That was what some members of staff said to me that some self-harm was.

Q. Any idea about what they might have wanted that this would lead to?

A. I heard some members of staff say that it could -- they thought it was something that was being used for very frivolous or trivial things, so, for example, to get access to a television or something like that. So it sounded quite flippant when they said that. But it also might have been -- in more extreme cases, it might have

been because they were pending removal and so it was a kind of last-ditch attempt to resist removal from the country or deportation.

Q. You only spoke to a small number of healthcare staff. Did any healthcare staff you spoke to hold similar views?

A. I can't remember if healthcare staff held similar views about self-harm as being manipulation or anything like that. I don't recall whether or not they said that.

Q. Again, bearing in mind it's only a minority, so a small sample size, but were these views expressed by newer members of staff, longer-serving or no real correlation?

A. Both. I certainly heard them from longer-serving members of staff.

Q. Did you see staff treating detained people in a way that suggested they believed they were putting it on, or was it just your view from what they told you?

A. This was primarily from what I had been told. As I say, in terms of the actions that I saw, generally speaking, they were done -- ACDT reviews and so on were done quite diligently and were taken fairly seriously.

One thing I could maybe add -- I don't know if it's relevant here -- is that I do remember a member of staff saying that they had -- of all the new detainees they had received in the previous two months, 20 of them

should have been on an open ACDT form when they arrived but only eight of them they had been made aware of the fact they were on that. So they were also sometimes receiving people into the centre who were high risk but staff hadn't necessarily been made aware of that. So that was a concern.

Q. How did they come to find out there should have been 20 but there were only eight?

A. I'm not sure how they found out, but it was someone sufficiently senior within the organisation that I would trust what they said about it.

Q. At paragraph 36 you mention that this hierarchy of what is considered to be serious self-harm created a problem for DCOs and DCMs if they were dealing with several at-risk detainees simultaneously and trying to decide who to focus their time and effort on, especially in periods where staffing levels were low or there were other issues to deal with in the centre.

So that's an issue about prioritisation, effectively, of people who need help. What did you see or hear about these prioritisation issues?

A. So what I heard from certainly one DCO was that he said that, in some cases, people are very intent on ending their life or self-harming very seriously; in other cases, they are doing it for attention or they are

faking it or something like that. And he said that the reason that that frustrated him was that he has to make choices about where he devotes his time and energy. There were a limited number of staff. Staff are often very overstretched as we have already alluded to, so he needs to decide which person to take seriously. He privately feels that one of them is much more deserving of his time and attention than another one, but he's supposed to take them, I suppose, equally seriously.

So, as you say, it's a problem about prioritising your time when you have limited resources and limited staff.

Q. Did you see for yourself any responses to self-harm or suicide risk events, for example, a call-out? Were you present at any of these responses?

A. Yes. Actually, one of the interviews that I was doing with a member of staff was cut short because a detainee was banging the door. He was in the Care and Separation Unit, the segregation unit. He was banging the door very loudly and then another member of staff came in and said to us, "He's self-harming". So I stayed -- I kind of hovered around briefly but I didn't want to sort of pry. We agreed that we would obviously terminate the interview and he would deal with that and we would meet up at a later date. In that case, I heard somebody,

I think, punching a cell door very loudly and I think he'd also cut himself and so staff were dealing with that immediately.

Q. The person you were speaking to, were they a DCO?

A. They were a DCO, yes.

Q. But you didn't attend the event. Did you speak to anyone afterwards about what happened or how they dealt with it?

A. No, I didn't speak to them about that particular case.

Q. Can you comment, if you are able to, on prioritisation of responding to more violent, disruptive events versus self-harm or welfare events?

A. Can you clarify what you mean?

Q. So you talked about the need to prioritise time when there's a couple of people who need help because they are at risk or vulnerable. There's obviously also a need to deal with any disruption within the centre or people who potentially, as you say, needed an unplanned use of force. Did anyone speak about any tensions between those two types of event that might materialise?

A. I don't think anyone spoke specifically about that, no.

Q. In relation to the sort of unplanned response that you discussed that interrupted your interview, can you say, from what you saw or what you were told, who responded? You say you were with a DCO. They responded,

presumably, because they were nearby?

A. Yes.

Q. Do you know whether healthcare would always be expected to respond to a reported self-harm event?

A. I'm not 100 per cent sure, but I would have thought they would be called upon immediately, yes.

Q. When your interview was interrupted and you milled around for a while, did you see or do you recall whether you saw anyone from healthcare responding?

A. I can't recall.

Q. You say at 35, paragraph 35 of your statement:

"It is to be expected that staff in an IRC will become somewhat desensitised to self-harm and other behaviours."

Did you feel that staff you spoke to were desensitised?

A. Many members of staff said to me that they had become desensitised and I suppose that's not surprising. They said it was shocking the first time they saw it, or the first few times they saw it, or in particularly severe cases it would get to them, but now it had become a much more routine part of working life, seeing somebody who had injured themselves.

Q. In your view, did that affect the seriousness of weight they put on self-harm risks or suicide risks?

A. I think it could have done. As I say, in terms of the actions that I saw members of staff taking, overwhelmingly, they took it seriously if and when it occurred. But in terms of perhaps making judgments or evaluating the seriousness of the risk, I think sometimes that might mean it was underestimated.

Q. Were you told about or did you see any specific examples of whether an underestimation or a desensitisation about the risk affected how an event was responded to?

A. I didn't directly see it. I heard a number of members of staff say they had had cases where colleagues of theirs had, essentially, underestimated a risk and then it had turned out that, in fact, someone was much more intent on ending their life or causing themselves serious harm than they or their colleagues had realised. So I heard a number of members of staff talk about experiences they had had, but I didn't see that myself.

Q. How did they reflect on that?

A. They said, I suppose, that it made them very aware that it needs to be taken seriously and it -- they only need to be wrong once for it to be a major problem.

Q. I'm going to ask you about rule 35 as far as you can comment. So you do cover it at paragraph 63 of your statement. You mention rule 35 and the various provisions within and say that staff didn't seem to have

a good understanding of rule 35. Was that all the staff you spoke to, certain levels of staff in particular?

A. This was a more general impression that I got from members of staff. It wasn't something that I explicitly asked about in interviews or anything like that, though I suppose I might have had the odd conversation more informally where we spoke about rule 35. But my impression from the few times that I did speak to staff about it was they didn't know a great deal about the related Adults at Risk policy. Some of the policy details, they weren't really sure about them.

Q. What about practical details? Did people, for example, in situations where you would have expected them to say it is a rule 35 event or "We had to refer for a rule 35 report", even if they didn't know the details of the policy, were they aware of its existence? Did they discuss it in circumstances where you would expect them to?

A. I can't really recall very clearly. I think rule 35, they probably would have been generally aware of its existence and they probably would have known they had some responsibility to do something.

Q. If you can remember, and as far as you can recall, was it mentioned in relation to the management of suicidal intentions?

A. I don't particularly recall it being mentioned in that context, although that is one of the conditions for it. But I don't particularly remember it being -- that was much more discussed in terms of the ACDT policy.

Q. Whether or not through the rule 35 process or with regard to any particular policies, was your impression that staff referred detained people with possible suicidal intentions to a doctor or to healthcare?

A. I'm not sure because I wouldn't have been directly observing it myself but I would have thought, yes, they would have been doing that.

Q. But you didn't specifically ask them about how they managed somebody who presented with suicidal intentions?

A. I can't remember specifically asking about what exact process they followed, no.

Q. On, then, to victims of torture. Duncan Lewis have requested that I ask you something about something you said in your Verita interview. The reference for the transcript is page 18. You referred to a detained man you spoke to while you were in Brook House. Then afterwards you read about Panorama in The Guardian which said that a man's deportation had been blocked as he was a torture survivor and you thought this was one of the men you had spoken to while you were there. Duncan Lewis believe this is one of the people they are

representing, who we are going to refer to as D668. Do you remember speaking about him to Verita?

A. I remember mentioning it to Verita. I don't remember a great deal about the conversation that I had actually had with the man.

Q. Do you remember speaking to him at all?

A. Looking at this, there were two people that I spoke to in Brook House who I think told me that they were torture survivors, so I'm unsure which of the two of them it would have been.

Q. Recalling the people who you spoke to who said they were torture survivors generally, whichever one of them, did this lead to concerns, did you have concerns about them being detained in circumstances where they said they were torture survivors?

A. Yes, I did. I think -- I can't recall if I mentioned it to a member of staff. I might have done. I also said -- I think I said to the men themselves that they should make staff aware of that fact if they hadn't already.

Q. Can you recall whether or not they said that they had already made staff aware?

A. I think they already had done.

Q. Did you ever, while you were there afterwards, understand any conclusions about why they were there,

nevertheless, having said they were tortured?

A. No, I don't remember anything about that.

Q. You may not remember but you said to Verita after mentioning this person, who we think is D668:

"There sometimes was concern that particularly the healthcare manager at Brook House could have done more to press those issues and to ask questions and to say 'What's happening with this person's case? We are concerned about this person'."

When you mentioned concern that the healthcare manager could press more, was this a concern that the detained person mentioned to you, a concern that you developed, a concern that staff told you about in their interviews?

A. From recollection, it was a staff member mentioning that they thought that the healthcare team could lead a bit more on these cases. Like we were saying earlier, could perhaps be more proactive.

Q. Moving on to adults at risk now. In your own words, if you are able to help us, what's the purpose of the Adults at Risk policy in a setting like Brook House?

A. So as I understand it, Adults at Risk, I think, was introduced in 2016, so not that long before I was in Brook House in 2017. It is essentially to sort of strengthen the presumption against detention and to

formally identify people who are at risk as per rule 35, what level of risk they are and then they are classified as being at level 1, 2 or 3 in an escalating severity, so being an adult at risk level 3 is the most serious.

Q. We have heard some other evidence about that this morning so I won't press you to give further details. But reflecting on what you heard about it at the time you were at Brook House you say at paragraph 63:

"Decision making on adults at risk was not very transparent."

Can you help us with what you mean by that? In what way was it not very transparent?

A. I think I'll probably be referring here to the fact that this was, again, a manager, or a senior manager, in fact, who said that people who had been recognised as an adult at risk had kind of bounced around between level 2 and level 3 and then perhaps back to level 2 and they might -- I think this particular person had been detained for a long period of time and there seemed to be no certainty about what was going to happen, so, again, not proactive enough.

Q. So lacking transparency because we didn't know what was happening, no certainty about where it was going?

A. Yes.

Q. I think the man that you mention is somebody you spoke

to at Verita about. You mention him at page 17 of the transcript. This is a man who had been detained for a long time and you say with various levels of risk. We will refer to him as D1531. So you attended a meeting where he was discussed. This is where you came to learn of his Adult at Risk history. You heard he'd been detained for two years, his risk had been taken from 3 to 2 and no-one knew why?

A. Yes. From memory, I think one of the people -- the person leading that meeting said that this person I think had previously been at the highest level of the Adults at Risk policy, level 3 and then they had been dropped to 2 and obviously detained for a very long time. And they didn't really know a great deal about what was happening to that person.

Q. Did they say, if you can recall, whether they had any plans to find out what was happening or why the risk had changed?

A. I can't remember what they said about that.

Q. You have referred to the person who was leading the meeting. What sort of staff level would that have been?

A. They were in the senior management team.

Q. Was it a formal meeting under the Adults at Risk policy?

A. I can't remember if it was a formal Adults at Risk policy or it might have been a more general sort of

weekly security meeting, I think it might have been.

Q. What concerns did you have at the time, if any, about the way that the meeting or the detained person was being dealt with under Adults at Risk?

A. I should say that this was -- everything that I'm saying now is based on what members of staff were saying about their concerns, rather than my own.

Q. Yes.

A. So they were concerned, firstly, about how long he had been detained for. I think they said two years. I'm not sure exactly how long. But at any rate, a very long time. And they felt that he was stuck, essentially. There were quite a few people who wrote something like that but they said his was a clear case of someone who was stuck for a very long time and they didn't really know what was going to happen about that.

Q. Do you recall who else would have been at the meeting? Was it a large meeting or just a couple of people?

A. It was relatively small but I can't remember exactly who was there.

Q. Do you know what their roles were and what their knowledge of him would have been?

A. I'm sorry, I can't remember.

Q. Can we move on to rules 40 and 42. Are you familiar with these? Rule 40 is the power to remove somebody

from association, 42 is temporary confinement. Is this something you witnessed whilst at Brook House, the exercise of these two powers?

A. I think I did witness it and I certainly would have heard it being used -- sorry, being mentioned to detainees, sort of saying, "If you continue to do this, you will be on rule 40 or rule 42".

Q. Is it something you came across or heard about as a means of managing vulnerable detainees or detainees with mental health issues?

A. I don't recall any examples of that, no.

Q. You said you spent time, significant time, on E wing or you were able to go on E wing?

A. Yes.

Q. As a general sort of picture, what sort of people were on E wing at the time you were there?

A. It's a smaller unit and it would typically be people who were identified as being vulnerable in some way. Sometimes people, if their behaviour had been quite difficult or if they had been disruptive, they might have been there. Adjacent to E wing was the so-called Care and Separation Unit, segregation unit, but in E wing itself it would typically be more sort of vulnerable detainees would be held there.

Q. Moving on to paragraphs 30 to 31 of your statement --

sorry to jump around it.

A. That's all right.

Q. You refer to detained persons' complaints and concerns. Where you refer to detainees' complaints, are you talking here, just to clarify before we start, about complaints as in things they mentioned to you or complaints they made through various complaints processes?

A. Things they mentioned to me, so not things they'd mentioned to the PPO or anything like that.

Q. You say there were complaints about Home Office processes relating to the fact or duration of the detention and planned deportation. How common was it that detained people would complain or speak to you about those sorts of issues?

A. I mean, pretty much everyone was unhappy about it, so pretty much everyone would mention that.

Q. You also said that there were consistent complaints about material conditions like the quality or variety of food, ventilation in cells, healthcare, quality of legal representation, support for detainees who are really struggling and many other individual issues, and you heard a range of these things from different people. Did detained people tell you whether they made these complaints to anyone else or just to you?

A. They didn't tell me who else they made them to but they would often be expressed to DCOs or DCMs. I'm unsure to what extent detainees made use of formal complaints procedures or anything like that. But they certainly were quite vocal about their unhappiness.

Q. Did you discuss with them official channels through which these could be raised or did you have any view on their knowledge of their ability to do so?

A. I don't remember speaking to them about formal complaints procedures or how aware they were of them.

Q. Finally, I wanted to ask you about senior management. So what was your exposure to senior management while you were at Brook House? Did you see them on the ground and, if so, how frequently?

A. So a couple of members of the senior management team, one member of the senior management team in particular, I spent quite a lot of time with. Others I maybe interviewed them so would spend maybe an hour or a bit more speaking to them but wouldn't be seeing them on a day-to-day basis. I might see them on the first day I went in and the final day before I left. There was one member of the senior management team whom I spent quite a lot of time with, but the others I didn't see a great deal.

Q. What about their interactions with detained people?

A. The member of the senior management team, who I spent a lot of time with, seemed to be slightly more involved in the kind of operational aspect of the institution as well as the kind of higher level or more strategic or managerial role as well. So I was with that person when they were going around the wings, when they were speaking to detainees, when they were checking in with staff and so on and so forth. So I saw them in a more operational role as well as getting to know them and getting to -- getting familiar with their sort of management perspective as well.

Q. That was Michelle Brown?

A. Yes.

Q. What about senior management's interaction with other members of staff, for example, DCOs, DCMs? Did you see discussions, meetings, briefings?

A. I saw maybe a small number of them, but in terms of actually observing the relationship between members of staff of different levels of seniority, I didn't see very much of that.

Q. Did you speak to staff about their relationship with senior management?

A. Yes, I spoke to some DCOs and probably also some DCMs. Particularly, detainee custody officers I spoke to about their relationship with senior managers. In some cases they certainly said that they thought the senior management team were quite distant or, if they had particular problems, they would more likely resolve them with their colleagues or not raise them at all because they felt quite disconnected from the senior management team. I don't remember that being an especially concerning thing. I thought that's probably quite a common thing to hear in an organisation. But I certainly heard some people say that.

Q. Thinking particularly about vulnerable people, people at risk of self-harm or suicide, did you -- do you have any -- did you gain any impression of the role of senior management in dealing with those people?

A. I didn't gain much insight into the specific role of senior management, although, like I was saying earlier, in some cases a senior manager would be expressing their frustration about a particular case and saying that "Not enough has been done about this" or, as I mentioned earlier, a different senior manager mentioned to me that they had only received eight out of 20 open ACDT referrals in the past two months. So that was all I saw.

MS MOORE: I have no other questions for you, Dr Aitken, but I'm going to ask the chair whether she has anything to ask you.

THE CHAIR: Thank you, Ms Moore, I do have few. Thank you.

Firstly, I wonder, Dr Aitken, if you could just give us a little bit of context to when you will have been agreeing your research project, I would imagine there would have been some sort of ethical framework process that you will have gone through to, firstly, agree the research and then some ground rules potentially of what would happen when you were on the ground at Brook House?

A. Mmm-hmm.

THE CHAIR: Perhaps you could just give us a bit of context about whether there was any expectation on you to whistleblow? Were you kind of given a guide to the kind of things that you should report on if you observed things or not report on things if you were there in a capacity as a researcher? Would you be able to just tell us a little bit about that?

A. Yes. So there was an ethical guidelines process that I had to go through at my university and then the arrangement for me to actually go into Brook House to carry out this research was done quite informally, so there wasn't any kind of form -- I had to get Home Office clearance to do research in IRCs generally, but then this specific project wasn't sort of formally approved. It was much more informally arranged between my supervisor and someone at Brook House, or a group of

people at Brook House. When I got there, no, I wasn't told anything about specific whistleblowing procedures. I wasn't told what to do if I observed someone doing X or Y. I don't recall hearing anything about that.

THE CHAIR: In a sort of similar theme, do you recall any conversations yourself about being warned about the risks of conditioning, risks to yourself, the need to be vigilant, any of those types of conversations?

A. I remember having a few quite informal conversations, usually with DCOs, detainee custody officers, about the risks of conditioning and they were saying it for other members of staff. I don't think they were warning me about it particularly. They might have been by implication, I'm not sure. But they certainly would mention it informally.

THE CHAIR: Likewise, were you ever given any information about your own ability to highlight if you felt that a detained person may be at risk?

A. I wasn't given much information about that, no. I don't recall being told what to do in that kind of situation. I think I might have informally agreed or said early on, you know, that if I had very serious concerns about a particular detainee that I would report it or I would say to that detainee that I would need to go and tell someone about this. But that was -- again, I think that

was a fairly informal arrangement.

THE CHAIR: Thank you. Also, just a little bit more about context. Could you tell us a bit about -- were you able to go in whenever you wanted? Could you go in at different times of the day for different shift patterns, different days of the week, or did you tend to have a more regular routine of when you went into Brook House?

A. Yes, I went in entirely on weekdays, so I never went in on a weekend, and I typically did -- I was going to say working hours, but every hour is a working hour for them. But I would typically go in roughly between 9.30 ant 5.30. I mean, it took me quite a long time to get there and get back, so ...

Yeah, but I was never there at night. I was never there past 7.00 pm, I don't think, and I wasn't there on a weekend.

THE CHAIR: Thank you. Final question about the kind of specifics of your research. The people that you were able to interview, did they self-select to be interviewed or were you able to say, "I'd like to speak to you"? How did that work?

A. So from what I recall, there were a number of people who I had gotten to know a little bit and I said to them, "Would you be interested in speaking to me at some

point?" But when it came to actually sort of timetabling it -- like we were saying earlier, there were concerns about staffing, so it was difficult to arrange for people to have an hour or something to be interviewed. So it was Michelle Brown -- I think she was newly the head of security at that time. So I said, would she be able to kind of help me come up with a kind of timetable and, also, I said, "Would it be possible for you to, like, sort of suggest some people that I speak to across a range of factors?", so men and women, members of staff of different ethnic groups, different age profiles, length of service, different levels of seniority. I think there were also -- so she was very helpful with that, but then there were also some individual members of staff who I was able to arrange to have an interview with. I should also say that interviews are -- they proceed on the basis of informed consent. So a member of staff could decline to be interviewed. I think, in the main, people were fairly happy to speak to me of the people who I spoke to.

THE CHAIR: Did that apply for detained people as well, that they -- could you ask people if they would be interested in speaking to you or people could come forward and say that they would like to? How did that work?

A. So I made a decision that because of the nature of what I was researching, I didn't feel it was appropriate to do formal interviews with detained people, in part because many of them might have had very distressing experiences and I didn't really think it was ethical for me to bring that up and also unlikely to have very much tangible benefit to them. So conversations I had with detainees I had in the fist couple of weeks I was there and they were on a much more informal basis. So I would go one day and spend time on B wing or C wing and I would chat to anyone and everyone who I saw around. So people on the wing, on the residential unit, people in the courtyard, people in the kind of recreational areas or whatever, and we'd just have much more informal conversations with them. Sometimes they lasted quite a long time and sometimes I would sort of jot down notes from what they said. But they weren't sort of formal interviews. So that was just anyone who I encountered that I was speaking to.

THE CHAIR: Thank you. My final question, and do feel free to say you can't answer this if it is not an observation that you feel able to make, but based on your experience of having been in other IRCs as well, was Brook House different in general to other IRCs that you had experience of? Was there anything that struck you as

different particularly?
A. I don't recall there being anything especially unique about Brook House. One of the things that I suppose you might notice is that it's quite small and it feels quite cramped, so there's very little kind of natural light, there's relatively little kind of ventilation and it was also, at times, very noisy on particular wings, especially if the door was closed -- so people would kind of batter the door and the sound echoes and it's quite kind of overwhelming at times. Other times, it could be very quiet.
So I recall that about Brook House. And people often complained about things like ventilation in their rooms or cells.
It was quite similar to Colnbrook and physically extremely similar to it and also was quite similar in terms of the kind of feel of it, for want of a better term. But I don't remember there being anything especially unique or sort of singularly important that I would note about Brook House rather than any other detention centre.
THE CHAIR: That's very helpful. Thank you very much. That's all the questions I have.
MS MOORE: Thank you for coming to give your evidence.
A. Thank you.

THE CHAIR: I'm very grateful. I know it not an easy experience. I'm sure you're glad to have it over with. But it's been very helpful, so thank you.
A. No problem.
(The witness withdrew)
MS MOORE: Chair, it is 12.15. Our next witness is Mr Bole. I suggest it is a bit early for lunch. We might have a five- to ten-minute break to set Mr Bole up and start his evidence before the lunch break.
THE CHAIR: I'll rise for five minutes.
(12.16 pm)
(A short break)
(12.25 pm)
MR ANTON BOLE (sworn)
Examination by MS MOORE
MS MOORE: Good afternoon, Mr Bole. Could you please confirm your whole name?
A. Yes, my name is Anton Bole.
Q. We have a witness statement to the inquiry signed and dated 19 November 2021, which is at <FWT000001>. Can you confirm that that's your witness statement?
A. Yes.
Q. Chair, I will ask for the statement to be adduced in full. Mr Bole, this means we are not going to go through everything in your statement, that's already

there as your evidence. There are just a few issues the inquiry would like to hear more from you on.
A. That's fine.
Q. You were also interviewed by Verita on 11 May 2018 and you confirm in your statement that, in general, that account is correct. I will ask also for the transcript of that interview to be adduced as well, that's <VER000222>.
During the relevant period, you were a team leader of the substance misuse team at Brook House?
A. Yes, yes.
Q. The organisation has been known by a few names -- Forward Trust and RAPT?
A. Yes.
Q. What was it called at the time?
A. The Forward Trust -- RAPT, still RAPT, yes, at that time. Then it changed to Forward Trust, I think, shortly after. I don't have exact dates.
Q. Was it the same organisation, apart from the name?
A. Yes, the same organisation.
Q. You and your team were working across both Brook House and Tinsley House?
A. In Tinsley, yes.
Q. You were there on, generally, a daily basis within either one of those two centres?

A. Tinsley we covered once a week. It was mostly drop-in, but if we had clients, so then we would as well come during the week for one-to-one sessions.
Q. You would be -- those sessions would be delivering drug and alcohol services to the detained populations?
A. Yes.
Q. Thinking back to Brook House specifically in 2017, what might your day-to-day work have involved?
A. So we would go for one-to-one sessions to residents, group work as well. We would have regular drop-ins. So on each wing we would come and talk to the detainees and deliver our leaflets. And obviously one of the most important was induction, so -- which was face to face, so all new arrivals -- so we would see in face to face and give them an induction pack and try to explain them as well harm minimisation advice, danger of use of drugs, mixing drugs and all other similar advices, yes.
Q. I will ask you more about those different stages in more detail as we go on. You're still working at Brook House now?
A. Yes.
Q. But, since 1 September this year, the Substance Misuse Services has now come up the under the umbrella of healthcare?
A. Yes.

Q. So you are now working for the Practice Plus Group, which we will call PPG, who now provide healthcare but substance misuse is now part of that?
A. It's part of it, yes.
Q. When you were managing Forward Trust, that was three of you?
A. Three of us, yes.
Q. I understand that, now you're part of PPG, there's just two of you?
A. Yes, but it just had a new strategy plan which was agreed just recently, and we will employ two more staff, part-timers, so we would be, like, then, one full time, two part time and me. So we will expand, which is good, so we will be able to cover more at Tinsley.
Q. So the two part-time staff, will they be 0.5 full-time equivalent?
A. Apparently it is 1.2, yes, shared between two.
Q. Is there any reason for having two part time rather than one full time to replace that last role?
A. I didn't really enquire, but we are extending our services to Saturday and Sunday. It might be easier to -- because we had really a lot of problems to employ and find appropriate persons who would work, so eventually, with the Forward Trust, we had to employ two ex-officers and train them. But probably part time it

will be probably easier to find someone who would agree to work at Brook House.
Q. During the relevant period, then, so 2017, did you do weekend services, Saturdays and Sundays?
A. No, we didn't. We did try weekend services, sort of as a pilot project, but detainees, they didn't really engage during weekends because they had -- mostly, I work from Monday to Friday, I have hearings, so Saturday and Sunday, I want to rest. So that's why we stop then, because of some request from senior management, and the pilot, I don't know for how long, but it wasn't really successful.
Q. Your team being Forward Trust was previously independent from healthcare, so it wasn't part of --
A. Yes, we were independent, yes.
Q. It obviously wasn't part of G4S that were generally running the centre either?
A. No, no.
Q. But you worked with them?
A. I worked with them, yes. So we had meeting -- it was sort of us managing the team, so I attended all meetings which were needed us, somebody who is service manager would do it.
Q. Did you consider the independence of Forward Trust from G4S and G4S Health to be a benefit?

A. Yes, I think, yes.
Q. In what way?
A. Because we could really raise the issues and obviously there was no fear there would be repercussions, so whatever sometimes you might think -- and, obviously, could consult as well independently the best option. Yeah, that -- especially that.
Q. So you are not part of the company that are running the detention side of things, but you are now part of healthcare at Brook House?
A. Now we are part of healthcare, yes, since 1 September.
Q. 1 September. Do you have any concerns about the fact that you are now not independent of healthcare, that you might not be able to raise issues in the same way you could before?
A. I mean, it's the early stage, I would say, so, yes, only since 1 September within the healthcare, and it's still, like, foundation time, but I do think -- so we are going to be part of a mental health team, integrated mental health team, and -- because 50 per cent, thereabouts, our clients, they have got mental health issues, it does make sense to work closely, so I do agree with that, yes.
Q. So it makes sense to work closely with them, but you have --

A. Mental health, yes.
Q. But you're part of the general health services, not just mental health?
A. Yes, part of the general, but we have own leads for mental health and substance misuse, so with some sort of independence there.
Q. At paragraph 11 of your witness statement to the inquiry, you set out the service delivery at Brook House, which is assessment and support for residents. You say there, and I will read it out:
"... interventions included assessment, agreement of recovery plan objectives that could include harm minimisation advice, one-to-one sessions, group work sessions, joint clinical reviews with main substitute prescribing team and holistic therapy options such as auricular acupuncture."
Just on that initial assessment, was this once someone had been referred to you or could they turn up to get your help to have that initial assessment done?
A. Yes, so, basically, we would -- yes, it is possible to refer from other teams, like healthcare at that time or even Home Office. So whoever -- or even officers from the wing. Obviously, we would have initial assessment where we would assess them and really care plan as well, what the most appropriate intervention would be best for

them. Obviously, after Verita report, so it was recommended to move us more central because we were, before, in very isolated area, a sterile area, where the clients -- detainees couldn't come and see us. So after that recommendation, we moved very -- moved to more central position and we would then experience increase of detainees coming to us --

Q. So drop-in?

A. Drop-in was really good. We had peer supporters as well, always, where normally I would train them and as well then they could talk to me. Normally, I would supervise them and they could come freely to me which was good as well.

Q. So thinking of a detainee whom you had never met before, so somebody whom you have for their initial assessment, you say you can develop a care plan. You take into account their history, presumably any substance issues in their history?

A. Yes.

Q. How much do you take into account other aspects of their clinical history?

A. We obviously -- we would ask other questions -- we had risk assessment as well. So we would discuss, are there any mental health issues, any child issues as well, so we would go through them --

Q. Sorry, "any child issues"?

A. I mean if there is children involved, like they got family with whom they live, sometimes it's known that if both parents are addicts, it can be quite detrimental for children, so we would refer to social services if anything like that happened. It was sort of holistic, yes, quite a holistic care plan.

Q. Did you work with, thinking of 2017, healthcare at all to understand the picture of somebody's clinical history or mental health history or did you do that as stand-alone?

A. We had access to SystmOne, which is -- which doctors and nurses could use, so we could refer back to SystmOne. We could read the notes. Obviously we had the meetings as well, background meetings, quality meetings with healthcare, and then, every three months as well, a meeting with commissioner, NHS commissioner. So sort of -- yes, I did feel that we worked together.

Q. So SystmOne is the online database that you can access somebody's medical records and make notes?

A. Yes, all clinical notes are -- we could see as well medication. Because it was important, some of our clients were on methadone, and normally, obviously, they would have complex case meetings called with doctor and with the client and me and then we would discuss any

issues regarding methadone prescription. It was quite good because sometimes the doctor really motivated them to work with us. Because they could see that we worked together.

Q. So those, for example, who were on methadone, would they be primarily dealt with healthcare or would you have the oversight of their prescriptions and drug management?

A. Yes, obviously, because I'm not medical educated, so that would be healthcare, but psychosocial part, it would be us.

Q. I think you mentioned you could also refer residents to healthcare --

A. Yes.

Q. -- if, in the assessment, you felt they needed it?

A. Yes.

Q. Would that be for mental health issues as well as --

A. As well, yes.

Q. -- prescription and --

A. Yes, anything related to healthcare.

Q. If you could help by giving us a general picture, and thinking about the relevant period, which is April to August 2017, what drugs were most common at Brook House?

A. If I remember right, it was mostly spice and cannabis. They wouldn't have much of other drugs. You would get

occasionally crack cocaine. I don't remember heroin was much present. That would be basically --

Q. Spice and cannabis. You mention in your witness statement hooch, so home-made alcohol?

A. Hooch, of course, yes, especially with detainees from Eastern Europe, it was really quite prevalent, yes.

Q. Would that be something that, as far as you knew, was produced within Brook House?

A. Within Brook House, yes.

Q. You've mentioned spice and you mention it in detail in your statement. We have heard evidence in the last few weeks about spice and spice overdoses, but perhaps you can help us understand it a bit more. It is a synthetic substance?

A. Yes, it is a synthetic, man-made drug, which mimics the effects of the active ingredient in cannabis, THC, which gives you a feeling to be stoned. There might be powder chemicals dissolved and sprayed onto paper or dried plant material, and it was, as well, becoming more and more common to find it as liquid, so it would be sprayed on paper and sent through the post, and I don't think we had, really, control over post because, obviously, you couldn't really recognise, as far as I'm aware.

Q. So you couldn't tell from looking at a piece of paper whether or not it had been sprayed, as far as you could

tell?
A. I haven't seen it how it looks when it is sprayed, never, but just the sheer amount of post, because I think it's only one prison, US prison, had this facility to check it, if I remember. But don't get me -- I'm not exact on that. But that was -- and obviously then smoking is one of the most-used methods of spice.
Q. So how do you smoke it? Say, for example, somebody has paper which it's been sprayed onto?
A. It's like tobacco. You can put in tobacco as well and just roll it and smoke it. The problem is that you never know what you get. It's a Russian roulette. So -- because it can have very bad effects, or it can really relax you and you feel nice, stoned. It can have, like, a depressive effect. Next time, it can have a stimulant effect. Because it's all been man made. You wouldn't know what it's in. If somebody has got heart problems, high blood pressure, once he was relaxed, the second he end up in hospital. I heard as well, when I used to work at HMP Coldingley, there was a prisoner who actually got blind. So it's rare, but that was -- but mostly, it's really inability to move, breathing difficulty, heart palpitations, extreme anxiety. I've seen guys who were long on spice with

heavy paranoia.
Q. Seizures?
A. Seizures as well, yes, as well, of course.
Q. I think you mentioned that it's like a Russian roulette, so you don't know what's going to happen when you take it?
A. Yes.
Q. Is that because you don't know what the dose is going to be, because you don't know what's in the batch, or a combination?
A. Yes, you don't know why -- literally, they inventing constantly new chemical structures, so you really don't know what you get. Obviously, they're using sometimes the most vulnerable detainees as checkers, to check the batch, so -- which is another problem, so they are aware of the risks, the dealers, but obviously they are checking batches and, if they see it's okay, then it goes around.
Q. We will come on to that, which we have heard referred to as using a detainee as a guinea pig to check a batch?
A. Yes, guinea pig.
Q. Before we leave the overview of spice, you said you can feel stoned or relaxed. Is that, as far as you understand, the desired effect? So when people take it, the intention is to feel relaxed?

A. Yes, especially, obviously in such an environment, which is very distressful, so obviously to experience, like -- is like a relaxation or sort of get -- getting away from the whole situation.
Q. You told us, at paragraph 49 of your witness statement, that there are some residents you worked who had previously used drugs and there were others who only started them when they were detained?
A. Yes, when I started, I came from HMP High Down, we started this service, and what really surprised me, we had so many -- it's still in my head -- so many referrals of detainees who actually really started to use at Brook House. Because, normally, I was used to -- from prison, there we would help people who were drug addicts, and obviously they would meet and they would access our services and we would help them, but not many would start in prison. There would be some, but really not that big amount of prisoners that would. But here, at that time, it was most -- more than half, even, I think, 70, 80 per cent was really just first time.
Q. Is that more than half of people who took spice or more than half of people who used drugs generally?
A. So we had a lot of referrals, and so -- then, obviously, at that time, I was alone. So actually I went to see all of them. And that's where I got this data, so that

it's -- yeah, it is really most of them were first-time users.
Q. Of your referrals?
A. Of referrals, yes. So they were referrals from security, healthcare, officers.
Q. When we talk about people who start to use drugs in Brook House, are we generally talking about spice for first-time users?
A. Spice, yes, and cannabis as well. Crack cocaine could be as well. And hooch.
Q. Can you tell us, as far as you know, about why people would start to use drugs, from your experience, when they were detained at Brook House, when they hadn't before?
A. Mostly, it would be really to try, obviously to de-stress, so they are stressed, obviously, it's sort of self-medication, and then, obviously, it was as well, I think, around Christmas can really increase. It would be then as well, missing family.
Q. Why would it increase around Christmas?
A. So especially they can't see family, children, partners, that was quite a big factor as well. Obviously, everyone is partying, they have got some nice time, and, "Me, I'm in detention centre. I don't know even when I'm going to be released". So it's quite daunting them.

Q. Anything about the type of person who you saw who might be more likely to start using when they were in detention, or is it difficult to predict?
A. So it was -- they were young, they were old, so you couldn't really -- but I would say a bit naive. So that's why we introduced, after that, inductions face to face, not in the group, where we could talk to them in person and warn them. So -- and I think after that the numbers really went down, yes.
Q. You said that people can use it to de-stress, so to relieve stress?
A. Yes, sort of to forget all sort of ...
Q. In your experience, did people start using drugs at times of other types of mental ill-health?
A. Yes, it can be as well. We had dual diagnoses, self-medicating.
Q. What sort of dual diagnoses would you have?
A. I mean we had people with anxiety, then schizophrenia as well, psychosis. So it's quite -- you know, I would say that 30 per cent of our clients, at least, had dual diagnoses, so who we saw and they were engaging with mental health.
Q. You have mentioned to us already this afternoon and you also say in your witness statement about vulnerable residents who might be used as guinea pigs to test spice

batches?
A. Yes.
Q. How much did you see this sort of thing happening?
A. I mean, I didn't see often, but it did come to my mind. It could -- I remember certainly a detainee from Ukraine who was -- yeah, I could see he was very vulnerable and as well could see that they were using him as guinea pig, so that's, for example -- and obviously he didn't want to engage with us as well.
Q. He didn't want to engage with you?
A. Engage with our services.
Q. Why not?
A. He just said no. I think it might be just pressure from drug dealer or because -- might be fearing we will get some information. It was just -- yeah.
Q. You say -- presumably, as well as seeing it, you sometimes heard that this was happening, but they didn't end up referred to you. Is that fair to say?
A. No, he never referred, yes. The officers are quite good in security. So if they see someone that --
Q. Can you just lean forward so the microphone picks up what you're saying?
A. Sorry. If they see someone who is using, we would receive security referrals quite often, and, as well, for a few years, now, that I'm running drug and alcohol

courses for all new officers, but as well explain and encourage them always it's not -- they can always refer people to us, even if it's the second, third time, because sometimes they might engage with us if we come to see them second or third time. So we got a good number of referrals. I can't complain with that. There is awareness. But, obviously, the second is, some of them they won't engage, some of them they will think, "Okay, that will be on Home Office records" so -- "and I will be deported". So it's -- it's really important we explain them so that, "Home Office is not after you, so it's really helping you". Then, "They never came and asked us for your records. Actually, if it's on your record, that could help you because, obviously, you have done some work and you are -- and that probably judge would be more happy if you done it than not". So sort of -- when they understand that, so then they would engage, many of them.
Q. Just to finish the point about the people who were used as guinea pigs or for testing, and you said this happened not often?
A. It happened, obviously, not in front of my eyes, so that I would be aware.
Q. But you heard about it happening?
A. Yes, yes.

Q. When you say "not often", do you mean only once a year, only once a month, once every ten years?
A. Not often that I was aware. So that means -- obviously, I was aware of a few cases, but I do believe it was happening because, when the spice was present, they did check it, I believe, always.
Q. So every new batch would have to be checked in some way?
A. Yes, I believe, yes, so that they would check unless -- they would just -- I don't really know how it worked, but I would imagine -- yes.
Q. You say in your statement that you warned new people about cigarette spiking, so don't share cigarettes. Is that because the paper can be sprayed?
A. Yes. Obviously, they can -- that happened a few times. They would just make fun. So they would give another detainee a cigarette spiked with spice and they would just observe what happened with him and then they would laugh at it. So it was really quite malicious. We would warn them, "These things are happening. They have happened before, so please be careful" and then as well that, "There are drug dealers who will come, they will offer you drugs" -- and, obviously, I think that preparation for them, so that they are not surprised when somebody comes and offers, was -- that sort of gave them ability to say no, I do believe.

Q. As well as warning them not to, for example, accept a cigarette from a stranger --
A. Yes, of course, yes.
Q. -- and not to accept drugs, even knowingly, did you tell them what they can do if that happens to them, who they can tell?
A. Yes. Obviously, they know that I could report to officers, but I don't believe they would because obviously, if you cross the drug dealer, the repercussions can be really big, so I don't think that was ever reported or, if it was, not often.
Q. So never reported, so you never got to the bottom of who was testing the batches?
A. Obviously, because I don't have access to security records, I hope it was reported, so -- actually, there was -- I got one report here that it was reported, and I'm glad to see that. Obviously, I don't see the end of the process.
Q. Just as to the, let's say, guinea pig testing, you're aware that it's happening, even if you don't always know all the details?
A. Yes.
Q. Did DCOs and DCMs know that this was happening?
A. I'm not aware that all of them would know. So it's just really how much they are sensitive and aware.

Obviously, like was mentioned previous, so they were really very busy. So sometimes you can't really see everyone and what state they are and then they were moved from wing to wing as well. I wouldn't expect, really, from them, but what I was expecting really, if it's something suspicious, to refer to us, which they would do now.
Q. What about Home Office staff? Did you ever discuss this issue about people being used to test batches of spice with Home Office staff or did you get an idea they knew that this was happening?
A. I think -- I never discussed with Home Office but it was known -- obviously, it's hard to find and to get recognition that this is really happening from the person, so I think the main problem would be really to admit, so that they need to admit, "I am doing that", because then he would be exposed to -- might be brutal abuse from dealer and from other detainees for using, and I think that's the main prevention.
Q. How did you know, other than it being commonsense, that this was what they were scared of? Did people tell you that they had those fears?
A. No, obviously I experienced that before. So obviously, I used to work at HMP High Down and there was a case when a prisoner didn't want to bring drugs and he was

beaten properly. So at that time, four of them managed to come in the room, without guards see -- officers saw them, and really he was in bad state. And then as well where I used to live, it was in the news, in the newspaper, actually, because it was at High Down, so there was an officer who was bringing drugs. Of course, the drug dealers, I don't know what it was, he didn't pay, or something, they found his address and they killed him at home. So it's quite -- so it was in my head, like, these comments that they will revenge sort of.
Q. Did you feel that detained people shared that fear?
A. Yes, yes.
Q. Is that something that people talked to you about?
A. Because there was obviously here in number 11 --
Q. Yes, let's turn to that. Can we have it on screen, in fact, <CJS005089>. It is at tab 10, I think, that you are referring to, rather than 11, the Detention Services security information report?
A. Yes.
Q. Do you have that at your tab 10?
A. Obviously, I wrote an SIR, so because one of my clients who used spice recently at that time --
Q. I'm just going to explain what the form is.
A. Yes.

Q. It's a Detention Services security information report. It is dated 11 April 2017. I think that's the first entry on it. So that's when you opened the report?
A. When I opened, yes.
Q. That's your name there at A. So you have opened the security information report here because of a security concern?
A. Obviously, you can see on the top, normally we would put names. Here he didn't want to do that out of fear.
Q. If we turn to page 2, we can see more details about what you were told on this occasion.
A. Yes, yes.
Q. So this is security information. There is no name, as you say, because they didn't want to --
A. He didn't want, and obviously, too, I would lose his trust.
Q. I'm just going to read it out:
"Subject heading: Drugs supply.
"Content of report.
"During 1:1 session one of my client who used spice recently stated that drugs are coming through a member of staff. Did not want to tell me the name of person."
A. His fear was, as well as -- later, I was able to read report, or James's report, from detainee group they had -- might be the same client who actually was afraid

to really to receive revenge from officers, or drug dealers who were bringing drugs. So we had always -- because I was attending security meeting, we had intel that some staff is bringing, so that's -- but that's everywhere in prison. You would have certain staff which is -- who are compromised. But most of them might be more from through visits, through visit post as well.

Q. You said you had certain intel that staff were bringing it in. Was it always intelligence you received from detained people who were using the services?

A. Yes, this one was from detained, but obviously it was, as well -- they are sometimes mentioned from staff as well. Obviously, always -- they always informed security. And I've seen that security was active, proactive, and they did manage to stop and some people were sacked and they lost jobs. It doesn't -- it was dealt with, but obviously it's hard -- so my understanding and my feeling is that, if we were flooded with drugs, it was more likely that staff was bringing because you can bring big amount of drugs. Staff -- went through visits normally, it's not such a big amount that you can really get through the post.

Q. If we talk in terms of sort of -- we have to do it in rough terms, but in terms of doses of spice, for example, how much would you be able to put in a letter?

How many kind of -- how long would that last one person, one piece of paper being sprayed, for example?

A. You would spray it on the paper. I really don't know this one.

Q. You say --

A. But not long.

Q. Why would a greater volume be possible if it was through staff rather than through the post?

A. Yes, because obviously they can bring in the bag.

Q. So a large amount?

A. A large amount, not checked. Obviously, if you have two workers working together, two dealers, then the one goes in, checks there is no searches, and for other one it's green light and you can bring. That's just my -- I don't know.

Q. Is that people working together, how have you got that information of --

A. No, just my imagination. Obviously, I never experienced that, but obviously --

Q. Sure.

A. Because, normally, it was unannounced. Searches would be unannounced.

Q. So random days?

A. Random, yes.

Q. Just going back to this report before we leave it and

have a lunch break, you filled in this report on 11 April 2017, you say at 11.50. And you note that one of your clients said "Staff members bringing in". It doesn't say what drugs but I presume it's spice because you say your client used spice recently?

A. Yes, I'm not sure as well, but probably -- yes, who used spice, yeah, yeah, probably, yes.

Q. They didn't want to tell you the name of the person but they told you it was a member of staff?

A. Yes.

Q. Did they say what their role was?

A. No, no, they didn't want to say anything.

Q. Nothing about it?

A. No. It was a sort of fear that there would be -- they would see reprisal. Obviously, if staff is bringing in, it might be that he's got drug dealers in, and obviously they can go after him. So I can imagine his fear --

Q. Do you remember specifically whether this person said what their fear was or did they just say, "I don't want to tell you"?

A. No, no, just said they don't want to tell me.

Q. We can see here, just above the signature box, it says:

"I have not informed my line manager", presumably because you were the team leader?

A. Yes.

Q. "... of the contents of this report" and you have written "But informed Deputy Director Stephen Skitt"?

A. Yes, that's normally the procedure.

Q. It is a five-page form. If we go to page 5, the document goes on to note that they don't know the name of the person who has reported it. Then the final page of the document is the email from Jason Murphy to you on 14 April?

A. From Jason, yes.

Q. "You put in an SIR with regards to information given by a detainee regarding spice. Can you please identify the detainee who passed over the information to you."

If you can remember -- please don't tell us the name of the person now -- did you give the detained person's name to Mr Murphy?

A. I think I answered him that person doesn't want to reveal his name and that I can't give the name, so that was according my recollection.

Q. Did you have, if you can recall, either in this instance or any other, a discussion about any protections that could be put in place so that the person could reveal further information?

A. No, I didn't really talk with security, so what it could be done. Because he didn't want to be noticed as well, so it could be really breach of trust and it would

jeopardise his security as well, it seems to me.
Q. Were there other occasions where you were told about staff bringing in drugs, similar to this one?
A. Yes, yes, there were occasions where we had this information, and obviously -- so we would always write SIRs from the team, but I think some detainees, they were not -- they didn't have any issue to write their name or (inaudible) if I remember well. So it's not everyone. But the problem is, if it's -- if somebody agrees to write name and (inaudible), then they are always asking, "So what is it behind? Is it arranged through someone or it's blackmailing officer or some ..."
Q. Some people didn't mind sharing their name with you and they also didn't mind naming the person who they said was bringing the drugs?
A. Yes, once, if I remember well, we had two groups bringing drugs, and obviously they were reporting each other, so sort of to disturb the trade.
Q. This was at Brook House?
A. Sorry?
Q. At Brook House?
A. At Brook House, yes.
Q. And approximately when? What year?
A. Oh, gosh. I think it was -- I really don't know, sorry.

Q. Don't guess if you can't remember. When you say they were reporting each other, they were reporting other detained people who were bringing in drugs. Were they also reporting staff?
A. Reporting names sort of, if I remember well. So that was at least one group.
Q. As well as staff names, or just detained people's names?
A. It was detained people.
Q. When you had a report like this, sorry, when somebody told you information like this, would you always put in an SIR?
A. Yes, yes, of course, that was a member of staff, and it was really working together with security.
Q. Would you find out what happened, for example, in this circumstance what happened --
A. No, we wouldn't be informed, because it's an intel and obviously -- yeah, I was trained, "On certain stuff, you don't question", and because it's -- there's some sort of confidentiality from security side.
MS MOORE: Chair, I have some more questions for Mr Bole, but I wonder if now is a good time to have a break for lunch and maybe return at 2.05 pm?
THE CHAIR: Agreed. Thank you very much. We will see you at 2.05 pm.
(1.06 pm)

(The short adjournment)
(2.05 pm)
MS MORRIS: A while before the lunch break, you were helping us understand a bit more about spice and telling us about its effects. Just a couple of further questions on that. Is spice addictive?
A. PCA, so prolonged use would have withdrawal symptoms. Not as much as heroin or alcohol, but it is still there.
Q. So taking it once probably wouldn't have --
A. Less, yes, of course, like any drug.
Q. What about its long-term effects other than causing withdrawal if you stop it? Does it have any long-term effects on the health?
A. I mean, it's -- obviously, it can cause mental health problems, like I mentioned, so obviously, if it causes any physical organ damage, it is permanent as well.
Q. You comment at paragraph 68 on an IRC security meeting. This is a meeting you would have been attending along with various other organisations at Brook House.
I won't take you to the record because you considered it for your statement and the reference is there. But the minutes are of a meeting on 11 April 2017. They record you saying that the use of spice has increased in the centre since the last meeting. How would you have known about an increase in spice?

A. I would audit the referrals, I would see the number of referrals would increase, especially from healthcare, because they would have to attend to incidents and obviously, normally, would get a referral. Then security, as well, would refer people to us, officers. So it was -- the amount of referrals would tell us that something is again happening.
Q. What do you expect to be done when you raise this? What's the purpose of telling people that there's more spice in the centre?
A. It would be done really so -- to find a solution. Also, obviously we would see people who use spice, we would offer our treatment. Some of them would agree, some not. Obviously, they -- I can imagine as well security would raise their security measures, checking staff, you know, that we had as well dog searches.
Q. Dog? Oh, sniffer dogs?
A. Yes, the dog on stage. They were searching staff as well, and -- unannounced, just whenever going home or before they come to work.
Q. Were you generally -- obviously you were working within the centre. Were you searched when you entered Brook House?
A. Yes, yes.
Q. How frequently?

A. Few times. Oh, God, it's hard to say. So before Covid, we had regular searches, I think quite -- and then obviously as well with dog. But since Covid started, it was a bit less.
Q. How regular before?
A. Actually, in my head, it was regular. I didn't really know. It might be every two/three months. I might be wrong --
Q. But not once a week?
A. No, no, not once a week.
Q. Not as regular as that?
A. No, no.
Q. How frequently would there be sniffer dogs?
A. No, that was not often, I think I remember only once.
Q. At paragraph 77 of your statement -- again, I won't ask for the document to go up on the screen because I can read it -- you refer to minutes of another security meeting, this one of 11 May 2017 so a month later. <CJS000917>, tab 8. This isn't a record of what you told the meeting, it's what somebody else said, although you were present.
A. Okay.
Q. It is about drugs. It said:
"Drug finds were spread across the centre, 2 x A wing, 2 x C wing, 1 x D wing, 2 x reception, recovered

significant amounts from property -- with no finds through the visits -- further work to be undertaken to look at trends and patterns and to trace source of ingress."
When it says "no finds through the visits", that's visitors being searched as they come in?
A. Yes, they haven't found -- obviously -- so the question would be really the training of officers, are they well trained to pick up drug deals in visits or not? As Panorama shows, and came to my mind then, and I think they are not. Some guys really didn't know what they are doing there, in that Panorama inquiry, which is hard because it should be more professional.
Q. If there's none found in the visits but you know it's in the centre, then potentially it's there because it hasn't been spotted, but it has been handed over in the visits --
A. Yes.
Q. -- or there's another source?
A. Yes. I wasn't aware that visits were not checked properly. I saw from Panorama documentary, it came to my awareness. I really didn't like it.
Q. You hadn't ever seen the process of searching people through the visits yourself?
A. No, no, because I'm not involved. It's more a security

task.
Q. Was anything done either at your instigation or generally after the programme to change the way visit searches were conducted?
A. I hope -- obviously, I don't have the detail, but I hope it is. Because I've seen the security measures, they increased, and so we had more searches, so it was a bit better.
Q. As it says here, "further work to be undertaken to look at trends and patterns and trace the source of ingress". That wouldn't be work that you were involved in?
A. No. Yeah, that would be done at security.
Q. You say at paragraph 78 that quantities of drugs would increase when there was a known drug dealer at Gatwick IRC. So this is your paragraph 78. So known drug dealers would increase the quantity of drugs?
A. Yes. Obviously, 30 per cent of our detainees would come from prisons. Yeah, it would be known, so there are some drug dealers, mostly from there, and they are dealing with drugs, yes.
Q. Do you know if any measures were put in place when it was known that somebody who had had a history of conviction for drug offences was coming in?
A. I would imagine that security would monitor more closely that one.

Q. But you don't know whether or not --
A. I don't know that, because it's confidential.
Q. In your view, was there generally an improvement, ie, a decline in drug use, throughout 2017?
A. I think after Panorama, so I think that we never had such number of referrals anymore. So I don't remember any time. And, as well, when the new security manager started the job, I think she was very robust as well, so I think this helped as well.
Q. You mentioned that, at paragraph 97, Michelle Brown -- that's who you mean by the new security manager?
A. Yes, Michelle Brown I was referring, yes. She actually really increased security activities, staff and resident searches, including dog-led searches. It was, I think, quite a good thing. We had less drugs coming in. That was my observation.
Q. But you only personally recall maybe one dog-led search?
A. Yes. So that was -- I can't remember the staff, but I can imagine they were using them as well, but -- I'm not sure, but that was my hope.
Q. We have discussed drugs which were brought into the centre, and we will go on to your work. But just before we move on, you mentioned hooch or home-brewed alcohol?
A. Yes.
Q. And you said that was one of the drugs that you were

dealing with as a service?
A. Yes.
Q. How prevalent was it? How frequently would you see people either under the influence or possessing it?
A. Hooch was quite prevalent, especially in the Eastern European population, and it was easy to get it as well because they could get fruits from our shops and they could manufacture it alone. So it was -- we had quite some number of referrals for hooch and hooch findings.
Q. If you know anything about it, did you understand it was being made in detainees' rooms or in communal areas?
A. Yes, yes, mostly in detainees' rooms.
Q. What sort of problems, if any, did that pose to you? Firstly, if we look at acute problems, so people who were under the influence at the time?
A. Obviously, it would be a problem, I can imagine, for officers, because people would be drunk, unorderly -- disorderly, and they wouldn't listen. Then, obviously, hooch is very dangerous, so it's not controlled like alcohol, so it can cause blindness. They don't know how much -- what's the percentage and all this stuff. So it's a very, very risky activity.
Q. Out of the people that you dealt with, either in groups or one-to-one sessions, what sort of percentage would come to you with alcohol-related issues?

A. Alcohol, it would be quite a big percentage, especially with Eastern European population. So I think Eastern European would mainly have alcohol problems.
Q. Mainly have?
A. Mainly, yes, or very big percentage, so that's Poland and Russia. Not all, but a big percentage.
Q. To what extent did you work with healthcare in respect of detained people with alcohol-related issues?
A. Obviously, it would be -- they would have regular detox when they come in, so we would have a look at rooms for them. Because detox -- alcohol detox which is not followed with medical treatment can be very dangerous, and then, obviously, it -- we would then work with them as well. We offer them social work, and, yes, some of them, they have done quite good work, so good experience.
Q. You've set out -- moving on now to the training that was provided to staff, you set out at paragraph 25 -- I won't get you to read it all, but there is a list there of training which you say was given to practitioners and clinical teams.
A. Yes.
Q. Thinking back to the relevant period, is this a list of training, training that was provided to all staff at Brook House or just to specific kind of groups?

A. 25 is provided -- would be provided for all staff. So when they start working for the Forward Trust, they would have to complete all this training, and so they would do probation time with me and I would just really then note and report into head office that that has been done. Otherwise, they wouldn't be confirmed in the post.
Q. The bullet point here starts with:
"Forward Trust Onboarding Day" --
A. Yes.
Q. -- and goes on to "Suicide and self-harm", et cetera. That's for Forward Trust staff?
A. That's for Forward Trust staff, yes.
Q. Can you tell me about suicide and self-harm? Did it have a drug and addiction focus or was it more of a general session to familiarise people with suicide and self-harm risks?
A. Because it was a long time when I completed the training, so it's -- I don't really know what was -- yeah, what did they teach staff.
Q. Okay.
A. But my understanding would be that it was general, but they would, as well, emphasise drug aspects, at least mention or -- that's my understanding.
Q. Fine.

A. But I didn't attend it for a long time.
Q. No problem. Did the Forward Trust provide training to other staff at Brook House, for example, DCOs, DCMs?
A. Yes, so we started to provide a drug and alcohol awareness course for all new officers, so if you are doing the training and induction time, so we would have one morning where we would complete drug and alcohol awareness course with them. It worked really well, because they sort of know -- they know us and they're much easier to approach us, refer to us, because we tell them, "You're always welcome to come to our office", explain where, and we did experience where they would come and they would talk to us and refer people, so that's really -- it's working really well.
Q. So that's during the six-week-ish period that they have?
A. Yes.
Q. And you said you did a morning of training?
A. Yes.
Q. Was there an assessment at the end or just a morning of presentations?
A. No, a general drug awareness course.
Q. What about people who already worked at Brook House, so they weren't new staff so they weren't on the six-week course. Did you provide them with any training?
A. So we were talking about -- but that was in previous

time. Because now, at the moment, I think they all -- all officers are actually new, most of them, is like my impression. So they have done the training. Some old staff, I think they haven't done it, which G4S, there was an agreement to do the refreshment, being part of refreshment training, but it never came to that, so we were happy to do it. But obviously it's very hard to get staff from the wing for the training. I can understand the implications, but, yeah, so that's -- I think it was because they were so busy and short staffed.

Q. Do you do refresher training now with people who have already had the induction but it might have been a while ago?

A. No, we don't do, not yet.

Q. There are further security minutes from 23 June 2017. Again, I won't put them on the screen but the reference is <CJS000911> page 2. Chair, you have it at tab 6. Under the heading "Substance misuse" it's stated:

"AB ..."

That's you:

"... suggested doing a PS [spice] awareness course for staff and MB [Michelle Brown] suggested that AB give updates in the staff morning [meeting]."

A. Yes.

Q. Do you remember that meeting?

A. Yes, yes, I remember. Actually, what they were trying is us to give an update, what's happening, but the time limit, yeah, would be -- wouldn't be there, so it was -- the meetings were very fast and they had to go then to the wings, so I suggested more to have really proper training, like we have got for new staff, something like that.

Q. Which we were just talking about?

A. Yes, and introduced, yes, so the ITC training they called it.

Q. Does that mean there was not, in 2017, a PS awareness course for staff?

A. I think we started later, yes.

Q. Were there staff morning meeting updates?

A. No, we didn't have them. But I think shortly after -- I don't know what happened because I don't have the exact date. So we started with drug awareness courses, I think there was some connection there. But my memory is not there.

Q. No problem.

A. Sorry.

Q. That's fine. Thinking, again, back to 2017, do you recall if you provided training, even informal training, to any healthcare staff about drug issues?

A. Not healthcare, no.

Q. There are a couple of semi-external organisations in Brook House, for example, the Independent Monitoring Board?

A. No.

Q. And the Gatwick Detainee Welfare Group?

A. Yes, we did once, yes. So they were interested and said, "Do you have time?", then our regional manager provided the training. We offered again just recently and, if they want, we can train their staff. Because I think they do talks with detainees and they might spot things and referrals to us, so they -- I'm waiting for them to get back to us.

Q. While we are on the Gatwick Detainee Welfare Group, which I will call GDWG, we have a statement from Anna Pincus, which she made for the inquiry, <DPG000002>. I will read out the relevant parts for you. She says at paragraph 32:

"In February 2017, we were told by Anton Bole ... that he had not seen our posters or leaflets in the centre, save for some of our leaflets in French and Spanish."

Do you remember having a discussion with GDWG or even just generally having the impression there wasn't much information about them?

A. Yes, probably at that time, yes, if I wrote it, probably it was, because I was always keen to have their adverts and their presence because I think they're doing a good job, and I've seen from feedbacks from our clients, but I didn't see -- didn't hear any complaint. So in that situation, the stressful situation, to have such an organisation on the site, we can take advice, help with money, clothes, I think it's very good. It reduces stress and it's actually helping, as well, officers on the wing. They don't need to deal with such stuff.

Q. Was your impression -- again, if you can, thinking back to 2017 -- that residents, detainees, were aware that GDWG existed or just some of them?

A. Yeah, well, I really don't remember how was the situation. But if I wrote it, the posters were not there, and I fear I would have thought that the presence wasn't as it should have been.

Q. I should say, this is someone from GDWG saying what they remember you saying --

A. Okay.

Q. -- rather than your written account.

A. Oh, okay.

Q. That there were some leaflets but only in French and Spanish?

A. Yes, yes.

Q. Let's move on to your work with residents at Brook House. You have already told us some of the details around this. But I just wanted to ask you about the first contact that you have with new residents. You explain this at paragraph 82 of the statement. You say that you see all new arrivals face to face. Is that one to one or do you see them, if they're coming together, as a group?

A. No, not as a group. We refused to see them as the group, although it was suggested, because in the group they wouldn't tell us about the drug use because sometimes they can be stigmatised from others and they just didn't feel confident. So we started, really, face to face. So we would see all new arrivals, go to the wing, talk to them, give them the pack as well, the induction pack, which, like, four pages. So -- and explain them what's happening, who we are and then, obviously, sometimes we will get referrals from there as well. But I think it was about preventive as well, so prevention, so they know drugs are present, so be careful.

Q. Did you say you would go and see them on the wing?

A. On the wing, yes.

Q. Would they be in the room on their own when you saw them?

A. Yes, in the room, mostly in the room or sometimes in the -- outside.

Q. In the recreation area?

A. Recreation, yes.

Q. Obviously there's many residents who don't have English as their first language?

A. Yes.

Q. How did you ensure that they understood what you were saying to them?

A. We normally didn't have a big problem, because, at that time, most of them were really ex-prisoners, so they came from community, and they had basic English, so it wasn't really -- but then as well we got some foreign national -- foreign language leaflets as well, so normally we would deliver them during our drop-ins, so they can -- obviously if you don't -- they had as well the translation in different languages as well, so who we are, so that's for basic, but then for drop-in they could always access us. So we didn't have big problem in translation. That increased really just recently with boat people, so who came over, so they don't speak any English, but they stay only three days mostly and so it wasn't really big involvement with them.

Q. Did you ever use interpretation service?

A. Yes, yes.

Q. In what circumstances would you use interpretation?

A. So normally -- so just now, I mean, I've got a client from Albania who doesn't speak English at all. And I managed to give him, like, three one-to-one sessions, everything through interpreter, so it's interpretation.

Q. Is that somebody who is there, is it a language line?

A. No, they got thebigword, so it's --

Q. Thebigword?

A. -- professional, yes.

Q. And it's a person who is in the centre with you, not someone on the phone translating remotely?

A. No, no, person in the centre. It is someone who is translating, yes, in the room --

Q. Yes --

A. -- so the person would translate.

Q. -- they are there in person?

A. Yes, yes.

Q. Thinking back to the relevant period, 2017, was that something that was available to you if you needed it?

A. Yeah, yeah, we would always use, yes.

Q. On to referrals. You say you have seen everyone in induction. Some people refer themselves directly, effectively, to you?

A. Yes, self-referrals.

Q. Where did most of your referrals come from?

A. Most of them really healthcare, healthcare would give us a lot. Security as well.

Q. How do you mean by security, sorry?

A. Security would -- obviously, if they had findings or incidents, routinely they would send a referral as well. And then a lot -- quite a number as well self-referrals. So they would come to our office or doing the drop-in, they would talk to us. So we tried to be present, so like a rota, every day we were present on one wing with leaflets and spending time there talking to them so that they knew us.

Q. You would go out onto the wing and people wouldn't need to have an appointment?

A. No, no --

Q. Your office at the time, so during 2017, wasn't in an area that was accessible to detainees?

A. Yes, it was in a sterile area, which is completely -- quite isolated, so no detainee was able to come to see us without officer coming with them, which was not really good for us. It affected self-referrals and, really, the drop-ins in the office, which was a pity at that time.

Q. I think it is noted in your Verita interview that you took some effort to try and get a room that wasn't in a sterile area?

A. Yes, I tried it. If I remember, I brought it to senior management, then commissioner, in hope that they will move us somewhere closer, but without success. And previous as well, original manager who started, actually, she tried as well, but without big success. After the report, then we were able to move.
Q. After the Verita report?
A. Yes.
Q. Where is your room now?
A. We are now next to induction wing, and it is quite central, so mostly got door open, it is like a drop-in, they can come and sit, talk to us. So it's quite -- it's really good now. They can -- because the problem is, sometimes when they come, they just walk around the centre, and they learn what's there, and then obviously if we are not present, so it will take time before they will be aware that we are there, so -- but with having office so central, in -- for second day, they might be aware, "Okay, I can come there".
Q. We have heard this evidence right at the start of the inquiry, but if you are on any of the residential wings, people can just come and go as they please during unlock time?
A. Yes.
Q. They don't have to be on that wing, they can just

circulate around?
A. Yes.
Q. So a detained person could come and see you whenever they wish to?
A. Yes.
Q. Can other people see them entering your office? How discreet is the entrance?
A. Obviously, they can see them, but they can find, as well, moments when nobody can see them. It is just really to find a moment, and then we can always close the door and then talk to them.
Q. Has that increased your number of drop-ins, then?
A. Yes, obviously there are -- the quality of treatment as well.
Q. Back to referrals, then. You have been asked about a document and you have answered it to some extent in your witness statement. Can I ask for it to be put on the screen, <GDW000003> and pages 45 to 46. You referred to this in paragraph 32. Chair, you have this at tab 4 but it is on the screen as well. <GDW000003>. It goes backwards, from the bottom up. The second email down. These are emails between you and Naomi Blackwell who is an advocacy coordinator at GDWG.
A. Ah, yes, Naomi, yeah.
Q. This one is dated 27 September 2017, so just after the

relevant period, from Ms Blackwell:
"Dear Anton, hope you are well.
"Can you confirm that we both continue to agree that we can refer cases directly to you and vice versa."
Pausing there, it suggests that, up to this point, you were able to refer people to GDWG and they could refer people to your services?
A. Yes, yes.
Q. In what circumstances would you refer someone to GDWG?
A. Obviously if they needed, like, emotional support, we would refer our clients to them, then clothes, money, if they need some legal advice how to find solicitors or something like that, they had bigger list, so we didn't get involved in that. So such small things. But especially emotional support was the main, because sometimes they just needed ear to listen to them.
Q. I assume that GDWG would refer people to you when they needed help with substance abuse and alcohol?
A. Yes, though we didn't receive many referrals from them because, as I said, they were not trained in drug addiction, and they couldn't spot it as well. So I don't think they were talking about it. That's why we had this training and we offered again.
Q. If we go to the top part of that page, please, this is your response:

"I hope you are well. I was informed that referral process has to go through Welfare Office please."
So GDWG could refer to welfare and then welfare would instead refer to you?
A. Yes, that was the meaning of that email.
Q. Then if we go to page 45, this is Ms Blackwell's response to you about halfway down the page. She says:
"Can you tell me when you were informed this and by whom? If you get a chance, can we discuss this?"
Just to finish, and then I'll ask you about it. The top is your response:
"Hi Naomi, I am not allowed to give any information regarding your questions. It would be the best to contact Deputy Director Stephen Skitt who can give you more informed information."
Can you tell us why you were told, firstly, that referrals couldn't go directly from Gatwick Detainee Welfare Group to you?
A. We were asked as -- I think it was Steve, I'm not sure, I think it was him, so that we shouldn't contact -- because I cc'd him. That we shouldn't contact them. They never gave me any explanations why at that time, but obviously I just followed the process because I was trained from prison as well. Sometimes they might have some intel, inappropriate engagement with detainees,

anything like that, and they needed -- my understanding was that's probably for short time and then obviously we go back to normal. But I didn't really know why, so I didn't get that information. Later on, obviously, I read the Verita report, I got understanding why it happened, but --

Q. What understanding did you get later when you read the Verita report?

A. Obviously that there were -- the Home Office and senior management were concerned that they might do activism, so in that direction, that was my -- I might be wrong, but that was written detail.

Q. Were there any other occasions where you were told what your relationship with GDWG should or shouldn't look like?

A. No, not -- that was the only one. Otherwise, we always had very good relationships from the beginning.

Q. With GDWG?

A. Yes.

Q. Are you now taking referrals from --

A. Yes, now it is back to normal and I even added the details of their company to our induction list, so it is more holistic, so they can now get information as well and call if they need any such help.

Q. You have also helped us with other ways residents could

be referred to you -- so the welfare office could refer you to --

A. Yes.

Q. -- security?

A. Yes.

Q. Would anyone be referred to you after they'd experienced an overdose? So you said healthcare would?

A. Yes, they would.

Q. So after an acute event, even if you didn't know them to be a drug user --

A. Yes, yes.

Q. Did the person have to consent to being referred to your services?

A. No. Because sometimes they don't know that they were referred, but obviously we would always explain them we are just checking, it is beneficial for you, we just want to help, but obviously they would know because obviously, if they overdose and drugs were involved, there are some consequences, but they had always free will to say, "No, I don't want to engage with you.

Q. I don't know if you can say from your experience of working elsewhere or your knowledge of other organisations, but does the referral process work a similar way in other institutions where --

A. Yes, pretty much. It's not big difference.

Q. Finally on referrals generally, at paragraph 60 of your statement, you referred to a meeting which was after the relevant period, but only shortly after, so 31 October 2017. Again, I don't need to take you to it. You are recorded there as saying you are unsure that all referrals were being made as the turnover of staff was so high?

A. Yes. Basically, I was questioning because I experienced high turnover of staff in healthcare, in G4S, and from my experience, it is not good for detainees, for anyone, because then you don't have experienced staff. Basically, we do -- we did experience in our organisation as well. So you lose your experienced staff, and then, obviously, the younger ones take over who sometimes won't have this experience and can go in wrong way. So obviously that was my concern.

The second was as well that, when you had this big number of referrals, so -- sometimes there is a danger to forget to write a referral for us. So we did remind a few times, so that not to forget, and sometimes they were repeat users, they were already referred to us, but we always would encourage as well to refer repeat users, because what happen is, if -- they say first time they don't want to engage, but second/third time, they might change their opinion --

Q. I see.

A. -- and then they could very likely say, "It would help us with -- listen, there is a problem", and I'd say, "Really -- we can really help you", and they can -- and we have cases where they engage with us.

Q. On the second attempt --

A. Yes --

Q. -- or third attempt?

A. -- or the third.

Q. I'm going to ask you another question about a document, <CJS007112>. You have it at tab 11. It is a question I want to ask on behalf of Deighton Pierce Glynn about a specific person we refer to as D687. This is one page from D687's medical records, and you've explained SystmOne. SystmOne is a system that you and healthcare have access to. I'm not going to ask you about your entry at the bottom of the page but instead about the one in the middle of the page, 5 May 2017. It is the one with the redactions on it. It says:

"History: Went to A wing to see D687 following call received from Oscar 1 who reported that he was informed that D687 told a Mr Bole (RAPT) that he is going to take an overdose."

It goes on to say what happened. So it looks like D687 told you he was going to take an overdose, you told

Oscar One, Oscar One told a nurse, the nurse goes to see D687. Is that a normal way referrals work?

A. Normally, it would be -- I believe here that he was on ACDT as well. So obviously he was monitored because he was quite vulnerable at the time, if I remember why he was -- he came to UK as a child and there was a process to be deported, as a young man. And it was really stressful for him. Yes, for any such information I would go straight to Oscar One. I would update as well his ACDT. Obviously, Oscar One, he warned staff as well on the wing.

Q. Why going to Oscar One rather than going to healthcare?

A. Oscar One was responsible for all operational and he can then, as well, order officer to monitor him better so that they can increase monitoring, yeah, hours, so it might be if he was before every two hours, he could be half an hour, he's got that power.

Q. Are you able to open an ACDT?

A. Yes, yes.

Q. If you think back to May 2017, or if you can't remember precisely, think generally back to your memories of D687, what can you tell us about how he was around this time? What were your concerns about him?

A. As I mentioned, he was very -- as I remember him, he was very distressed. Obviously threatening that he's going

to take an overdose, that was real, because obviously he didn't want to go back to his country. He came here as a child. I know he was five or six years old. He's done all schools here. He looked -- he even told me, "Look, Anton, I'm looking as British, my accent is British, I don't speak the language of my African country and I don't have any relatives there as well, so if I -- if they deport me, probably I will die there". That was really the main -- what was his issue.

Q. He's obviously expressed a specific concern to you that he's going to take an overdose on this day.

A. Yes.

Q. Do you remember whether he said similar things to you at other times or if it was just this occasion?

A. If I remember, he threatened -- I think he was on ACDT, so he'd threatened to kill himself a few times, so that's -- my recollection is still there.

Q. Thank you. That's all I wanted to ask you about that document and that individual. Just turning to one-to-one sessions, you set out in your paragraphs 34 to 48 that you would do both one-to-one sessions and group sessions with detained people. During one-to one-sessions, would residents share issues with you outside of their substance abuse, for example, histories of being mistreated, tortured in their home country?

A. In all my years, it was never, never done before. They wouldn't tell me; "I was mistreated by officer or staff", or anything like that.

Q. Not mistreated by staff within the centre?

A. Within the centre, yes.

Q. What about bullying by other detained people?

A. Normally -- the problem is, because they -- they are afraid of -- if they report to me, and then I report to security, and they then discipline that person and it is known that it was him who was reporting, he might be in big trouble, so that's the main problem.

Q. What about if somebody told you about mistreatment that had happened before they came to the UK?

A. Obviously the thing is, our clients are mostly ex-prisoners, so -- and from the community they had some sort of settled life, so for them to be able to do our therapeutic work, they have to have some settled life. If they are really very distressed, it's hard to do one-to-one sessions. Sometimes as well, when they come detoxing for methadone, sometimes we wait for a while, that they stabilise and then we start with our sessions. It's sort of -- I don't believe -- yeah, what I'm saying is, if somebody is very distressed, I don't believe they would access our help as well because you need some sort of stability and being able to think through and work

through.

Q. You develop with detained people you're working with a plan, a care plan?

A. Yes, yes.

Q. How does the fact that these people may be removed from the UK affect your ability to plan forward?

A. Obviously it did affect, yes. So it was quite different than we would do in prison. Because in prison, like, six weeks prior to release, we would open release plan and then try to get referral to drug intervention programme to community, but here, because sometimes they are released on such short notice, four hours' notice, it's often really hard to prepare anything for them. So that's why during the initial assessment we would talk about DIP team that it's possible to really be -- to engage with them if you know the location, as soon as you know, let us arrange, give the details and everything, but in most of the cases it didn't happen because the release short notice is so short. But I did always explain them how to find DIP team, they can always call us as well and we can then find for them. So we tried to really expand the possibility the treatment will carry on.

Then, obviously, if they go to EU country, so we'd now really introduce as well they don't need to be

detoxed very fast, methadone, they don't need to have methadone detox very fast, but they can finish detox in the EU countries because they all got opiates treatment.

Q. Some people stayed in Brook House for very long periods of time, up to a year, two years. Were you able to work on longer-term projects with them or -- for example, I think the 12-step programme is quite a prolonged programme?

A. Yes.

Q. Is that something you were able to do with people who were there for a long time?

A. Yes. So we didn't have many clients who were such long time. I remember in my mind only two, one or two. So, obviously, we would complete -- what we have is, like, six sessions we offer them, then we review, and then you can offer more. So it's to see what is their interest.

So if somebody was interested in 12 steps, one to one, we were able to offer that. So obviously in limited way, but we have some, you know, packs. We had, like, if I've got it here somewhere, all interventions written what we offer. It's number 2.

Q. Yes, tab 2.

A. Obviously, they could always choose from there and update. So if they find that they need more, we are happy to work with them.

Q. I'll just give the reference to the document you just referred to for anyone else's note. It is <FWT000002> and that's a list of your group and one-to-one sessions you were offering. Thank you.

Can I ask, apart from your planned work with residents, did you have a role in dealing with acute events, for example, when somebody on the wings had had an adverse reaction to spice. Were you involved in those responses?

A. No, only nurses. Because I'm not medical trained.

Q. When somebody was -- had an event like this or was suspected to have had an event because of drug use, do you know how it was verified what had led to that, what drug they had taken?

A. Obviously, they would refer them to us so then we would talk to them and normally then we could identify what drug was and why, what happened.

Q. By asking them?

A. Yes, yes. But obviously, as well, nurses would write a form as well, social -- or summary so that we would know what we can expect. And then obviously you could always read as well on SystmOne their notes, so it would be helpful as well so we go to them prepared.

Q. In your statement at paragraph 63, you talk about your relationship with the management, both G4S and then you

go on to talk about your current management. At 63, you say that most of the time you felt you were supported during the relevant period. In what ways do you think support could have been better?

A. Obviously, when I came to Gatwick IRC, I -- obviously it was everything new to me, but I remember, at that time, deputy director would call me in his office and he would just ask me, like a human, "How are you? How are you doing?" So that was really a nice gesture.

Q. What's the name of that director?

A. Steve Skitt. That was really nice. I found it really motivational and sort of helpful. As well, obviously, later on as well, I found senior management, especially, obviously, I was talking mostly deputy director, so then, later on, Sarah took over and she was, as well, very open, they had open-door policy, so actually everyone who wanted to talk to them could talk. Obviously that one, the door was always open there, so that's -- but -- so improvement, obviously, was really the office.

Q. Yes.

A. So that I felt it was a bit -- it took too long to move us and there was not really understanding of the nature of our service. So that was the main problem. But later on, then, Michelle as well, she was very helpful

and introduced acupuncture. I can't complain, yes, really.

Q. Now you're with PPG. Obviously, you've only just transferred?

A. Yes, just 1 September, yes.

Q. And you say that management there has been supportive?

A. Yes. Obviously, it is a short -- it is a very short time, but so far I've found it, yeah, I don't have any concerns or any complaints, but it's really short time there to say anything really more, too early for anything.

Q. On to the reason we are here, so you saw the Panorama documentary of course?

A. Yes.

Q. And you're aware of the issues that gave rise to this inquiry, and you say, and you said to us just now, you weren't aware of the physical and verbal abuse or anything of that nature?

A. No.

Q. And it wasn't reported to you?

A. No, no. I find it really -- at that time, I was quite shocked that these things are happening, because I personally would react. But the other -- we were not involved in incidents, we were not involved in restraint, so when this abuse happened, and obviously it

seems to me none of our clients as well was really restrained heavily like any -- or had any problems like that. It seems to me it was a certain number, but I don't -- I don't think it was, like, majority of officers involved in that.

Q. You reflected in your statement of why you might not have even heard rumours or why people wouldn't have reported this sort of thing to Forward Trust. And you add:

"I consider this was probably due to concerns about repercussions for those who made whistleblowing disclosures."

This is at 87.

A. Yes.

Q. What repercussions do you think people were afraid of?

A. Obviously, it can be revenge towards them. That was obviously my -- for my understanding. Later on, I did read the Gatwick Detainee Group report, I have seen revenge did happen, like one detainee reported that the drugs were coming and he reported an officer, and he was then -- revenge -- revenge came on to him. So sort of -- there is fear, and obviously as well it was reported as well that one officer's reported doing some misbehaviour and she was demoted. So this -- obviously they knew that can happen to them. So that's

they report. It is really sad for me to hear that. Because I was never aware of it.

Q. Then I wanted to move on to any improvements or suggestions that you set out. So you say at paragraph 58 of your statement:

"I think it would help if the Forward Trust offered level 2/3 counselling courses to all staff (not just those who worked on programmes)to enable them to have a better understanding of addiction. However, my understanding is that funding prevented this."

When you say "not just those who worked on programmes", so not just Forward Trust stuff, but all --

A. No, the programme is -- within the Forward Trust, we would run certain more intensive programmes, like the Bridge, six weeks long; then rehab, (inaudible). So we would train workers in counselling. So level 3 as minimum to be able to deliver and facilitate, so groups. So I did experience that other staff, who were not really involved in such intensive programmes, wished as well to do some such education, but obviously it was limited just to -- really to problem staff.

I understand, obviously, funding was -- prevented this, but it would still be nice, because I think it enhanced, really, the ability of workers, and levels 2 and 3, it's not so much that is not possible.

obviously -- I don't believe -- if you know all these facts, you wouldn't come to us and report to us, because we would report straight away to security and obviously, if they are afraid there would be leakage from security, then they wouldn't even start the process.

Q. So that's about detainees not sharing their --

A. Obviously they were afraid as well, how it will affect the Home Office records, am I a troublemaker, and all this stuff can be in their heads.

Q. You said to Verita, this is from page 10 of the transcript:

"... staff don't use the whistleblowing procedures either because people don't like to be a grass. That's the main thing. 'They'll get me if I do'. Revenge and this type of thing. I think that the procedure of confidentiality has to be really assured."

A. Yes.

Q. When you say "They'll get me if I do", who are you referring to?

A. Just in general. I didn't have any case that somebody who told me that, but I just clarify that's what could happen. And obviously, again, when I read the report later on, actually these things did happen, and so it seems to me there was a clique of officers who actually would mistreat other people who were not with them or if

Q. Just in rough terms, what's the sort of time commitment of a course like that? Is it something you can do in a week, is it a year-long course --

A. I have done level 3 in six months and level 2 in six months, yes.

Q. Part time or full time?

A. Part time, yeah.

Q. Obviously it's early days since you transferred to PPG. We have heard only a couple of months. You mentioned you were completing your induction training when you wrote your statement?

A. Yes.

Q. Is that now complete?

A. Most of it, I would say, yes.

Q. Obviously we are in a situation where I think it is a bit different because of the coronavirus. Is the centre quieter generally at the moment?

A. Yes, it is, yes. It's much quieter. Because we have got less people in the centre and they don't mix. It's just association time for one wing when they can come out. Yes, it is much quieter. And each has got his own room most of the time.

Q. Most of them have their own room?

A. Yes.

Q. What's that meant in terms of your workload? Are you

still dealing with a lot of people with substance misuse issues or has it reduced with the numbers?
A. The caseload has reduced, yes, so that we don't have so much. But you've got a lot of outreach work. We do a lot of drop-ins and inductions, that's still going on. Sometimes it's -- just last time, I had a case where he said he is going to be deported in two weeks. That's why he can't work with us. And during the drop-in, I have talked with him almost one hour about his drug issues and consequence of using. Actually, it was done in that outreach. And that's -- I have quite a few. Another case I had with another detainee, who actually tried to persuade me how cannabis is beneficial and that we shouldn't really be talking against, and then obviously, again, talking the pros/cons, cannabis consequence of using. So maybe not really -- we don't see this work, but it does prevent.
Q. So it's not your formal planned sessions?
A. Yes, not really one to one where you would really put on care plan.
MS MOORE: Thank you for the update. I have no further questions for Mr Bole. I'm going to ask if the chair has anything she would like to ask you?
THE CHAIR: Yes, just one short question. In your experience, did you have detainees speaking to you about

some of the other consequences of drug taking, such as running up debts and that causing other problems on the units?
A. Yes, they would, yes. So we would -- obviously, when we talk about consequences, even in the groups, we would always emphasise the physical one, the social one as well. So, like, they had family issues, not being there for children, so we would mention that, yes.
THE CHAIR: In your experience, when there was a lot of spice at Brook House, were the problems with debts the same as they would have been with other forms of drug use?
A. I didn't get it. Would you be able to repeat the question?
THE CHAIR: Of course. In your experience, did detainees have the same issues with running up debts when we are talking about spice as if we were talking about other types of drugs? If we were talking about crack cocaine or heroin, was it the same problem?
A. They wouldn't really talk about -- much about debt, so that one is -- I don't remember really talking to us, because obviously it would be then debt to dealers or -- and obviously it would expose him, but we -- like, we used to have as well, or not now, but drug dealers as well would work with us, and then it would actually go

with -- we would discuss as well and explain what damage drug dealing can do, debts, put in other debts as well, and affecting other lives, so things doing that.
THE CHAIR: When you say you had drug dealers working with you, do you mean they came to you as a client for support?
A. Yes, yes. We had even one peer supporter who really changed his view as a drug dealer.
THE CHAIR: Thank you. That's all my questions.
MS MOORE: Thank you, Mr Bole. Chair, we have one more witness today, Mr MacPherson, but I wonder if now would be a good time for a 15-minute break and then we can hear his evidence after the break?
THE CHAIR: That sounds like a good idea. If I can just thank you for coming and giving evidence.
A. Thank you.
THE CHAIR: I know it is not an easy experience and I do really appreciate it. We will return at 3.20 pm.
(The witness withdrew)
(3.05 pm)
(A short break)
(3.18 pm)
MR JAMIE TREVOR MACPHERSON (affirmed)

Examination by MS TOWNSHEND
MS TOWNSHEND: Chair, before we start this witness, I just wanted to check that everybody was okay to sit until 4.30 pm, if necessary.
THE CHAIR: That's certainly fine from my point of view. No objections from anybody? Is that okay with you, Mr MacPherson?
A. That's absolutely fine.
MS TOWNSHEND: I'm grateful, chair.
Chair, we now hear from Mr Jamie MacPherson. He is the first of our witnesses from Gatwick Detainee Welfare Group, which I'll call GDWG. He was a volunteer visitor but tomorrow you will hear from the current director, Anna Pincus, and the former director during the relevant period, who is James Wilson.
Mr MacPherson, if we can start. Please could you give your full name to the inquiry?
A. Yes, Jamie Trevor MacPherson.
Q. Mr MacPherson, is it correct that you have written a witness statement which is dated 19 May of this year?
A. That's correct.
Q. Chair, the inquiry reference is <INQ0000027>. I would ask that Mr MacPherson's witness statement is adduced into evidence in its entirety?
THE CHAIR: Indeed. Thank you very much.

MS TOWNSHEND: Mr MacPherson, I want to deal with six topics. The first is about GDWG more generally and your role as a volunteer visitor. The second is about your experience of attending Brook House as a visitor. The third is in relation to complaints and healthcare. The fourth is in relation to the complaints made by D191. The fifth is barriers to reporting. And the sixth is, after Panorama, improvements and recommendations. If we can start with some background, as you are the first witness to give evidence in relation to the role of GDWG, I am just going to go through quickly GDWG's purpose, and you can tell me whether you agree with that or not.

A. Okay.

Q. I have taken this from Anna Pincus's witness statement to this inquiry, reference <DPG000002>. I don't wish to take the inquiry to it, but I will summarise paragraphs 7, 9 and 10.

GDWG is a registered charity that provides a wide range of emotional and practical support to detained persons held at Gatwick Immigration Removal Centres -- that's Brook House and Tinsley House. The charity was set up in 1995 and the charity has worked with detained people at Brook House since Brook House opened in 2009.

Ms Pincus describes a network of trained volunteer

visitors, one of which you are, and also advocacy coordinators, who co-ordinate and support the work of volunteer visitors and provide support and advocacy for detainees. Is that correct, from your understanding?

A. That is correct, yes.

Q. Secondly, I'd like to explore your role. You have been a volunteer visitor for ten years; is that correct?

A. That's correct.

Q. You first visited Gatwick Immigration Removal Centres, both Brook House and Tinsley House, in 2011?

A. Yes.

Q. You have also been a trustee of the charity for five and a half years?

A. That's correct, yes.

Q. Firstly, may I ask, are you still a volunteer?

A. I am.

Q. When was the last time you visited Brook House?

A. It would have been just before the pandemic, the first lockdown. So it would have been around April 2020.

Q. Have you been able to continue, in any way, your volunteer role?

A. Yes. When the pandemic started, I was supporting somebody via the telephone for about four/five weeks before he was released.

Q. In terms of your role as a volunteer visitor, you

describe in your witness statement at paragraphs 1 to 5 that you provide support for those held in Gatwick Immigration Removal Centres and that you are paired with a detained person and then commit to visit them on a weekly basis for about an hour, and that you are usually paired with one detained person for the duration of their whole detention. You provide support and assist them with practical things, such as clothing and phone cards, but you also act as befrienders and provide emotional support. Do you have anything to add to that, in terms of your role as a volunteer visitor?

A. No. I would say that's a correct description. Primarily, we are there to befriend people in detention and also to -- yeah, to offer and relay messages back to the office, in terms of whether they need clothing or phone cards, that kind of thing.

Q. In terms of pairing with a detained person -- this is your paragraphs 6 and 7 of your statement -- you personally are often matched with more distressed detained persons, people who are detained for longer, and that's due to your experience. Is that correct?

A. Yes. Certainly it's the case now. It wouldn't have been the case when I first started visiting. But now, yes, definitely. We would try not to pair people that have just started visiting with people with -- that we

perceive to have mental health problems, or particularly if they're distressed in some way.

Q. You've previously visited three detained persons who were detained at Brook House for more than one year?

A. That's correct.

Q. Of those three detained persons, did you visit any of those detained persons within the relevant period, so within April to August 2017?

A. Yes. One of those people.

Q. Usually, as we have just discussed, you would see them on a weekly basis for about an hour. Was that right in respect of the people that you saw who had been detained over a year?

A. Yes, it was.

Q. Given those weekly intervals, were you able to build a rapport and a relationship of trust during this period?

A. I believe so. I mean, it all depended on the individual. Some people are more open than others. But generally, yes. I mean, over that period of time, you get to know somebody quite well.

Q. Once you've been paired with somebody and you've visited them, there would be follow-up work. At paragraph 8 of your statement, you say that each detained person is allocated a caseworker and that you have a duty to then

alert the central office if a detained person raises concerns about basic issues. You give examples of those, like accessing a solicitor, contacting Bail for Immigration Detainees, a charity who deals with bail applications, and requesting rule 35 reports. How often did those kinds of issues arise which meant that you had to contact central office?

A. It depended on the individuals, again, and it depended on the length of time that they were in detention. It depended on whether they had any particular healthcare issues. Healthcare issues were the main complaints that were given to us by people in detention. I would have thought, perhaps not after every visit, but certainly on quite a regular basis.

Q. You said about healthcare issues. We will touch upon those later. Would they go under the category of basic issues which you were under a duty to report to central office?

A. I wouldn't say we were under a duty to report. I think it was encouraged that we report those issues back to the office, to the caseworker, and then they could decide how and when to follow those up with G4S.

Q. This is a question that G4S have asked me to ask. Was this duty to report or, as you said, encouragement to report, monitored or enforced in any way?

A. I don't think it was enforced. That would be the wrong word. I mean, it would certainly be monitored. If we reported something, it would be logged, it would go into the database, and there would usually be a follow-up. Perhaps their caseworker in the office would phone us up on the next visit and ask us if anything had changed, if they'd seen healthcare or if the problem had been sorted.

Q. You also say that central office would then investigate the matter if they deemed it appropriate to do so. Do you know if there was a particular policy governing whether or not central office would investigate the matter?

A. I wasn't aware of any particular policy. I think they would -- because of the amount of complaints that we received from people in detention, I think the office would have to be careful and would have to pick and choose which of those complaints they raised with G4S. Otherwise, we would just be constantly complaining, which I believe they thought we were anyway. So they would -- I guess they would have to decide which ones were worth pursuing. They couldn't pursue every single complaint. There were too many.

Q. We will go into more detail on that in a moment. In terms of complaints, as we are on that subject, in terms

of your role as a volunteer visitor, you say at paragraph 10 that it wasn't your role to deal with complaints, but, rather, that was the advocacy support volunteer's. What was the difference between your role as a volunteer visitor and the role of an advocacy support volunteer?

A. The advocacy support volunteer came in at a later date. I'm not quite sure when we started using those. They were office based. They came in maybe one day a week, two days a week, depending on how much free time they had, and they would assist the advocacy coordinators who did casework on behalf of the detained person.

So it was a different role. Our role, it was made quite clear, we weren't there to liaise or to deal with G4S. We were there purely to befriend the person. If we had issues, then we related those back to the office.

Q. At paragraph 11 of your statement, you explain that you suggested to a detained person that they make a complaint to the IMB, the Independent Monitoring Board. IMB told GDWG that detained persons should contact them directly and that IMB would then take up the complaint with G4S, you say. What was the complaint about?

A. I really don't remember what that particular complaint was about. I remember that there was an issue where G4S and the IMB had told the GDWG office that detainees should make the complaint, that we shouldn't be complaining on their behalf.

Q. Do you know, in fact, if the detained person did make a complaint through IMB?

A. I don't for definite know. They were hesitant to at the time. They tended to perceive the IMB as an extension of G4S. I think he was quite dismissive of actually making a complaint. He didn't think it would go anywhere.

Q. When you say "they", who do you mean?

A. Sorry, the detained person.

Q. You said that you thought that detained persons perceived the IMB as being a branch of G4S. Why did you think that?

A. We were told that they would walk around the centre, they had keys, they had access to all areas --

Q. Just to pause there. When you say "they", are you talking about IMB this time?

A. Sorry, yes, IMB. So they had free access around the wings. Organisations like GDWG didn't. We weren't allowed onto the wings. We didn't go any further than the visits hall. So I think they didn't really differentiate between -- they thought they were part of the organisation. I think the detained people felt that

the IMB were all part of the system, as it were.
Q. Do you know this because you were told by a detained person, or how did you form that view?
A. I have been told by at least one detained person that I remember, yes.
Q. What is your opinion as to the independence or otherwise of the IMB?
A. I didn't really have any formed opinion on that. I had no contact with the IMB at all whilst a visitor. I was never approached by the IMB. I had no idea who they were. I don't ever remember seeing anybody in the visits hall that was an IMB member.
Q. At paragraph 13 of your witness statement, you say that you were not aware of any other means by which GDWG or detained persons could complain directly to the Home Office. This is a question that the Home Office would like the inquiry to ask. Were you aware of complaint forms that detained persons could access from the library?
A. We were told -- yes, and the caseworkers working at GDWG had told us that there were complaint forms available for people in detention to make complaints and we would pass that information on. I think most detained persons that I visited were aware of those complaint forms.
Q. I want to ask you now, moving on to the second topic,

about your experience of attending Brook House as a visitor. I just want to run through first what exactly happens when you arrive, how you get to see a detained person, and so on. In terms of booking a slot, you deal with that at paragraphs 21 and 22 of your statement. In 2017, it was only possible to book -- see one detained person per slot. Is that right?
A. That's correct.
Q. How long was the slot?
A. It would be an afternoon slot or an evening slot.
Q. How many hours was each afternoon or evening slot?
A. I think it was 2.00 till 5.00 and then 6.00 until 9.00 -- 8.30/9.00.
Q. Does that mean you got to see, you could see, a detained person for the whole of the three-hour slot, if you wanted to, or were they broken down into one-hour slots?
A. No, you could visit somebody for the whole period.
Q. How long, roughly, did you usually spend with a detained person, if it's possible to generalise?
A. Generally about an hour, and I felt that an hour was usually long enough -- yeah, long enough for both parties, I think. An hour is quite a long time.
Q. We will see. What effect did this have, only being able to see one person per slot, on your work as a volunteer

visitor?
A. On most occasions, it didn't really matter. There were some occasions when it became problematic. If we were trying to cover for somebody, another visitor, that was on holiday and we'd been asked to see their detained person as well, it would have been nice to fit them both into one afternoon session or an evening session.
The other situation where it became very difficult was if the detained person we were visiting didn't speak very good English or had no English. They couldn't bring their cellmate or another detained person along with them to act as an interpreter.
Q. We will come on to language difficulties in a moment. Do you know the rationale behind the fact that you could only see one detained person in that three-hour slot?
A. I don't, I'm sorry. I did ask on a couple of occasions, and I was just informed that that was G4S policy.
Q. So we have booked a slot as a volunteer visitor, and now we will go to the registration of you as a person who is going to visit somebody. You would register at the gatehouse -- this is paragraphs 23 to 25 of your statement. Your passport would be checked. You would be photographed, given a wrist band and lanyard, a picture would be taken of you every time you went in, you would be given a locker, and a small amount of

change which you could use in a vending machine, presumably in order to buy a coffee or something for you and the detained person you were visiting?
A. Yes, that's correct.
Q. You say that you could take a pen and notebook in, in the relevant period in 2017, but, in 2018, G4S stopped this without an explanation, but you say more recently they have allowed that to happen again. When you say "more recently", how recently?
A. I'm not entirely sure of that. Yeah, I'm sorry, I don't know the dates. I just remember that --
Q. Does it coincide with a change of company, so Serco taking over in May of this year?
A. No, it would have been before that, when G4S was still running the centre. I've not been since Serco have taken over.
Q. You say, at paragraph 25, that they never explained why, that is, why you weren't allowed to bring a pen and notebook in. Do you have any idea why they implemented the policy?
A. None whatsoever.
Q. How did the lack of writing materials affect the service that you could provide?
A. It was difficult and we would quite often -- I would personally make notes of what the person was saying, if

they were having problems with healthcare or other issues. It was very handy to take notes and it helped us report back to the office afterwards. Otherwise, it was -- you had to commit everything to memory.

Q. So we have been through the gate, we have been through registration and now we are at reception where you have to go through an air lock, security air lock. Then you arrive in the visits hall. This is paragraphs 31 to 37 of your statement. No need to look through them.

You said that often there were delays in bringing detained persons out. On average, how long would you have to wait for a detained person to be brought out?

A. Once we were in the visits hall, do you mean?

Q. Yes.

A. It would vary. I mean, some people, detained people, would be actually in the visits hall corridor waiting for us, so as soon as we arrived, they would come in. Other people, there may be a delay, they might have been down in the medical centre, they could have been in the gym or an area of the wings where they couldn't hear their name called over the tannoy.

Usually, it wasn't too long, but sometimes it could be up to half an hour.

Q. Do you know why there were delays?

A. We'd usually just be told that the person just hadn't

responded to the tannoy, that they hadn't come up. Sometimes I'd be told by the detained person that they didn't -- just simply didn't recognise the name that they were calling out as being their name.

Q. Why was that?

A. I think they were often mispronounced. So it just didn't sound familiar to them.

Q. Can you give us an idea of how big the visits hall was, roughly? Was it the size of this room, half the room, double?

A. I would say approximately about the size of this room.

Q. How many sort of groups of tables and chairs would there be?

A. Probably about 20 chairs and tables.

Q. So there was room for 20 groups of people to sit, visitors and detainees together on a table?

A. Yes, I think so, yes, around about that number.

Q. Was it usually full or usually empty? Or was it varied?

A. It would depend on the time of day, it would depend sometimes on the time of the month, really -- sometimes I've been there when it's been quite full, and other times when I've been the only visitor.

Q. What would the officers be doing whilst you were speaking to the detained person at the table and chairs?

A. They'd -- generally, there were two officers. They

would generally sit behind the desk. Approximately every ten to 15 minutes, one of them would get up and they would patrol the visits hall. They would just walk around the tables slowly and then return to the desk again.

Q. How easy would you say it was for detention custody officers to overhear conversations?

A. I think it would be very easy. I have no idea whether they were listening. It was hard to tell. But I think it wouldn't be hard for them to overhear conversations.

Q. What effect, if any, do you think that had on detained persons' ability to speak about any distressing subjects?

A. Most detained people would go quiet when an officer walked past. Noticeably, they would just either go very quiet or stop talking and, when they passed, they would carry on with what they were saying. I think they would be unlikely to tell us troubling things if they thought they were going to be overheard.

Q. Paragraph 34 of your statement. You have said:

"We were to shake hands and/or hug. Officers did not like prolonged physical contact."

Why do you think -- what made you think that officers didn't like prolonged physical contact with detained persons?

A. Well, I saw them breaking up couples if they were holding each other too long. So I actually saw that on numerous occasions. It was usually with friends and family of a detained person, because GDWG visitors didn't often hug them. They would give them a quick hug or shake their hand, but that was it. So it was mostly with the detained person's family or friends.

Q. Have you or any volunteer visitors that you have seen previously been reprimanded by officers for physical contact?

A. Nobody I know at the time. There was a complaint made to the GDWG office from G4S that said one of the visitors was holding hands with a detained person during their visit and I believe they thought that was unprofessional and unnecessary, which to me seemed very surprising that they could come to that judgment without knowing the circumstances of why they were doing that. It's a natural thing to do, to try and comfort somebody if they're distressed, so why they should perceive that as a threat, as a security threat, or a breach of any kind of policy, I'm not sure.

Q. The volunteer visits took place in the visitors hall. Do you know where legal visits and GDWG's advocacy support volunteers' took place?

A. Yes. There were rooms, there were legal visits rooms,

off the visits hall, and I think at one time we -- the advocacy volunteers were visiting inside the visits hall with -- and doing drop-ins, and then they managed to persuade G4S to be able to use the legal visits rooms.

Q. Did you ever have volunteer visits in that place?

A. No, never.

Q. Do you think that would be a good idea, to have those volunteer visits in that space?

A. I think it would be good and I think it would be particularly useful for visitors and for friends and family of detained people at times when they were about to be removed or if they were particularly distressed, just to give a level of privacy.

Q. Have you ever asked to use that space?

A. I never have. It just never occurred to me that it would be available to us.

Q. I want to ask about the conversations in general that you had with detained persons. You say at paragraphs 38 and 39 of your witness statement that conversations were varied, some people liked to talk about simple things, like the weather or sport, and others wanted to talk about their case or anything but their case, and some would raise concerns about their treatment, for example, you said earlier about healthcare complaints. Overall, did you find that detained persons mostly raised issues

to do with their immigration case or was it more their treatment in immigration detention?

A. They raised issues and frustrations about the lack of correspondence between the Home Office and the detained person. They found it very difficult to get information about the progress of their case. This was particularly frustrating for people that had signed up for voluntary return, that were told at the time that they would probably only be in Brook House for a matter of a couple of weeks before they were returned home, only to find themselves, a year later, still in Brook House and unable to get information from the Home Office, unable to get bail because the Home Office would say that their removal was imminent and they were about to issue travel documents, and then several months would go by and they'd still be in the same position.

Q. In terms of the issues that they were raising, were they more to do with their immigration case or more to do with their treatment at Brook House, or was it difficult to say?

A. It would depend on the individual. Some detained people had great concerns about the healthcare they were receiving or the lack of healthcare, and that was their main concern. I think it depends on what their priority is at the time. I mean, obviously, if you have severe

healthcare issues and you're not getting treatment, then that is your priority. If those are addressed and you feel reassured that you are being cared for, then they might become more concerned with their immigration case and how that's progressing.

Q. I want to now ask you about the conversations you had and the language barriers that you had talking to detained persons. You deal with this at paragraphs 40 to 43 of your witness statement. How did you communicate with detained persons for whom English wasn't their first language?

A. With difficulty. It was very hard. We had no translation devices. There were a few basic dictionaries in the visits hall that we had placed there which we were allowed to put in there. There was one time when I was visiting a guy from Iran who spoke no English. He sat there for an hour with a dictionary just picking out odd words. But it was frustrating. It was frustrating for him, it was frustrating for me. There is only so much help you can give people in that situation.

Q. You referred to devices, translation devices. What kind of devices are you talking about?

A. We looked into electronic translation devices that could do sort of basic interpretation for us. Unfortunately,

they all required WiFi and there was no WiFi in the visits hall and we were not allowed to bring in any electronic devices anyway, so that really came to nothing.

Q. Is there still no WiFi in the visits hall?

A. Not to my knowledge, no.

Q. You also talk about the possibility of using other detained persons as interpreters. Was that permitted?

A. That happened to me on one occasion and one occasion only. I don't know why they allowed the person to bring in another detained person on that occasion. But certainly, when I requested that on other occasions, it was just denied and said it wasn't allowed. We were only allowed to visit one detained person at a time.

Q. I want to bring up, now, a document, <GDW000003>. That's tab 5 of your bundle, madam. Turn to page 22 of that document. It is an email there on 13 April, at the bottom, from James Wilson, who was the director at the time of GDWG, to Stephen Skitt, who is from -- works at G4S. It says:

"One of our visitors ... -- is visiting a detainee called [X]. She had a visit booked on Tuesday this week ... but was unable to have much of a conversation ... as he needs an interpreter ... had requested that another detainee ... room number ... be allowed to come

into the visits hall to interpret for him. However, this was denied by the staff on duty that day.

"Would it be possible for permission to be granted for ... to accompany [X] to subsequent visits that ... books with [X]. We are concerned that if this does not happen [X] will not be able to communicate with [X] and a vital form of social support will not be available. If visits continue then [X] will try to help [X] practice his English and we would hope that the need for an interpreter will gradually reduce."

If we can just then turn to the page just before that, and we will see the response. Just right at the bottom there, 19 April:

"Good morning, James. I am getting numerous requests for translators can we please discuss before I make any further decisions."

We have just spoken about requests for detained persons -- to use other detained persons as interpreters. Was this -- were you one of those people who was making those numerous requests? Was that something that you felt was necessary when visiting detained persons?

A. Yes. On occasions, depending on the person that I was paired with, the detained person, but it wasn't -- it was most visitors, on occasions, found the same

frustrations and difficulties.

Q. Did GDWG ever provide interpreters?

A. We had telephone interpreters. Unfortunately, that was no use in the visits hall. We did have a number --

Q. Can I pause there, why was it no use?

A. Well, there were no telephones. They used a telephone interpreting service when they were doing drop-ins. We started recruiting volunteer interpreters to help. We do have certain languages that we have volunteer interpreters now that can accompany a visitor into the visits hall, if necessary, but the number of languages that we can provide for is quite limited.

Q. At paragraph 46 of your statement -- I'm going to read it out and then I'm going to ask a question. You say:

"Although there were some kind and helpful staff members at Brook House during the relevant period that I believe were working to help those retained in Brook House in difficult circumstances, I was disturbed at times to see other staff members' approach to non-GDWG visitors (eg, detained individuals' friends and family). For some context, most volunteer visitors are white, whilst the detained individuals' family members are often not. I felt that some of the Brook House staff spoke to the volunteer visitors differently from the way that they spoke to detained [persons'] family

members and friends. In particular I think that the way staff members raised their voices and used a disrespectful tone when speaking with detained [persons'] families and friends could be interpreted as being racist and discriminatory."

What made you think that this difference in treatment between the way volunteer visitors were treated and detainees' family and friends were treated -- what made you think that was racist and discriminatory?

A. That mostly refers to the reception, the booking-in area, where we would walk to the desk and we would -- you know, we'd have no problems, we'd be greeted politely, we would fill out the forms and have our photo taken and there would be no issues. I witnessed, on numerous occasions, where friends and family of detained people, who were not white, that were -- had difficulties understanding the English, didn't fully understand what was being required of them, and voices would just become raised, they would just talk to them in -- which felt a very rude way, really, that I didn't think was appropriate.

Q. You've mentioned language barriers there. Was it possible that there was -- that it was the problem with the language barrier that made it difficult to

communicate, and that was the difference?

A. On a lot of occasions, it was a language barrier, yes, but, I mean, raising your voice and constantly repeating the request doesn't really help. They didn't really try, and they weren't -- they didn't appear to be very respectful of people that didn't understand.

Q. I want to move on to the third topic I'd like to cover today, and that is complaints about healthcare. I will deal with this shortly, if I can.

Paragraph 64 of your statement. You have said, and it's something you have mentioned earlier, that healthcare and access to healthcare was probably the most common issue that detained persons would complain to you about. You said at paragraph 65:

"... shortly before the relevant period ... I was visiting D191. He saw healthcare [concerning] toothache."

You say it was approximately six months from the date of his initial complaint to healthcare before he received treatment. You go on to talk about that treatment, or, as you said, lack of treatment. How did you know this?

A. Well, he told me at the time. He suffered for many months with a tooth infection, and he was clearly in a lot of pain. I could see that during the visits. He

was distracted, he found it difficult to talk about anything else but the pain in his tooth, and he'd been to healthcare and he felt that he wasn't really being listened to and he wasn't getting any treatment, apart from paracetamol.

Q. Those observations were throughout the visies or just on the initial visit or what?

A. Throughout that period, until he finally had the tooth removed.

Q. At paragraphs 66 to 68 of your statement, you say that detained persons told you that there was an issue where medication was removed from detained persons on arrival at Brook House and that they would then have to wait to see a doctor in order to get medicine.

You say, at paragraph 67, you would always report these issues to GDWG's central office, but the central office had to pick and choose which issues they could raise. You say that G4S told GDWG's central office that it was not GDWG's place to make complaints against healthcare. You also said almost precisely the same thing earlier this afternoon, that GDWG would have to pick and choose which complaints to take forward.

Do you know who told GDWG central office that it should not be making complaints?

A. I don't know the name of the person. I know that when

12 months prior to the relevant period in 2017 and about 14 months in total.

The second, you visited three or four times before the relevant period.

The third, you only saw them during the relevant period and visited once during that period.

And the fourth, you only saw them during the relevant period and that was on two occasions.

Is that right?

A. Yes, that's right.

Q. In terms of visiting D191, you say at paragraph 51 that you visited him from February 2016 to May 2017 and then he was moved on to an immigration removal centre near Heathrow?

A. Yes.

Q. How often did you visit him during the relevant period?

A. With the exception of holidays that I may have taken, it would have been once a week. There was two occasions when he was placed on closed visits, so on occasions he would request that I didn't visit him because he found it quite distressing seeing me on closed visits, really.

Q. Why did he find it distressing seeing you in closed visits?

A. It was very claustrophobic, it was a very small room. It had a double-glazed screen between us, so each side

I was -- I was a trustee then and it came up in one of our trustee meetings that James Wilson had a meeting with one of the management meetings. It was with management of G4S and I think the Home Office would have been there as well. And he was told in no uncertain terms that basically we should stay out of it and stick to visiting.

Q. Do you know when that was?

A. That would probably have been in maybe 2016/17. I can't say the date.

Q. Do you know if it was before -- would that have been before the Panorama documentary?

A. I believe so, yes.

Q. Did GDWG assist detainees to make complaints about healthcare?

A. I don't know what the office did, whether they actually did that. I certainly never did. I never saw it as my role. I can't say whether the advocacy coordinators did or not.

Q. I want to ask you now on the fourth topic, questions about the fourth topic, which is the complaint made by D191. During the relevant period, you visited four detained persons. You say this in your witness statement at paragraphs 48 to 50.

Number one was D191, and you visited him for

was probably no more than six feet square. There didn't seem to be any microphone, there was no grille, it was really hard to hear the other person. I think he just found it -- you know, it just wasn't really conducive to a visit -- to having a proper conversation. You had to struggle to be heard.

Q. Because you had to struggle to hear, did you have to shout?

A. You certainly had to use raised voices, yes.

Q. How often did you see him during the relevant period on closed visits?

A. I can't remember the number of times. I would say five to eight times. It was particularly interesting that -- it seemed a very arbitrary system, that I was informed that he was on closed visits for three months, but on two occasions I was allowed to visit him in the visits hall. They just sent him into the visits hall, no explanation. On other occasions when that had happened, the following week I would ask if he could come into the visits hall and they would phone security and security would say no, he must go in closed visits. So there didn't seem to be any rationale in when he was being put into closed visits. It didn't seem -- I was told that the reason for the closed visits was so he couldn't receive drugs through the visits hall, so that didn't

really make sense. It appeared to be more of a punishment. So whether something had happened and he was placed on closed visits or whether they perceived that he was behaving well and he was allowed to come into the visits hall, I don't know.

Q. Just to pick up on a couple things there, so you saw him about five to eight times during the relevant period, which was a five-month period. If you were seeing him weekly, and perhaps with a holiday or two in between, that was -- up to a half of those times that you saw him were on closed visits; would that make sense?

A. Yes, towards the end that I was visiting him, he was in closed visits a lot, yes.

Q. Do you know if he was told the reason why he was on closed visits?

A. He was told because of spice, that he was taking spice, and they believed that he was receiving it through the visits hall.

Q. You said just a moment ago that that didn't make any sense; why did you think that?

A. Because I was D191's only visitor during that time, and I knew that I wasn't providing him with spice, so I can only assume that they were doing it to punish him for taking spice, rather than for actually receiving spice.

Q. Given that's what you thought, did you make any

complaint or raise this?

A. I raised it with the director at the time, James Wilson. He told me --

Q. Just to pause there, James Wilson being the director of GDWG --

A. The director of GDWG, yes.

Q. -- rather than Brook House.

A. Yes. He told me that the relationship with G4S at that time was particularly rocky, they were making various threats to withdraw drop-ins, so he didn't feel that he could raise that with G4S without destabilising that relationship further.

So I then took it upon myself after a visit to -- I went into the visits hall and asked one of the officers to phone security to come down and talk to me, and I wanted to ask them what evidence they had that they thought I might be passing on spice to D191.

I waited in the visits hall on two occasions for over an hour, and I was told eventually that they were all too busy, they were in meetings, nobody was free to come and talk to me, and they suggested that I telephoned, which I did on at least five occasions, and I was told that, again, there was nobody free to talk to me. So I got nowhere.

Q. So you never got to the bottom of it, in the end?

A. No.

Q. You mentioned a rocky relationship between G4S and GDWG at the time. Why did you understand it to be rocky? Do you know the reason why?

A. I believe G4S thought that we were overstepping our remit, that we were going beyond the bounds of visiting and befriending. They thought that we were going too far in terms of helping detainees with casework.

Q. I want to carry on now talking about D191 and, in particular, the complaint he made regarding excessive force. You deal with this at paragraphs 58 to 61 of your witness statement.

You said that in late 2017/early 2018, you were made aware by D191 that he'd been subjected to physical mistreatment whilst at Brook House, and you were told by a WhatsApp message from his home country. How did this communication come about?

A. I was in regular, if infrequent, contact with him after his return to Somaliland. He contacted me. He said that he missed being in the UK and he liked to hear from people in the UK, so it meant a lot for him to stay in contact. So we would have a conversation -- or usually it was -- because the internet wasn't always reliable, usually it worked in the way that I would leave a message for him, a voice message, he would send one

back to me, and it was during one of those voice messages that he told me.

Q. Could you summarise very briefly as to what he told you had happened?

A. He already had a -- there was a complaint that went to the Home Office from his legal representative, because he had told them. So he was just telling me what was happening, really, as far as the complaint.

Q. He, I understand, told you -- paragraph 59 of your witness statement -- that he had been physically restrained by three officers after taking spice and that he was worried that he'd suffered a permanent injury. Now, he named an officer called "Steve", who was in management, and that he thought his hand had been broken.

A. Yes.

Q. You said that you were aware that he made a complaint to the Home Office and, in fact, he made a complaint to the Professional Standards Unit. Have you seen the Professional Standards Unit report?

A. I've seen it in the bundle I was issued with, yes.

Q. You're aware that that complaint was found to be unsubstantiated?

A. Yes.

Q. Chair, for your reference -- I don't wish to go to it --

it's <CJS002741>.
You obviously weren't present at the time of this happening; is that right?
A. Yes.
Q. So you don't have any personal knowledge of what indeed did happen?
A. That's correct.
Q. When you first heard about this from D191 by WhatsApp message, how did you feel?
A. I was shocked. I mean, I'd seen the Panorama programme. I didn't realise that any of the people I had visited might have been subject to that kind of abuse.
Q. When you were visiting him during the time, did he tell you anything about the incident, particularly about his hands, because he said he'd injured his hands?
A. No, he didn't mention it while I was visiting him. No.
Q. When you spoke to him through WhatsApp message long after the incident, did he tell you why he didn't tell you at the time that this had happened to him?
A. He did not, no. I didn't ask him. It had already gone through to the Professional Standards Unit, so I didn't really -- I knew he had a legal representative representing him, so I didn't really pursue it.
Q. In paragraph 61 of your statement, you suggest that D191's failure to tell you about his treatment during

visits might have been because he was already in enough trouble with staff. What did you mean by that?
A. Well, I knew that he -- well, because he was on closed visits -- he was taking spice, he told me, he admitted that, so I think it could be that he felt that he was already in a lot of trouble. All he wanted was to get on a flight back to Somaliland, and I don't think he would have wanted to do anything that he thought might hinder that process.
Q. I want to move on to the next topic, number 5, barriers to reporting. You say at paragraph 58 of your statement that, prior to the Panorama documentary, "it never occurred to me that physical mistreatment of detained persons at the hands of Brook House staff could be taking place". Is this because detainees had never mentioned it to you, or was there another reason?
A. It was never mentioned to me. I mean, I was unaware of the kind of physical and verbal abuse that was shown on the Panorama programme. That was new to me until I saw -- I didn't know about it until I saw the Panorama programme. There were other forms of abuse that were going on, and mistreatment, that I was aware of, such as the inadequate healthcare and the use of segregation as a form of punishment. That cropped up on numerous occasions, and I would report that back to the GDWG

office.
Q. As I understand your evidence, there seems to be two categories of reasons why you believe that detained persons didn't inform you or others about that mistreatment. I think the first can be categorised as psychological, or fear of immigration reprisals; and the second to do with physical aspects of detention and poor facilities.
Taking the first, which appear to be more psychological, you say in your statement at paragraph 62 that it was fear of immigration reprisals that may have been the reason why detained persons did not speak up about mistreatment. What made you think that?
A. I think that the detained people I visited were very wary of the Home Office. They knew that they weren't believed, their stories weren't believed. There seemed to be a culture of sort of mistrust, and I just believe that they would be extremely wary of raising any issues that they thought could impact negatively on their case.
Q. I don't wish to turn to it now, but in Anna Pincus's witness statement to this inquiry at <DPG000002>, paragraphs 78 and 79, she raises some other issues as to why it may be that detained persons didn't report mistreatment. She suggests a perceived lack of independence by detainees: they couldn't distinguish

between G4S and Home Office and GDWG. Would you agree with that?
A. It could be equally the case as well. I mean, it could be that they knew that we were an NGO, that we were not part of the system, but, on the other hand, they knew we had limitations; perhaps they perceived that we were not likely to be taken any more seriously than the detained person would be.
Q. She also suggests that detained persons may have experiences of being disbelieved by G4S and healthcare and the Home Office and, therefore, may believe that GDWG would also not believe them. Would you agree with that also?
A. I honestly couldn't say, really, whether that would be the case.
Q. James Wilson in his witness statement, <GDW000001>, paragraph 65, says:
"It is possible it might be improved if we could hold drop-in surgeries at the welfare office which is deeper into the centre."
I think he was talking about improving relationships between detained persons and GDWG in order to make complaints. Do you agree that this could assist?
A. It could do. I don't really have much experience. I mean, I don't do drop-ins. It's hard for me to

actually say whether that's -- if he says that's the case, then I would respect his answer, but, yeah, I can't really say. I mean, I would have thought it probably would. It would certainly make access easier. I think we have problems reaching out to detained persons inside the centre, and I know that G4S were extremely reluctant to allow us to have more than one drop-in with a detained person, and having one drop-in isn't usually long enough to get them to open up and tell us everything that they might want to tell us.

Q. Those drop-in sessions, they are separate, I assume, from the volunteer visitor role which you are talking about, where you could make repeat visits?

A. Yes. So they would be carried out by the advocacy coordinators. They would have a drop-in centre where I believe the detained people would have to put their name down to come to a drop-in session and, depending on how many people turned up would depend the length of time that they had to spend with that person, each individual person.

Q. But that was entirely separate from your role as a volunteer visitor?

A. Absolutely separate, yes.

Q. We have talked about the fear of immigration reprisals as a possible reason for why mistreatment wasn't raised

by detained persons with GDWG. Also, turning then to physical and poor facilities within Brook House, at paragraphs 79 to 81 you deal with poor mobile phone signal and you say that sometimes there was none on the wing at all and so that meant that detained persons had to go out of their room and try and find some signal?

A. Mmm.

Q. You say that that meant that there wasn't much privacy and it was very noisy. How did you know that?

A. If I phoned a detained person, they would tell me that they're out of their cell, that they can't -- they have no reception in there so they're out on the corridor. You could hear the noise, the banging of doors, the shouting. It was very hard to hear people and it was very hard for them to hear us.

Q. How did that affect your communication with detained persons?

A. It was very limiting. So, I mean, I could tell them I was coming to visit them on a certain day, and hopefully they understood and heard that. But it was difficult to have any kind of meaningful conversation with somebody, in the circumstances.

Q. You also mention at paragraph 82 that there was no WiFi access, but there was internet in the library. Again, how did you know the issue about there being no WiFi

access?

A. We were told by them that they -- I mean, they had -- they weren't allowed to have smart phones. They could only have phones that could make phone calls or texts. So, yeah, there was no WiFi, so they couldn't use social media, and even when they had access to the computers in the library and the IT suite, they couldn't use it for social media, they couldn't use Facebook or Instagram, or anything like that, which many of them used as their main point of contact with friends and relatives. That's how they kept in touch with people.

Q. How did that lack of WiFi affect your communication with detained persons?

A. Most of our communications were done in face-to-face visits, so, personally, I didn't find it hard for myself. I think for the detained people it would have been much better that they could have sent us messages, they could have talked to us much easier, and could have kept in more regular contact in between visits, if necessary.

Q. Presumably, by email?

A. By email or WhatsApp, or however they chose to, yeah.

Q. In your witness statement, when you're talking about recommendations, paragraphs 88(h) and (j), you suggest improved mobile phone signal and WiFi, greater privacy

during visits, that closed visits should not be used and should not be used for punitive purposes, that detained persons should be able to act as an interpreter, that you can see two people at a time, and to reduce the time going through reception centre. They're the physical things that may assist.

In Anna Pincus's witness statement -- no need to bring it up -- <DPG000002> paragraph 29, she suggests that private rooms would be preferable. We spoke about that a few moments ago. Do you think that would have assisted, for example, speaking to D191 -- not a closed visit, but a private room -- in terms of him disclosing any mistreatment?

A. I think it's highly likely he might have opened up and disclosed things if he was in a private environment. I think the visits hall was extremely public. There were people sitting next to other visitors and the detained people, and the G4S officers walking around every 10 to 15 minutes didn't really encourage people to open up.

Q. I'd like to move now on to the final topic, about after Panorama, the improvements that you have seen and recommendations. You say at paragraph 44 of your witness statement that, following Panorama being broadcast, there were a few superficial changes to the

arrangements at Brook House. For example, they made changes to the visits hall so that the furniture was less structured. This meant that visitors could move the furniture and could sit next to detained individuals that they were visiting. You describe these changes as superficial.

James Wilson in his witness statement at <GDW000001>, page 19, paragraph 59, said that things had broadly improved since Panorama; in particular, repeat visits were allowed and managers -- and in the way that managers responded to concerns raised by GDWG.

Do you have any experience about the repeat visits or about managers responding better to complaints that are made?

A. Not personally, because I wasn't involved in any day-to-day management of GDWG. I mean, we would get regular updates at trustee meetings from James Wilson, so we knew that, following Panorama, the relationship had improved somewhat, but we -- I think the feeling was that they were -- it was a "wait and see", really, to see if that lasted or if that was just a kind of a knee-jerk reaction to the Panorama programme.

Q. Since Panorama was now a few years ago now, four years ago, was it a knee-jerk reaction to Panorama, do you think, or have things generally improved?

A. I think things had generally improved a bit, up until the pandemic, and then everything changed then. I'm not sure how the situation is now, because it's still very varied, and I'm not sure how often the meetings are between director of GDWG and the management of -- well, Serco now.

Q. In terms of recommendations, you've made a few recommendations at paragraph 88 of your witness statement. If you could choose just one to emphasise, which would that be? I can take you through them very briefly.

A. Yes, I can see them here. That's quite hard. I would say --

Q. I will give you two, if absolutely necessary.

A. Thank you. I would say probably the first one being a limit on immigration detention, a time limit. Detained people find it very hard to be faced with indefinite detention. You can see people's kind of mental health unravelling over time, so I think a clear limit, so they know how long they will be held, the maximum they will be held, in detention would go a long way to help the situation.

And the other would be, probably, a radical overhaul of the healthcare system in Brook House; that it should be put on a par with healthcare that's available to

general society outside of detention. I don't see why they should be receiving an inferior healthcare than anybody else.

MS TOWNSHEND: Thank you, Mr MacPherson. I don't have any more questions for you. Chair, do you have any questions?

THE CHAIR: Two brief ones, if you don't mind.

A. Okay.

THE CHAIR: I will keep them short. I know we have got you for two more minutes.

In your experience, was the issue of perhaps not using translators -- whether that was using LanguageLine or another method -- also a problem with staff, in terms of their interaction with detained men? You talked about an incident that you observed, or perhaps a series of incidents that you observed, where you felt that staff were perhaps becoming impatient with those who couldn't understand what was being said to them. Did you ever observe them then trying to find another way to communicate with somebody who wasn't speaking English as their first language?

A. I never saw that with G4S, no. I mean, the office staff at GDWG would use LanguageLine a lot. It's quite expensive for us; quite a large amount of our budget goes on LanguageLine. So it would be nice if there were

other ways, more accessible ways, that you could talk to detainees.

THE CHAIR: Then the other question, and you may not be able to answer this, so please say if you can't, but did you also spend time at Tinsley House as well as Brook House as part of your role and would you make any comparison between the two?

A. Yes, I have been to Tinsley House on a number of occasions. Yes, it was kind of chalk and cheese. They were totally different. The situation at Tinsley House was much more relaxed. There was -- for instance, going in as a visitor, there was one locked door to go through, rather than four. The staff in the visits hall at Tinsley House didn't patrol around the room; they just sat behind the desk. Generally, the staff were friendly, helpful, they would come up and ask if they could assist with anything, if there were any issues.

So it was a totally different environment, it felt, and I know that the detained people I visited there felt that as well, that they felt a lot more relaxed, more respected, they weren't locked in their cells, they were allowed to move around. So, yeah, it was less of a prison environment.

THE CHAIR: Did your organisation have a less rocky relationship with the staff at Tinsley House?

A. I think the sort of higher management probably covered both, I think. I didn't hear of any separate kind of meetings particularly with Tinsley House. I think the meetings that were held between the director of GDWG and the senior management were probably for Brook House and Tinsley House, to the best of my knowledge.

THE CHAIR: Thank you very much. That's very helpful. Thank you, no other questions from me.

MS TOWNSHEND: Thank you, chair. Thank you very much for giving your evidence today, Mr MacPherson.

A. Thank you.

MS TOWNSHEND: Chair, I think we will reconvene tomorrow at 10.00 am.

THE CHAIR: Yes. We can have a little bit of a lie-in. Thank you, Mr MacPherson.

A. Thank you.

THE CHAIR: I know it is not easy. You have been very patient, waiting to give your evidence, and we are grateful for it. I appreciate it.

A. Thank you for allowing me to come.

(The witness withdrew)

THE CHAIR: We will reconvene at 10.00 am tomorrow.

(4.32 pm)

(The hearing was adjourned to Thursday, 9 December 2021 at 10.00 am)

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