Tuesday, 1 March 2022
(10.00 am)
THE CHAIR: Good morning.
MR LIVINGSTON: Good morning, chair. We will now be hearing from Dan Lake.
MR DANIEL LAKE (affirmed)
Examination by MR LIVINGSTON
MR LIVINGSTON: Can you give your full name, please?
A. Daniel Lake.
Q. Mr Lake, you have given an inquiry statement dated 31 January 2022. We have that at reference <BDP000002>. I am going to ask the chair to adduce that in full?
THE CHAIR: Will do, thank you.
MR LIVINGSTON: Mr Lake, what that means is your statement is now evidence to the inquiry and it means I don't have to go through each paragraph because it is already in evidence.
So I can start with your background. So you worked at Brook House from August 2016 to December 2017; is that right?
A. That's correct.
Q. Your specific role was as activities officer; yes?
A. Yes.
Q. You say in your statement, Mr Lake, that you applied because you thought the role of DCO at Brook House would

provide a steady career and steady income; is that right?
A. That's correct, yes.
Q. Was there anything in particular that gave you that impression, or was it just the idea of working for a big company?
A. Yeah, just a big company. I'd worked in construction before, so it had its ups and downs, but I knew this would be constant income, basically.
Q. You say in your statement that the recruitment process didn't prepare you for the role. You say that the training was largely theoretical and didn't prepare you for the reality of the place.
A. Yes.
Q. If you can sort of take yourself back to what you were thinking at that point, during your training, what were you expecting Brook House to be like?
A. I mean, nothing you can do can prepare you to work in an environment like that, I don't think. It's hard to say, really. I mean, doing theory work, like in classrooms, and stuff, it's nothing like what the centre's like, basically. I didn't know what to expect, to be fair, but it definitely wasn't that.
Q. When you did start, was it quite a shock to you?
A. At the start, no; it sort of got worse as it went on.

Q. You say in your statement that, because you had no knowledge of the role that you were going to be doing, you had no reason to doubt the adequacy of the training whilst you were doing it. Once you started work, did you begin to doubt whether the training was adequate?
A. I did think to myself, this isn't -- this isn't what we were sold at the start.
Q. Do you think --
A. I think they made it -- sorry. They made it -- obviously made it sound better, to get people in, which companies do do. But it was the complete opposite from what they were training us for.
Q. So you think they were sort of deliberately making the job sound a bit more attractive than it was in reality?
A. 100 per cent. 100 per cent.
Q. Was that something that you sort of talked to your colleagues about?
A. No.
Q. It was just something you thought?
A. Yes.
Q. Looking at the culture at Brook House, you describe in your statement, Mr Lake, that -- you describe it as a "pretty bad" culture, is the phrase you use, a very macho type of place, in which the attitudes between staff and detainees were not great, and you describe

a general mutual disrespect; yes?
A. Yes.
Q. Why did staff have a disrespect for detainees?
A. I think it was more just the stress of the job and frustration. You know, like, people would come to you and want help, and we didn't have the facilities to help them. It's just natural to get frustrated in that situation.
Q. With the detained people?
A. Yes.
Q. Do you think that -- how did you, if you can remember, see this group of people? Like --
A. I mean, I didn't personally deal with it every day, because I was an activities officer, not on the wings, but when you're sports -- when you're the sports officer, and activities, you wander around because you've got to check on the pool tables and stuff like that, so you get a vibe of what's going on, and it was just a bad vibe generally.
Q. And --
A. From both. From staff and detainees.
Q. You talk about that mutual disrespect. But do you accept that, given that the staff choose to be there and the detainees don't choose to be there, do you accept that there's a difference between --

A. Oh, yeah, 100 per cent.
Q. -- the positions of the people?
A. Yes.
Q. So there's a difference between staff being verbally abusive to detained people and detained people being verbally abusive to staff, because, whilst it might be the same words they're speaking, you're coming from different positions; right?
A. Yes.
Q. You also say in your statement that managers were largely absent and not supportive, and you say that the attitude was to get on with it or to man up if there were any issues; yes?
A. Yes.
Q. When you talk about managers, in that context, is that referring to DCMs or is that more senior managers?
A. DCMs, yes.
Q. We heard yesterday -- I don't know if you listened to the evidence of Dan Small yesterday, but he used similar language to talk about Brook House. He talked about a macho culture and being told to "man up". Are these things that you guys spoke about while you were there?
A. No, never really spoke about it, no. No-one really spoke about that sort of stuff to each other at work.
Q. Is it something you've spoken about with him since?

A. No.
Q. So it's just a coincidence that you're using the same sort of words?
A. Yeah, must be.
Q. At paragraph 11 of your statement, you say that, if management did show up to deal with an issue, they would just immediately agree with a detainee to keep the peace?
A. Yes.
Q. Can you give an example of the type of situation in which that might happen?
A. I couldn't think of a situation, no. It was very much just agree with them to keep the peace, basically. So if we -- it's easier to tell the staff just to get on with it than to tell a detainee to get on with it because then they would kick up more of a fuss. It was just more to keep the peace.
Q. You don't mean, do you, that if a detainee complained that they'd been attacked or abused --
A. Oh, no.
Q. -- that the managers would just agree with that; no?
A. No, no, no.
Q. So what type of thing do you mean?
A. Just little arguments, like -- oh, to be honest with you, I can't remember a specific incident.

Q. Okay.
A. They would just normally take the detainees' side regardless.
Q. We have heard evidence from formerly detained people who say that they felt that management would always take the side of officers. Do you think that's wrong?
A. Yeah, that's wrong.
Q. You think the management would take the side of detainees?
A. 100 per cent wrong.
Q. Later in your statement, Mr Lake, you say that Brook House wasn't the sort of place where you'd raise any issues because, if you reported someone, you might be concerned that managers would go straight to that person with your allegation; yeah?
A. Mmm-hmm.
Q. Was there ever any thought that you could report someone anonymously, make an anonymous complaint about somebody?
A. No, I think it would all get out in the end.
Q. What were you worried would happen if you reported someone?
A. Personally?
Q. Yes.
A. I wasn't worried about anything, but it can make it awkward, can't it, working with people that you know

have said you've done this and done that. It would just become an awkward place to work.
Q. So is this you talking more generally about why there might be a culture of not reporting?
A. Yeah.
Q. Not you talking about why you didn't report things?
A. Yes.
Q. Okay. We have already talked -- you say in your statement, at paragraph 22, about it being a very macho culture, and you say that it was not a place where people would necessarily feel they could take action. You say, for example, management would probably laugh at you if you complained someone was bullying you. Is that a theoretical example or is that --
A. Yeah, that's the vibe they give off.
Q. Is that referring to DCMs or senior management?
A. Yeah, DCMs. I didn't really have anything to do with the senior -- never saw or never spoke to them.
Q. So you felt that if you went to a DCM, saying, "X was bullying me", they'd just laugh at you and tell you to man up?
A. Yeah, I reckon so. If not to your face, definitely behind your back.
Q. More broadly, talking about senior management, Mr Lake, you say at paragraph 24:

"I think they showed a very poor quality of leadership, were invisible and left staff unsupported and outnumbered."

What do you mean by them being invisible? Is that them not being around on the wings?

A. Just, yeah, I never saw them. They never made themselves visible at all.

Q. When we are talking about senior management here, are we talking about, what, Ben Saunders, Steve Skitt, these type of guys, or who are you thinking about?

A. I think so, if they were the senior managers. I can't remember if they were. But if they were, then yes.

Q. Okay.

A. I mean, I don't remember them, so they were clearly not visible enough for me to remember them.

Q. I know that you were activities officer, so you weren't constantly on a wing, but you were walking around the wings often; yes?

A. Yes.

Q. So were there senior management that you saw regularly?

A. No.

Q. One of the things you say -- I know we are on the same issues, but it's important to try to get to the bottom of this -- is that the very macho culture was shaped by senior management. That's something that you say at

paragraph 68 of your statement. Is there anyone in particular that you think shaped that culture?

A. What, senior?

Q. Yes. If you look at paragraph 68 of your statement, page 22. It's the final sentence of paragraph 68.

A. Oh, yeah.

Q. Who are you thinking of when you're saying that?

A. I wouldn't know. I couldn't remember names of senior management at all.

Q. Why do you say that they are shaping the culture, then?

A. Because I would assume that the managers would have got their role through senior managers, so they would have taken a leaf out of their book, sort of thing, so almost like a ladder.

Q. It's not that you saw or heard them shaping the culture?

A. No.

Q. It's just that you assumed that that was --

A. Yes, that was my thought, yeah.

Q. Do you think that this macho culture that you talk about, did that affect the way that you and your colleagues approached control and restraint and use of force, and things like that?

A. Possibly. I mean, I didn't really do many of them. I would say so.

Q. Because, I mean, obviously control and restraint is

a physical act?

A. Yeah.

Q. Using force on somebody who doesn't want to have force used on them. Do you think the macho culture sort of feeds into -- I mean, for example, do you think that that culture led to people using force when they didn't need to use force, ever?

A. I never saw it. I wouldn't know if people used force without needing to.

Q. I mean, when you were involved in or saw it, did you ever think, you know, "That's not quite necessary" or, "We don't need to do that"?

A. No.

Q. Did you ever see excessive force?

A. No.

Q. One of the things you say in your statement, talking about morale, is -- this is back at paragraph 7 of your statement -- that staff morale was very low and you were always understaffed and turnover was extremely high. That's something we heard from Mr Small yesterday as well.

A. Mmm.

Q. Was that something that was talked about amongst you?

A. Yeah, everyone spoke about being short staffed.

Q. And the consequences of that?

A. Just morale was low. Low on -- everyone was just -- it was just downbeat from the start. You come in and see the rota straight away and realise how many people are in the building and straight away you're on the back burner, you think, "Oh, it's going to be a long day". Yeah, that's why morale was mostly down, was staffing reasons.

Q. You say that the consequences of it were that sort of people felt downbeat. What were the consequences -- you've then got a 13-hour shift?

A. Yes.

Q. How does that affect you when you're --

A. Because you'd be doing -- say there's three officers on the wing, you're doing that officer's work if they're not there, so your workload becomes more, basically.

Q. So you have more work, so that makes you downbeat?

A. Well, it's just added stress.

Q. Okay. And do you think that was ever taken out, that frustration was ever taken out, on detainees?

A. Not that I saw.

Q. Did you ever raise any concerns, either formally or informally, about staffing levels?

A. No.

Q. Was that something you ever talked about, you know, "We should put in a complaint"?

A. No.
Q. "We should ask for more staff"?
A. No.
Q. Did you have any understanding of why there was a shortage of staff?
A. I mean, the staff come in, they just left straight away. The actual turnover of staff --
Q. Do you mean people would start and then they would leave pretty quickly?
A. Oh, yeah, within weeks.
Q. Is that, do you think, related to what you said at the beginning, about the training not really preparing --
A. Yeah, people would come in and be like, "Wow, this is not what I thought", and then they leave. The staff were coming through the door, but they were going out quicker than they were coming in.
Q. So your perception was that the reason why staffing levels were so low was that there just weren't enough people that could actually --
A. Just wasn't prepared for what they thought they were going into.
Q. Okay.
A. If that makes sense.
Q. One of the things you say was a consequence of that, and we have already talked about this a little, is that

attitudes towards detainees weren't great, due to shortages of staff, meaning that staff were on the back foot and that there was a lot of hostility from detainees. What sort of examples can you give of that attitude towards detainees not being great? Is that shouting? Is that swearing? Is that just the way that people --
A. From officers?
Q. Yes.
A. I wouldn't -- like I say, I didn't work on the wings, so I wouldn't know -- I mean, I did a few shifts on the wings, but where -- normally, when activities have got work on the wings, you just become the guy that opens the door. You have to open the door to the wing and let people in and out. They would normally just spend 13 hours doing that, because obviously -- I didn't know the runnings of the wing, I didn't know how to operate the wing office. So literally, I'd be opening a door for 13 hours.
Q. For 13 hours. How did that sort of work affect you?
A. Draining.
Q. Draining?
A. It was just draining, yeah.
Q. Boring?
A. You have no issue with anyone because all you're doing

is opening and closing the door, but yeah.
Q. But when you talk about attitudes towards detainees not being great, is that then something you got an impression of from talking to staff?
A. Yeah, and normally it would come from, when -- it would normally come from a detainee talking to you. You'd be in the office and someone would come in with a bad attitude, and then you'd just give bad attitude back, I would have thought.
Q. Okay.
A. That's how I think it would have gone down, anyway.
Q. Did you think that the way -- I know this is talking quite broadly, but did you think that the way that staff talked about detainees was appropriately, mostly?
A. No.
Q. Why not?
A. I just -- like I say, it was just a bad place to work. I don't think anyone wanted to actually work there.
Q. You don't think anyone wanted to work there?
A. Yeah, I don't think anyone actually wanted to work -- everyone wanted to get out, I think, personally.
Q. One of the things you say is that, because you were short staffed -- this is at paragraph 29 of your statement. You say that sometimes you were short-staffed to such an extent that you weren't able to

open the courtyards, which meant detainees couldn't get any fresh air. Again, we heard about this a little bit from Dan Small yesterday. But can you tell us, why couldn't you open the courtyard? Was that because --
A. Short-staffed.
Q. And would that mean that activities officers were on the wings?
A. Yeah.
Q. Right.
A. We would open the courtyards, but if we're covering break and people aren't coming back or they started late, then obviously we can't just leave the wing until they return. So then nothing gets opened until we are free.
Q. And do you think that people who weren't activities officers valued the importance of things like opening the courtyards --
A. No.
Q. -- and activities and that?
A. No.
Q. Why do you say that?
A. I think people just thought, just sit around all day, sit in the library, sit in the IT room. That's what I think, anyway.
Q. That's what they thought of you guys and the activities

team?
A. Yeah, definitely.
Q. What did you think about the value of activities? How important did you see it?
A. I didn't know any different, really. I knew it was important because, obviously, the IT room is where they get their emails from solicitors and stuff and the library is where they can get all their forms to apply for bail and stuff. So I knew it was important. But when you've done nothing else but activities, I suppose you don't really realise until you get out of there, you look back and think, without that, it would have been a lot worse in there.
Q. Do you think it was an attitude from others to see activities as a sort of bonus that people can get if things are going well?
A. Yeah.
Q. Rather than something that was needed?
A. Say that again, sorry?
Q. Do you think that staff who weren't activities officers saw activities, and that means whether we're talking about sports or even just getting into the courtyard for fresh air, if you can call that an activity, do you think that they saw that as just like a bonus that would happen if things were going well rather than

something --
A. No, the wing staff were aware that it needed to open.
Q. Right.
A. But they just -- it just sometimes didn't work out, where breaks would overlap and then people wouldn't get back on time. As soon as you were relieved of the wing, you would go straight to your post and do whatever you've got to do. It was never a case of "I'm not opening that" or "You don't deserve that". It was always just waiting for people to get back to positions.
Q. I know it is going to be hard to give any specifics here, but how often do you think it was that the courtyards wouldn't be open? Are we talking once a week, once a month, once a day?
A. I wouldn't know. I wouldn't be able to say.
Q. You were there for, what, a year and a half, or something like that? Roughly, can you remember, you know, did it happen three times or 20 times?
A. What, they didn't open at all?
Q. Yeah.
A. Oh, no, they always opened.
Q. Okay, so it would just be late?
A. Sometimes it would be late, they wouldn't get the full -- yeah, they wouldn't get out there for the full time they were supposed to.

Q. Okay. Now, some of the words you use at paragraph 9 of your statement to describe Brook House, before we move on, you talk about it being a crazy place, not really being a safe place, and you talk about some detainees being terrified and about staff not feeling safe either. Did you consider that the people that were in there, the detained people, were vulnerable? Did you see them as vulnerable?
A. Some. Not all.
Q. Obviously, the way it's described there might suggest to people that there was a sort of equal lack of safety, but, presumably, you would accept that, given that staff have equipment and an emergency button, et cetera, that it's not quite the same level of safety?
A. I mean, when you're on a wing with two officers and there's 100-odd detainees, it's not the safe place to be, because, if they decide that they've had enough, red button or not, you've not got a chance. But, equally, I do get what you're saying, that once people do arrive, we have got the equipment and stuff like that.
Q. I mean, personally, were you scared, physically?
A. Personally?
Q. Yes.
A. No, because I was -- I think the detainees saw us as activities officers, not wing -- I think they separated

us from wing officers, if that makes sense.
Q. You thought they were less likely to --
A. Yeah, they wouldn't really come to us with their issues or tell us their problems because they thought, oh, we were just library officers or IT officers.
Q. Okay. And just briefly, whilst we are still talking about sort of staffing levels and safety, one of the things you say at paragraph 66 in the context of talking about drugs at Brook House is, you say you didn't have the staffing levels to actually challenge anyone in relation to drugs. What do you mean by that?
A. I think that means carry out searches and stuff. So you'd obviously have to have officers to do searching. But if you're -- if you've got basic staffing, say two on a wing, how can you form a three-man team to go and do a room search?
Q. Was it necessary to have a three-man team?
A. I think it was three. I'm pretty sure two searched and a manager would overlook, I think. I might be wrong, but I think that is it.
Q. So you felt that part of the reason why drugs were a big issue at Brook House was because you just didn't have the staffing to do the searches?
A. I think so.
Q. I want to move on to talk about the facilities at

Brook House. One issue that you say caused frustration to detainees was the computers being very slow.

A. Yes.

Q. Meaning that they often had trouble accessing emails. You say that you reported it to management -- and we are going to come on to a transcript about that -- and nothing was done. Is that right?

A. Yes.

Q. Do you have any idea why nothing was done by management? Do you think it was deliberate or they didn't care or something else?

A. I think a bit of both.

Q. Okay.

A. Mainly care. I mean, management, talking about my line manager --

Q. Who was your line manager?

A. Ramon.

Q. Ramon, thank you.

A. They never dealt with any of the issues. So they didn't care because they didn't get the brunt of it.

Q. Is that back to what we were talking about before, about them not really realising the importance of this stuff for detainees?

A. Yeah, I think so.

Q. Were you aware of -- because we have heard some evidence

from detainees complaining that WiFi and mobile phone signal would drop around the time of charter flights or big removals. Were you aware of that being an issue?

A. No. I never heard that when I was there.

Q. If we can have up on screen, please, <TRN0000083>. That's at tab 12 of your bundle, chair. If we can go to page 31, please.

Mr Lake, this is a transcript of a conversation that you had with Callum Tulley and an officer called Kerry, in which you describe -- I'm going to summarise it because it is about three pages, so rather than go through everything, you describe the slowness of the computers as "a fucking joke" and say it's going to kick off. When you say it's going to kick off, is that detainees reacting badly to the slowness?

A. Yes.

Q. One of the things you say at the bottom of that is that you told -- you describe them as the IBM, but I think it's the IMB, about it, and they said -- if we turn over to page 32, you said -- they come in and you said to them "Look", and they said, "Oh, I've heard it's a bit hit and miss", and you said, "No, it's not even a hit. It's just completely missed every single day. It's a fucking joke". And you say, "Well, I didn't actually say it like that, but I was like 'It's a joke, they

can't even access their emails let alone anything to do with the case'". Do you think the IMB took it seriously?

A. No, because nothing was ever done about it.

Q. You go on to say, just to summarise it, that you thought the detainees might smash up the computers because then they'd be sent away, the computers, because they weren't working. Did that ever actually happen?

A. Yes, it did.

Q. Did the computers get fixed?

A. No. It just meant there was less computers available for detainees.

Q. At the bottom of this page, it is noted that you had handed in a letter -- line 1156 -- Kerry says, "Dan handed in that letter", and you say, "Yeah". And it's from the detainees saying how bad it was, and you say there's about 30 signatures on it. Do you remember that?

A. No.

Q. If we go over to the next page, you say at the top:

"Nothing will get done [about it] until they do something. As soon as they kick off, that's when -- the letter isn't nothing. They'll go upstairs and throw it away before it goes to Home Office."

Do you remember who you were talking about when you

say they'll throw it away?

A. Probably senior managers. That's who I would have thought it would have went to.

Q. I know you can't remember exactly what happened. But you had a letter with 30 signatures saying something about the computers being rubbish?

A. Yes.

Q. You'd handed that in but nothing had happened in response?

A. Going by that, yes, but I don't remember it.

Q. Okay. I mean, one of the things that obviously comes across from this is that you talked about detainees potentially kicking off, smashing computers, but, equally, what this seems to suggest is that there was quite what you might call a sort of democratic response, which is organising a petition with 30 signatures?

A. Mmm.

Q. Was that something that -- I know you can't remember this exact scenario. Did that ever happen otherwise --

A. No --

Q. -- with detainees getting --

A. -- not that I'm aware of.

Q. I want to ask about another aspect of access to facilities. If we can have up on screen <TRN0000082>, please, at page 10. Chair, that's tab 20 of your

bundle. Just while it is coming up, this is a transcript of a conversation between you, Dan Small, Callum Tulley and potentially somebody else on 11 June 2017. One of the discussions in the middle of the page is about who is cooking, which I think is about the cultural kitchen. Do you remember the cultural kitchen?

A. Yes.

Q. Can you briefly explain what the cultural kitchen was?

A. The detainees could cook their own food from where they were from. Basically get their own ingredients and cook their own meals.

Q. Was that something that was important to them?

A. Yes.

Q. At line 225 there, Callum Tulley asks:

"Didn't you say [DX4, a detainee] was cooking?"

And it records Dan Small as replying, saying:

"No, he's not, he's pissing me off ..."

I know this is not you saying it, but you were part of this conversation. Were you aware of staff preventing detained people from using the cultural kitchen as a punishment?

A. No.

Q. Did you ever do that?

A. No.

Q. One of the -- sorry, I should ask, if you had been aware of that, was that something you'd have seen as appropriate, as sort of preventing access just because someone is pissing you off?

A. Would I see it as appropriate?

Q. Yes.

A. No. Although, if you was arguing with a detainee that was going to go into the cultural kitchen, it would probably be a good idea not to, because they have got access to all sorts in there, as it's a kitchen -- knives, the lot. So you'd have to -- only certain detainees could go in there, not everyone.

Q. So you would see it as appropriate if it was a safety issue?

A. You'd probably swap officers. So if you've had an argument with one, you didn't feel comfortable going in there because, obviously, it's risky, you would swap officers.

Q. So rather than banning the detainee from accessing it, you'd swap officers?

A. Yeah.

Q. If we can turn to your statement at paragraph 30, you talk about Tinsley House staff, and you describe them as being completely out of their depth at Brook House and it being obvious they were scared. What were the

consequences of having scared staff in there?

A. No consequences, really.

Q. How did you know they were scared or see that they were scared?

A. Just mannerisms, really. I mean, they're not used to that environment because, obviously, Tinsley House is a completely different environment to Brook House.

Q. Yeah. You describe -- you say that the reality is that Tinsley House was like a daycare, whereas Brook House was like a prison?

A. Yes.

Q. What did you see as the reason for that difference?

A. Why Brook House was more like a prison?

Q. Mmm.

A. The people in it, the way it was built. Tinsley House is not built anything like Brook House.

Q. Do you think that detainees at Brook House were treated like prisoners?

A. I wouldn't know, really. I don't know how prisoners are -- I've never worked in a prison.

Q. Well, you say Brook House is like a prison?

A. From what I've seen and what I would expect from a prison.

Q. Okay.

A. I would have thought it was very similar.

Q. One of the things you say in your statement -- this is back to the end of it, where you're asked about -- you were asked, before you did your statement, about the list of staff who were disciplined after Panorama, and you say that there were members of staff at Brook House that you would witness displaying attitudes and behaviours --

A. Where is this?

Q. This is paragraph 68 again, sorry. The second sentence. You say:

"There were members of staff at Brook House that you would witness displaying attitudes and behaviour that I did not agree with, for example, verbally aggressive behaviour."

Do you remember which members of staff?

A. No. Yeah, I said it in there. "I do not recall specific details of the incidents".

Q. What do you mean by "verbally aggressive"? I mean, I know you can't remember exact things, but what sort of thing are we talking about?

A. Probably swearing, that sort of --

Q. At detainees?

A. Yeah, I would have thought.

Q. Shouting?

A. Raised voice. I wouldn't say shouting.

Q. Any racism?
A. No.
Q. Towards detainees?
A. No.
Q. Sexism?
A. No.
Q. Homophobia?
A. No.
Q. I want to come on to the issue of mental health. You've said a couple of times in your statement that you didn't feel that you were adequately trained to deal with the mental health of detainees; is that right?
A. Yes.
Q. At paragraph 10 of your statement, you say:
"There were so many people there that needed to be in hospital, in my opinion. It was not a suitable place for them to be. You would have people starving themselves, or self-harming."
And then you say that the only thing you would be able to do was put them on E wing so they could be watched more closely. Were you -- I mean, you're talking there about so many people that needed to be in hospital. Were you aware of any way in which you could say, whether it's healthcare or a manager, you know, "This guy needs to be in hospital. He shouldn't be in

here"?
A. No.
Q. Did you ever do that?
A. No.
Q. It was just something that you thought?
A. Yeah, just -- I mean, the people that were that vulnerable were normally on E wing. So staff would be aware of it, managers would be aware of it, that they were obviously not mentally stable enough to be in there, if that's the right words to say.
Q. Yeah.
A. Yeah, but nothing was done about it.
Q. And presumably, then, you never raised any concerns with healthcare, with any nurses or doctors or anything?
A. No.
Q. You say that healthcare would visit, but there was no-one really assessing whether people were mentally stable enough to be in there, and say that you think that a lot of detainees should have been formally assessed to be established whether they were safe to stay at Brook House. Are you referring to being formally assessed before they came in or whilst they were in or both?
A. Can you repeat the question, sorry?
Q. Yes. One of the things you say at paragraph 34 of your

statement is:
"I think lots of the detainees should have been formally assessed to establish whether they were safe to stay at Brook House."
A. Yeah, I was talking about as they come in.
Q. Prior to --
A. Yeah, they should have been assessed properly, because if they was, then they wouldn't have been allowed in there.
Q. Were you aware of Home Office policies intended to ensure that people who were unfit for detention weren't admitted?
A. Sorry, say that again? Sorry.
Q. Obviously, people who are admitted to Brook House and other detention centres, although it's run by G4S, it's the Home Office who have overall control. Were you aware of any Home Office policies for --
A. No.
Q. -- formally assessing?
A. No.
Q. Do you think that -- I mean, you may not know, but this inquiry knows that there are policies in place, but is it your view that any policies to assess whether people were fit for detention weren't working?
A. Yeah, they wasn't working at all.

Q. Did you know of any way that you could refer someone to a doctor to be assessed?
A. No.
Q. Were you familiar with the concept of a rule 35 report? Does that mean anything to you?
A. No.
Q. If someone came to you and said they had been tortured before they came into Brook House, would you know what to do with that information?
A. Probably tell the manager so the manager -- yeah, that's what you'd normally do.
Q. One of the things you say is that you -- we have already talked about how you said that E wing was sort of the only place you could put people who were particularly vulnerable. One of the things you also say is that E wing was used to put people who misbehaved; is that right?
A. Yes.
Q. I think we have understood from other witnesses that you have E wing and you have the CSU?
A. Yes.
Q. They are next to each other but they are meant to be separate. Is that your understanding?
A. Yes.
Q. So am I right in thinking that the vulnerable detainees

were meant to be on E wing and the people who had allegedly misbehaved were meant to be on the CSU?
A. Yes, they would go into CSU and, after they'd finished in CSU, they would go onto E wing for a certain amount of time before being released back to the wings.
Q. Did you have any concerns about those groups of people, the most vulnerable and the people that had behavioural issues, being -- mixing together?
A. I mean, I didn't have any concerns, no, because I never really worked there, so I didn't see it.
Q. Okay.
A. But, yes, it's obviously not right.
Q. One of the things you have said in your statement is that you had no training on how to deal with serious mental health issues and instances of self-harm. Does that include both before your employment and during as well?
A. Yes.
Q. Did you have any training on dealing with self-harm and suicidal behaviour?
A. Just basic first aid.
Q. Any training or talks on how to support people with PTSD?
A. No.
Q. Would you have known anything about PTSD at the time?

A. No.
Q. Were you taught about opening ACDTs?
A. No.
Q. Do you remember what ACDTs are?
A. Sort of. You know, you write logs about the detainee, I think. I'm not really sure.
Q. Yeah. So we can tell you, ACDTs are -- that you would open for a vulnerable person and anyone who mentioned anything to do with self-harm or food refusal, for example?
A. That's right. You write a log in when they eat and if they don't eat and stuff like that.
Q. We have heard evidence from people who were doing the observations, and did you ever do those observations of people?
A. Yeah, I would have done some, yeah.
Q. Would you have known of the facility to actually open the ACDT in the first place?
A. No.
Q. One of the things you say is that you could open the ACDT if someone was refusing to eat, but it was only really taken seriously if something had actually happened to the person, as you say at paragraph 21 of your statement. If we can bring that up. You say, if you had concerns about someone, for example, refusing to

eat, you would open an ACDT and they would be checked every meal time:
"The managers would have to sign off on the ACDT, so they would be aware of the issue. My experience was it was only really taken seriously if something had actually happened to the person because there were so many people in there dealing with these sorts of issues."
What do you mean by something actually happening? Are you talking about the difference in someone threatening with self-harm and actually doing it?
A. Possibly, yeah, possibly.
Q. How did, in your experience, staff see the issue of self-harm?
A. How serious was it?
Q. Yes, how seriously did you take it?
A. Personally?
Q. Personally and your colleagues?
A. Well, I never really come across it, to be honest with you, like, first hand. You'd hear about stuff.
Q. So you never came across a detainee self-harming?
A. Very rarely. Because, obviously, when you're in the IT room or the library and you -- a first response goes on, you're not supposed to leave -- wing staff are first response, not activities. But, yeah, I would have,

obviously, taken it seriously.
Q. Was there ever any discussion about people self-harming amongst staff?
A. Not that I'm aware of.
Q. One of the things you say in your statement is that when an individual self-harmed, first aid would be the priority. But am I right in thinking that you didn't actually have any experience of --
A. I don't think I did first aid on anyone in there.
Q. Maybe I already know the answer to this, but the inquiry has received some evidence from detained people saying that self-harm incidents were responded to by use of force rather than as a clinical issue.
A. Okay.
Q. Did you have any experience of that?
A. No.
Q. I'm now going to take you on, Mr Lake, to some issues in relation to attitudes towards detainees and some specific incidents. First of all, in relation to some comments made on 19 April.
If we can turn up on screen, please, <TRN0000036>. We can go to page 5 once that's up. Just to give you the context for this, Mr Lake, this is a transcript of a video diary that Callum Tulley would do at the end of each shift whilst he was filming, so it's not a record

of anything that you said, it's a record of what he said at the end of the day to his producer.

Again, to avoid having to read the whole thing out, and to summarise, this is Callum Tulley talking on 19 April, and he says that you and Dan Small were talking about a bed watch you'd been on for a detainee who had been on hunger strike for six weeks. He says that the detainee wasn't in very good condition and that you and Dan Small had been openly talking about how you were eating a feast or a banquet in front of the detainee and that there was then laughter between you. Do you remember this? Do you remember talking about a feast or a banquet in front of a detainee on hunger strike?

A. No. I don't remember doing the bed watch.

Q. At paragraph 44 of your statement, you say that if you did make the remarks, they absolutely aren't appropriate and you're truly sorry?

A. If I did say the remarks, yeah.

Q. I mean, given that this is Callum Tulley talking the same day about what happened, there's presumably no reason that he would make that up?

A. Well, like I say, I can't remember it, but if I did say it, then obviously it's wrong, but yeah.

Q. One of the ways you explain it, if you did, in fact, say

it, in your statement is, you say it was a toxic culture in which it was usual for staff to use inappropriate banter to deal with stress. Did that ever extend to actually mocking detainees, in your experience?

A. Not that I can remember, no.

Q. One of the things Callum Tulley says in this recording, actually over the next page, is:

"It was sad for me personally because Dan Lake's not been in the job that long and when I first met him he was really quite a sweet guy. And I didn't think he [would] come out with something like that. And I've virtually become friends with him in ways. And ... today ... what he said was quite horrific and I didn't enjoy hearing it and filming it."

Do you think that your approach, the way you saw detainees, changed through the period you were at Brook House?

A. I think you just -- not changed, no. I don't know what the right words are to say, really. The longer you're there, the more you don't want to be there, so the less effort you put in, if that makes sense.

Q. Yesterday, Dan Small talked about Brook House having sort of made him racist. Now, we are not talking about racism on this occasion, but did you feel that Brook House had an effect on the way that you perceived

detainees, the level of respect you had for them, for example?

A. Yeah.

Q. Do you think that that decreased during the time that you were there?

A. Yes.

Q. Coming on to some other comments on a different day, firstly, on 27 May. If we can turn up <TRN0000087>, please, at page 19. Chair, that's at tab 15 of your bundle.

THE CHAIR: Thank you.

MR LIVINGSTON: While this is coming up, just to explain the context, this is a transcript of a recording that Callum Tulley made on 27 May, and it is a conversation between you and Callum Tulley about a guy who we refer to as D1914, and in this conversation, there's a mention by you, in the top half of the page, that this detained person had already had three triple bypasses, and already had a heart attack. Do you remember this?

A. No.

Q. I'm going to ask you some questions about it anyway, because we have got the transcript.

A. Okay.

Q. This is talking about someone who is about to be removed and you've mentioned that he's got a medical condition,

he's booked in for another bypass, you say a triple bypass. Callum Tulley says, "I can tell you he's had triple bypasses, he's already had a heart attack", and you say:

"... he's booked him for another, and the doctor said we can use force on him."

You say:

"I dunno, I dunno, it could tits up. If he fucking drops, bruv."

Does that suggest to you that you had some concern that this detainee would come to harm during the use of force?

A. Yeah, reading this, yeah.

Q. If we go further down the page, at line 673 there, you say:

"He claims, yeah, he'll fake having a heart attack."

Do you remember why you thought he might fake having a heart attack?

A. I don't know. I don't remember it. But if he was to fake it, probably to get out of the removal, or whatever they're trying to do to him, possibly.

Q. Do you accept that, given this is a guy who you've described as already having had three triple heart bypasses, or a triple heart bypass, suggesting that he'd fake a heart attack is undermining his condition?

A. Yeah.
Q. Did you have a general belief that detainees might fake health problems?
A. Yeah.
Q. You did? Why did you think they might do that?
A. Just because it had been done.
Q. How did you know that?
A. Because nothing would happen after. When you stopped the C&R, everything would be normal.
Q. Why did you think they were faking it?
A. To either postpone their removal, or for any reason. Obviously, no-one likes C&R, so ...
Q. So does that mean that, because you'd had it before and because you thought that this might happen, that if somebody said they had a health issue, they said they were having a heart attack or they said something was happening, your instinct would be they might be faking it?
A. They should be taken seriously, but obviously this is just me and Callum talking. But obviously it's not down to us to make that decision. I mean, we're just talking about it before, like -- it's just me and Callum in the office. But, ultimately, it would be down to whoever is running the C&R if we go in or not, regardless of what we said.

Q. But if you thought that somebody might be faking something, presumably that might make you respond less seriously to it?
A. Well, no, I'd still -- I'd still go -- I'd still do what you have to do. I wouldn't be, like -- if I was told it was okay and the doctors have said it's okay, then it's okay.
Q. Still on this page, further down, Callum Tulley says:
"We'll see what happens."
And you say -- it's recorded that you say:
"If he dies, he dies."
Can you explain why you said that?
A. No. I don't remember saying that.
Q. This is a transcript that records you having said it. We have also heard evidence of other officers using that phrase at other times. Do you remember that being a common phrase?
A. I've heard it around, yeah, but I don't remember saying it.
Q. Do you remember where it comes from, or anything like that?
A. No. Just the culture at Brook House.
Q. Do you accept that saying that about a detainee with heart problems is a pretty callous thing to have said?
A. Yeah. If I said it.

Q. Now, the transcript, although part of it's redacted, suggests that you had accessed D1914's criminal convictions, his criminal records, and that you discussed it with Callum Tulley. Do you remember that?
A. No.
Q. We can see at paragraph 54 of your statement you talk about this. You say:
"I'm asked whether I accept using language, including 'nonce' and 'murderer' to describe D1914. The transcript indicates it was another officer who used the term 'nonce' and DCO referred to him as a 'murderer'. I cannot confirm whether or not I used this language. If I did, it was entirely inappropriate. It was used in the context of a private conversation."
But you say:
"It appears that we, DCO Tulley and myself, had accessed D1914's criminal history on the database."
Do you remember how you would do that?
A. Just on the system, you could write in -- they carry ID cards with them and, if you type in their names or their numbers, it would come up with all their history.
Q. And when were you meant to do that or when were you allowed to do that?
A. You could do it whenever you want -- no-one told you you couldn't do it.

Q. Okay. When would you do it?
A. When would I do it?
Q. Yeah.
A. Probably when he was in the library, I would have thought, because the IT room, the computers were too slow, didn't load that --
Q. Why would you do it?
A. I don't know. Just to have a look, I suppose, be nosey.
Q. So there was no -- nothing to prevent you from accessing this information?
A. No.
Q. No policy that you knew of --
A. No.
Q. -- that said you shouldn't access it? Did learning about the criminal records of detainees affect the way you treated them?
A. Not really, no.
Q. Now, we don't have the transcript of this, but at paragraph 52 of your statement, this is -- you talk -- we have already talked about the comment about feigning a heart attack, and then, halfway down the page, you say:
"I accept that I used the phrase 'give him a right hook, mate' in response to DCO Tulley's safety concerns ... this was meant as a joke between

colleagues -- I did not mean it literally. I accept that this remark, however intended, was inappropriate and I apologise for any offence caused."

Yes?

A. Yes.

Q. Was discussion of using violence towards detained people normal?

A. No.

Q. Do you think that's the only occasion you did it?

A. That I can -- well, I can't even remember this, but yeah. Yeah.

Q. You've seen the footage, and it was Callum Tulley saying that he was worried about D1914 and you said, "Give him a right hook, mate"?

A. Yeah. I was just -- just talking to Callum Tulley in the office, that's all it was. Just talking, just banter with Callum.

Q. You've talked in your statement a few times about this macho culture that was there, but do you not think that using words like that is you contributing to that macho culture?

A. Oh, yeah, because you get sucked into whatever the culture is. You just adapt to the situation. Everyone was the same.

Q. So you think you were saying this to fit in?

A. Yeah, basically, yeah.

Q. You say that you wouldn't have meant that seriously?

A. No.

Q. Would you have ever condoned giving a detainee --

A. No.

Q. -- a right hook?

A. Never.

Q. I want to move on to ask you about another incident, this time on 31 May. If we can get up on screen <TRN0000079>, and at page 10, please. This is a conversation that you had with Dan Small and Callum Tulley on 31 May. I already asked Dan Small about this yesterday, and it is a discussion where Dan Small says that he wouldn't go to Cleveland because "it's black central", and says "Too many blacks. It's 80 per cent black".

In your statement, Mr Lake, you say that you would have taken these comments to be workplace banter. What do you mean by that?

A. Just not serious.

Q. Were these sort of comments common?

A. Not around me, no, not that I can remember.

Q. Were you surprised by these sort of comments?

A. No.

Q. You had black colleagues, you were meant to be

responsible for a lot of black people in Brook House. Did that not alarm you?

A. Not really, because, as I say, it was normal. Like, yeah.

Q. Towards the bottom of the page, it records you saying:

"You couldn't have said that at a worse time. The only black worker in here walked past."

And then a discussion about whether the guy that walked past is black or not. Given that you were saying, "You couldn't have said that at a worse time because a black officer walked past", that suggests that you knew it was a wrong thing to say, doesn't it?

A. Yes.

Q. You knew it was a racist thing to say?

A. Yes.

Q. Why wouldn't you report a racist thing from Dan Small?

A. Reporting never happened in Brook House.

Q. Would it have even occurred to you to report it?

A. No.

Q. Would it have occurred to you to challenge him in using those sort of words? Would you ever have done that?

A. No.

Q. Do you see the potential issue with a lot of staff who were responsible for looking -- responsible for hundreds of detained people, many of whom are black, talking

about black people in this way? And so, looking back on it, do you see that that is a problem?

A. Yes.

Q. But you didn't see that at the time?

A. No.

Q. This might just be a disconnect, but in your statement, you say that you can't remember the details of any specific instance of racism, homophobia or misogyny by any member of staff.

A. Yes.

Q. This is an example of racism.

A. I also said I don't remember in the first set of questions, and you come back with this -- these afterwards. Obviously, now, I've seen it, but I didn't remember it to start with, no.

Q. Understood. I'm going to come on now to ask about a few comments you made about force used by staff. If we can turn first on the screen to <TRN0000095> at page 32, please. It is tab 14, chair, if that helps.

Mr Lake, this is a conversation between you and Dan Small. It is about a comment you make -- this is on 13 May. You say:

"On B wing, that geezer bit his hand. Do you remember they wrapped up in the office? The geezer bit Derek's hand, and then he bent over, and Derek

upper-cutted him and cracked him straight in the jaw. And afterwards, Jules come up, he was like 'What happened to his lip?' His lip was all over the place. Nice. And Derek was like, 'I don't know'. I saw everything. He was undoubted -- Derek just went smack ... Oh dear, just to make sure. I'll be back."

"Derek" is Derek Murphy in that conversation?

A. I would have thought so, yes.

Q. And "Jules", Jules Williams?

A. I don't remember Jules Williams.

Q. Jules Williams was the residential manager?

A. Oh, okay.

Q. You don't remember?

A. I don't remember him, no.

Q. Okay. When you were asked about this in your statement, you say that you can't now recall the incident and, therefore, you're not sure whether you witnessed it directly or whether you were told by another officer?

A. Yes.

Q. But the transcript records you saying, at row 1047, "I saw everything". So do you accept that that suggests it is likely you saw this?

A. I don't remember seeing it, no.

Q. Do you think if you had seen a member of staff upper cut someone straight in the jaw, that's something you would

have remembered?

A. Possibly, yes.

Q. Do you have any idea when you were talking about this happening? You're talking about 31 May.

A. No. I don't remember the incident, no.

Q. We have heard quite a lot of evidence about alleged assaults at Brook House, but this is a suggestion that a member of staff upper-cutted and cracked someone in the jaw, bleeding to his lip being "all over the place", I think it said. That would be quite a serious thing to be describing, isn't it?

A. Yes.

Q. I know you say you can't remember it now, but, thinking quite hard about it --

A. I have thought about it.

Q. Okay. And you still can't remember it?

A. No.

Q. If you had seen it, do you accept that it's something that you should have reported?

A. Yes.

Q. If you had seen it, do you think it's something you would have reported?

A. No.

Q. One of the things that's in the bundle -- I don't know whether you have had a chance to read it. We had

evidence from Owen Syred --

A. The new stuff?

Q. -- back in December, yes.

A. Okay. No, I've not read it. Briefly, in the room.

Q. If we can have that up on screen, please, it is at <INQ000101>. First of all, do you remember Owen Syred, the welfare officer?

A. No. No.

Q. It is page 31 of this document.

A. I can't read that.

Q. Given that you can't remember Owen Syred and given that you can't remember the incident, we may not get very far with this, but Owen Syred describes an incident where he saw Derek Murphy upper cut somebody as well. Do you have any idea whether that's the same incident?

A. No. I don't remember who Owen is.

Q. He describes the incident, just to summarise, as a detained guy who tried to punch him, Owen Syred -- this is at the bottom of the page, sorry.

A. I can't read this.

Q. It is going to get a bit bigger.

A. Thank you.

Q. I'm just going to summarise it, again, but he describes this incident where this detained person tried to punch him, tried to punch Owen Syred, clipped his face:

"Answer: ... a spontaneous incident happened. The officers in the wing took control of [him] ... he was angry ... someone had called a first response ..."

If we can move over to the next page, please, the top half of the page on the left-hand side. It says:

"Answer: So a designated team would be called out ... the first officer that came in ... was Derek Murphy ... the detained guy had his head facing the wing door ... Derek Murphy came in very low and upper cut a couple of times, I think two or three times, in the face and I intervened ..."

And then he talks about how he had that conversation with him.

Obviously, the language that's used here, both of you use the term "upper cut", which is quite a specific form of punching someone?

A. I understand that.

Q. Do you have any recollection whether that's the same incident?

A. No.

Q. No?

A. None at all.

Q. Okay. One of the things you say in your statement when you were asked about this incident that you described with Derek Murphy is that, on reflection, you realise

you should have reported it. Your reason for failing to report it is the general culture of non-reporting. But the way that you described it, this guy Jules had come in as well, but do you remember that?

A. No, not -- no, I don't remember Jules.

Q. If we can turn up <TRN0000079> at page 20, please. This is a conversation on 31 May, so a couple of weeks after you'd described that incident with Derek Murphy. This is a conversation between you and Callum Tulley, and you refer to speaking with someone who had been on training, and that person had said to you, "I'm not a snitch. I'm not a grass. I'd never grass", and you say:

"Which is, to be fair, everyone would do that. I'm not a grass at all. He said he is all right, to be fair. He's a good lad."

Were you saying he's a good lad because he wouldn't snitch on someone?

A. I don't know how it was said. I mean, the way you read it is obviously different to how you say it. I don't know what context I would have said it in.

Q. If you can't remember exactly, then let's try and sort of think about it more hypothetically, then. A new member of staff says to you, "I'm not a grass, I'm not a snitch". How would you react to that?

A. Fair play.

Q. Do you think that was a good thing, that people wouldn't snitch?

A. Yeah, that's the environment it was like in there, yeah. You don't grass on people.

Q. Looking back on it, do you think that was a good thing?

A. Looking back on it?

Q. Mmm.

A. No. Definitely not.

Q. Why not?

A. Because you could have prevented a lot of situations.

Q. Did you feel like there was a culture of not grassing or snitching on fellow officers?

A. Yes.

Q. And do you accept that you fed into that culture as well?

A. Yes.

Q. Another set of comments I want to ask you about, <TRN0000080> at page 16 and going on to the next page. Again, I'm not going to read all of this out because I only want to ask you about part of it, and so I'm going to sort of take bits out. This is a conversation on 5 June 2017?

A. This is one of the new documents you put in on Thursday.

Q. I think -- I think we put them in earlier, but you only got them on Thursday.

A. I never got them.

Q. Okay. Well, we can ask you --

A. Yeah.

Q. -- about them now anyway. This is a record of a conversation between you, Dan Small and Callum Tulley. Just before we actually get into the specifics, there is obviously quite a lot of records of conversations between the three of you. Were the three of you --

A. We worked together, all activities, yeah. So when we was on shift, we was in a shift as a three.

Q. Okay. Now, you are talking here about somebody called Darren, who we think is Darren Tomsett. Do you remember him?

A. No.

Q. Talks about a guy called Darren, and there's a description here about Darren Tomsett having a goal, a detained person losing the plot, saying that he went nuts, and you describe him as "a fucking nutter". You describe an incident where Darren was looking at someone and he said, "'Do you want to kiss me or something?'. Out of nowhere, 'Do you want to fucking kiss me?'" and you say "Literally" -- that's Dan Small saying that, he says, "Literally ... 'What the fuck is going on?'" and you say:

"... He's the sort of guy, I might have said to you,

he will go home and when the TV remote runs out of battery, he will argue with that and all ... He's a fucking nutter, bro, he's completely lost the plot."

Do you remember the person you're talking about at all?

A. No, I don't remember him, no.

Q. Does it surprise you that you'd be talking about a colleague in those terms?

A. To that extreme, yeah. But I can't remember who he is. Darren who? What's his name?

Q. We think it's Darren Tomsett, but obviously it's not for us to say.

A. Yeah.

Q. One of the things you also say in this transcript is -- I'm trying to find it on the page. Oh, yes, at the bottom, line 362. You say:

"Yeah, definitely ..."

Sorry, Dan Small asks:

"What he does is he will argue with them and then bin them off."

You say:

"Yeah, definitely, he winds them up and then sends them out."

Any idea what that means?

A. I would have thought wind someone up and then leave the

wing, leave it with someone else.
Q. We have heard evidence from a number of detainees that some staff members would deliberately provoke people so that they had to -- so there was a justification for using force on people?
A. Okay.
Q. Is that something you ever experienced?
A. No.
Q. I'm going to move on to the next issue, which is some comments you made on 14 and 15 June. If we can look at <TRN0000093> at page 27, please. I'm going to read a bit more of this out. This is a discussion between you and Callum Tulley about what had happened between Sean Sayers, and you will be aware of this issue --
A. Yes.
Q. -- because this came up after Panorama. You start describing what happened at line 973. You say:
"He called Sean a fat cunt and Sean went, 'Do something about it, then', and then he come over like he was going to hit Sean, Sean grabbed him and threw him in his room, went into his room and went bang at it ..."
You go on to say:
"Sean picked him out."
That's at line 983:
"Sean picked him out. I was standing next to Sean

and Sean had him, picked him up like this in a bearhug."
And it records you imitating wrapping your arms around the back of someone:
"Threw him in his room."
At line 987 you say:
"Backhanded him and locked him in."
Further down the page at line 994, Callum Tulley asks you:
"Did he give him a proper smack?"
And you reply:
"Yeah, backhander, right on his face."
Callum Tulley asks why Sean did it and you say:
"Angry. Called him a fat cunt ..."
Then towards the bottom of the page there is a discussion about whether this took place on camera, and you say:
"Right there."
And Callum Tulley says:
"... backhanded him across the face on camera?"
And you say:
"No, no, picked him up on camera, carrying him into his room."
If we turn to the next page, you say:
"Threw him in his room, backhanded him in his room. But it did look like, to be fair on Sean ... it looked

like he was going to hit Sean, like the way he approached Sean with his hands back like that."
When you were asked about this, Mr Lake, you say that you accept that the transcript accurately records the conversation?
A. Yes.
Q. And you don't dispute, obviously, what you said to Callum Tulley because it is here in black and white?
A. Yep.
Q. But to the best of your recollection, you don't actually recall DCO Sayers --
A. No. No, no. Went through this loads after it, when I was being interrogated about it, and I didn't remember it then and I don't remember it now.
Q. So you were asked about it in September 2017 after Panorama, and you said you didn't remember being there.
A. Yeah.
Q. But you'd accept from this that it looks like you were there?
A. Well, reading that, yeah.
Q. Given the way that you describe it, and this is obviously the day or the day -- I think it's the same day that it happened. Presumably, you'd accept that that's probably the best evidence of what you saw?
A. Well, I don't remember seeing it, no. I don't remember

it.
Q. So what you've described is that Sean Sayers bear hugged him, lifted him up, put him in the room and then backhanded him. Can you think of any reason why you would say that Sean Sayers backhanded him if he hadn't done that?
A. No.
Q. So do you think the most likely thing is that you did see Sean Sayers backhand him?
A. No, and I'm not just going to randomly turn around now and be like, "Yeah, I saw it".
Q. I appreciate that you don't remember it --
A. It's just this has gone on so long about this one incident, and I have no -- no, I don't remember it at all.
Q. We talked about this in the context of the Derek Murphy thing, in terms of upper cutting someone and you not remembering it. This is you describing a big officer -- I think Sean Sayers is a big guy; he is described somewhere else as being a 20-stone guy. If you had seen him backhand somebody, is that something that you think you would remember?
A. Probably, yeah.
Q. Do you think the most likely thing from reading this is you did see him backhand him or you didn't see him

backhand him?
A. I don't remember. I'm not going to say I remember seeing it when I don't remember seeing it.
Q. Do you remember seeing him bearhug him and lift him into the room?
A. No, when I got interviewed after it, I couldn't even remember -- I didn't remember I was on the wing. They showed me -- I think they said they showed me video footage of me being on the wing, but I didn't even remember being on the wing at the time.
Q. Generally, and I appreciate this is a long time ago now, is your memory of this --
A. I mean, I've done, the last four or five years, everything possible to forget about the place, and then this randomly comes up and you're asking me to remember certain days, certain times.
Q. Okay.
A. I think I've done well to remember what I have remembered.
Q. Okay. I appreciate that we are talking a long time ago, but we are talking about quite extreme incidents, I think you'd agree.
A. Yep.
Q. The idea of upper cutting someone, backhanding someone --

A. It doesn't mean it stays in your mind, though. I mean, things happen in work and out of work that would, you know, take your mind off of certain things, and these -- this place doesn't stay in my mind at all. Yeah.
Q. Okay. You'll remember from the disciplinary investigation afterwards that you were shown footage that suggested you'd been in the room with Sean Sayers for 13 seconds?
A. Yeah, something like that.
Q. But you don't remember --
A. No.
Q. -- what happened in the room at that time?
A. No.
Q. Okay. Now, one of the things you were asked, and you commented about this, was about whether you completed the use of force statement or anything like that, and you said you wouldn't have done because you didn't use force?
A. Yeah.
Q. Was your understanding that you only had to complete a use of force form if you, yourself, used force?
A. Yes, that was my understanding, yes.
Q. Again, I appreciate this is asking you to think back, and it is more generally, but if you saw someone hitting a detainee, was it your understanding there was no

paperwork that you had to --
A. I wouldn't have filled anything out. Not that I was aware of, anyway.
Q. No incident report?
A. I was never told to fill out anything like that, no.
Q. Do you know about SIRs, serious incident reports?
A. Didn't they go to security; right? I think.
Q. Did you ever complete them?
A. No.
Q. I appreciate you can't remember what happened on -- or you say you can't remember what happened on this day, and you say the same in relation to the Derek Murphy incident. That's you describing two incidents of staff members assaulting, or allegedly assaulting, detainees. Even if you can't remember the specific incidents, can you help us with why that sort of behaviour might be occurring at Brook House?
A. I mean, going by this transcript, the detainee's obviously verbally abusing, so I guess it's a reaction.
Q. Do you think officers felt provoked?
A. Possibly, yeah.
Q. Just very briefly, so after -- Panorama is broadcast in August, or early September, 2017. You say that it had a very damaging impact on staff morale; yep?
A. Yep.

Q. And everyone became very suspicious of one another. One of the things you say at paragraph 63 of your statement is that there was a feeling that detainees felt empowered and this impacted on your ability to maintain control. Did you see it as a bad thing that detainees would feel empowered?
A. In an environment like that, yeah.
Q. Do you think it was better that they felt powerless?
A. Not powerless, no. It's got to be level ground.
Q. What do you mean by "empowered"? What did they feel empowered?
A. Because, obviously, the whole centre was -- with what happened, they just -- you felt like they had control of the centre because of it.
Q. Just very briefly, I'm not going to go through each of the documents, but we know that you were investigated about the failure to report the Sean Sayers incident --
A. Yeah.
Q. -- and that led to a disciplinary hearing, following which you were issued with a written warning; yes? And it was put to you that, as part of the investigation report, there was a finding that your inability to record the detail --
A. There was a lack of evidence.
Q. -- was suspicious and you were evasive and unhelpful

during the interview. What do you say about that?
A. It wasn't an interview. It was an interrogation.
Q. Do you feel like the process was unfair?
A. 100 per cent. They were just trying to make you say what they wanted to hear, basically. Put words in your mouth and -- yeah, it was awful. That's why it probably says I was a bit, you know, not long with them, because you felt backed into a corner and you had to fight out of it.
Q. Obviously -- was there a sort of collective feeling amongst staff that you were all under attack, essentially, at this stage?
A. Yes, definitely.
Q. Did you feel like you had to protect other officers?
A. No, and, like I say now, I've got no -- I've not seen any of these guys since then. I don't owe them anything. You know, if I was to turn around now and say, "Yeah, Derek and Sean done that", it makes no difference to my life whatsoever, but I'm not willing to sit here and say, "Yeah, I saw it", when I don't remember seeing it. I don't think that's fair.
Q. I appreciate that's the position now, but trying to go back to September 2017, do you think you might have been trying to protect them at that stage?
A. No.

Q. Okay. Now, you say in your statement that the disciplinary process had a profoundly negative effect on you and it led to you -- or it was part of the reason you say you were signed off with stress afterwards?
A. Mmm-hmm.
Q. Do you have any explanation as to why it had that effect on you?
A. Just anxiety. Just didn't want to be there. I don't think I returned to normal duties.
Q. I think you say that you were signed off for six weeks, returned on light duties and then shortly thereafter --
A. Yeah.
Q. -- you left Brook House. You say that the stressful work place environment, the long hours and the travel time were too much for you at that time in your life?
A. And I'd just had a baby as well.
Q. Those reasons for leaving -- the stressful environment, the long hours and the travel time -- we had similar reasons from Dan Small yesterday. He left at a similar time?
A. Yeah.
Q. Were you guys -- I mean, you said you were working together a lot. Was that something that you both decided together?
A. No, we both went our separate ways.

Q. It was individual decisions, just for the same reasons?
A. Yeah, yeah.
MR LIVINGSTON: Chair, I've got no further questions for this witness.
THE CHAIR: Thank you very much. I have two questions for you, Mr Lake.
Questions from THE CHAIR
THE CHAIR: One relating to something you mentioned about search teams searching in cells for drugs. Did you -- from your recollection, were you ever involved as a member of a search team?
A. I think I did one or two, yes.
THE CHAIR: Did you have any training on that in your training course?
A. Searching?
THE CHAIR: Yes.
A. Minimal. But sitting in a classroom is different to searching someone's room. I can't remember exactly, but it might have just been like a bag you had to search or something silly like that. Nothing to the scale of what you would be doing in there.
THE CHAIR: So when you carried out your first search of a cell, how were you shown what to do? Was it kind of an on-the-job training --
A. Yeah.

THE CHAIR: -- or did somebody show you how to do it?
A. Yes.
THE CHAIR: Another question in relation to searches, and this time searches of staff as they were entering the centre, can you remember how often you were searched and what that search was like?
A. I can remember once, searched once, going on, and it was just a patdown.
THE CHAIR: By another member of staff?
A. Just a very basic -- yeah, a guy that was on my training course, I believe.
THE CHAIR: Thank you. One other question. You talked about the number of staff who would complete their training and then start working and then would very quickly leave again. Obviously, that wasn't the case for all staff. Some staff did stay.
A. Yeah.
THE CHAIR: Were there any differences between the sort of people who did stay and the sort of people that did leave? Anything that you could kind of describe to us?
A. We never -- I personally would never see them because, obviously, not being on the wings, activities, there was -- there was no spaces in activities, it was full. So I just -- I just personally think it was not sold to them how they thought. They thought they were going to

something completely different, that's all. And the people that did stay quickly moulded into the culture and everything of Brook House. No-one come with any different thoughts or ideas.

THE CHAIR: Did you feel people that stayed were just able to adapt to what the culture was?

A. Yeah.

THE CHAIR: And the people who couldn't do that were the ones that perhaps left? Is that fair?

A. Possibly, yeah.

THE CHAIR: They are my only questions, thank you very much, Mr Lake.

MR LIVINGSTON: That concludes Mr Lake's evidence. Chair, I would invite you to have a 15-minute break now and then we will return with Steve Loughton at 11.40 am.

THE CHAIR: Thank you for coming to give your evidence. I know it's not an easy experience, but it's been important to hear from you.

A. No worries.

(The witness withdrew)

THE CHAIR: Thank you. We will return at 11.40 am. Thank you.

(11.25 am)

(A short break)

(11.40 am)

MS MOORE: Chair, we now have the evidence of Mr Loughton.

MR STEPHEN MARK LOUGHTON (sworn)

Examination by MS MOORE

MS MOORE: Good morning, Mr Loughton.

A. Good morning.

Q. Can you confirm your full name for us, please?

A. Stephen Mark Loughton.

Q. You should have a bundle of documents in front of you in that folder --

A. Yes.

Q. -- which I may refer you to or I may show them on the screen which is in front of you.

At tab 1 of that bundle is your witness statement which you made to the inquiry and signed on 18 February 2022. You might wish to have that open as we go through. It is just behind the first tab. If you use the one in the bundle. Chair, I will ask for that to be adduced in full, and the reference for that is <SER000447>.

What that means, Mr Loughton, is we won't go over everything that you have said in your statement today. That is already in your evidence. We will just focus on some of the key issues.

First as to work history, which you set out in your statement at paragraph 1, I understand you spent ten

years at Gatwick Airport as a ground handling agent and then you joined Brook House in early 2009, first as a DCO?

A. That's correct.

Q. Brook House hadn't opened then, had it?

A. No.

Q. So it was empty?

A. Yes.

Q. So you could do your training within the centre?

A. We did, yes.

Q. You have been there from the start, effectively?

A. From day one, yes.

Q. Later, in 2009, or perhaps early 2010, you became a DCM?

A. Later in -- September 2009, I believe, yeah.

Q. Then, in 2018, you became an E1 grade, and you have helped us with what that is. It is between a DCM role and a senior management role?

A. That's correct.

Q. And, in 2019, you were seconded to a D2 grade job, which is a senior management role, and in 2020, effectively, you had a role at that level which became permanent; is that right?

A. Yes.

Q. As a member of the senior management team?

A. Yes.

Q. So now you're with Serco, who have taken over the contract, and you're still at Brook House and you're now an assistant director?

A. Correct.

Q. Tracing it back, during the relevant period, which is the middle of 2017, you were a DCM?

A. Yes.

Q. You say at paragraph 3 that you were a manager on the wings and then you became an Oscar 1?

A. Yes.

Q. Was that one wing or various wings that you were managing?

A. I managed D wing at the time but I could be covering other wings as well.

Q. Do you remember when you became an Oscar 1?

A. 2012, '13 maybe.

Q. You say in your statement at 3:

"The culture was fine on the wings but it did get worse when I became Oscar 1."

A. Yes.

Q. So was that around that time, that you think --

A. Yes.

Q. -- it started to become worse? The reason that you give is staffing levels and the centre being quite full most of the time?

A. It was, yes.
Q. Was that related to -- I suppose not if it was 2013. It wasn't related to the 60-bed expansion. It was just generally a full centre, lots of detainees?
A. We were generally at capacity, yes.
Q. At 6(b) you give more detail. You mention the lack of managers and staff during the relevant period. So now we are talking about 2017?
A. Staffing was low.
Q. In 2018, January 2018, you were interviewed by Ms Lampard and Mr Marsden for the Verita investigation interview, the events that were shown on Panorama?
A. Yes.
Q. We have the notes of that interview at <VER000270>. I won't show them on the screen. But you were asked about staffing and you said:
"If you'd have asked me two months ago, I would have said, if I can be totally honest with you, it was bordering on dangerous."
A. It was.
Q. Two months before your interview, so November 2017, so after Panorama. Why did you think it was dangerous?
A. The staffing levels were really low. I mean, you had four wings, you often had two DCOs looking after that wing. A DCM could be looking after two, three wings at

the time. So the staffing levels were really low.
Q. Just to be very clear, although you said "two months ago", it wasn't just that it became low after Panorama. Did you think it was low even before then?
A. Yes.
Q. So during the relevant period?
A. Yes.
Q. You mentioned one DCM sometimes between two wings?
A. Yeah, you'd have one DCM looking after two wings at one end of the building and one DCM looking after two wings at the other end of the building. But if that wasn't DCM -- I mean, I've done it -- I've some days looked after all four wings.
Q. I think you say in your statement at 6(b) if one of the DCMs was off sick, you'd effectively have one looking after all four?
A. Yes.
Q. We know it is a sort of H-shape, so they are quite far apart and the one DCM -- might be two on the same side or might be all four all across the centre?
A. Yes.
Q. How often would it be that a DCM was off sick or, for whatever reason, not there, meaning one person had to do all four?
A. I had to do all four quite regularly. It could be

someone off sick, it could be someone on leave. I think one side of the shift had more staff than the other side of the shift. Normally, you'd be looking after two wings. But, on occasion, you could be looking after four.
Q. Once a month, once a week, once a year?
A. Every couple of months maybe.
Q. You say one side of the shift had more than others. Are you talking about days versus nights or sides?
A. No, no, you had different sides of the shift so, you know, you always had someone on. So you had different sides. Normally, a weekend. So if someone was working a weekend, the other side of the shift would be off that weekend.
Q. Your view, at paragraph 30, is that two DCOs per wing, which is what the allocation was at the time, and you say that was for about 120 detainees, or up to 120?
A. 120 was the capacity, so you wouldn't have 120, but you could sometimes have 120 residents on the wing for two staff.
Q. You say, at 30, that wasn't adequate to enable staff to perform all the functions of the role?
A. Correct.
Q. You have described it, as we said, in the Verita interview, as "dangerous"?

A. Borderline dangerous, it could be, yes.
Q. Dangerous to ...?
A. Staff and residents.
Q. With understaffing, although perhaps this is a simplistic way to say it, either the company is willing to employ and pay people, but people don't want to work so you can't get enough people to join or, rather, maybe, they leave; or the company is choosing not to spend the money to employ enough staff. Do you have a view on which one it was during the relevant period?
A. I wasn't involved in the recruitment or staffing levels. I just did my job on a daily basis.
Q. Your observation was that there just weren't enough people but you didn't know why?
A. Yes.
Q. In your Verita interview at page 14 of the copy that we have, you are discussing various members of the SMT and you say in relation to Ben, which I understand must be Ben Saunders, because you're talking about the SMT during the relevant period?
A. He was a governor at the time.
Q. This is you speaking:
"I'll be honest with you. In my eyes, Ben was a stats/graphs man, all he's worried about is hitting

targets, making sure objectives were met. Very rarely you'd see him walking round the place. I shouldn't really say this, but I think he neglected the staff a bit, not interested in them."

Do you think that that's fair?

A. Fair enough, yes.

Q. When you say he was interested in hitting targets, did you mean sort of complying with the contract?

A. Yes, which I didn't know a lot about at the time. I do now, but I didn't at the time. But, yeah, that's what it seemed like.

Q. So financial targets or targets --

A. Contractual targets.

Q. Contractual targets. You say:

"I shouldn't ... say this, but I think he neglected the staff a bit ..."

Why does that equate to neglecting staff?

A. He wasn't visible. I mean, if you -- in my opinion, if you're a governor in a centre, you should be out and about engaging with staff.

Q. Has your view on that changed now that you're a member of the senior management team about, you know, the need for visibility?

A. Yes.

Q. It has changed or that remains your view?

A. No, no, it has changed.

Q. What's your view now?

A. The SMT do get out and about. They are doing a lot of work at the moment. We are more visible.

Q. It still needs to be done and now it is being done. Is that what you are saying?

A. Yes.

Q. Fine. In your statement at paragraph 10, you say:

"As a --"

Talking about the relevant period:

"As a DCM, it was hard to support DCOs, not through lack of wanting to but, because we did not have the time to support all their daily tasks."

You say you always tried to support them but it could be difficult due to pressures.

Is that, again, affected by the amount of people who you had to care for versus the amount of staff you had to do it?

A. If you're running one wing, you can spend more time with your staff so you can support them. But if you're -- say, like we spoke about earlier, if I was looking after four wings, it feels like your being dragged here, there. Even though you wanted to, it was more difficult to support your staff.

Q. You say at paragraph 11:

"I didn't formally report the fact that it was difficult to support DCOs at the time. But it wasn't secret. It was common knowledge within the SMT."

But you might have mentioned it during your yearly development review?

A. That's correct, yes.

Q. The reason you didn't normally report it, is that because they already knew?

A. It wasn't a secret.

Q. How do you think the SMT knew about this when you say they weren't present on the wings?

A. But they still know the staffing levels.

Q. How did they know about the effect of the staffing levels on the day to day?

A. Maybe the sickness went up. I don't know. There just wasn't enough -- the bottom line is there wasn't enough staff at the time.

Q. And the SMT knew this?

A. I assume so.

Q. Your statement covers the impact of staffing levels on morale. You mention stress and feeling overworked. You mention sickness levels. Did you mean sickness levels caused by being overworked or they would cause understaffing because people are off sick?

A. A bit of both, really.

Q. You say, at 31, it was mentally draining --

A. Yes.

Q. -- and that often people couldn't have breaks because, obviously, they have to work to cover. And you say, at paragraph 7:

"The SMT were not visible to staff which ... made it feel as though there was a 'them and us' culture and that staff were not properly supported."

The "them and us" culture you're talking about there, the "them" is the SMT, is it, and the "us" is the people on the wings?

A. DOMs and DCOs, yes.

Q. So "DOMs", known at the time as DCMs?

A. Sorry, DCMs, yeah. They are DOMs now; they were DCMs then.

Q. No problem. Known now as DOMs?

A. Yes.

Q. So the people on the wing versus the SMT is the "us and them" you talk about?

A. Yes.

Q. But, nevertheless, there were at least friendships between staffers within many workplaces?

A. Yes.

Q. That's the DOMs and DCOs?

A. Yes.

Q. You had friendships, as well as working relationships, with DCOs?
A. (Witness nods).
Q. I think also, at senior management level, you got on well with Jules Williams at least?
A. Yeah, he was my line manager for a time when I was on res.
Q. When you were on residential?
A. Residential, yes.
Q. You were asked to cover in your statement some issues raised by Michelle Brown in her Verita interview. She raised concerns, or made comments, including that she'd been left short-staffed while a number of people had gone away at the same time. I think -- I believe your answer is she was exaggerating the number of people who were away at one time and, in any event, if there were staffing issues, the company doesn't sign off annual leave. So you don't approve leave unless you have enough people to cover?
A. Yeah. If you want time off, there's a procedure of booking your time off. I think the time that you're referring to is -- everyone asked for leave, everyone got their leave approved. So that's the way of doing it and it still is now.
Q. Did Michelle Brown raise any issues around being left

short-staffed with you at the time?
A. Not with me, no.
Q. Were there any other issues which she appears to have had about you or your colleagues' actions which she raised with you at the time?
A. She didn't raise it with me.
Q. Did you feel it was an environment where you could raise concerns with the SMT, if you needed to, or indeed where they would tell you if they had concerns?
A. Yes. I mean, I was a DCM, so I could go and see the SMT if I thought I had to, but I also had my annual reviews with my line manager.
Q. This where you'd normally kind of raise any general issues that had been affecting you over the year?
A. It would be part of your review, you know, how you're getting on, it's your development, are there any issues?
Q. I think you say the sort of things you might have raised, although I know you can't remember specifically from 2017, are things like lack of being able to support your DCOs, and staffing, and also the time served national foreign offenders sharing cells?
A. Yes.
Q. You paint a negative picture in your Verita interview and in your statement to the inquiry and in front of us today about working at Brook House during the relevant

period with regard to staffing levels at least and morale being low and a distant SMT or an SMT that it was hard for people to engage with. Was that feeling shared generally between DCOs and DCMs at the time?
A. I believe so.
Q. Did anyone enjoy their work or feel positive about --
A. I'm not saying they didn't enjoy their work. They felt under pressure. I mean, back in those days, there was -- the staffing levels were a lot lower than they are now, so everyone had a bit of a -- you're spending 13-and-a-half-hour shifts. It's a lot of time to spend with the same people every day, day in, day out. So people were low, the morale was low, but the staff at the time did an amazing job for what they were doing and the resources they had to them.
Q. As to the friendship groups which formed, would it be fair to say that there were cliques in Brook House, so groups who inevitably end up chatting together, having their breaks together, maybe socialising together, together more than with others?
A. No more than normal. As I say, you're working in the same place with people for that length of time, you're going to see more of them.
Q. Was there a culture of looking out for each other in a difficult working environment?

A. Staff, back then, they did look out for each other, I feel, yeah. You had to.
Q. Was there a culture where perhaps friends or colleagues wouldn't grass on other colleagues if they saw something that concerned them or wouldn't report it because of the friendships?
A. Not that I'm aware of, no.
Q. Would you say that there was a laddish culture between you or between other staff at Brook House during the relevant period?
A. No. No.
Q. I'm going to ask you about a couple of specific incidents now. So the first is related to D1527. You were involved in an incident with D1527 on 25 April 2017. You were called up to his room by Callum Tulley, who had found him attempting to strangulate himself, or with a ligature around his neck, in any event. That was in the toilet. You were the person who used, I believe, a fish knife to cut off that ligature?
A. I wasn't called up there by Callum Tulley, no.
Q. Oh, so you were called up by -- was it Mr Fraser?
A. No. I wasn't called up by -- I was doing my rounds.
Q. Yes.
A. As an Oscar 1, I did my rounds. After dinner time,

I did my rounds of all the wings to see if the staff were okay, to see if they'd had their breaks and to check on the food refusals. I came onto E wing. I believe, at the time, D1527 was on a food refusal. So I checked to see if he'd had dinner. I made my way up to his room to see if there was any observations in his ACDT that he was currently on, because he was on constant supervision. When I got there, the officer on the door said he hasn't seen him, he hadn't seen him for a couple of minutes, so I went into the room and saw him in the toilet area with a -- what appeared to be a ripped T-shirt around his neck.

Q. So no-one called you there. You happened to be walking past. The officer on the door was Clayton Fraser, I believe?

A. I believe so, yes.

Q. Can we have a transcript on the screen, please, <TRN000001>. Chair, you have this at tab 9. We have seen the footage from this day earlier in the inquiry and some of it appears on Panorama as well. And, yesterday, we heard from Clayton Fraser about his involvement.

A. Yes.

Q. Turning to your involvement, you enter his wing as you say. You see the ligature around his neck, which you --

A. In his room, yes.

Q. Sorry, in his room on E wing.

A. Yes.

Q. You call for healthcare to attend immediately, I think, pretty much. You call healthcare. It's shown on the transcript. And then they duly do attend. If we turn to page 3, there's -- you realise he's got a battery I think, so second column, line 65, you say, "He's got a battery. Give me the battery", and then below that, 71, "Don't put it in your mouth", then you say, "He's got a battery in his mouth".

A. Yes.

Q. If you turn to page 4, please, when healthcare arrive you tell them "He tried to swallow a battery", which is on the second column at 66:

"... He tried to swallow a battery. He tried to swallow a phone battery."

That's you talking to Nurse Jo Buss. I believe. If you go to page 5, line 5, Callum says:

"What is -- what is wrong, mate? I thought we were making a bit of progress yesterday."

And you address the detained person. Going down to line 24, you say:

"Now, what do we do, just sit here all flipping night?"

You say:

"Take the battery out of your mouth."

Then, at 36:

"It isn't going to get you [off] this wing, is it?"

Then, at 42:

"When all we do is stuff like this, the longer you're going to stay in here."

You're saying these things, I think, to the detained person, to D1527. Is it because you felt inconvenienced by what he'd done with the ligature and the battery?

A. Not inconvenienced. I mean, I'd dealt with this particular resident prior to the incident. I mean, what happened is, when I removed the ligature from his neck -- I think you've skipped a bit here. If you look at the footage, he started shouting quite aggressively in my face. In my experience, you let -- I let them vent, so let him -- and then he calmed down. I knew this guy. It is not as if it's the first time I saw him, so I could speak to him -- the sort of rapport I had with him, I could speak to him the way I did.

Q. What do you mean by "it isn't going to get you off this wing" or "out of this wing"?

A. If I remember rightly, he wanted to go back to his previous wing. I mean, the reason he was down there is because he was on a constant supervision and I believe

he was on rule 40 at the time as well.

Q. Did you think he was -- he did the thing with the ligature and did the thing with the battery as a way to get moved, rather than for any other reasons relating to his mental health, for example?

A. I don't think he did that to get moved. He was obviously -- the guy -- you know, he had issues. That's not normal behaviour, to tie a ligature around your neck. It's not normal behaviour to put a battery in your mouth. But I spoke to him the way I did because that's -- you know, it's not the first time I spoke to him. I actually got -- I've sat down and had conversations with this resident.

Q. At 77, on the same page, you say:

"He's running around all day, he is."

And then you ask if he'll let the nurse talk to him. If we turn the page, at page 6, line 11, you comment "Could be a late one and all". You say that again. And then:

"The use of force flipping paperwork ..."

And then something inaudible. So you're in the room still with D1527 at the time and you're saying you're going to be there late completing use of force paperwork?

A. I could be potentially, yes.

Q. Did you want him to know that you had been inconvenienced by what he'd done?
A. I don't think I was talking to him at the time. I may have been talking to another officer.
Q. I think you are talking to another officer because it looks like it is staffer 2, but it is in front of the detained person?
A. Yes.
Q. Did you have any concerns about him hearing that you were saying it's going to be a late one and you have to complete all this paperwork?
A. Well, I don't see that as relevant. How would that concern him?
Q. He might be thinking that you feel like all of this is just an inconvenience to you?
A. I don't agree with that.
Q. The camera, as we now know, Mr Tulley was wearing is on D1527 in his room and you're in there as well. You're heard saying, at the top of the second column there, not to but while you're walking past and leaving the room in front of the detained person:
"[Something] a battery in his mouth, the cock."
Do you accept that D1527 could have heard this as well?
A. I said this to another officer. I think the officer

said to me "What's going on?" And I made that comment. It is a regrettable comment. It's not sort of the comment I would use. It's not the language that should have been used. I apologise for that. But you've just got to take into consideration, my adrenaline was going, I'd just potentially saved this guy's life, removed a ligature from his neck. He was screaming in my face. I was -- you know, my feelings were raised at the time. So I did say that. And I regret it. But I didn't say it to him, I said it to another officer.
Q. I think it is to Nathan Ring. It looks like you're walking out and Nathan Ring is walking in. Because he responds, as we see --
A. Maybe.
Q. -- and says "Has he?".
A. Maybe. There was a lot of people around at the time.
Q. You wouldn't use those words, you say, to a detainee?
A. No.
Q. But you would use them in their presence in certain circumstances?
A. I wouldn't normally use it. This is a one-off. I said it, and I say I regret it. But my adrenaline was running quite high because of what had just happened.
Q. So as well as D1527 being in the room, you said it in

front of Mr Tulley, as we know, because he's the one who recorded it, and Nurse Jo Buss, and it looks like Nathan Ring is entering. Did you know, when you said that, that none of them would take you up on it, using that kind of language?
A. Not at the time. I mean, everything was going on at the time. It's in the middle of an incident going on. It's not you stop and say -- maybe they already brought it up afterwards. I don't know.
Q. You don't recall that any of them did?
A. No.
Q. Would you have used that kind of language if a member of -- for example, I know that IMB sometimes oversee use of force events, obviously not unplanned ones. But would you have used that kind of language in front of the IMB?
A. I wouldn't have used that kind of language normally at all. It was a one-off situation and I have explained because of the incident that was going on.
Q. Nathan Ring enters, as we said, and he gave evidence last Friday -- I don't know if you saw that. He was asked about referring to D1527, just slightly down the page here, as "a Duracell bunny". About ten seconds after you left, he's entered. We can see that from the transcript timestamp. He then referred to D1527 as

a child and said he was sulking, and later he says about him, on page 7, "He's just a dick".
This is more of the same, isn't it? Your comments as you left the room to Mr Ring and his comments as he came in follow a theme, all insulting language?
A. It wasn't my "comments"; it was my "comment". One comment.
Q. Your comment, and Mr Ring's comments, all follow a theme?
A. I didn't hear those comments, but they were said because it was on Panorama and it's on this transcript.
Q. You agree it's all inappropriate language?
A. It is inappropriate language, yes.
Q. Demeaning, possibly, if a detainee hears it?
A. Potentially.
Q. If you had heard Mr Ring say those comments -- you say you didn't -- would you have challenged him on them?
A. Maybe afterwards. I don't know. I didn't hear those comments, so I can't really say. I didn't hear those comments. It was an incident that just happened. It was quite a major incident that just happened. I had to go off to do my reports. I had to make sure I handed over -- I handed over to DCM Ring. He took control. I had to go off. But I spoke to Jo Buss outside and then I left the wing to do my report.

Q. If you had heard him say, as I asked, "He's just a dick" or call him a "Duracell bunny", you might or might not have followed it up with him?
A. I probably would have done.
Q. Would that have been a bit hypocritical, given that he's heard you call the detainee a "cock"?
A. Maybe. But, as I said, my adrenaline was running at the time.
Q. According to your statement at paragraph 63, you car shared with Mr Ring when you were both working at Brook House from time to time. So you'd heard him talk about detained people before, presumably, just sort of chat in the car about your days and things like that?
A. Not really. When we were outside of work, I didn't really want to talk about work.
Q. Had you ever heard him, within work, talk about detainees using these sorts of terms?
A. No.
Q. How do you feel about it now, now that you've seen what he said? Do you feel it is appropriate for someone who makes comments like that to be working with detained people?
A. It is not appropriate, but I think -- I did see Mr Ring the other day. He said maybe it's a coping mechanism. I can't speak for him. I can only speak for myself.

Q. A coping mechanism because of all the pressures that you were under, that you --
A. That's what he said.
Q. I see.
A. I mean, my coping -- everyone's coping mechanisms are different.
Q. What were yours?
A. I used to try and make light and joke of things. That was my way of coping.
Q. If we go to page 8, please -- so you're now out of the room. You're talking sort of on the E wing shared area. You say at the top:
"You need to keep an eye on him."
Either to Mr Tulley or to Nurse Buss, I think.
Line 23, you say:
"What's he doing now?"
Then, at line 28, you say "Sulking".
A. Mmm-hmm.
Q. At the bottom of that we see D1527 says:
"I will die. No, you don't need to do this."
To Nurse Buss. So you find him with a ligature around his neck which you had to cut off and he'd put a battery in his mouth. You said to us it's not the actions of someone who's well?
A. No.

Q. Did you think he was sulking?
A. It's just the way he came across. The way -- he was up, as you've seen by the footage. After I cut the ligature off, he was shouting in my face, his mood was up. Then, all of a sudden, he went down, he sat on the bed with his head down. I didn't mean anything derogatory by it, that he's "sulking". That's just the way I explained his demeanour at the time.
Q. Having thought about it now and had an opportunity to think about the events after that day, do you regret using the word "sulking"?
A. It might have been not the best word to use, but sulking's not -- if someone is sulking, it's not really a bad thing. It's just the way he came across to me. Someone asked me how he is, I said, "He looks like he's sulking", at the time.
Q. Do you stand by your description of him during the ligature and battery event as being aggressive to you?
A. He was aggressive after he stood up. I cut the ligature down. We pulled him out of the toilet area. We sat him down and his mood escalated. So he was aggressive, yes. He was shouting in my face.
Q. You were Oscar 1 during this event and we have Mr Ring here who is a DCM. Thinking about the example of the language that the one word "cock" and then the use

of "sulking" to describe him, and then the language that Mr Ring used, which I know you say you didn't see, but you've now read, thinking about the sort of example that that sort of language sets to maybe more junior members of staff who are around -- for example, Mr Tulley was there, of course, he was more junior -- do you agree that it would make it pretty hard for you to later pull up a staff member for using inappropriate language if they have heard you say such things?
A. I made one comment and I've explained that it was a wrong comment. I didn't hear Nathan Ring's comment so I can't comment on what he said.
Q. Do you agree that if detainees heard you speak like this about one of them, it might make them less likely to come to you with concerns they had about any actions?
A. Potentially.
Q. It might make a member of staff who was concerned about a colleague's language less likely to come to you or, I suppose, to Mr Ring?
A. Yeah, I think you're focusing on language. I mean, you're focusing on language. I think you're reading into this too much. It was a one-off incident. It was an incident. These things happened. I've explained my comment. I can't speak to -- I think you're reading into it too much, if I'm honest.

Q. Finally, then, on this incident, in your witness statement at paragraph 85, you say:

"I was perhaps frustrated by the fact that a member of staff on constant watch waited many minutes before entering D1527's room after they'd lost sight of the detainee. If you are tasked with watching someone, you should take appropriate action when you cannot see them. I was perhaps also frustrated from a safeguarding perspective as it should have not got to a point where a resident could place a ligature around his neck. I take my role very seriously and this incident should have been acted upon earlier."

A. That's correct.

Q. You think, and I think it was confirmed yesterday, Clayton Fraser was the officer who was keeping constant watch of D1527 at this time?

A. (Witness nods).

Q. So he told the inquiry yesterday it happened in a split second and he acted as soon as he noticed something was wrong, but your statement suggests it should not have got to that point, where he hadn't seen what was going on and you had to come in?

A. Yes.

Q. That caused you frustration and concern?

A. Yes.

Q. Did you report Mr Fraser for failing to do proper observations, as you see it?

A. I didn't report him, no. I was frustrated at the time because I felt I did his job for him. A constant -- if someone is on a constant supervision, it means what it says: you should be supervising them constantly. He didn't for a split -- which is why I entered the room. I think maybe he should have entered the room earlier and it could have been, you know -- that -- it may not have happened.

Q. Before it got to that point?

A. Yes.

Q. You say you didn't report him. But did you speak to Mr Fraser informally, as far as you remember, about failing to do constant observations?

A. I don't think so, no.

Q. Did you take any action at all to ensure what you call a safeguarding issue here doesn't happen again?

A. What, with Mr Fraser?

Q. Yes.

A. I didn't speak to Clayton. He didn't often work at Brook House. I didn't work with him a lot. He worked at Tinsley. In hindsight, maybe -- I mean, I might have made a comment to him. If you are on a constant supervision, you should be watching someone all the time.

Q. You've been asked in your witness statement, and you deal with it at 97, about an occasion where you called a detained person a "knobhead" and a "fucking arsehole". This is about the detainee rather than to him. You can turn up 97. You say you don't consider that the use of those words was appropriate and you say the use of your language was regrettable.

A. It is, and I remember that. It's when I left the room. I think the document said the door was closed. You've got to bear in mind that these -- you're dealing with -- you have quite good relations with some of those residents. I remember that resident. I'd been helping him pretty much for a big part of the day with the case, and then you go back and see them and they sort of throw it in your face a bit. You get abuse constantly on a daily basis. Quite bad abuse. So when I -- I left that room, the door was closed and I made those comments I would not say it to his face. It's like the previous one. It was said to someone else.

Q. The previous one you described as a one-off. It's not just a one-off, but unusual?

A. Yeah, I would never speak to a resident using that language. And both occasions, it wasn't to the resident. It was both as I was leaving the room.

Q. Again, it's to another member of staff, and of course it was Mr Tulley because he was the one who recorded it, so we know it was him, and he's a DCO I think at the time?

A. He was a DCO, yes.

Q. So, again, you're using it in front of a more junior member of staff, although, as we see, not a resident.

Can I ask about mental health training then. You discuss this at paragraph 64 of your statement. You say that you spent a lot of time on CSU, the Care and Separation Unit; is that right? As well as E wing generally?

A. Yeah, E wing is here, so the one -- one leads into the other. It's the same level.

Q. Can I ask, as someone with experience of E wing, what's your view on using E wing for detainees with mental health issues?

A. E wing was -- you had constant supervision rooms. E wing was used for people -- maybe vulnerable detainees -- residents, sorry, vulnerable residents. There was a couple of rooms there that could be for medical rooms. You had the constant supervision rooms. So it was used for all different -- it was a quite challenging wing to work on.

Q. If vulnerable people or vulnerable residents didn't want to be moved to E wing, would you use force to take them

there while they were -- there had been a planned removal of them to be removed to E wing because they were vulnerable, not because they'd done anything wrong, but would you use force in those circumstances?

A. You wouldn't use force. Force is a last resort. You wouldn't use force on someone that was vulnerable to move them to another area. That doesn't make sense.

Q. Did you consider there was a difference between the reasons why somebody would be on E wing? So you can be there because you need to be kept there to keep you safe, to keep an eye on you or sometimes because you're on rule 40 or 42?

A. If rule 40/42, you'd be in CSU.

Q. One leads to the other, you said, but they're separate --

A. CSU had six rooms and it follows on from the 13 rooms in E wing.

Q. People in their rooms in E wing are kept in their room for a period of time. Their rooms are locked. Which I think is the same with everybody. Obviously, overnight, the rooms are locked. Is that different on E wing or is it the same?

A. It's the same. This gentleman was on rule 40, I believe, on E wing. The reason he was on rule 40 on E wing is because he was on a constant supervision and

the doors are different in rooms 7 and 8. They are big glass panels so it is easier to observe them. But his door would have been locked because that's the regime for rule 40.

Q. What about being allowed off the wing, so off E wing getting to sort of, you know, go to the gym or whatever?

A. People on E wing were allowed off the wings. It depends what they're down there for. Some people could be down there for their own protection so they wouldn't be going off the wings.

Q. I wanted to ask more about sort of mental health and vulnerable people. So you say, at 42 to 44, that during the relevant period -- I'll let you turn to it -- there were not enough mental health nurses and you also note that DCOs were not mental health trained and could not support detainees with those needs.

A. That's correct, yes.

Q. Did you consider that you -- you were obviously not a DCO but a DCM. Were you trained in that at all --

A. No.

Q. -- or were you the same? When you became a DCM from a DCO, no extra mental health training at all?

A. No.

Q. Would that have been the same for all DCMs, as far as you know?

A. I don't recall any mental health training.

Q. Did you consider, then, that you and the DCOs you worked with were equipped to deal with mentally ill detainees?

A. No.

Q. Do you think that you and your colleagues could distinguish between someone who was being disruptive, you know, for another reason and someone who was being disruptive because they are mentally unwell?

A. I wouldn't know the difference as I'm not trained in it.

Q. What about someone who's showing signs and symptoms of some of the more complex conditions we get, like PTSD, for example, or trauma survivors?

A. I'm not trained in that either.

Q. You wouldn't be able to spot it. Were you aware of the introduction, in August 2016, of a DSO on the management of Adults at Risk? The Adults at Risk policy, it's called, or AAR it's sometimes referred to.

A. Adult at Risk, yes.

Q. Did you know about that at the time, so 2017, after it came in?

A. Potentially, yes, I might have been aware of it. Whether I read it or not, I don't know.

Q. Do you recall any training on it or not? Don't know?

A. I don't recall any, no.

Q. You say, at 44, that while you believed at the time that

there were not enough mental health nurses, you didn't formally raise this with the SMT. You say, again, it was not a secret, the SMT were aware of those issues?

A. In my view, there weren't enough mental health nurses. The ones we did have were really good. Some of them still work there today.

Q. Yes.

A. But, again, it was like everyone, you know, you're being stretched, because you'd have -- mental health service would normally be involved in rule 40, the ACDT constant reviews, I think --

Q. They were in demand?

A. They were in demand, yes. We all were.

Q. If you've got DCOs and DCMs who aren't trained in caring for people with mental illnesses, you potentially need more healthcare staff with those skills?

A. (Witness nods).

Q. You say the SMT were aware of these issues?

A. I believe so, yes. So it wasn't a secret.

Q. Do you know how they became aware of those issues?

A. I just assume they were aware of these issues. I mean, as I said before, when I had my yearly review, any concerns it brought up, that's probably one of the concerns I would have brought up.

Q. Would you have spoken to -- so you're the DCM. Was

there an E1 in between you and the SMT during the relevant period?
A. I can't remember, to be honest.
Q. You don't remember if you spoke to anyone specifically? Did you have, like, somebody you could more informally raise --
A. I had so many line managers during my time there as a DCM, so I can't -- specific dates and that, I don't know. George was my line manager. A guy called Chris Milliken was the line manager and Michelle Brown was my line manager.
Q. You don't remember speaking to any of them about this in particular?
A. Only in my reviews.
Q. Do you remember that you definitely spoke to them about it in your reviews or it's just the sort of thing you might have done?
A. Not definitely. Yes, it's the sort of thing you might have brought up.
Q. Thank you. We have some questions about D1914 now. You address this incident at paragraph 88 onwards. Just to remind everybody, it is an incident where D1914 was due to be removed out of the country the following day, and so, in preparation for that, he was moved to E wing. This is the detained person who had a history of some

heart conditions.
A. Oh, yes.
Q. In terms of your involvement, there's various officers you record on the DCF 2, so the use of force paperwork, the red sheet, that you called them to tell them that they were on the team. You appear at the briefing and, indeed, when Mr Dix introduces the event, he says it will be supervised by DCOs, although he means DCM in your case, Steve Loughton and Shane Farrell. So Mr Dix is also a DCM, isn't he?
A. Yes.
Q. He was at the time?
A. Yes.
Q. He's briefing the team, from the note I just quoted, at about 9.25, so just before the event. We saw footage of this during the first phase of the inquiry because Mr Tulley was asked about it, and I understand you have been provided with that footage too. Has that jogged your memory of your role in the events? As I understand it, there were two teams -- one was focused on the roommate of D1914 and one on 1914 himself?
A. Mmm-hmm.
Q. What was your role in relation to those teams?
A. I had -- was supervising the team of -- what was his --
Q. 1914?

A. -- 1914, the other gentleman, so his roommate. So my role was to ask that gentleman to exit the room.
Q. You're not part of the team, of course, in PPE who carry out the force on anyone or carry out the removal of anyone?
A. I had a team in PPE.
Q. Sorry, you're not wearing it?
A. No, supervising it.
Q. Supervising it. Who is in charge of the event as it relates to D1914?
A. Who was running it?
Q. Me.
A. Steve Dix was running it. I think he did the briefing.
Q. Yes, he did. What, if anything, was your decision-making role in terms of the decision to use force on 1914? Was that completely up to Mr Dix or were you involved in that or were you solely focused on the roommate?
A. I was focused on the roommate.
Q. You didn't, for example, decide when to go in, what sort of negotiations to use on D1914? You were just talking about the roommate with your team?
A. I believe so. I can't remember the briefing, but my job was to get the roommate out of the room as quickly and safely as possible.

Q. I understand that you chose some of the officers to use on this occasion, which was possibly the ones to be on your team, which I suppose would make sense. In any event, even if we're talking about other times, talk to me about how you would choose a team for a use of force event?
A. Sometimes you wouldn't -- you wouldn't choose the team yourself. It depends how quickly you needed to get a team together for whatever incident or situation it was. Because you need to be going away and doing your briefing script. So sometimes you would call the control room, "I need a certain amount of officers in full PPE kit for an intervention". But if you were choosing a team, you would probably choose people of the same height, you would put experienced people, depending on -- it depends on the guy's history, the resident's history.
Q. Mr Paschali gave evidence about use of force to the inquiry and he said that the same people tended to be used. He said he was one of those people. And he'd raised concerns about it and was told get on with it and that there were jokes made that he and others would enjoy it and he said he, in fact, didn't enjoy it. Do you recall the same people being repeatedly used, maybe the strongest people or tallest people?

A. It did seem that the same people were used a lot more than others, so I agree with Mr Paschali on that, yes.
Q. Who was making the decision to use those same people more than others?
A. As I said, it could be the DCM if you have time, it could be the control room just maybe picking the same people.
Q. Who works in the control room. What's their level?
A. DCO.
Q. So sometimes DCOs can make up the teams based on who is there and sometimes DCMs choose them themselves?
A. Because they know where people are working and where they can spare staff.
Q. Did anyone ever complain to you that they were being used more often than other people?
A. Not complain to me, no.
Q. Did they mention it to you, "I'm always being chosen"?
A. Not that I can remember.
Q. Mr Collier, the inquiry's use of force expert, has reviewed this incident, and I think you've been given an opportunity to consider his report generally. However, he only focuses on the use of force in relation to D1914. I understand that that was Mr Dix, that's why he did the briefing, and he is mentioned and you're not, in fact, mentioned in the report in relation to that

incident at all. So all I will say about that is that Mr Collier says that, in general, force was not used as a last resort on that occasion, and he says that there was an opportunity to continue with dialogue, and he also says that using staff in PPE was not necessary or reasonable, neither was using force at all. Just a question about PPE. Mr Ring was asked about this yesterday and said, with planned use of force, you were all in full PPE. He said there's no planned use of force without full PPE. Is that right?
A. That's correct.
Q. Is that a Brook House policy or, as far as you know, is it a wider policy? Why always PPE for planned use of force?
A. I think that's what's in the Use of Force manual.
Q. Even with somebody who, you know, is quite small or doesn't -- you know, they are a bit resistant to going but they're not likely to put up a fight. You still use --
A. Full PPE.
Q. -- full PPE for everything. Thinking back to that incident. If you'd have had concerns about Mr Dix's choice to use force in those circumstances, would you have been able to raise them with him?
A. I wasn't there. I had gone away. I didn't see the use of force.

Q. Sorry, not during the event. In the lead-up. So you were there during some of the briefing discussion?
A. I was there for the briefing.
Q. We will have a look at that. Would you say that you knew enough about the background and, if you did know enough about the background and had concerns, would you have felt happy to raise them with Mr Dix, say, "Have you tried having one last chat with him?" or "Try again tomorrow"?
A. I don't understand what you mean.
Q. Mr Collier is critical of the decision to use force. He says that the flight wasn't until the next day. It wasn't necessary to use force on that day. If you'd have been in the room with Mr Dix when he was making that decision to use force and if you would have had a concern at the time, would you have felt able to raise that with Mr Dix?
A. Yes, I think so. But I think he's been moved to facilitate his flight for the next day.
Q. That's right. He was being moved to E wing and the flight was the following day?
A. Yes.
Q. Perhaps we can turn now to the transcripts which relate to this event. So if we go to <TRN0000087>. It is

tab 10 of your bundle, chair.
A. Is this coming up on the screen?
Q. Yes, there we go. Page 16, if you don't mind. Thank you. So this is the briefing in which you're sort of involved sometimes and sometimes not involved. You introduce there, at 551, the background, "Detainee is [fit] to fly", it should say, "will need a medical [expert]", and you read out --
A. "Escort", "medical escort".
Q. "Escort". You read out:
"I'm happy for reasonable force to be used to facilitate the removal."
You're reading from a sheet there, I think, somebody else's decision. I believe. Then you speak about the doctor. At 570, you mention:
"Bypass. Triple bypass, heart attack, triple bypass booked in for August."
Down to the bottom of that page at 594, Callum Tulley, who has heard that medical background and is preparing to be involved, says:
"Now you've got me nervous for slightly different reasons now". Yan Paschali says "Oh, relax, man, you will be fine". Dave Webb says, "If he dies, he dies."
Going over to the next page, Yan says:
"Yeah, exactly."

Dave Webb says:
"It's nothing on us."
Now, you'd left the room at this point, you can see from the footage. Turning to page 19, at 674 onwards, Callum Tulley says, at line 674, so the bottom part:
"'Cause I am wearing the shield ... and, like, just thinking, you know? They need to get -- they should get a -- surely they should get like a supervisor in for this. C&R supervisor."
Dan Lake says:
"Yeah, John Connolly or something like that."
Callum says:
"I suppose Dave Webb is actually on the restraints, isn't he?"
Dan Lake says:
"Yeah."
Callum Tulley says:
"We'll see what happens ..."
Dan Lake:
"If he dies, he dies.
"Callum Tulley: I hope, well obviously I hope not."
Then there's another reference which I won't take you to at page 20 where Callum says he's worried about this guy and Dave Webb says that they've got the fit to fly letter which he describes as a disclaimer.

Had you heard talk like that in front of you?
A. No.
Q. Had you heard the phrase "If he dies, he dies"?
A. I haven't heard that mentioned myself.
Q. In relation to use of force?
A. It was talked about in the wing office at E wing. I think it was a bit of a joke. It refers to a phrase from a famous film, I think.
Q. Is it Rocky IV?
A. It is Rocky IV, I believe.
Q. What was it talked about on the E wing?
A. It was just a phrase that someone made once. I've never heard it said -- that was the only time I've heard it said. I've never heard it said in front of residents, I've never heard it said -- like Dave Webb said it there, I haven't heard that.
Q. You haven't heard it said in front of residents?
A. No.
Q. Have you heard it said about residents?
A. No.
Q. So in what context was it said?
A. No, they were talking, like, discussing where it comes from. That was all. That it's from a film. It's a phrase from a film.
Q. Why was it brought up?

A. It was just talk in the E wing office one day.
Q. About who dying?
A. No-one dying. They were talk about the phrase from the film.
Q. They were just saying, "Have you seen a film where there's a phrase, 'If he dies, he dies'"?
A. They mentioned that phrase and said it's from a film.
Q. Mr Lake gave evidence this morning and said he didn't recall saying it himself, but he said, "I've heard it around", and when he was asked specifically, he said, "It's just the culture of Brook House". Similar to what you are saying: the phrase has been heard, said around?
A. I haven't heard it being said around. I just know that that's where it's from.
Q. Right. When people were talking about it on E wing, were they talking about, "I heard someone else say it and here's where it's from"?
A. No, it's just said it was from a film. That's all. I think -- that's all. I haven't heard it said. The phrase is from a film; that's all I know.
Q. How do you feel listening to people saying it in relation to use of force, planned use of force on someone?
A. But I don't think they did.
Q. Here in this example, where Callum says, "I suppose

Dave Webb is actually on the restraints", Dan Lake says "Yeah". Callum says, "We'll see what happens" and Dan Lake says "If he dies, he dies"?
A. Which line is that?
Q. Line 680:
"Callum Tulley: We'll see what happens.
"Dan Lake: If he dies, he dies."
Callum says "... I hope not"?
A. And then laughed. I wasn't there. I didn't hear that.
Q. Do you accept that's used in relation to the use of force they're planning?
A. I don't think so.
Q. You think they were just quoting from a film and a conversation?
A. Yeah. That's why he's laughing afterwards. It's probably something he's just said. No-one wants to see anyone die, do they?
Q. Then if we go to page 33, it's 1124, line 1124, this is you, Steve Loughton:
"... staying outside. So [something] you're going into the right, stand there like that [imitates holding a shield up]. It stops him fucking about."
Callum Tulley says:
"Yeah, understood."
Steve Loughton:

"Yan will probably push you into him anyway."
And then Dave Webb says:
"Alice is our four."
So use a shield to "stop him fucking about" and the plan is for Yan to push Callum and his shield into D1914. Do you remember that conversation?
A. Not really. I'm guessing that where it says you hold the shield, you hold the shield to stop them moving. You can maybe hold -- not on them. You could put it at an angle. What I mean by Yan probably pushing him anyway, I think Callum was a bit worried about being on the shield, maybe, and I just said, "Look", trying to reassure him, "you've got two officers behind you". You go in a team of three.
Q. Can we turn to the transcript <TRN0000090>, please. This is page 3. Tab 13, for your note, chair. Talking about the same detained man, but this is two weeks later.
A. 1914?
Q. Sorry? It hasn't come up on the screen yet. If you just wait a second. It's at tab 13.
THE CHAIR: Tab 13, page 3.
MS MOORE: It is only a short excerpt. This is, we see from the cipher, the same detainee. You are saying:
"That D1914 (inaudible) triple heart bypass."

Ryan Bromley says:
"His body's just been butchered."
You say:
"[Something] can fight. He looks like a traveller, you seen like travelling circus, like a, bare knuckle, he looks like one of them."
Do you think that's an appropriate way to refer to a detainee in front of other staff, looking like a traveller or someone from a travelling circus?
A. He was a traveller, I knew this guy. He was a Romanian gentleman. I had a lot of dealings with him. I got on really quite well with him, to be fair. He told me he was a traveller.
Q. So you're referring to him in the way he would refer to himself?
A. Yes.
Q. Finally on this point, you took part in an interview with Verita on 26 January 2018, which we do have, although I won't ask for it to be on the screen. I will read it out to you unless you wish to look at it. It's at <VER000270> for anyone's note. You were asked:
"What groups of the population would you say are most difficult to deal with? Or aren't they? Is it just individuals?"
And you say:

"It is individuals. On the whole, the Albanians can be quite problematic. They tend to go around in groups and they can be a bit problematic before there is any charter, if they are told to go, which is done on the overnight. Jamaicans can be a bit loud, play the dominoes and that, but it's a bit unfair saying."
Then you stop. You say:
"You do get your problematic individuals who then can incite other individuals ..."
You go on to say it is part of the job you have to deal with. Were detainees treated differently, depending on their nationality and perceptions about how they might behave?
A. No.
Q. Was there an assumption that certain nationalities might be more problematic than others?
A. Not really. As I've explained there, you get trends with different nationalities, but you get problematic people whatever, any walk of life.
Q. Would different decisions be made about, for example, about the use of force team to use on detainees from one nationality versus another?
A. No.
Q. We have heard in the course of the inquiry -- not attributed to you -- very explicitly racist language,

for example, the use of the N word being used at Brook House. Did you ever hear anything like that when you worked at Brook House?
A. Absolutely not. Never.
Q. What would you have done if you had?
A. I would have challenged it.
Q. Are you shocked to hear now that that was happening?
A. Yes.
Q. Can I ask about another specific event. You mention this at 113 of your witness statement. So you might wish to turn back to tab 1. Page 24 is where that section of your statement starts. This is an incident where D1538 was restrained by Mr Bromley, Mr London and Mr Farrell in a classroom. You weren't directly involved in this incident yourself, so we may have questions for those who were. But you were asked about some comments that were made by Mr Bromley after the incident. So on 10 June, Mr Bromley spoke about this incident to Mr Tulley and said:
"Did you see Shane?"
Sorry, Mr Tulley said:
"Did you see Shane?"
Mr Bromley responded:
"He took his head clean off."
And then went on later to say they pulled him,

pulled his neck right down. Obviously, we can ask Mr Bromley about the comments he made. It is obviously clearly a figure of speech as well. His head didn't come clean off. But these words suggest, don't they, that Mr Bromley felt a lot of force had been used?

A. (Witness nods).

Q. If he felt that way, would you have expected him to tell you or to tell another DCM about that?

A. Yes, I would, yes.

Q. Do you recall that anyone did speak to you about this event?

A. No.

Q. Did Mr Bromley tell you --

A. I was involved in this event. I was the Oscar 1 at the time. So I attended this incident.

Q. Oh, you did attend, fine.

A. Yes.

Q. You do say that you reviewed this incident as well at 116.

A. Mmm.

Q. I believe close to the time. You say either you or another manager would have reviewed the reports and viewed CCTV footage as well?

A. I reviewed the reports because the reports end up with the Oscar 1.

Q. So you say at 116:

"I or other managers would have reviewed the reports and viewed CCTV footage."

The top paragraph of the last page of your statement.

A. Yes.

Q. Was that what you'd normally do when there'd been a use of force or why would CCTV --

A. I'm trying to think. CCTV -- I wouldn't have reviewed the CCTV. I would have reviewed the reports.

Q. I see. Mr Collier mentions in his statement in relation to this event that no body-worn video cameras had been turned on at the time, so we only have the CCTV?

A. Right.

Q. He also says there was no record of injury form, even a blank one to say there is no injury. Did you pick up on those things when you reviewed the reports?

A. That there was no body-worn cameras turned on? Yes, I did.

Q. Did you do anything about that? Did you speak to the people involved?

A. Sometimes, when there's an incident and it happens that quick, you don't have a chance to put your body-worn camera on.

Q. Do you think this was one of those incidents?

A. Yeah, maybe, potentially. I remember the incident. I was in and out. I was at the incident, but I was sort of overseeing the whole incident, not just the use of force incident.

Q. I see.

A. You've got to take a lot of things into consideration when you're dealing with an incident like that.

Q. There had been a period where I think the detained person had picked up a pencil, a sharpened pencil?

A. I believe so, yeah.

Q. And then the force was used and there was a period of time. So there wasn't time, as far as you can remember, that body-worn video cameras could have been turned on?

A. Potentially maybe. But I don't know.

Q. What about the lack of a record of injury form? Did you notice that when you were reviewing the records?

A. A lack of ...?

Q. Record of injury to detainee forms. So it wasn't filled in?

A. I don't know.

Q. I'm asking you about another specific incident now, just a brief one. We have heard from a formerly detained person D643, who you should have on your list there, we heard his live evidence to the inquiry on Tuesday, 22 February. He was noted or accused of plotting to

escape Brook House and this was an occasion -- from his recollection, he'd attended hospital due to chest pain. The doctor had told him he needed to come back for a CT scan and she'd written her phone number on a form given to the escort so that the scan could be arranged. We have seen his healthcare notes that confirm the same. Healthcare viewed this as a possible escape attempt and it was recorded this way on his records. We see later on, a few months later, he's still mentioned as a possible escape risk. He says in his statement at page 32, and his statement is <DL0000228> he complained to you about this accusation. He says:

"I remember that I complained to DCM Steve Loughton about this but he did not listen to me."

Do you remember this gentleman?

A. I vaguely remember it. The guy, I think, was at the centre for quite some time. I had quite a good relationship with the guy, which is probably why he came to me. If that was the case, maybe he thought I didn't listen to him. I would have reported that to our security department.

Q. What would you have reported, just that he's complained about it?

A. His concerns, yeah.

Q. Is it then for the security department to update

someone's escape risk?
A. Yes.
Q. So you'd assume that, if he did talk to you, you've told security and then it's their action to take forward?
A. Yes.
Q. The inquiry has also heard evidence from a former Brook House employee, Mr Owen Syred. So he spoke of an occasion, back in 2015/2016, when he suspected a female officer of bringing in --
A. 2015?
Q. Yes.
A. Blimey, seven years ago.
Q. I will summarise the account given in his statement for you but, for the reference, it is <INN000007>. It is paragraph 90. He said he could recall a DCO failing to challenge the presence of a detainee who was a suspected drug dealer. He raised the issue with this DCO. And they said, "Don't go throwing your weight around with him", which Mr Syred took to be a threat. Then he says:
"In these circumstances, together with my colleague Shaun Nicholls, we submitted a security report and spoke to the night manager, Steve Loughton. We inspected the security camera recording and we could see clearly that the suspected drug dealer passed objects to other detainees on the stairs (which ... we assumed to be

drugs) and before leaving he spoke in [this DCO's] ear."
Then he says that she "was subsequently suspended but I don't know the precise details". Do you remember this event at all?
A. No.
Q. If you were told not even just in 2015, but in any period, about a DCO being seen speaking to a known drug dealer and someone raised concerns about it and maybe they were seen passing objects, what sort of actions would you have taken?
A. So they filled out an SIR, did they? Is that what it says?
Q. I'm afraid I'm just quoting from his statement, but is that what you expect would happen, someone would fill out a serious incident --
A. If they'd seen -- sorry, can you repeat, please?
Q. If a DCO came to you and said, "I think another DCO is potentially passing packages to a detainee. Can you help me with this? Can you look at the CCTV?", you seem to suggest you'd fill out an SIR?
A. I would go straight to the security department with that and report it straight away, yes.
Q. Would that be to the head of security or anyone in security?
A. Potentially, if that's the information I was given,

I probably would go to the head of security, yes.
Q. Because it's particularly serious?
A. Yes.
Q. Other witnesses have told us about drug taking in the centre, particularly spice, amongst detainees, and I think yesterday hooch was mentioned as well. Thinking about 2017 in particular, do you recall a particularly high level of spice use by the detained people?
A. There was -- it came in fits and starts. You'd have a certain time when it was rife and then it would settle down. There was a certain -- numerous medical responses where spice -- what we believed to be spice was taken.
Q. Yes. Did you have any view on how drugs might be getting into the centre?
A. Visits, post. The thing is, with spice, it's very hard to detect. From what we are told, you could put it on a blank bit of paper. It's not like cannabis where you actually see it. It's harder to detect.
Q. You can spray it onto paper?
A. I believe so, yes.
Q. You said visits might have been --
A. Visits could have been a contact or through the post.
Q. Were visitors searched before they came into the centre?
A. Yes.
Q. Was the post searched in any way or checked?

A. I believe so.
Q. It might not be your area?
A. It wasn't my area, no.
Q. What about staff? So you worked there, would you have been searched when you entered the centre?
A. Not very often.
Q. How often?
A. Staff searches didn't happen very often then at all. It's hard to say, it was a long time ago, but it didn't happen. Very rarely. Sometimes they'd have dogs in but, again, that was very rare.
Q. Would it be random or would you know in advance that there was going to be dogs?
A. You wouldn't know in advance, no. That defeats the object, really, doesn't it?
Q. When you say "not very often", do you mean less than once a month?
A. Yes.
Q. Maybe a couple of times a year?
A. Sometimes you might have a few in a month then you wouldn't have them for -- there was no pattern.
Q. Were staff ever drug tested?
A. Not as far as I'm aware, no.
Q. Do you recall any concerns being raised, whether in the relevant period or otherwise, about drugs being brought

into the centre by staff?
A. It was a possibility. I never knew of it.
Q. Was it something people talked about as something that might be happening?
A. Not to me, they didn't.
Q. What about concerns about staff taking drugs? Were there concerns that staff weren't fit to work because they, themselves, were taking drugs?
A. It wasn't brought to my attention, no.
Q. I'm going to move on to the period after the Panorama broadcast now. The first thing I'd like you to look at, on the screen, please, is <CJS001036>. You have this also at tab 14. This is a supported living plan for a detained person called D1275. You have the cipher. So this supported living plan, while we are just waiting for it to come up on the screen, was opened on 4 September 2017. You may remember that was the day of the broadcast of the Panorama programme?
A. Okay.
Q. It was opened, we can see from the document, in anticipation of the broadcast, because I think you were told it was going to be on TV, but obviously not what the content exactly would be for the broadcast.
A. Yes.
Q. We have it there. You will see from the face of it

there, the detainee's name, which is ciphered. It is ticked there "learning disabilities", as is "other" and somebody has filled in "safeguarding". We see halfway down the page:
"Required frequency of observations and conversations. 1. Observation each AM, PM, eve, with a conversation plus two nightly observations."
So that's three conversations a day and then at night you just sort of check that they're okay, but obviously don't wake them up.
If we go to page 2, there's space there for the detainee's signature but it says "would not sign" and if we go to 4, we can see the reason for it to be opened. Sorry, page 5. The document has page numbers written on it as well. It says that have they stated they are suspected of being at risk:
"No -- concerns over safeguarding of him due to allegations made by BBC Panorama."
There below:
"Detainee ..."
In box C:
"Detainee requires support from staff in light of BBC Panorama programme."
We can see this is all completed, I think, by Mr Povey-Meier. He signs it off at the bottom as head

of safeguarding. You have seen Panorama, I assume?
A. I have, yes.
Q. D1275 was filmed on 14 June 2017, having been suspected of taking spice. So he is lying on the ground, and there is footage of him being mocked, with officers making remarks like calling him a "div" and "scrotum" and saying about him -- this is Derek Murphy this time -- "If he dies, he dies". We have heard evidence on D1275's behalf, although not from him directly, addressing his mental condition, vulnerability and his lack of capacity in relation to various matters. So that's who he is. The SLP, as we can see, was opened due to concerns about what was on Panorama. You are involved because you close it and I'm going to ask you about that. Do you happen to remember what those concerns more specifically were or just that, "It looks like, in the light of Panorama, we might need to keep an eye on him"?
A. I didn't open it. I wasn't even on site all the next day. I was away on a course when Panorama was aired.
Q. So you weren't in the centre?
A. No.
Q. Can we turn to page 11, please. You signed it at the bottom. That's your writing. You've written your name there at the bottom.

A. Yes.
Q. So you're the one to close it. It says:
"D1275 came to the office and I asked him how he feels as he felt affected and vulnerable after the events shown in the Panorama documentary. He now feels more settled and safer in the centre. He has no issues with any detainees or staff in the centre and will let us know if he has any issues. Therefore, the document is now closed."
Then the reason closed:
"Feels okay now after Panorama and feeling a lot more safer and settled."
You have signed it off there?
A. Mmm-hmm.
Q. Did you know that he hadn't yet seen the Panorama broadcast by this point, because, according to the notes in the same document, he missed it when it was on because he couldn't use his remote?
A. No, I didn't know that, no. It's not the sort of thing you ask in a review, "Have you seen a programme?".
Q. He is being watched because of concerns about the events that are shown on the programme?
A. Right.
Q. But you don't know whether or not he saw it?
A. (Witness shakes head).

Q. Did you know he'd been on an anti-bullying plan in June 2017 with information that there was a concern, maybe, that he lacked capacity?
A. No.
Q. Did you, or anyone else, when closing this plan, have an opinion on whether he had capacity or would you say that you're not trained to assess mental capacity?
A. I'm not, and that's why we've got a mental health nurse present at the review. I don't really -- I don't recall this SLP anyway. I deal with documents daily. It was a long time ago.
Q. If there is a capacity issue, maybe not just with him but with anyone, because obviously some detainees can lack capacity to make various different decisions, is that something that you'd always defer to a mental health nurse --
A. Yes.
Q. -- or qualified person?
A. I always have them present as much as I can when it comes to reviews.
Q. Thank you. Can we go to page 9, please. On that, there is a care plan. I think it is going to be sideways, so -- no, it is not. Fantastic. This is a care plan. So they're the issues that kind of need to happen while the SLP is opened, as I understand it. Point 3 says --

it is a bit difficult to read. It looks like "Requires solicitor" and then:
"Action required:
"Welfare to book [opportunity] for ..."
A. "Appointment".
Q. "... book appointment for solicitor".
A. Mmm-hmm.
Q. That's signed by somebody "Trisha (Welfare)"?
A. Yes.
Q. Then the action is completed, but it says "Saw welfare". It doesn't say he saw a solicitor. On behalf of D1275, we are told that he, in fact, didn't see a solicitor at that time. Did you know that when you closed the form, he'd been noted as requiring a solicitor but hadn't, in fact, seen a solicitor?
A. No, he was referred to welfare there.
Q. Is the consequence of deciding to close an SLP that no-one is then monitoring him in the same way that they were, so you're not doing the three observations a day and conversations? Does that all come to an end when you close an SLP?
A. It does, yes.
Q. If you had have heard differently about his capacity or vulnerability, for example, that he continued to be vulnerable or he continued to need to see a solicitor,

would that have prevented you from closing the SLP?
A. I don't remember this one, but, yes, possibly it would be. I mean, you have -- the whole point of a review, you have people -- a multi-disciplinary team there present. It was decided by all of us afterwards that he no longer needed to be on a document so it was closed.
Q. One last issue for you, again about the post-Panorama period. Can we show on the screen <INQ000001>. Chair, you have this at your tab 7. This is a Facebook comment made in the wake of Panorama. Your statement says you don't often use social media. Do you remember if you went on there specifically to see what people were saying about the broadcast or was it just that you happened to see something?
A. I can't remember. This was just after Panorama, was it?
Q. Actually, it is not dated. It says "a year ago", but we don't know when the screenshot was taken. The person who first commented, their name has been redacted, but they say:
"Poor Callum being bullied by other staff members for crying over what they were doing to the people in that centre. Callum is a gentleman with a big heart and I wish him all the best in his future football career."
You have replied:
"He's a fake. It's all an act. I worked with him.

Don't be fooled."
So "He's a fake", "It's all an act" and "Don't be fooled". You're not suggesting, are you, that things that were recorded didn't, in fact, happen?
A. I'm not suggesting that, no.
Q. Why was it an act?
A. I worked with Callum a lot and I knew him before he went off, because he was working, then he went off for a period of time, and then he came back, which is when he was doing what he was doing. I knew him before and after and he was a totally different person. I worked with Callum quite a lot. He stayed away from trouble in those days. I mean, I've had an officer come to me saying that he was upset about him because he made inappropriate comments. I said, "You need to report it". You know, I wasn't there. But he stayed away from trouble in those days. He came back, obviously we know now in hindsight, he wanted to be involved in everything.
Q. So when you say "Don't be fooled", you're not saying, "Don't be fooled by what you've seen on the broadcast, the scenes from inside Brook House"; you're just talking about --
A. People were upset with Callum. They felt disappointed. They were angry, frustrated with what had happened.

Q. Did people see him as a snitch?
A. I can't answer that. I didn't see him as a snitch. I was just angry at what had happened. I felt let down. I had quite a good working relationship with Callum, but I felt quite let down.
MS MOORE: I have no further questions for you, Mr Loughton. The chair may do, though.
THE CHAIR: Thank you, yes, I do have a couple of questions.
Questions from THE CHAIR
THE CHAIR: You say you felt let down by what happened in relation to Mr Tulley. In what respect did you feel let down?
A. As I said earlier, the centre was running on low staff. Those staff that were there, it was very challenging. On a daily basis, you would get abused, threatened, your family would be threatened. It wasn't nice. But then -- I've had it myself. You know, someone could come in there, they're not happy, a resident could be not happy. They would abuse me, they would threaten to do things to my wife, they'd threaten to do things to my kids, threaten -- say they're going to do awful things to my parents. An hour later, once they'd calmed down, staff would then -- we'd sit down with these people and help them. It's very frustrating. Everyone is human beings and, to take that abuse, it's not nice. It's not

nice. That's what it was like. And this is regular. So I think people felt let down by Callum because he was part of a team. It was a close-knit team, the staff, in those days. Everyone looked out for everyone. I think that's why people felt let down by Callum.
THE CHAIR: Mr Loughton, did you have a view on some of the footage that we saw in Panorama of the treatment of detained people? Were you surprised by any of that, that you saw on the footage?
A. Such as?
THE CHAIR: The use of force, the use of language, the swearing, some of the disrespectful language that we've heard.
A. Yes, I've never encountered any of that disrespectful language. What do you mean by "use of force"? Which use of force?
THE CHAIR: I'm specifically referring to the event on 25 April on E wing.
A. On E Wing, the division -- after I cut that resident --
THE CHAIR: Indeed, yeah.
A. I wasn't there, so I can't comment on that. You have spoken to people involved in that previously so it's down to them to comment on that.
THE CHAIR: Thank you. I'd also just like to ask you a brief question about -- you will have heard evidence,

I'm sure, from some of the other members of staff that talked about their own coping mechanisms for some of the difficult -- the environment that they were in, some of the challenging experiences that they had while they were working at Brook House. You told us earlier one of your coping mechanisms was the use of humour. Can you remember whether coping mechanisms, the need to kind of think about some of the things that you were dealing with, was any of that covered in any of the training?
A. What, coping mechanisms?
THE CHAIR: Yes.
A. Well, no, everyone has their own coping mechanisms. You can't train that to someone, it's in you. I mean, I tried to do it, I had a good relationship with staff. I used to get around laughing and joking, just trying to keep morale up. I tried to support my staff as much as -- and I still do now. It's totally different now. The centre is like night and day. The way the centre is run now, the way it was then, it's totally different.
THE CHAIR: Are there ever discussions now about what might be inappropriate or more appropriate coping mechanisms?
A. In the training?
THE CHAIR: In the training or in your day-to-day involvement with more junior members of staff.
A. I engage with my staff on a daily basis, I speak with

them. I don't see how you can teach people coping mechanisms. Everyone has their own coping mechanisms, whatever they are. You can't teach someone that, I don't think.
THE CHAIR: Thank you, Mr Loughton. They are all the questions I have. Thank you very much, Ms Moore.
MS MOORE: Thank you, chair. It seems like a good time for a lunch break now. We can return at 2.00 pm when we have evidence from Sandra Calver.
THE CHAIR: Thank you very much, Mr Loughton. I know it is not an easy experience, but I'm grateful for the evidence.
A. Thank you. You're welcome.
THE CHAIR: See you at 2.00 pm.
(1.00 pm)
(The short adjournment)
(2.00 pm)
MS SIMCOCK: Chair, the next witness this afternoon is Ms Sandra Calver.
MRS SANDRA CALVER (sworn)
Examination by MS SIMCOCK
MS SIMCOCK: Can you give your full name, please?
A. Mrs Sandra Calver.
Q. You have made two witness statements to the inquiry, <DWF000009> and <DWF000016>. Chair, I ask that those

witness statements are adduced in full, please.
Ms Calver, because those witness statements stand as your evidence, I'm not going to ask you about every single thing within them, but I'm going to ask you some questions about your role as head of healthcare at Brook House and then about some specific topics that you were involved in, in the relevant period and now.
A. Thank you.
Q. Your first witness statement is at tab 1 of the bundle in front of you. If you want to have that open in front of you, it might help you just to navigate with me. First of all, I want to ask about your background and the roles you have held. You qualified as a Registered General Nurse in 1986?
A. That's correct.
Q. You say you've worked in various hospitals and, from November 2004, you started as a night nurse at Tinsley House Immigration Removal Centre employed by Saxonbrook Medical in a team of four nurses?
A. That's correct.
Q. In 2009, as we know, Brook House opened and the team, you say, expanded to cover both sites and you became the deputy nurse manager covering both sites and then transferred to G4S in 2012, becoming clinical lead?
A. That's correct.

Q. What does the role of clinical lead entail?
A. It was looking after all the nursing staff and leading the nursing team, so being in charge of all the nursing roles, giving them supervision and ensuring they are undertaking the correct clinics, et cetera.
Q. You then say that, in 2017, you were made head of healthcare for Tinsley, Brook House and Yarl's Wood Immigration Centre in Bedford?
A. That's correct.
Q. In 2019, the Yarl's Wood contract ended and you moved back to be based at the Gatwick IRC?
A. That's correct.
Q. What's the difference between head of healthcare and clinical lead?
A. Head of healthcare, you're looking at the whole process, so all of the contracts, you're looking at financial budgetary control, as well as just the clinical aspects.
Q. Do you line manage the clinical lead underneath you?
A. Yes, I do.
Q. The clinical lead for Brook House at the time, in 2017, was that Chrissie Williams?
A. That's correct.
Q. At paragraph 4 of your statement you set out additional roles that you held and you mention one in particular, safeguarding lead, and you say trained to level 4

standard?
A. That's correct.
Q. What does the role of safeguarding lead entail?
A. So that is being -- giving guidance to all safeguarding aspects within the healthcare and looking at any referrals that do come through and showing that they are put to the right -- to the local -- sorry, looking at going to the local council, if required, or if any safeguarding concerns needed to be raised, that they would be raised appropriately.
Q. What does level 4 training mean?
A. That's a two-day training course, so it is further in-depth. So you're looking at being an overviewer of all of the referrals, rather than just doing -- all of our staff are level 3 trained because of the level -- the care for both children and adults. Level 4 is that next level up. That is a two-day course.
Q. Is it the top level?
A. No, level 5 would be a regional managerial post.
Q. You say that, in between 2016 and 2019, you spent three days a week at Brook House. How many days a week do you now spend there?
A. Five days a week.
Q. You say that the contract transferred to PPG on 1 September 2021 and your employment transferred to them

at that time?
A. That's correct.
Q. Am I right that you are still working as head of healthcare in Brook House now?
A. Yes, that's correct.
Q. I want to ask you a few questions about the culture of the healthcare team in Brook House at the time, in 2017. You say that the healthcare team tried their best to create a caring, compassionate culture at Brook House. How did they go about doing that?
A. I think we worked very closely, all together, but we also worked with the officers as well. So we'd spend time doing as many extra services as we possibly could, looking at the full care for the patients. We tried not to call them detainees, they were patients to us, as they would be within any healthcare environment. And we want to do our utmost -- a lot of the people had not had previous healthcare experiences, so to give them as much input as possible.
Q. What role, as head of healthcare, did you take in particular in trying to create that culture?
A. Having healthcare promotion calendars, so ensuring -- and getting staff to actually undertake healthcare promotion, and trying to look at different ways that we can work our health services for the benefit of

the patients.
Q. You say at paragraph 109 of your statement that staff acted appropriately in managing intoxicated residents, but, occasionally, there were one or two detention staff who made silly comments, though nothing to cause you concern. What do you mean there by "silly comments"?
A. I think -- I mean, looking back at the footage and seeing some of the comments that were made in the footage and being derogatory to the patients, it could be that they were talking to them, undermining themselves. I can't think of any specific words that they were using, but ...
Q. Are you referring there to detention staff --
A. Yes.
Q. -- alone or healthcare staff as well?
A. Detention staff.
Q. Detention staff. If nursing staff were present when those type of comments were made, what would you expect them to do?
A. Report it back, specifically to myself. If they haven't reported it to myself, they could report it directly on what's called an SIR, one of the serious incident report forms, through to the custodial team.
Q. There's an incident we have heard about on 14 June where Nathan Ring was saying things such as, "Does your face

taste nice? Because you appear to be chewing it off", in relation to a detained person who was intoxicated with spice. Is that the sort of thing you're referring to?
A. Definitely.
Q. Would you have expected a nurse present, when those sorts of comments were made, to report it back?
A. 100 per cent.
Q. Would you expect a nurse to have been saying comments such as "Homies after your coke"?
A. Definitely not.
Q. That's completely inappropriate?
A. Very much so.
Q. Where a nurse is caring for and conducting observations on a detained person who has been unconscious due to intoxication with spice and says along the lines of these comments, "Let's open your eyes. Oh, like saucers. That's what we like. You've had a good old time, haven't you? Was that fun? You enjoyed a good time. I think you enjoyed your stash. That's going on."
Again, would you say that comment is just a silly comment or is that inappropriate by healthcare staff?
A. I do think it's inappropriate.
Q. If you had heard comments of that nature by your nursing

staff, what would you have done?
A. I would have spoken to them immediately to explain to them that, actually, it is not appropriate for them to be talking to any patient like that.
Q. The reason it's -- this type of language isn't appropriate is because it's dehumanising and degrading?
A. Correct.
Q. You presumably accept, as indeed I think Joanne Buss does, that the comments we see her make in the Panorama footage in relation to D1527 -- "He's an arse, basically", and that which follows -- are completely inappropriate as well?
A. I was horrified when I saw that.
Q. You do say in your statement, at paragraph 153, that staff need a safe, private place to talk to colleagues and decompress, and you say isolated moments of black humour are often simply a way of coping with a difficult situation in what can be a challenging environment. But you'd accept that where these type of comments were made was in the presence of detainees?
A. Yes.
Q. And that's another reason --
A. Inappropriate.
Q. -- why they are inappropriate?
A. Definitely. Safe space has definitely got to be

confined space, away from any detainees.
Q. The language, some of the language, that we see, though, from the likes of the detention staff, such as "div", "scrotum", the types of derogatory words applied to detainees, do you say that, if it's in a safe space, that's appropriate or not?
A. It's not appropriate. I think sometimes it's a way of people getting out their frustrations. So if it's in a safe space, you can allow them to talk, but explain to them afterwards about the appropriateness of it.
Q. I see. There's been some comment in reviews, such as the Shaw Review, about a culture of disbelief within the healthcare department. Do you have any particular comment to make about that as it refers to 2017?
A. No. I mean, we had a lot of residents that actually didn't -- that felt that healthcare would actually be working with Home Office to say people were not fit to travel -- or were fit to travel when they felt they were not fit to travel. We were just trying to do our utmost for the patients.
Q. Because, if it's right that there was a culture of disbelief, that is, healthcare staff not believing reports of symptoms or conditions reported to them by detained people, that wouldn't fit with the description of a caring and compassionate culture you've described,

would it?
A. No, definitely not, and we would do as much as we can for each individual.
Q. I just want to deal very briefly, because your our first healthcare witness, with some general training questions. You say that you're an experienced Registered General Nurse and you built up a lot of training through years of experience. You, yourself, completed a foundation management training course with G4S which covered different areas, including grievance and disciplinary procedures; is that right?
A. That's correct, yes.
Q. You mention in your statement that there was an induction booklet at one time. Was there one in 2017?
A. I think we started one around then because we had Cedars operating as well at the same time. So that was the one we used previous to that.
Q. What sort thing did the induction booklet cover?
A. It would talk about the routine of the day, both day and night, for the patients; it would talk about the clinics; it would talk about training that was required. It would also talk about ACDTs, rule 35s, rule 34s, all of the DC rules.
Q. I see. We will come to those in more detail later, as I'm sure you will appreciate.

A. Yes.
Q. You also mention mandatory training online. Was that of the nature of things like health and safety?
A. Correct, yes.
Q. And you mention mental health first aid. Just briefly describe what that training is?
A. That was a very brief training that we were given because, as health professionals, we have had mental health training instilled into us throughout our training as registered nurses, so it was a brief -- just a refresh on training that was actually developed by our mental health lead at the time.
Q. You also talk about torture awareness training run by the Home Office and NHS England. Did you undertake that training?
A. I did, yes.
Q. When was that?
A. So I undertook one of the first ones -- there was a further training that was actually put in 2017, which I was unable to go to because I was on leave at the time. There have been a couple of training sessions.
Q. So prior to 2017?
A. Yes.
Q. Generally speaking, what did that cover?
A. It didn't talk about the document of rule 35 specifically, but it talked about torture awareness, so people's effects of torture, how it affects them and the outcomes that could show.

Q. You mentioned rule 35 training as being essential to the job. Is that essential to a nurse's job, working in an IRC?
A. When I first started, nurses did undertake rule 35s. They were completing them. Then the DC rule changed, whereby it had to be a medical practitioner only. So now it's not given to nurses because they don't undertake those. However, the DC rule 32, which is for short-term holding, which is exactly the same document, can be undertaken by a nurse.
Q. So do you think it would have been beneficial for nurses to have the full training on rule 35s?
A. Yes.
Q. Do they now?
A. No, because there is still very limited training out there.
Q. The reason that it's important, in your view, for them to undertake that training is that they play an important role in referring --
A. Correct.
Q. -- detained people to GPs in order to --
A. They're asking the initial questions.

Q. So it is a screening type of role, because a GP may not know that a detained person needs to be considered for a rule 35 report unless someone's referred the person to them?
A. That's correct.
Q. When you did the training prior to 2017, did it cover all three limbs of rule 35, the three subsections, or just the one concerning torture?
A. It was more torture awareness. It didn't talk specifically about rule 35. It was more torture awareness.
Q. You also say that training ahead of policy changes would enable you to work more effectively with the Home Office. How did, in 2017, the Home Office cascade down knowledge and guidance in relation to new policies?
A. We did actually have Adults at Risk training for all of our staff, and, at a push, we managed to get the Home Office policy team to come into site and actually deliver that over two sessions so I could get the majority of our healthcare staff -- have that Adults at Risk policy, and they actually found that they were -- we were really engaging and asking a lot of questions over it as well.
Q. That was provided by the Home Office, was it?
A. Correct, yes.

Q. You also mention ACDT, the document that's used to -- and the system that's used the manage those at risk of self-harm and suicide. You say that when it came in, in 2007, you had training, but you say refreshers were very ad hoc. Given the importance of ACDT to the management of those risks, do you think that ad hoc training was satisfactory?

A. No. I mean, part of our orientation, we would actually go through the ACDT booklet and we'd advise all of our staff how to open an ACDT, so we'd go through that front page of the first awareness for opening up a document, but that was us, as healthcare professionals, doing it. It wasn't through the site doing them. It wasn't the official training course.

Q. You thought that it would be beneficial for them --

A. Definitely.

Q. -- all to undergo the official course?

A. Definitely.

Q. Do they now?

A. It is still very -- it is better. We now have yearly refresher training for everybody, which -- and all new staffers do have to have some ACDT training to start. That has improved.

Q. Thank you. Just in relation to the management of healthcare staff -- again, I'll try and deal with this

briefly, but, as you're the first person here talking about healthcare, it may just help to bring up a paragraph of your statement on the screen. It's <DWF000009>, page 6, please. If you could just zoom in slightly on paragraph 27, the sort of table in the middle, this sets out the structure of healthcare very helpfully in tabular form, which is more difficult to describe just using words. There you are at the top, as head of healthcare. There were then the two clinical leads, Chrissie Williams, who we have heard about, and it says "Joanne Bass" there, but I take it you mean Buss?

A. Buss, yes.

Q. There were then practice managers, Michael Wells at Brook House and Jacintha Dix at Tinsley House. What does a practice manager do, very briefly?

A. They're your business managers, so they'd look after the budgetary roles, they'd look at stock ordering and all of the sort of senior admin role specifically.

Q. So administrative roles, not clinical?

A. Correct.

Q. Underneath, you then have RGNs, Registered General Nurses, and you give the numbers there; RMNs, Registered Mental Health Nurses; and then other nursing staff, including pharmacy technician, healthcare assistants,

et cetera, and then two administrators, although you say one post was vacant during the relevant period. Thank you. You can take that down now.

At paragraph 29, you say the clinical leads and practice managers reported to you as their direct line manager; is that right?

A. That's correct.

Q. The clinical leads, as you might expect, managed the senior nurses below them and the senior nurses then managed the nurses underneath them --

A. That's right.

Q. -- the Registered General Nurses and Mental Health Nurses; is that right?

A. That's correct.

Q. What happened in relation to bank staff, in terms of management?

A. So they were looked after by the senior team as well. So bank RGNs were looked after by sort of the senior nurses and clinical lead and the bank RMNs were looked after by mental health.

Q. I see. You say that a healthcare manager was on call 24 hours a day. What level was classed as a healthcare manager? You?

A. Myself or the clinical leads --

Q. The clinical leads.

A. -- and sometimes the business managers, but they'd always have myself as background for being clinical back-up.

Q. I see. Thank you. You say that you had an office in the healthcare department and staff would approach you with questions and you say that you worked collaboratively with the team. What exactly do you mean by "worked collaboratively with the team"?

A. We had one office, so the door was always open for all staff to come in and out. It was literally we'd all work together to solve issues. I wouldn't let anyone do anything that I wouldn't undertake myself.

Q. You also carried out clinical supervision. Just for those who aren't in a clinical profession, what does "clinical supervision" mean? What does that entail?

A. It will be reviewing any incidents that have gone on, asking them for reflective practice of how they feel that that incident went, if there are any changes they felt they could do, anything that we could change within healthcare together, but also looking at safeguarding aspects as well.

Q. Was that of nursing staff only? You didn't have, and the clinical leads didn't have, any role in the clinical supervision of GPs, for example?

A. No.

Q. Do you recall any particular issues being fed back to you at the relevant time in 2017 from clinical supervision?
A. No, nothing.
Q. Moving on, then, to reception and induction of detained persons. At paragraph 61 of your statement, you say that all detainees underwent a health screening on arrival within two hours.
A. That's correct.
Q. There could be an occasional set of extenuating circumstances if something exceptional was happening in the centre, for example, an emergency. Are you there referring to where there were delays in the health screen happening so that it didn't happen within two hours?
A. Yes, that's right.
Q. Was that a regular occurrence?
A. No.
Q. There were only delays in extenuating circumstances?
A. That's correct.
Q. What about when there were large numbers of arrivals of detainees?
A. Again, that could be that you'd see them for -- very briefly on -- as they came off the bus, but then you'd actually go and go through their full process

afterwards. So you'd have seen them, but you wouldn't be doing their full documentation within that two hours, it may be three hours by the time you got to see them, but they would be completed within that -- as soon as possible.
Q. At paragraph 62, you say that screenings were done 24/7?
A. That's correct.
Q. So at night as well?
A. Yes.
Q. Did that cause challenges or problems?
A. The main challenge would be if it hit over a medication time for the night-time, because often you've got one nurse doing medications. That limits the number of staff around. We'd only have two nurses on at night. That could be one trained, one healthcare assistant.
Q. Were screenings carried out by a nurse or a healthcare assistant?
A. Yes. If they were completed by a healthcare assistant, they were reviewed by a nurse as well. They had to be reviewed to ensure that they had -- there weren't any referrals that needed to be done as well. So we always made them be reviewed as well.
Q. When did that review take place in relation to the screening by the healthcare assistant?
A. As soon as possible, so within that shift, definitely.

Q. I see. Briefly, then, what did the screening process cover? What sort of things was the screening process designed to bring out?
A. Physical, mental health, vaccination background, medication backgrounds, any previous history of self-harm. And they did ask if they had been tortured as well.
Q. What was the primary purpose of the screening at that time?
A. To safeguard the patients.
Q. That safeguarding, was that focused very much on the fact they had just arrived and so keeping them safe immediately overnight, or was it a longer, forward-looking process?
A. It was longer. In a prison circumstance, you'd have first screening and second screening. In the IRCs, we just do one initial screening. So we do look at all of the things within that first screen. And it is to look at all of their care and make sure we don't miss any future ongoing care that is required.
Q. The screening that you have been referring to here is carried out by a nurse or a healthcare assistant. So that is not, for the purposes of rule 34, an assessment under rule 34 of the Detention Centre Rules because that assessment is required to be done by a GP; is that

right?
A. That's the -- rule 34 has two parts to it. It has the initial screening by a nurse within two hours and then the screening by a GP within 24 hours.
Q. Thank you. And that screening by the GP first of all, which you refer to at paragraph 67, within that first 24 hours, is that the one you're referring to as being the assessment required under rule 34 or is it different?
A. Yes, that would be the one I refer to.
Q. You have talked about the screening by the nurse initially, checking for vulnerabilities and mental health issues. What sort of thing is the nurse looking for? What's the screening designed to check for?
A. For any disabilities that they may have, they may be vulnerable, it may be mental health issues, any medications that need to be ongoing, any substance misuse that they may need treatment for.
Q. Risk of self-harm?
A. Risk of self-harm and infections as well. Any infection risks.
Q. You say you would put in place an SLP at that point if vulnerabilities were uncovered. What is an SLP?
A. A supported living plan. It is a care plan but it's one that's for use for everybody within the centre, so not

a specific healthcare care plan. So if somebody had got any disabilities or anything and needed support with any daily activities of living, then that would be written into the SLP. If somebody had got any vulnerabilities that -- maybe claustrophobia or something as well, that would be put onto the supported living plan as well.

Q. Was it also designed to provide support for mental health issues such as risk of self-harm or suicide?

A. Yes. So that would be more -- if they had got an active risk of self-harm, then that would be the ACDT document would be completed.

Q. You say, at paragraph 70, that if there was a risk of self-harm and suicide, a nurse will open an ACDT immediately and alert the officers. That's the detention staff on the wing?

A. Yes.

Q. The ACDT document was designed to manage that risk of self-harm or suicidal intentions?

A. That's correct.

Q. I will come in more detail to that later, but you then say that they wouldn't be taken out of reception until the custodial manager assessed them to ensure they would go to the appropriate place. What do you mean by "the appropriate place"?

A. Depending on how much observations they were requiring

and their risk of self-harm. If they were a minor risk, they may go into a wing and only need to be reviewed every two to three hours or have conversations twice a day. If they were at a high risk of suicide, they may be required to go to the constant watch observation room, so therefore we'd need to ensure that they weren't being put at any risk of moving on elsewhere.

Q. And the constant watch observation room, was that on E wing?

A. That's correct, yes.

Q. Would they sometimes also go to CSU, or not at that stage?

A. Not generally, because that would be behind a door. You wouldn't be able to see so obviously.

Q. Whose decision was it as to where a detained person would go after the reception screening?

A. It was the officers', but it was often in discussion with us as well.

Q. So healthcare had some input?

A. Yes.

Q. What would you consider to be an appropriate place for someone on an ACDT or does it just depend upon the circumstances?

A. It does depend on the circumstances. Some people may have -- may state that they're going to self-harm but

they've got no indication of how they're going to do it. They've got no thoughts of when they're going to do it or any plans of how they're going to do it. Another person may actually have obvious cuts on them, may sort of be very withdrawn and they're obviously at a higher risk.

Q. Is a history of self-harm relevant?

A. Yes.

Q. You have mentioned E wing and the constant watch rooms. You describe E wing at paragraph 94 of your statement and you say there are two constant watch rooms for ACDT constant watch, and just so we are clear, "constant watch" means exactly that?

A. That's correct.

Q. It means an officer --

A. 24 hours.

Q. -- 24 hours, every second of every minute of every hour?

A. That's correct, yes.

Q. That, therefore, indicates a very high risk?

A. That's correct.

Q. A high risk of self-harm or suicide, because they simply can't be left alone?

A. That's correct.

Q. You also say that people who could be difficult for removals would also be put onto E wing so they were in

a smaller area, to make removal easier for flights; is that right?

A. That's correct.

Q. So E wing was used for vulnerable people who were at risk of self-harm, or indeed suicide, and who could be on constant watch?

A. Mmm-hmm.

Q. But it was also used for people refusing to be removed --

A. That's correct.

Q. -- who might resist their removal and, therefore, who could be violent, presumably?

A. They could be, yes.

Q. And who might need to have force used against them --

A. That's correct.

Q. -- to effect their removal; is that right?

A. Yes.

Q. Was E wing used as a sort of de facto way to impose additional restrictions on people who you didn't know how to manage them otherwise?

A. Sorry, I didn't quite understand that one.

Q. Well, were the people being sent to E wing capable of being managed anywhere else?

A. I think the majority were appropriately placed. We had -- if they were needing constant watch rooms, that's

where they need to be. You've got the hidden areas within a room and the locked -- doors need to be locked on the wings, so I think that would be an issue if you needed somebody on a constant watch on a wing. Just because they are on a constant watch on E wing also didn't mean to say they had to be behind that door. If they wanted to go to the library, they could be taken to the library with the officer with them. So they could still go to places whilst on constant watch.

Q. Was E wing regarded as a sort of informal segregation away from the wing? So not under the formal ways of rule 40 and rule 42, but informally taking them away from the normal residential wings?

A. I think the officers often -- if they knew that somebody had intended that -- had stated that they weren't keen to go on their flight, then sometimes they felt it would be easier to remove from a smaller area than to have to -- if their flight was at a time when it's normal unlock, rather than having to close down a whole wing to get that one gentleman out, it may be easier to take from a smaller wing.

Q. In relation to those who were vulnerable, it was used as -- to bring them away from the larger wing --

A. That's right.

Q. -- than the greater number of detainees to a smaller

environment?

A. The calmer wing.

Q. The calmer wing. Force would sometimes need to be used to move someone onto E wing; is that right?

A. Yes.

Q. That occurred with those not just who were deliberately trying to refuse their removal, but also with vulnerable people who were at risk of self-harm?

A. Yes.

Q. Was force also used more frequently on E wing than the other wings, given it was used to effect the removal of those who didn't want to be removed?

A. It was probably, yes, looking back at it.

Q. Did you think mixing these two groups of people on E wing was appropriate?

A. It's not appropriate to mix vulnerables with people that are then refractory as well. Sometimes it eats into your space available. If you have a lot of refractories and they are extremely refractory, they would have been in the CSU area.

Q. I see. I'd just like to look at the witness statement of Dr Rachel Bingham, who is a doctor at Medical Justice, and it is paragraph 157, which is at <BHM000033> and page 62. It's on the list. I'm sorry, do you not have the document? I'll maybe just read it

out then. Dr Bingham says -- you can follow it in your bundle. It is at tab 13 for the witness and for you, chair. It says:

"There is considerable clinical literature on the adverse mental health effects of physical isolation, particularly in respect of those who suffer from pre-existing mental health conditions or histories of trauma."

She states that she's reviewed the literature and goes on:

"Segregation has been associated with worsening symptoms of depression, severe anxiety, psychotic symptoms and exacerbation of post-traumatic stress disorder. Suicidal thoughts and risks of suicide are also increased. In the context of asylum seekers suffering from PTSD, for instance, it can precipitate or intensify the traumatic memories of flashbacks of their past mistreatment and increase their feelings of powerlessness."

Were you aware of that type of research, in general terms?

A. I was aware of research and that's why we have actually looked at -- you know, because they're on constant watch, it doesn't mean to say that they are stuck behind that door now, and we are moving them -- if they want to

go to the gym, if they want to go out to the library, they can go to those areas as well.

Q. What about at the time, in 2017?

A. I think probably then it was more so that they were behind their doors.

Q. Do you agree with what Dr Bingham says there?

A. Yes. That's why we have changed things.

Q. Is that something you observed at the time in detained people held on E wing due to mental health issues or suicide risk, that they tended to deteriorate?

A. Some did. Not all of them. Some did.

Q. Dr Bingham goes on at paragraph 157:

"It is accordingly imperative that healthcare discharges its safeguarding role diligently in the context of assessing and monitoring whether there are any clinical contraindications to the use or continuation of segregation."

Do you agree with that?

A. Yes.

Q. At paragraph 158, Dr Bingham says that she notes, however, "a recurrent pattern that emerges on the available evidence is the use of segregation, both under the rule 40 and 42 safeguards and held on E wing, as a mechanism to manage detainees suffering from mental illness or at risk of suicide and self-harm."

You would agree with that as well, given what you have just told me?
A. That's right, yes.
Q. Dr Bingham concludes that, effectively, this was a failure of healthcare, in those cases, to properly identify and escalate clinical concerns over a detainee's unsuitable for segregation, and she says:
"The primary purpose of segregation within this context is as a means to contain the distressed and high-risk behaviours associated with mental illness, such as self-harm or suicidality, rather than to seek to provide any form of enhanced safeguarding or clinical treatment for the vulnerable detainees. It is important to be clear that, as it is detrimental to mental health overall, the segregation of detainees who are at risk of self-harm cannot be viewed as therapeutic."
Would you agree that housing those types of detained persons on E wing was to manage distressed behaviour including self-harm and suicidal ideation?
A. Yes, it was.
Q. It certainly wasn't for the primary purpose of providing treatment?
A. No.
Q. It is not an inpatient --
A. No, no, we don't have any inpatients.

Q. Do you agree that it is also an important role of healthcare staff to identify and escalate any clinical concerns over the suitability for someone to be housed on E wing in segregation?
A. Yes, and we review everybody.
Q. Do you have any comment on Dr Bingham's view that there was a failure of healthcare staff to identify concerns about unsuitability for detention on E wing?
A. I don't think so, because, for healthcare, it is looking at the risks for the patient. So on a wing that's fully operational, that would not be suitable for them either, that would be too noisy for them, for mental health. Again, bringing them to E wing, it was the best environment for them to be in.
Q. Calmer, as you said?
A. That's correct.
Q. Except when there were violent or refractory detainees --
A. That's correct.
Q. -- or those resisting their removal?
A. That's correct.
Q. You say healthcare would visit detainees a minimum of once a day, including a GP, but from Dr Oozeerally's statement, he says he has no knowledge of how healthcare staff treat or monitor detainees in E wing. Can you

explain the discrepancy between those two?
A. He does come down to healthcare -- he does come down to E wing to visit them on a daily basis, but I don't think he is fully aware of what else we do within our role of healthcare.
Q. I see. We can ask him.
A. You can.
Q. Was the management of detained persons on E wing driven primarily by custody staff?
A. Yes.
Q. You mentioned visiting, but it would be those who were managing them?
A. Yes.
Q. That was the case, even though these were highly vulnerable people with clinical needs?
A. That's correct.
Q. Was any clinical risk assessment carried out prior to locating a vulnerable detainee on E wing?
A. If they were on an ACDT, we would have had the input within the ACDT document. We're there for every ACDT review.
Q. And if they weren't on an ACDT?
A. If they're not on an ACDT -- if they're under rule 40 or rule 42, we assess every single person that is placed on rule 40 or 42. So that's within the CSU. But not

necessarily for a basic vulnerability.
Q. I see. In relation to, then, rules 40 and 42, at paragraph 97, you say that you think someone would be moved to the CSU to maintain order in the centre. So do you think you have a full understanding of the criteria that are applied to remove someone under rules 40 and 42?
A. Yes.
Q. Just explain to me briefly, then, what those rules do?
A. So rule 40 is removal from association due to behaviour or safety within the centre. Rule 42 is somebody that's being more refractory, maybe in a dirty protest as well, and that's for a much shorter time that anybody would be placed on a rule 42.
Q. As you have said, in 2017, those rules were sometimes used on detainees who had mental illness or who were self-harming or had suicide risks?
A. Yes.
Q. Was it only GPs who made assessments of suitability for segregation or did nurses do so as well?
A. Nurses would as well.
Q. How do you check whether someone is suitable to be on CSU?
A. Looking at their background, looking at their mental health -- their medical records to see if there is any

issues behind them, and how they are at that present time.
Q. So would an assessment be made of them?
A. Yes.
Q. Would that be a clinical assessment of their physical and mental health?
A. Depending on how refractory they are at the time, because you may not be able to get as close. That might be part of -- the assessment will be that you wouldn't be able to get there.
Q. Do you accept that segregation should be used as a last resort?
A. Totally.
Q. If someone's behaviour due to their underlying mental illness has become such that they need to be segregated, does that suggest that they have become very unwell?
A. Yes.
Q. From a healthcare perspective, that should then identify the need for either a rule 35(1) report or a rule 35(2) report from a GP, shouldn't it?
A. The rule 35(2) is for if they are suicidal.
Q. Yes.
A. If they have suicidal thoughts.
Q. And rule 35(1)?
A. (1) is for medical conditions.

Q. For medical conditions?
A. Yes.
Q. We will come to that in a bit more detail in a moment. We know that, in the relevant period, in 2017, there were very few rule 35(1) reports done, and we know that there were no rule 35(2) reports at all in that period. Indeed, I think for the entirety of 2017.
A. Mmm-hmm.
Q. Does that indicate, then, a failure in the management of those safeguards for vulnerable detainees?
A. I don't think so, because, for rule 35(1)s, I did look at -- because I covered the IRC forum for all of the other IRCs as well, we talked about it in quite depth at the IRC forums, and this was over all of the IRCs, it was the same figures. So we looked at ways that we could actually challenge this. So I did design the rule 35(2) pathway, of which I think is in the bundle, and that was to actually safeguard and to actually -- to ensure that we were capturing everybody that had got any self-harm risks. A lot of the GPs felt, for the rule 35(1), that there was often a delay in the response because it could take up to 48 hours for a response to come back from Home Office, so therefore, by writing a Part C, they sometimes felt -- and contacting Home Office, they would often get a faster

response, and then patient could maybe be released or put in -- appropriately moved by that Part C.
Q. I see. Just looking at, then -- we will come in a moment to some parts of what you have mentioned, the rule 35(2) pathway, in a moment. I just want to look at detainees' access to healthcare.
A. Mmm-hmm.
Q. You set this out to some extent at paragraph 79 of your statement, and you say that primary healthcare services provided at Brook House included access to a GP, who is on site seven days a week, physical health nurses, opticians and dentists. How would a detained person access a GP?
A. So we had the open triage clinic that was available seven days a week. They would come in and see a nurse first and then state that they would request to see a GP and we would make the appropriate appointment, and that would generally be the following day.
Q. That's routine sorts of GP appointments that are irrespective of the assessments under rule 34?
A. Yes.
Q. Were there delays in obtaining those types of GP appointments at all in the relevant period?
A. No, only if the clinic had got full for the following day you would be posted to the next one. But we would

always keep two, what we call embargo slots, so if there was any emergency appointments came up, they would always be seen on that same day.
Q. You also deal with mental health services which are provided by the Registered Mental Health Nurses in the first instance?
A. That's correct.
Q. How would a detained person access a mental health nurse?
A. So they can be made direct referrals from either the Registered Nurses, the GPs would also do direct referrals, and officers have done as well.
Q. You talk about Registered Mental Health Nurses providing talking therapy groups and psychology groups. What type of talking therapies and psychology groups were provided?
A. Psychology group, we had actually subcontracted in from a local provider. They'd come once a week and do group sessions for people.
Q. What type of psychology?
A. Coping skills. It was more the coping skills at low level.
Q. And the talking therapy?
A. Talking therapy was more of a one-to-one basis. A lot of it was low-level talking therapy coping skills,

again, how to cope with detention and imminent removals.
Q. Were any of them trauma based?
A. No.
Q. You say Registered Mental Health Nurses were also involved in ACDT reviews and rule 40 and 42 reviews?
A. Yes.
Q. What was their role in those types of reviews?
A. For the ACDTs, they'd be a key participant. They'd be within the whole team of the review. And their points would be asked on every time as to how the patient was at the time.
Q. So they'd provide clinical information?
A. Yes, within the team. So it would be talked about, you've got the patient there as well at the same time. So it would be a joint multi-disciplinary team meeting.
Q. Would they provide a view on their risks, for example, of self-harm and suicide?
A. Yes.
Q. And in rule 40 and 42 reviews?
A. Again, that is looking at a suitability for maintaining in rule 40 and 42.
Q. At paragraph 43 of your second statement, which is at tab 2, if you would like to look at it, you deal with what happened when a detained person didn't attend a medical appointment.

A. Mmm-hmm.
Q. You say that if they had a known medical condition or were on medication, they would be followed up?
A. Yes.
Q. If they did not have a known medical condition or were not on medication, you wouldn't follow them up, as it is their right to choose whether to attend the appointment or not?
A. Mmm-hmm.
Q. So did that mean that, where there was no medical condition or medication, you would gain that information from the medical records?
A. They would have had that on the -- we would have worked that out from the initial health screening from the nurse on arrival, to know that they have no known medical condition, no medication that they're on. But they would also be given a leaflet to tell them how to access healthcare at any point.
Q. I see. What were the processes for following up those who didn't attend? What would actually happen?
A. We'd actually go to the wings, find them, if we could, and rebook the appointment for them.
Q. Were there any processes in place to check why someone had not attended a medical appointment, and particularly perhaps mental health appointments, where there wasn't

a known medical condition or medication involved?
A. If they'd got mental health issues, we'd class that as a medical condition, so that would be -- we would be following those through, if they'd got a known mental health condition behind them.
Q. What if it wasn't a diagnosed medical condition? What if they were simply vulnerable?
A. We generally would wait to see if they had come up to the wing, we'd see if they got any reports from the wing. Majority were coming through were fit young men and their first priority, that first 24 hours, was to contact the solicitors, and to see healthcare was not their priority.
Q. What about when there were other medical appointments that had been made for them, so not in that initial period, but later, when those appointments were missed and there were requests from the wing, what was the process then?
A. We did always follow up if they'd got appointments that they weren't attending. We'd find out why they were not attending.
Q. How would you do that?
A. Go to the wings, see if we could chase them to see whereabouts they were. Sometimes it is that they've got a visit that day, they've got the gym that they'd like

to go to instead. So maybe it's a case that we need to change the time of the appointments to fit in with what they need too.
Q. Was there any consideration or exploration of the detained person's mental capacity to make those decisions, or was it still regarded as their choice?
A. At that time, it would be at their choice.
Q. Was there any consideration given to -- that someone might be so unwell they're unable to make those decisions about attending appointments or otherwise?
A. If we've got to that stage, usually we have got -- we are involved because the officers would've alerted us as well. I do an induction talk to the officers and the one thing I always say to the officers is they see them more than we do, so if they do have any concerns about anybody, how they're interacting, to raise to us. It is called one of the red flags and early indications is far better than treating at a later stage.
Q. You're saying that, as far as you were concerned, on every occasion, those missed appointments would be followed up?
A. I do think there may be one or two that haven't been. I can't say specifically the number that have not been followed up.
Q. But you accept some may have slipped through the cracks?

A. Yes.
Q. If we could look at <BHM000042>, paragraph 42, it is page 12. What I'm looking at is a witness statement that deals with a case of D1275. In relation to this particular detained person, he missed 13 appointments at Brook House in 2017 for mental health assessment. What happened was, he was discharged from the caseload on a number of occasions because of a failure to attend those appointments. On 22 June, a security information report from the wing noted that he may not have capacity to understand appointments with doctors and attend them. He was later diagnosed with schizoaffective disorder and was assessed to have no capacity to make those decisions and, after he was released, he was hospitalised under the Mental Health Act and treated for several months. It appears that this may be one of the cases, at least, where it wasn't followed up, the reasons why he had missed so many appointments. Would you agree?
A. Yes. The mental health team generally did go to the wings to check why people hadn't attended. I can't comment as to why they didn't do this one.
Q. But you agree they should have done?
A. Totally, yes.
Q. Should they have, at that time, assessed whether he had the mental capacity to make those decisions?

A. Yes.
Q. It seems that the only action taken was to discharge him from the caseload. That shouldn't have happened?
A. No.
Q. Are security information reports generally read by healthcare staff?
A. Only if there is a reason to come back to us. So it goes directly to security. If they feel there was a need for healthcare to be informed, then they send us that part of the security information form. They wouldn't send us the whole form.
Q. No, sure. But would you have expected this one, given what it says about mental capacity and understanding --
A. Definitely.
Q. -- about medical appointments to have come to you?
A. Yes.
Q. So it is of concern that it doesn't appear to have done, isn't it?
A. That's right, yes.
Q. That appears to be a serious omission in his case because the system operating to safeguard him failed?
A. Failed.
Q. We will just go a little bit longer, if that is all right with everyone.
At paragraph 108 of your first witness statement,

you mention attending several individuals in 2017 who had a problem with spice, who were intoxicated and needed medical attendance. In your view, was there any possible link between the use of drugs, such as spice, in Brook House and a detained person's mental ill-health?
A. It certainly did affect their mental health, yes.
Q. Not just that spice affected their mental health, but that their mental health may lead them to take spice?
A. Yes, and I think some of them were used -- some of the gentlemen that had got mental health issues may well have been used as guinea pigs for trial of spice as well.
Q. It wasn't practice to undertake a mental health assessment on a detained person regarding their recurring use of spice; is that right?
A. That's correct, yes.
Q. Why not, given what you have just told me about the link with their mental health?
A. I think we were looking more at the drug-seeking side first. So they would be put through -- Forward Trust would have looked at them for their substance misuse. If they felt there was a need within mental health, they would refer them back as well.
Q. I see. It wasn't an assumption that it was their choice

whether to take spice or not?
A. No.
Q. In effect, showing that they would -- an attitude that they were doing this to themselves?
A. No.
Q. At paragraph 110 of your statement, you say that low-level mental health issues, which you have mentioned before in your evidence, are dealt with by the Registered Mental Health Nurses, and you give an example of stress-related problems?
A. Yes.
Q. You say that if a resident had a more serious mental health problem, they might be managed by weekly psychiatric appointments or reviews, reviewing their medication. Longstanding mental health conditions, you tell us, are also managed by Registered Mental Health Nurses; is that right?
A. That's correct.
Q. Is that still the case?
A. Yes, that's still the case.
Q. At paragraph 86, you say that the most significant health problem experienced by detainees in 2017 related to stress?
A. Yes.
Q. And that there was a lot of low-level mental health

issues stemming from stress?
A. Yes, that's correct.
Q. Was it also your experience, though, that a high proportion of immigration detainees have clinically significant levels of depression and PTSD and anxiety?
A. Quite a few do, yes.
Q. And medical research tends to support that. PTSD is particularly prevalent in the refugee or asylum seeker population. Would you agree with that?
A. That's correct, yes.
Q. It's therefore important, as we have briefly touched on in relation to your training, to be in a position to identify trauma symptoms, isn't it?
A. Yes.
Q. At least to ensure that your staff, the nursing staff, are referring those detainees in that situation to a GP to carry out an assessment?
A. Yes.
Q. Or indeed, I suppose, to a psychiatrist in relation to treatment?
A. Yes.
Q. But, in particular, in relation to a GP carrying out an assessment, it's important because it's relevant to identifying the impact of detention upon that person; is that right?

A. Yes.
Q. It's important because identifying people who are not suitable for detention is part of that system, of that process. A GP needs to assess under rule 35?
A. Yes.
Q. You don't seem to recognise, in that paragraph I have just referred you to, that PTSD was really a prevailing mental disorder amongst detainees, but you do accept that?
A. I do, yes.
Q. Are you confident that you and your staff, in 2017, were available to identify symptoms of trauma?
A. Probably not enough, no.
Q. Not enough?
A. And that's due to the fact there wasn't enough actual specific training on PTSD for our nursing team.
Q. Or indeed on torture awareness?
A. Yes.
Q. Or on rule 35?
A. Yes, and that is still ongoing.
Q. And that's still ongoing?
A. (Witness nods).
Q. It wasn't a downplaying of the severity of mental illness for stress?
A. Definitely not. Definitely not. I mean, mental health

for the detainees has always been very high for the simple fact that, in a prison, they have got an end of sentence and, in an immigration removal centre, there often isn't an end of time, so that's what can often play on their mental health.
Q. Yes. Because not recognising that symptoms may be due to PTSD would affect the ability of healthcare staff to keep detainees safe, wouldn't it?
A. Yes.
Q. Because they wouldn't be referring them for rule 35 reports?
A. Mmm-hmm. That's correct.
Q. That plays a key role, that healthcare role of your nursing staff plays a key role, in identifying those who are vulnerable and who, therefore, the Home Office needs to know about --
A. Yes.
Q. -- to consider in its detention decisions?
A. That's correct.
MS SIMCOCK: In fact, a little early, chair, that may be just an appropriate pause for a break, so I suggest 15 minutes. Perhaps we can say 3.20 pm?
THE CHAIR: That's fine. Return at 3.20 pm.
(3.04 pm)
(A short break)

(3.22 pm)
MS SIMCOCK: Ms Calver, at paragraph 110 of your statement, you say that, on occasions, detained persons would need to be sent out to hospital. That was if they had become so unwell that they needed inpatient psychiatric treatment in a mental health hospital; is that right?
A. Or physical care, yes.
Q. Or physical care. You say:
"In extreme circumstances, we can get people released if we think their mental health is so seriously affected by detention."
What do you mean by "extreme circumstances"?
A. We have had a couple of patients that we have had released, but they have actually been released and sent, under section 2, from hospital. So -- but they felt they didn't need to be detained. Whereas, normally, if we are sectioning people whilst they are with us, they would go under a section 48, which means they will remain detained.
Q. I see. So you're talking about section 2 of the Mental Health Act?
A. Mental Health Act.
Q. So the extreme circumstances are when they are so unwell they need inpatient psychiatric treatment?
A. That's correct, yes.

Q. What do you mean by "so seriously affected by detention", just that, that they are very unwell?
A. That's right, yes.
Q. The mechanism for doing that, then, was transfer under the Mental Health Act?
A. That's correct.
Q. So you're not here talking about rule 35?
A. No.
Q. I see. Thank you for clarifying. You also say:
"The difficulty with mental health treatment in a detention setting is that we cannot provide long-term treatment or cognitive behavioural therapy (CBT), as it's not safe for the resident for us to open up wounds and then leave them unhealed."
A. That's correct.
Q. And that this can be very frustrating for the practitioner. By opening up old wounds, do you mean exploring a history of trauma?
A. Yes. If you get to the point of extreme and then they're released, that's very dangerous for them.
Q. That might include being a victim of torture?
A. Totally.
Q. By leaving them unhealed, you mean that, without the full range of treatment necessary to be -- for them likely to be able to recover?

A. Yes, and there'd be a serious risk of self-harm if they're going out in that extreme point of -- if they have got to that point of opening up, but then nothing else is going to happen, that's when they're at a high risk.
Q. I see. In terms of access to care and treatment, you're aware of the principle that detained persons in an immigration centre should receive equivalent care to those patients in the community?
A. Yes.
Q. At paragraph 111 of your statement, you say that residents have far better access to mental health care than they would in the community. In what sense --
A. I think I was talking about in total care, so not just mental health. It was a case of, we can give them GP appointments within the following day, and then they -- the majority of us cannot get a GP appointment that quickly and haven't done for many a year -- but also they have got access to the dentist, the opticians and our primary care aspects that we do as well on site.
Q. So you were more there talking about physical --
A. Physical healthcare, yes.
Q. Because, as you have just said, they certainly don't have access to the full range of psychiatric treatment?
A. No.

Q. Or CBT?
A. No.
Q. I see. In Professor Katona's statement at <BHM000030> at page 9, Professor Katona, as I'm sure you know, is the medical and research director of the Helen Bamber Foundation?
A. Mmm.
Q. And a professor of psychiatry, and the Helen Bamber Foundation is a charity which helps survivors of torture and trafficking.
A. Mmm-hmm.
Q. He mentions that detention centres are not appropriate therapeutic environments to promote recovery from mental ill-health due to the nature of the environment and the lack of specialist mental health treatment resources?
A. That's correct.
Q. Presumably, you would agree with that?
A. Yes.
Q. He also says that the current ethos of mental health services is on recovery and community rehabilitation, and that this can't be provided in a detention centre. Do you agree with that as well?
A. That's correct, yes.
Q. He then says, at paragraph 19 of his statement, that it was therefore crucial that clinical and other staff

working in detention centres were given adequate training and support to identify mental disorder when it does arise or deteriorate significantly in a detention centre and clear guidelines on how to manage this appropriately and to link up with existing local mental health provision outside the detention centre, and this should include specific attention to appropriate monitoring and management of risk. Do you agree with that suggestion?
A. Yes. I mean, we did have good links with our local mental health provider.
Q. Do you think that was provided in Brook House in 2017?
A. We had the links to the mental health team. It wasn't as strong as it was. We have now changed providers.
Q. What about adequate training and support to identify a mental disorder when it does arise or deteriorate?
A. We didn't have enough at that point.
Q. What about now?
A. Now we're with PPG, we have further mental health training within our mandatory training. We have also got -- within our mental health team coming in, we have psychologists coming in to work on site and assistant psychologists, so the whole mental health team is expanding so we can have a lot more services available for people.

Q. At paragraph 113, and you have dealt with this briefly in your evidence before the break, you say that there were sometimes detained persons on a constant watch due to suicide risk, and you again refer to those being managed on E wing in the rooms used for constant watch. I think you agreed with me also that self-harm in the past is a risk factor for suicide?
A. Yes.
Q. I think you also mention in your statement that your nursing team would be working to the appropriate NICE guidelines?
A. That's correct.
Q. NICE being the National Institute for Clinical Excellence?
A. Excellence.
Q. The NICE guidance on self-harm and short-term management and prevention of recurrence stresses the important role that primary care plays in assessment and treatment of people who self-harm. Would you agree that primary care, so nurses --
A. Yes.
Q. -- including nurses, play an important role --
A. Yes, we do.
Q. When an individual presents following an episode of self-harm, healthcare professionals should urgently

establish the likely risk and the person's emotional and mental state. Would you agree that, where someone self-harms, there should be an assessment of someone's physical risk and emotional and mental state.
A. Yes, and we generally -- anybody that has self-harmed, they will be -- if they haven't been referred to the mental health team before, will definitely be referred to it at that point.
Q. Do you think that your team were carrying out those types of assessments when someone was referred to them for self-harm?
A. Yes, it wasn't an in-depth assessment, but it was an assessment and they were referred to the mental health team.
Q. You have said that a suicidal risk would trigger an ACDT and a constant watch. Does that mean that, if someone is on an ACDT on a constant watch, it is likely they are at high risk of suicide?
A. Yes.
Q. We will come to rule 35 in particular in some detail in a moment, but suicidal intentions should also trigger a rule 35(2) report, shouldn't it? And so, in the case where it's the nurse who is aware of suicidal intentions, that should trigger a referral to a GP, shouldn't it?

A. Yes. If the self-harm is for suicidal -- some of our self-harms is not for suicide intentions.
Q. Indeed. But where someone --
A. That is difficult to assess.
Q. But where someone has been placed on an ACDT for a constant watch, for example --
A. Yes, definitely.
Q. -- then it should trigger consideration of rule 35(2)?
A. Mmm-hmm.
Q. You mentioned that GPs perhaps weren't always doing rule 35(2) reports -- in fact, we know they weren't in 2017?
A. Yes.
Q. You mentioned a Part C as an alternative route?
A. That's more -- the Part C was more for the medical condition, to alert the Home Office that somebody has a medical condition that would be not suitable for them to remain in detention.
Q. Do you think doctors were doing Part Cs to notify the Home Office instead of rule 35(2) reports, given there are no rule 35(2) reports?
A. Not so much for the rule 35(2)s, no.
Q. Indeed, that would be inappropriate, wouldn't it?
A. Yes.
Q. Because a Part C doesn't trigger a review of

detention --
A. No.
Q. -- which rule 35(2) does?
A. That's correct.
Q. Would self-harm trigger an assessment to determine whether more urgent care is needed?
A. Yes.
Q. Was that routinely happening in those assessments, that -- not just about rule 35, but actual -- the care in Brook House of the --
A. If anybody did self-harm and were on an open ACDT, then that may trigger an earlier review than the next planned review. They may do an emergency case review at that stage if they'd just self-harmed. That would be a multi-disciplinary team as well.
Q. Was that up to the individual nurse or was it a system operating to protect those detainees?
A. That would be the nurse and the officers as well, so it would be more of a system.
Q. At paragraph 68 of her statement, Dr Bingham sets out -- it is at page 23 of <BHM000033>. She sets out that she is aware, in working for Medical Justice, of several cases where detainees were noted as being advised by a nurse to use an elastic band around their wrist to help with thoughts of self-harming. She says:

"This is, at best, a harm-reduction approach through a less dangerous means of inflicting pain. It does not address or treat the underlying cause, be it distress, unmanageable symptoms, lack of other coping mechanism, or other mental health issues. To provide this without other intervention to mitigate the distress shows a focus purely on risk management and not on therapeutic care. In my view, it should not be used as a substitute for exploration of the underlying causes and exacerbating or perpetuating factors and for therapeutic intervention to reduce the person's risk in the longer term."

So, first of all, are you aware of detained persons being advised in this way in how to cope with thoughts of self-harm?

A. The mental health team will have actually been assessing them at the time and it was the mental health team that did issue out elastic bands to a couple of residents.

Q. So you were aware of that?

A. Yes.

Q. Was that in 2017 or is that ongoing as well?

A. I think that was 2017. I don't believe it's ongoing at the moment.

Q. Do you agree with Dr Bingham that that shouldn't be used as a method on its own?

A. And it wasn't, at the time, used as a method on its own. They were being reviewed at the time as well by the mental health team.

Q. So there should be further intervention to mitigate distress?

A. Yes.

Q. Do you think that there was?

A. Yes, I believe it was.

Q. The underlying causes and the triggers and exacerbating factors should also be explored?

A. Yes.

Q. Did you think that was happening?

A. Yes. I mean, a lot of our triggers are the fact that they have got a pending flight coming up. We can't always be the ones that say "Stop the flight". That's not for healthcare to do, unfortunately.

Q. No, of course. Do you agree there should be some further therapeutic intervention to reduce the risk in the longer term?

A. Yes.

Q. What sort of therapeutic interventions could your team provide?

A. Difficult for us. At the time, we didn't have many other services to provide. So it was one-to-one therapies that they were dealing with. The mental health nurse would be able to say more about the care that they gave. Now we do have pending sort of the psychologist team coming in and assistant psychologist team coming in, they would be able to give a lot more support.

Q. Can we look at, please, the management of Adults at Risk in immigration detention policy. It's <CJS000731> at page 5. You say in your witness statement, at paragraph 20, that -- you describe this policy as a Home Office document, which we see that it is, and that G4S healthcare didn't have its own equivalent policy. But it is right that this is a policy that you and your healthcare staff were expected to apply, wasn't it?

A. Yes.

Q. Even though it was a Home Office document?

A. Yes.

Q. Indeed, we can see at paragraphs 1 and 3 that it refers specifically to healthcare staff, and then also to all staff, because it is important to recognise that this is the statutory framework governing the safeguards against detaining vulnerable people?

A. That's correct.

Q. What is your understanding of the definition of an Adult at Risk?

A. Definition of somebody at risk would be somebody that is vulnerable or may actually have cause for concern whilst they're in a detention state.

Q. If we look at paragraphs 5 to 8 of the policy, so starting at the bottom there of page 5:

"If they declare that they are suffering from a condition, or have experienced a traumatic event (such as trafficking, torture or sexual violence), that would be likely to render them particularly vulnerable to harm if they were placed in detention or remain in detention" --

A. That's correct.

Q. -- that would classify them as an Adult at Risk?

A. Yes.

Q. Over the page:

"If a case owner considering or reviewing detention becomes aware of medical or other professional evidence, or observational evidence, which indicates that an individual is suffering from a condition, or has ... a traumatic event ... that would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention. In these circumstances the individual will be considered as an Adult at Risk whether or not the individual has highlighted this themselves."

A. Correct.
Q. Underneath there, there are several things listed at paragraph 7, and we see "victim of torture" there, for example. We see "suffering from a mental health condition or impairment", being a victim of various different things, "suffering from PTSD" also, "suffering from a serious physical disability" and some physical health conditions and age.
In relation to your role as head of healthcare, how were you instructing or guiding your staff to apply this policy?
A. As I said earlier, they actually had training from Home Office on this policy, of which I managed to get majority of the staff on it. They also were all sent the policy with clear instructions of what to raise as a vulnerable person. And a Part C would be opened if anybody came in claiming any of those conditions or any of those reasons. And then that would be sent to Home Office, if they weren't already declared as an Adult at Risk.
Q. But the policy serves to work in conjunction with rule 35, doesn't it?
A. Yes.
Q. Whereas Part C doesn't prompt a review of detention in the same way as 35?

A. Part C was to do that alert to the case owners and that's what we were advised by the Home Office to do, to do Part C. If anybody had a claimed medical condition or suffered torture, they'd have a Part C completed.
Q. I see. In relation to your understanding of the different levels, if we can look at, please, <INQ000112> at page 46, this is the report of Dr Hard, who is the expert instructed by the inquiry in clinical matters. He comments -- page 47, I'm sorry. In that third bullet point, Dr Hard comments on an entry you made in the records of D801 in March 2017, and you state there that you provide -- he states there that you provided an IS911 RA Part C. That's what you have just referred to?
A. That's correct, yes.
Q. So that's not a rule 35?
A. No.
Q. You, as a nurse, can't do rule 35 reports?
A. No, that's correct.
Q. Why did you provide a Part C instead of referring to a GP for a rule 35 report?
A. That's a notification rather than the actual referral. So this is a gentleman that's come back -- that was due to be going for a section. So -- and then they -- the psychiatrist actually revoked the section.

Q. Yes.
A. So therefore it was a notification. It wasn't -- he had actually improved and it was immediate care to be put onto his records.
Q. I see. What you say there is he'd had his mental health section revoked and was no longer under section 48, as you have just said:
"He remains under the psychiatrist care at Brook House or, if released, under the care of the community. He remains as an Adult at Risk level 2/3."
Dr Hard points out that the Adults at Risk policy doesn't contain a category of 2/3. One is either one or the other.
A. As in healthcare, we are not allowed to actually state what levels they're at. Home Office had stated just before that we are not able to stipulate the level. So therefore we can put we recommend a level by putting 2/3. It would be for them -- the case worker would actually make that decision.
Q. I see. So, in referring the case to the Home Office, you were instructed by the Home Office not to record what your view of the level of risk was?
A. So we can put "we recommend", but we can't state what it is. That's for the actual case worker to make the final

decision.
Q. Who at the Home Office instructed you --
A. That was in the policy team when we had our first training.
Q. I see. When was that, before 2017?
A. Yes.
Q. Did you understand the difference between levels 2 and 3?
A. Yes. It is fairly blurred. The level 2 is a very vast level. It encapsulates an awful lot of people. 3 is people that are unfit to be in detention.
Q. So level 2 indicates there's independent evidence, such as a medical report?
A. Yes.
Q. Or a rule 35 report that someone is at risk --
A. Yes.
Q. -- which might include those factors we have just been through, such as being a victim of torture or various other different things such as a mental health condition?
A. Yes.
Q. Level 3 indicates there's independent evidence such as a medical report or a rule 35 report that someone is at risk and also that detention is likely to cause them harm?

A. That's correct.
Q. So they're unfit to be in detention?
A. That's correct.
Q. So describing someone as level 2 or 3 is somewhat confusing?
A. Yes.
Q. In relation --
A. I think the fact that somebody requires to be sectioned means that they are fairly unwell.
Q. Yes, indeed. Dr Hard comments that, in D801's case, we know that he arrived in Brook House on 1 March 2017, an ACDT was opened in relation to him due to a risk of self-harm and he reported he was a victim of torture. He didn't attend an appointment with the GP and there wasn't any follow-up, but he did later see Dr Belda and Dr Chaudhary and the plan, as you said, was to transfer him to hospital because he was so unwell?
A. That's correct.
Q. That didn't happen. In fact, the transfer was revoked and he was seen by Dr Belda on 9 March. On 3 April, Dr Chaudhary completed a rule 35(1) report dealing with his deterioration in detention. That seems to be a significant delay in carrying out a rule 35(1) report between -- of something in the order of a month, and Dr Hard comments that it should have happened earlier.

A. Yes.
Q. Do you agree with that?
A. Yes.
Q. Do you have any explanation as to how that happened?
A. I can't recall, unfortunately.
Q. Moving on then, you can take that down, thank you. At paragraph 81 of your statement, you say that everyone also has to be seen by the GP within 24 hours of arrival at Brook House. That's in addition to the health screen that you have talked about that the nurse carries out, or the healthcare assistant?
A. That's correct.
Q. So that GP assessment is the assessment under rule 34, is it?
A. That's correct, yes.
Q. It's not some other routine GP appointment --
A. No, no.
Q. -- for a different purpose?
A. No, it's new arrival, rule 34 appointments.
Q. You don't specifically mention that at paragraph 81. Is there a reason for that?
A. No.
Q. Oversight?
A. Yes, sorry.
Q. What is your understanding of the primary purpose of

rule 34?
A. To check the vulnerabilities and awareness of any medical conditions that may be coming into the centre.
Q. In your interview with Kate Lampard and Ed Marsden for the Verita report, you describe this initial GP appointment as a five-minute appointment; is that right?
A. That's correct, yes.
Q. Was that in 2017 or is that still the case?
A. They're ten-minute appointments now.
Q. So five minutes in 2017, ten minutes now?
A. Yes.
Q. In relation to rule 34, and perhaps we can have it up on screen. It's <CJS006120> at page 11, please. The Detention Centre Rules, at page 11, should be rule 34. If we could just zoom in slightly on rule 34. It is quite small. There we have the wording of the rule. It says:
"Every detained person shall be given a physical and mental examination by the medical practitioner (or another registered medical practitioner in accordance with rules 33(7) ...) within 24 hours of his admission to the detention centre."
That's that initial appointment you're talking about?
A. That's correct, yes.

Q. So the rule requires a full assessment, both a physical and mental examination, by a GP of everyone who arrives in the centre?
A. That's correct.
Q. It's specifically not only if a detained person requests it?
A. No.
Q. Is that right?
A. They're all given an appointment.
Q. And it's not only if the nurse screening the detained person assesses that they need to be seen?
A. No.
Q. It's mandatory?
A. That's why we did get a lot of DNAs on that one because the residents don't want to attend.
Q. Yes. Is it realistically possible to adequately do a physical and mental state examination in a five-minute appointment?
A. That's why they do -- it is a very brief one. If anybody does have any conditions, then they will make a further appointment of a longer time.
Q. But if it's not possible to adequately do a mental and physical examination in that initial appointment, it can't properly be regarded as the rule 34 assessment, can it, given that's what the rule requires?

A. This is the same as it's been throughout all of the other IRCs as well, so we have reviewed it. When you have vast numbers coming in in one day, you know, you can't have a 20-minute appointment for everybody because you'd never -- the doctors would be there 24 hours a day.

Q. No, understood. But just dealing with whether it reflects the requirement of the rule, it may not be possible to achieve that, but it doesn't reflect what the rule requires, does it?

A. No, it doesn't say the extent of the appointment, it doesn't say the extent of the medical and physical examination, which is why we do go -- if anybody does have a condition, we make a further appointment for them.

Q. I see. As we have dealt with briefly before, the first reception health screening, given it's carried out by a nurse, also can't be regarded as a rule 34 assessment, can it?

A. No.

Q. Because it doesn't fulfil the requirements of the rule being that a GP has to carry it out?

A. That's correct.

Q. Could we just look at then <CJS006045>, please, at page 21. This is the detainee reception and departures

policy in G4S from 2017. At page 21, it says underneath the bullet point that deals with the Detention Centre Rules, the sentence that starts, "Detainees", do you see that?

A. Yes.

Q. "Detainees who have been seen by the triage nurse and require (or request) to see a doctor (subject to their consent) will be seen on his/her next visit. Detainees will see a doctor in any such event within 24 hours of admission."

Does that suggest that a detained person will see a doctor within 24 hours, firstly, if a nurse thinks they require it, or, secondly, if they request it, as opposed to everyone having to see one?

A. So this wasn't a G4S health document. We do give every single person an appointment. So this states that people were requesting appointments. They don't request them, they are given an appointment.

Q. So this doesn't adequately or accurately reflect either the rule or what was happening?

A. No.

Q. At the very least, it's pretty confusing?

A. Yes.

Q. Evidence from Medical Justice suggests that they were aware from their case work that rule 34 assessments were

routinely not carried out within the first 24 hours of a detained person arriving in Brook House. Do you have any particular comment to make about that?

A. I think we do sometimes have -- if we have a large number come in or if they have come in early hours of the morning, they may not get their appointment until the following day in the day time, which could be just over the 24-hour period, but we carry out our audits to ensure we have got everybody being seen.

Q. So, so far as you were concerned, it was individual cases --

A. Yes.

Q. -- and not a systemic issue?

A. No.

Q. Is that the case even though there were these only very short appointments, which you have accepted would allow only for a limited examination?

A. Yes.

Q. So could it be that there was a systemic issue in that certainly the detainees, perhaps, but also Medical Justice, were of the view that those initial appointments were being treated as a rule 34, when, actually, there hadn't been an adequate examination?

A. I think there probably needs to be a further explanation from Home Office as to what they -- the full extent they

want from a rule 34 appointment. Because when you do have large numbers coming in of young, fit people that -- the majority do get transferred from prisons whereabouts they have had medical care. Do they require to be seen by a GP at that point? Some certainly do, but I'm not sure everybody does on that first 24 hours.

Q. I see. One reason it's important that it's done quickly is because, in contrast to that screening with the nurse, it should involve that full examination, so may pick up something that the nurse hasn't?

A. Mmm.

Q. Would you agree with that?

A. Yes.

Q. The importance of picking up physical conditions as well as mental health conditions is that they may require treatment?

A. Yes.

Q. That's certainly one thing that's important?

A. Certainly.

Q. But it's also for picking up vulnerabilities, as you have said?

A. Mmm-hmm.

Q. So, for example, clinical concerns that someone may have been a victim of torture, may have PTSD, whose symptoms

might be made worse by detention, may, in another way, be harmed by detention. That's right?
A. Yes.
Q. So that assessment is important in allowing for consideration for a referral to be made for a rule 35 report; is that right?
A. Yes.
Q. So, in other words, it's an important safeguard for vulnerable detained persons relating to whether they should be detained at all at the outset, isn't it?
A. Yes.
Q. So if it's not being adequately done quickly, someone could be being detained when they really shouldn't be?
A. There is that possibility.
Q. And maybe harmed by that detention?
A. Mmm-hmm.
Q. Again, the evidence the inquiry has received from Medical Justice suggests that they were aware that, often, the nurse screening was being treated as the rule 34 assessment, in breach of the rule. Do you have any comment upon that?
A. No, it was part of the rule 34, because the rule 34 states to be seen by a nurse within two hours, but --
Q. And by the doctor?
A. -- then also by the GP.

Q. I see. As head of healthcare then and now, are you satisfied with the guidance you were giving, and are giving, your staff about the purpose of that first health screening? Did your staff understand that that wasn't the full assessment needed by GPs?
A. Yes, and that's why we do give everybody a GP appointment.
Q. So your evidence is that you were taking steps to ensure that every single detained person was seen by a GP for a rule 34 assessment within 24 hours?
A. Yes, they were. Some do refuse to attend, but they are given that appointment.
Q. And even if it is only for five minutes?
A. Yes.
Q. In your Verita interview at page 5, you say that doctors' appointments are running four to five days and you describe that detained persons will see a nurse, are triaged and, if required, a doctor's appointment will be made. Are you there talking about other --
A. Routine appointments.
Q. So not those under rule 34?
A. No, no.
Q. Again, evidence the inquiry has received from Medical Justice suggests that rule 357 referrals did not always happen, even when the nurse at screening had been

given a history of torture by the detainee. Do you have any comment upon that?
A. I have found occasions where nurses have missed making the appointment. I have gone back to them and asked them why. They are all told that they need to make the appointment. It is now a mandatory question, asking about torture, and if it prompts "Yes", there is a prompt that comes up to say make the appointment.
Q. But that wasn't a prompt in 2017?
A. No.
Q. Do you think that if it wasn't happening in 2017, that was an individual problem or a systemic one?
A. I think it was a couple of individuals.
Q. Who were they?
A. It was a couple of the healthcare assistants and that's why we did make sure that we got the general nurses checking through their screenings as well.
Q. I see. So it was a problem of inexperience --
A. Yes.
Q. -- and of inferior qualification and training. Nurses are trained to a higher level --
A. Yes.
Q. -- than healthcare assistants?
A. Yes.
Q. You are now satisfied, as head of healthcare, that your

staff are correctly applying the Adults at Risk policy, in particular because of the prompts that you talked about on the system?
A. Yes.
Q. What about training? Is further training given to them now than was available in --
A. No, there is no further training available on the policy. So part of their induction will be to show them the policy and to talk them through it.
Q. You say, at paragraph 117 of your witness statement, that a rule 35 report is a report saying someone has suffered from torture -- that's rule 35(3) --
A. Mmm.
Q. -- has a severe or unstable medical condition, which means they are not suitable for detention -- that's rule 35(1)?
A. (1).
Q. Or is severely suicidal and not suitable for detention and that's rule 35(2)?
A. 35(2).
Q. Is that your understanding of rule 35?
A. Yes.
Q. Was it at the time?
A. Yes.
Q. If we perhaps then just look at the wording of the rule,

can we have on screen <CJS006120> at page 11 again, please. Can we look at rule 35, please? It is right in the middle. We see there the first three subsections are the relevant ones we want to look at and we see subsection (1) says:

"The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention."

Rule 35(2) says:

"The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions and the detained person shall be placed under special observation."

So looking first at rule 35(1), the language of rule 35(1) doesn't require a diagnosis of a medical condition, does it?

A. It doesn't there, but it does within the DSO of rule 35, I believe.

Q. So your understanding is that the Home Office document has put a gloss on the wording of the rule?

A. The torture definition has been changed numerous times as well, which has caused some confusion.

Q. I see. It doesn't require, in the wording of the rule, a medical condition of a particular level of severity or

instability, does it?

A. No.

Q. Contrary to what you say in your witness statement.

A. It says it's "likely to be injuriously affected by continued detention". That's what I mean by the severity.

Q. I see. If someone has mental health problems, if rule 35(1) works as you have set out in those two respects, it would require someone to become so unstable that detention has already actually harmed them, wouldn't it --

A. Yes.

Q. -- before considering release? That's a very risky approach to take.

A. Yes.

Q. Indeed, it could be dangerous.

A. Mmm-hmm.

Q. Because they could be harming themselves to an extent of attempting suicide, for example?

A. Mmm-hmm.

Q. Or they could be deteriorating in relation to their medical condition and their mental health in a way that just wouldn't have happened were they not in detention?

A. Mmm-hmm.

Q. In that sense, then, it would be the wrong approach to

take, wouldn't it?

A. Yes, in that respect.

Q. It is certainly in breach of the wording of the rule?

A. Yes.

Q. Is that something you, as head of healthcare, should understand?

A. Yes.

Q. If we look at rule 35(2), a GP is to do a rule 35(2) report if he suspects that a detained person has suicidal intentions. Do you agree that a suspicion of suicidal intentions is a much lower threshold than the threshold you have used in your witness statement of severely suicidal?

A. Yes.

Q. So it seems as though your understanding of the way these rules were to operate was inaccurate; would you agree with that?

A. From what you said, yes.

Q. In that, in particular, you seem to be setting a higher threshold than the wording of the rule for its operation?

A. Probably.

Q. Again, that creates a potential problem, doesn't it, particularly in your leadership role as head of healthcare, in that it's likely your staff are also

applying too high a threshold?

A. I mean, I've discussed rule 35(1)s and rule 35(2)s in all of the IRC forums as well. This is throughout all of the IRCs. This is not just specific to Gatwick.

Q. So you were reassured that everyone else was doing it?

A. Yes, and it wasn't because I was leading. That was their understanding as well. We had GPs talking to us, we had Home Office officials there at it as well.

Q. And in that forum, just describe to me what the purpose of the forum was?

A. It was to get uniformity across all of the IRCs. So we talk about the Home Office policies, any issues coming up that are -- any trends coming through for IRCs, but just to get some uniformity across all of the IRCs.

Q. I see. And the Home Office were content with the thresholds that you were applying?

A. They were, and they have seen the pathway for rule 35(2), they have seen that pathway and they were happy with that pathway that I put in place.

Q. I see. We will come to that in just a moment.

A. That's fine.

Q. We will look at it, I promise.

A. That's fine.

Q. Just staying with this point at the moment, so your understanding, as being approved by other IRCs doing the

same thing and the Home Office knowing that, was that you were setting a higher threshold than the rule actually required?
A. It wasn't me personally setting it. It was a general understanding that we all had of how we interpreted it.
Q. And that's how you were interpreting the rule?
A. Yes.
Q. So that, in practice, was what was happening?
A. Yes.
Q. And amongst your staff as well?
A. Yes.
Q. In order for a GP to consider making the report, a detained person has to be referred to them, don't they?
A. Yes.
Q. And that may be by your staff, by seeing a detained person in a variety of different situations, mightn't it, not just a rule 34 assessment?
A. No, that's correct.
Q. So, for example, in mental health appointments with an RMN; in triaging for GP appointments, for nurse?
A. Yes.
Q. In ACDT reviews?
A. Yes.
Q. Or having been called in an emergency response to

a particular situation such as a self-harm attempt or suicide attempt?
A. And also multi-disciplinary team meetings we had. Any of those could bring up patients as well.
Q. Food and fluid refusal observations?
A. Yes.
Q. And rule 40 or 42 reviews?
A. Yes.
Q. We know, in 2017, that there were eight rule 35(1) reports and no rule 35(2) reports at all, as we have mentioned previously. That also reflects, doesn't it, that a higher threshold than was appropriate was being applied?
A. That's correct.
Q. Your explanation for the reason why there were only eight rule 35(1) reports and no rule 35(2) reports was partly what you had gained in your knowledge and understanding from the IRC forum; is that right?
A. Yes.
Q. As approved by the Home Office, in your view?
A. That's correct.
Q. And were also other mechanisms being used to notify the Home Office of concerns, such as the Part C you have mentioned?
A. Part C talks about it in the Adults at Risk meetings.

Anybody in those -- that was dealt with by Home Office, health and G4S staff there as well.
Q. Yes. But, as we have established, Part C doesn't trigger a review of detention by the Home Office, does it?
A. No.
Q. So, as a safeguard, it is inferior than to rule 35; you'd agree with that?
A. Yes. The reason for the rule 35(1)s we found often were physical, but the delay sometimes for getting the response back from case workers, sometimes you want a more immediate action. Hence why a Part C has been completed.
Q. Was your experience that Part Cs were responded to more quickly?
A. Yes.
Q. Were they prompting, though, a review of detention?
A. Yes. Especially if the GP had actually written in there "unfit to be detained".
Q. Was that in relation to physical conditions --
A. Generally physical.
Q. I see. But rule 35(1) isn't confined to physical conditions, is it?
A. No.
Q. And it should be being used, and should have been used

in 2017, to notify to the Home Office someone whose mental health was likely to be injuriously affected by continued detention in accordance with the wording of the rule?
A. Mmm-hmm.
Q. And the rule says "likely to be injuriously affected" not "has been injuriously affected", doesn't it?
A. Mmm-hmm.
Q. So it is a risk assessment looking forwards as well as assessing whether harm has already occurred; is that right?
A. Yes.
Q. Or at least it should have been?
A. Yes.
Q. We know from the IMB reports, the inspections by the IMB, in the months between April and -- from April to August, in the relevant period, that there were 195 new ACDTs opened and a total of 248 ACDTs opened. That suggests there should have been significantly more of both of these types of report, doesn't it, rule 35(1) and rule 35(2)?
A. If there were suicide ideations, yes.
Q. Certainly rule 35(2) for suicide, but in relation to rule 35(1), that's just someone whose health is likely to be injuriously affected by continued detention.

A. Mmm-hmm.
Q. An ACDT suggests that there has been a concern about a risk of self-harm, doesn't it, not just suicide?
A. Yes.
Q. So even if, which it is likely it isn't, but even if all of those ACDTs were purely in relation to self-harm only and not suicidal ideation, one would have expected significantly more rule 35(1) reports, wouldn't one?
A. Yes.
Q. That suggests that vulnerable detainees weren't being protected by the safeguards under this rule, doesn't it?
A. Yes.
Q. Those safeguards failed. Who is responsible for that, in your view?
A. Healthcare plus the Home Office. I think there needs to be further training on rule 35s --
Q. Yes.
A. -- because there was not that training out there for myself, for the GPs, or anyone, giving the specific wording to them.
Q. Yes, Dr Hard agrees with you. Did you give any consideration at the time, in 2017, to the reasons you weren't seeing very many rule 35(1)s or any rule 35(2)s, given that number of ACDTs?
A. I don't think so at the time.

Q. Was there any monitoring by you, as head of healthcare, of these reports and the numbers that were written?
A. We have an audit that we do collating the numbers that we do each month. I think my main priority was actually trying to push to get training.
Q. I see.
A. I have pushed for that since before 2017, to get training, and I'm ongoing with pushing to get that training.
Q. Who are you pushing and who did you push?
A. Home Office policy team.
Q. I see. Anyone in particular at the Home Office policy team?
A. I've been through to all of them. Through the IRC forum that we've gone through trying to get further training developed. At one point, it was a combined of Home Office and NHS England. Now I believe it is back to just Home Office.
Q. You certainly were then, and are still, pushing for training. Did you raise concerns about the numbers you were seeing or was that not part of your consideration?
A. No. I looked at the quality of our rule 35s as well. Because, in response to one of the HMIP reports, there was an issue about our quality.
Q. Yes.

A. With that, I actually developed -- I asked again if Home Office could tell me what a quality of rule 35 should be and, again, they couldn't come back with what the quality of one would be. So I then developed, along with my medical director at the time, our own internal audit going through, looking at the quality of them, and I shared that audit also with Home Office.
Q. What did your audit show?
A. There was some disparity between different GPs. One wrote very little, one wrote a lot more. So we did a lot of review with the GPs and asked them to actually do peer-to-peer reviews as well.
Q. Did the Home Office ever raise with you the quality of rule 35 reports they were receiving?
A. No.
Q. They never came to you and said, "These aren't good enough"?
A. Very occasionally, you'd get one coming back saying there wasn't -- the GP didn't state if they were to be detained or what their thoughts were of detention at the end. That was a rare --
Q. Did -- sorry. It was rare?
A. Yes.
Q. Did the Home Office ever raise with you a concern about the numbers of rule 35 reports coming through under

rule 35(1) or rule 35(2)?
A. No.
Q. Not at all?
A. No.
Q. Have they ever raised that with you --
A. No.
Q. -- in the entirety of the time you have been in healthcare at Brook House?
A. Not that I've been aware of.
Q. It sounds as though you now consider the numbers -- is that right? --
A. Yes. I mean --
Q. -- in your audit process?
A. Yes. We look at the numbers -- numbers are still extremely low for (1)s and (2)s. I wouldn't say they have improved from 2017.
Q. Why do you think that's the case?
A. Because they are still going by the training they are aware of and not being told to look at anything different.
Q. I see.
A. That training has not changed.
Q. And no concerns have been raised with you by the Home Office about the numbers now?
A. No.

Q. Can we just look a little bit more at the training. You say you had training on rule 35 several times. Was that the Home Office and NHS England training you're talking about?
A. Yes.
Q. You had it before 2017?
A. Yes.
Q. Have you had it since?
A. No.
Q. So what are the "several times" you are talking about?
A. I did have them listed, I think, in my statement. I think there was some training in 2016. There was a training course put on in 2017, but I was unable to attend that one.
Q. Was the training primarily for GPs?
A. Yes.
Q. So your nursing staff weren't trained in rule 35, as you have said before?
A. No.
Q. Did they receive any training in when to refer for a rule 35 report?
A. No.
Q. Do they now?
A. No.
Q. How, then, are they to understand the importance of

healthcare screening, either initially within the first two hours of arrival in a detention centre or -- in a removal centre, I'm sorry, or afterwards if they are not trained in when to refer for a rule 35?
A. Part of their orientation process. I do share with them and go through with them all of the DSOs and DC rules. They are all given a copy of those as well.
Q. Rule 35(3) seems to be more capable of easy understanding?
A. Mmm-hmm.
Q. Because it relates to being a victim of torture?
A. That's right.
Q. Whatever one thinks about the definition of that, it is, at least -- if someone says, "I'm a victim of torture", one can understand that prompts a referral for a rule 35 assessment and report by a GP?
A. Mmm-hmm.
Q. Do you think your staff have a good understanding, or an adequate understanding, of the other two limbs of the rule?
A. No.
Q. That's a significant gap in knowledge, then, isn't it?
A. Yes.
Q. Does that remain today?
A. Yes.

Q. You said, as head of healthcare, you have tried to source training, "push for training", I think was what you said, several times?
A. Mmm-hmm.
Q. Have you approached, given your lack of success with the Home Office, any other body in relation to training?
A. I haven't, no, because of it being a Home Office policy and their DSO, it should be them promoting the training for their policy, and it is their document, so it is quite difficult to actually source specifics for rule 35s.
Q. You would agree with Dr Hart that the training is inadequate?
A. Yes.
Q. It remains inadequate today?
A. When I first started at the immigration centres, it was actually the nurses who were undertaking rule 35, which we often do have more time to complete these. And now it's back to medical practitioners only completing, unless they're a short-term holding.
Q. Yes, you mentioned nurses completing rule 35 reports before. When was that?
A. This was -- I started in 2004. The first couple of years, at least, I was doing them.
Q. I see. Were you aware that, even at that time, the rule

certainly, the letter of the rule, required it to be a GP?
A. We were told at that time for it -- that we could complete it. It was, I think, reviewed, and that's when they said it was medical practitioners only.
Q. But the wording of the rule hadn't changed. You weren't aware of that?
A. No.
Q. Let's look, then, as I promised we would, at the rule 35(2) pathway briefly. It is at <CJS0073839>. It is a one-page document. Were you the author of this?
A. I was, yes.
Q. Was it in use in 2017?
A. No.
Q. When did it come into use?
A. I think this was in response to -- following this review. Following -- we had Dr Linsell came from NHS England to do an inspection following the Panorama, and he looked at them.
Q. So following Panorama?
A. Yes.
Q. Do you think that was 2018, then, or --
A. It is likely to be 2018. Unfortunately, I didn't date it.
Q. We know also that this is -- remains in use currently --

A. That's correct.
Q. -- in Brook House. Although I believe it is said to be under review by PPG, them having just taken over the contract?
A. That's right.
Q. How would staff be aware of this document?
A. It's advertised in each of the clinic rooms, and the GPs have all got a copy.
Q. Was there any training or guidance provided by anyone on how to use the pathway, or did it speak for itself?
A. It was talked through at a staff meeting.
Q. I see.
A. So at a staff meeting they had it. And it is now part of what we call the MPCCC, which is the multi-disciplinary team meeting that's held weekly. It's part of that.
Q. In your view, does this pathway comply with the requirements of rule 35(2) from the wording of the rule?
A. No. This complies to how I've interpreted it previously.
Q. I see. Is that because of the delay built in between day 1 and day 7 in a doctor considering?
A. Yes, but, obviously, I have put the asterisk there that, if there is any serious concerns, then that is to be brought forward.

Q. So not just those on a constant watch?
A. No, no, all ACDTs are reviewed, and if they're not for a rule 35(2), then I recommended to the GPs that they actually document "not suitable at that time for rule 35(2)". Then it's actually acknowledged that it's been investigated.
Q. Are GPs doing such documentation?
A. We have just had to sort of reprompt it because they weren't, they had let it slip, and I have actually just reput this through to the GPs again.
Q. Again, if someone is on a constant watch on an ACDT, that suggests suicidal intentions, doesn't it?
A. Mmm-hmm.
Q. It's the highest level of observation?
A. Yes.
Q. So, in at least those cases, there should be a rule 35(2) report not just considered, but done; is that right?
A. Yes.
Q. Are they being done?
A. No.
Q. No. Why not?
A. I think it's the GPs are thinking -- I can't answer for the GPs, to be fair, but the GPs haven't done them.
Q. So the GPs aren't doing them. What action have you

Q. Yes. But the review by the mental health nurse is an additional step in between, isn't it?
A. Yes. It is to give that mental health background before the GP sees, so that gives the GP a little bit more to go through.
Q. But if the nurse is concerned about suicidal intentions, there should be an immediate referral to a doctor, shouldn't there?
A. I think if they have that concern, then there would be. That's why there is that asterisk there.
Q. I see.
A. So ...
Q. So, in your view, does this pathway adequately safeguard the welfare of vulnerable detained persons with suicidal intentions, or are there still concerns over the interpretation of the rule?
A. There are still a lot of questions over interpretation of the rules.
Q. I see. What the pathway does do is invite consideration of a rule 35(2) report, albeit potentially some days later, by a GP, when an ACDT has been opened?
A. That's correct.
Q. That's, as is said at the bottom there in relation to the weekly review, all ACDT cases?
A. Yes.

taken in relation to that, as head of healthcare?
A. So I've been -- I've gone through the rule 35s again with them. We have had a recent gentleman, a mental health case, that we have put through for rule 35(1). That's been put through. That was the first thing that I stipulated that needed to be completed.
I think it's -- it depends on how long the patient's actually been on a constant watch for. They are coming in -- some people are only on a constant watch for a short time, and it can be prior to their flight leaving the following morning, in which case the GP may not see them.
Q. Yes.
A. That may be different, but if they are on it longer, then, yes, they should have a rule 35(2).
Q. If they are not, that's, again, a pretty serious failing in the system, isn't it?
A. Mmm.
Q. Your view of who is responsible for that is the GPs?
A. And myself.
Q. And the Home Office, presumably?
A. Yes.
Q. Because, as you said, they haven't raised the lack of rule 35(2)s with you?
A. Mmm.

Q. In relation to ACDT, one of the Medical Justice witnesses, Emma Ginn, her witness statement -- she's the medical director of Medical Justice. Her view is that, because the ACDT system is not clinically led and is not therapeutic in its interventions, it's a risk management tool, and it clearly isn't leading to rule 35(2) reports or, indeed, a substantial number of rule 35(1) reports, the ACDT system is inadequate. Would you agree with that?

A. No, because I don't think the ACDT should be related to the rule 35s. I think they should be separate. I think there needs to be the boundaries between the clinical and the operational.

Q. But doesn't your rule 35(2) pathway, at least in relation to rule 35(2), directly link the ACDT system with rule 35?

A. Yes, but because the ACDT is not owned by healthcare, so therefore it shouldn't be coming from ACDTs to healthcare that way.

Q. But if the concern as to why someone is being managed on an ACDT is a deterioration in their mental health due to being in detention or suicidal intentions, those things, in themselves, should be leading to rule 35(1) and (2) reports, shouldn't it?

A. Yes.

Q. So shouldn't, in those cases, the opening of the ACDT prompt the rule 35 report?

A. It can do. It can do. I think it depends on how --

Q. But it is not?

A. No, it is not.

Q. In your Verita interview, at page 17, you say:

"I do find we get an awful lot of requests from solicitors, and even occasionally from the Home Office, to say you need to go and get a rule 35 condition ..."

I suspect you meant "report":

"... when actually it doesn't meet the criteria. We get a lot of pushbacks and they want repeats of rule 35s. It used to be, if you have one rule 35 completed, then that was the answer. Now, if you don't like what was written, you can ask for changes to be put into it. If you move to a centre, you can get another one written at another centre. Sometimes, you have had one response that torture should be the same no matter where you have been, and it's not rehappening. So it's not going to change."

So you seem there to be saying that you were getting requests for more than one rule 35 report and that that was inappropriate; is that right?

A. Yes.

Q. Leaving aside rule 35(3), which deals with --

A. That's what these were all regarding, was (3)s.

Q. I see. Because that doesn't account for, does it, rule 35(1) and (2)?

A. No, that would be completely different.

Q. Because that concerns the impact of detention?

A. And that can change at any time.

Q. Exactly. So that comment related only to rule 35(3).

A. (3).

Q. I understand. Evidence from Medical Justice suggests that doctors in Brook House have refused to complete rule 35 reports on detained persons because they already had one under rule 35(3), when in fact what had happened was either an act of self-harm, perhaps indicating a deterioration in their health, or a suicide attempt, indicating suicidal intentions. If a doctor was refusing a rule 35(1) or rule 35(2) report in those circumstances, in the presence of a rule 35(3) report, that would be wrong, wouldn't it?

A. Yes.

Q. Were you aware of that happening at Brook House?

A. No.

Q. Are you aware of it happening now?

A. No.

Q. In relation to Her Majesty's Inspector of Prisons' report on the unannounced inspection in October

and November 2016, there was a conclusion reached that:

"Despite the long average cumulative length of detention, no regular healthcare checks were carried out to determine the impact of detention on the mental health of detainees. Combined with a general lack of oversight, this meant there were no effective arrangements to monitor vulnerability over time."

Are you aware of that conclusion in that report?

A. Yes.

Q. Did you agree with it?

A. I did at the time, and we changed things.

Q. Yes.

A. So we actually changed to do regular reviews so people were reviewed -- anybody who had not been seen within healthcare within six weeks was actually then reviewed by healthcare to check that they were okay.

MS SIMCOCK: Chair, I'm conscious of the time. I do still have some questions, but I'll try and be as quick as I can. I'm conscious it's 4.30.

In relation to food and fluid refusal, you say that healthcare would see people who were on day 1 of fluid or day 2 of food refusal and do a full set of observations?

A. That's correct.

Q. Including blood sugars, weight, and, if required, would

be referred to see the GP; is that right?
A. That's correct.
Q. So there would be some assessment of physical observations and physical condition. What would prompt a referral to a GP?
A. Abnormalities within their readings or big drops within their readings.
Q. Was that solely focused upon the physical?
A. Generally, yes.
Q. How would you assess the underlying reasons for food and fluid refusal? How would your staff --
A. It was actually -- they were asked within that assessment why they were refusing.
Q. Was there --
A. What the reasons were.
Q. Was there a mental state examination?
A. Not a full mental state. That wasn't always undertaken by the mental health team. If they were continuing, then, yes, a mental state would be completed.
Q. Was consideration given to food and fluid refusal as a form of self-harm?
A. Not always.
Q. Why not?
A. Because a lot of them were refusing literally to prevent their flights as well.

Q. So it was viewed as a form of protest, primarily?
A. Yes. Some were self-harm. Some did go to extreme. I have seen some extreme cases.
Q. Was consideration given to refusal as a manifestation of mental illness?
A. Yes.
Q. In every case, or ...?
A. Not in every case, no.
Q. But you would agree that food and fluid refusal can be a symptom of mental illness?
A. Yes.
Q. So it's important to explore the reasons for food and fluid refusal in a therapeutic way?
A. Yes.
Q. And to make a clinical assessment?
A. Yes.
Q. Both clearly of the physical implications but also of their mental health?
A. Yes.
Q. That wasn't always done, in 2017?
A. No. Mental health nurses are now undertaking the assessments so then they can explore more as well.
Q. Do you agree that an assessment should also have been made of their mental capacity to make the decision?
A. Yes.

Q. Was that always done in 2017?
A. It wasn't always done. It is now --
Q. It is now?
A. Yes.
Q. Use of force. You say at paragraph 148 of your statement that if there is a planned use of force, you would be called to the briefing beforehand and would be alerted to who the detained person was and would let staff know if there were any concerns?
A. That's correct.
Q. If it's unplanned, you say you would get there as soon as possible?
A. Yes.
Q. And the same presumably applies to your staff. Who from healthcare would generally attend planned or unplanned uses of force?
A. A general nurse/paramedic as our first responder, and then you'd usually have a second person so then they could be a runner, and that could be a healthcare assistant or sometimes it was even the mental health nurses.
Q. But it wasn't routinely a mental health nurse who attended?
A. No. They would often go for the review afterwards because the height of the time of the use of force,

that's not always the best time for them to be assessed.
Q. The decision to use force is not a medical or clinical one for healthcare?
A. No.
Q. It's a custodial staff decision. The role that healthcare does have is in raising clinical concerns that may contraindicate restraint; is that right?
A. That's correct.
Q. In other words, an important safeguarding role is healthcare before a planned use of force --
A. Yes.
Q. -- to raise a concern that, "Actually, this is someone we shouldn't be using force against"?
A. Yes.
Q. From a clinical perspective?
A. Yes.
Q. That could relate to either physical conditions or mental health conditions?
A. Yes.
Q. Underlying vulnerability, risk of self-harm and suicide?
A. That's correct.
Q. Presumably, you agree that that's a very important safeguarding role?
A. Definitely. Definitely.
Q. Were there occasions, so far as you were aware, in 2017,

that that role wasn't being fulfilled by nursing staff?
A. No, we have always been very good at attending and completing the paperwork for them and giving the correct information.
Q. What about the raising of concerns that this person is too vulnerable and force shouldn't be being considered here?
A. I think if we had anybody that we did have concerns, we'd have raised it before a planned use of force was required. You know, we do that as a pre-empt. Anybody we have got major concerns, we will be talking to the officers and to Home Office to state that they are unsuitable for any use of force.
Q. Was that happening in 2017?
A. I've known of one case. It was a physical condition. We said they couldn't use force. We had a multi-disciplinary team meeting regarding it.
Q. Were you aware of force being used on mentally vulnerable people due to self-harm incidents, particularly to relocate them to E wing?
A. Yes.
Q. Did you think that was appropriate at the time?
A. I think it's -- depending on the individual case. I can't remember the specific cases. But it may be to safeguard them for their vulnerability later on it.

Q. It should be a last resort, though --
A. Totally.
Q. -- shouldn't it, a use of force?
A. Yes.
Q. To save life?
A. Yes.
Q. In the immediate moment?
A. Mmm-hmm.
Q. A second important role is the monitoring of the detainee in providing clinical advice during the use of force itself; is that right?
A. That's correct.
Q. Would you expect the person fulfilling that role to be able to put themselves in a position to observe what was happening then with the use of force?
A. Yes.
Q. Because one can't monitor and intervene if something is wrong --
A. Exactly.
Q. -- if you can't see what's happening?
A. That's correct.
Q. And you would expect your staff to know that?
A. Yes.
Q. And to act accordingly?
A. Yes.

Q. So if they couldn't see?
A. They make sure that they move or tell people to move out of the way so that they can see.
Q. Were you aware of decisions or advice being given by GPs in Brook House in 2017 in the context of fit to fly memos, in other words, a doctor --
A. Yes.
Q. -- certifying that someone was fit to fly to be removed?
A. Yes.
Q. Were you aware that, on occasion, a doctor would say, "Happy for reasonable force to be used"?
A. I didn't see any of those documents.
Q. And you weren't aware of it any other way?
A. No.
Q. If you had been aware of it, would that have concerned you?
A. Yes, because it's not for us to decide on the force being used.
Q. It's not for healthcare to sanction the use of force?
A. No. No.
Q. The documentation that healthcare are required to fill out following a use of force is called an F213 form?
A. 213.
Q. There are lots of forms?

A. There are.
Q. It is annexed to the DCF 2, which is the use of force form --
A. That's correct.
Q. -- which is a custodial document?
A. That's correct.
Q. The F213, itself, also has sections for custodial staff to fill in, the first two sections; is that right? You're familiar with the form?
A. Yes, yes.
Q. The healthcare section is section 3; is that right?
A. That's right.
Q. And that contains healthcare's report as to the time and date of examination and the report itself, and it also contains body maps for recording of injuries; is that right?
A. Body maps, that's correct, yes.
Q. In filling out those forms, would mental health also be considered, as well as physical injury?
A. Not generally, no.
Q. Did that concern you, given that force was being used on vulnerable detainees who were self-harming?
A. It didn't at the time.
Q. Does it now?
A. Yes.

Q. What process was in place at the time for auditing those forms and assessing the quality of healthcare's input on those forms?
A. All of the forms go together as a pack from the custodial team through to Home Office, and Home Office compliance will then come back with any comments as well.
Q. And did they?
A. They have usually come back if we haven't -- if a nurse hasn't signed, but that's generally it. It's not usually about the quality --
Q. Not on the substantive quality of the report?
A. No.
Q. Internally, did healthcare carry out any audit of those reports?
A. No, because we don't keep hold of those reports. They go off to the custodial site.
Q. I see. Is that still the case?
A. Yes.
Q. At paragraph 150, you say you're not trained to do use of force?
A. That's correct.
Q. Of course because you don't carry it out. Do you receive any training in the appropriate circumstances in which force may be used?

A. That's right, yes.
Q. So use of force was a custodial remit?
A. Yes.
Q. Not healthcare?
A. Yes.
Q. So --
A. We have had the security team and the use of force instructors come to staff meetings since then, and we've promoted the fact that nurses are the ones that -- are the one people that can say "Stop" in a use of force, to do emergency hands off.
Q. In an emergency. But also to raise concerns over the effect of the force being used upon the detainee?
A. Yes.
Q. And would that include on their mental health, if they --
A. Yes.
Q. -- seemed distressed, if they were vulnerable --
A. Yes.
Q. -- if they had mental illness underlying?
You will be pleased to hear this is the last question. In relation to CQC inspections, can we just look at <GDW000011>, please. This is a report entitled "The Right to Community Equivalent Healthcare in Immigration Removal Centres. A Public Law Analysis of

A. Nurses are allowed to go to use of force training so then they can be a witness to the use of force and can actually be told how to stop a use of force, should they feel they need to.
Q. I see.
A. We promote that with all of our team.
Q. Was that the case in 2017, or is that just now?
A. I think it's more recently.
Q. So there wasn't any such training at the time?
A. No.
Q. Would you --
A. We struggled to get the -- our own personal protection training in 2017.
Q. Yes. Would you consider that a deficiency in the training --
A. Yes.
Q. -- in relation to use of force?
A. Yes.
Q. For nursing staff?
A. Yes, because I think there was definitely -- staff were not keen to say "Stop" either, if required.
Q. Why was that?
A. Unaware, and feeling that it wasn't their -- it's -- they weren't in control.
Q. They didn't want to challenge the custodial staff?

Systemic Issues in the Inspection Regime". I think this report has been brought to your attention by the inquiry; is that right?
A. I haven't seen this, actually, before.
Q. Were you aware of this report otherwise?
A. No.
Q. It sets out very briefly a conclusion that the report -- that a detained -- I will start again. It's a long day.
It sets out that detained person healthcare complaints don't feature in CQC inspections in the same way that they do in CQC inspections in the community of GP practices, so the voice of the patient is effectively not heard. Would you agree with that?
A. Yes. It's very hard to get the patient to voice any opinions in detention. We have struggled for a long time get any patient engagement.
Q. Why do you think that is?
A. Whenever you go to any patient forums, they always just say, "Oh, healthcare is fine", and that doesn't give you any feedback. I think they just have so many other things that they want to deal with. Food is often a priority for them. And the Home Office is their priority. Healthcare, they're really -- that's not their priority.
Q. I see. Is that a concern?

A. Oh, yes.
Q. What are you doing to address that concern?
A. So we have now got questions put out on all the kiosks. So whereabouts they order their food is a question -- a very short questionnaire that's available in all different languages, so they can actually access it. So we can get some feedback and we can change those questions as appropriate. And we're also looking at getting a patient engagement lead nurse in as well, so we can actually get some further information back from the patients.
MS SIMCOCK: Thank you. Chair, those are all my questions for this witness. Do you have any questions?
THE CHAIR: Thank you. I do have a few and I will try to keep them short. I know it's been a long afternoon, Ms Calver.

Questions from THE CHAIR

THE CHAIR: My first question was, you told us a little bit about the IRC forums that I believe you established and chair those forums?
A. That's correct.
THE CHAIR: Do Home Office staff attend those forums at all?
A. Yes, they do. I get a Home Office member from every IRC as well.
THE CHAIR: So it is your understanding that they would be

familiar with the subject that you're discussing, they would get copies of the minutes for example, of those meetings?
A. Yes.
THE CHAIR: You also mentioned orientation for GPs working within Brook House. Is that something that you, yourself, put together as a kind of training, a briefing?
A. Yes, it is very brief, because, obviously, GPs are a subcontractor. So we just try to give them as much -- I give them the links to the DSOs, to the DC rules and then anything specific that is for an immigration removal centre.
THE CHAIR: Am I correct in thinking that's because you -- in your experience, that's helpful for a GP who maybe doesn't have that experience of working in the detention environment?
A. That's correct, yes.
THE CHAIR: Thank you. Then my final question: you mention in paragraph 9 of your statement, if you want to have a look, it's on page 2, your first statement, you talk about dips in morale and some of the sort of challenges that healthcare staff deal with. One of the things that you say is:
"Factors which have caused morale to dip have been

if we have had any specific challenging detainees, if we have had to run clinics without any officer support and then end up having to deal with verbal abuse from detainees."
Can you tell me anything about, how do you equip the staff that work within healthcare to deal with some of those challenges? Is it anything that's dealt with in terms of management relationships, mentoring?
A. So we have got clinical supervision and management one-to-ones that we do with the staff, and make sure that, if they have any incidents, we raise them for them as well and take it higher, but feed back to them as well, so they do get the flow of any incidents -- issues that have been raised.
THE CHAIR: Is there any element of those conversations that's about finding ways to cope, strategies to cope, with some of those challenges, like people speaking abusively to you because you're frustrated or those kind of things?
A. Not specifically. No, there isn't anything that we do specifically to get them to cope. Obviously, they've got the Employee Assist Programme that they can contact for any counselling advice. We have that for all of our staff. But it's ensuring that we are doing as much as we can and we are getting involved and we do listen to

them.
THE CHAIR: How often do staff have clinical supervision?
A. Monthly.
THE CHAIR: Those are all the questions I have, Ms Calver. I'm very grateful. I know it's been a long afternoon but your evidence has been important and I'm grateful for you taking this time to come.
A. Thank you.
MS SIMCOCK: Thank you, chair. Tomorrow, at 10 am, we will hear from Derek Murphy and then John Connolly.
THE CHAIR: Thank you very much. I will see you tomorrow. Thank you. I hope everybody has a relatively smooth journey home.
(4.46 pm)
(The hearing was adjourned to Wednesday, 2 March 2022 at 10.00 am)

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