Thursday, 31 March 2022
(10.00 am)
THE CHAIR: Good morning, thank you very much.
Mr Altman, good morning.
MR GORDON COLIN BROCKINGTON (sworn)
Examination by MR ALTMAN
MR ALTMAN: Thank you, Mr Brockington, give us your full name, please.
A. Gordon Colin Brockington.
Q. Mr Brockington, tell us, please, first of all, what your position is with G4S?
A. My current role is Managing Director of Justice and the Government Chief Commercial Officer.
Q. And since how long have you been in that role?
A. Since November 9, 2020.
Q. You said that is your current role. How long have you worked with G4S?
A. I joined G4S in March 2015, and I have held a number of roles in G4S throughout that time.
Q. So you were an employee of G4S during the period that we are interested in, April through to August 2017. Where were you at the time?
A. At the time, I was the regional business development director.
Q. Head office?

A. Head office, correct.
Q. Which is where?
A. Victoria.
Q. And presumably you were aware, even though remote, from the allegations that arose through the Panorama recording of incidents during that period, April to August, presumably wasn't much of a secret at G4S; is that correct?
A. That is absolutely correct. I was fully sighted. I saw the Panorama programme and I was based in head office at the time.
Q. Yes. Were you on the board at the time?
A. I wasn't on the board, no.
Q. No. Were you privy to any of the meetings which took place, or must have taken place, about what Panorama had shown?
A. Limited meetings.
Q. Yes. But, clearly, directors like you would have been sighted on the issues which Panorama exposed?
A. Not clearly. We were sighted on what was -- at the time, what we saw on Panorama, but a lot of the meetings that were held in relation to the Panorama were held by the project team, were held by the senior execs at the time and the operations team responsible for the Gatwick IRC.

Q. When you talk about a project team, was a team especially set up in order to deal with the matter?
A. Absolutely. The immediate actions and the action plan were compiled by a specific project team immediately after Panorama, amongst other things, which we look immediate action on.
Q. Who headed the team; do you remember now?
A. I believe initial investigations were taken place by Lee Hanford and Pete Small, and then the project team was put together to develop the actions required, in collaboration with the Home Office and others, and then the action plan was then put in place and deployed.
Q. Who did the project team report to on the board?
A. I believe that would have been Jerry Petherick at the time.
Q. But he left, didn't he?
A. Jerry Petherick?
Q. Yes. Didn't he leave G4S?
A. He did, but not at the time, not immediately post Panorama.
Q. We will look at a document in a moment and I will ask you about it then.
At your paragraph 77 of your first witness statement, of which you made two -- we will come to that in a second and I will ask the chair if we can adduce

both of the statements, respectively <CJS0074041> and <CJS0074043>, and you will confirm you made two witness statements to the inquiry, Mr Brockington: the first on 7 February of this year, I think; and the second on 10 February. Is that correct?
A. I can confirm that is correct.
Q. Yes. Let's look at what you say at paragraph 77 of your first witness statement -- we don't have to put it up on screen, but you say:
"Following the broadcast, the company sent a clear message to all employees that the behaviours witnessed in the programme were unacceptable and would not be tolerated. The message was reinforced by the swift suspensions that followed, together with the subsequent investigations and cooperation and engagement with Sussex Police."
So that was the message that the company sent out; yes?
A. That is correct. That came from Peter Neden.
Q. Came from ...?
A. Peter Neden. That is where I saw it; in an email from Peter Neden.
Q. Did G4S, as you understand it, accept all of the Lampard findings and recommendations, the Verita?
A. We did, so of the 52 recommendations in the Verita

report -- clearly that came some time after.
Q. Yes, that was -- the final report was November the following year.
A. Yes, absolutely. So we broadly accepted the 52 recommendations; that is correct.
Q. When you say "broadly", what does that mean?
A. In essence, we accepted the 52 findings. When it came out in the final report some time after, of course, I believe late in -- December 2018.
Q. Yes. Let's look at a document. It is dated 10 January 2019, and it is one which has been disclosed to you, so I hope you have had an opportunity to look at it <HOM005917>. Chair, it's tab 29 -- 30 for you, sorry.
This is a Home Office document; headed "Shaw Programme Board", 10 January 2019. It is in relation to the Verita report on Brook House. At the bottom, it gives a summary of it. We don't need to go through that.
Over the page, under "The Recommendations", it tells us:
"There are 52 recommendations under seven broad headings. G4S have recently shared their internal response (attached at annex A) ..."
Although it is not attached to the document in your

bundle:
"... indicating that they have accepted all of the recommendations. They are showing 40 as having been completed, with the other 12 either in progress or under consideration.
"At face value their response appears appropriate although lacking in dates for actions that remain outstanding."
And there is some further text there.
So, first of all, the Home Office's understanding -- and this is a document, if we look to the bottom of the next page, which is under the authorship of Phil Riley, who we will be hearing from next week, and is dated 2 January 2019, but, clearly, the Home Office's understanding is that the 52 recommendations under the seven broad headings had been accepted by G4S without qualification? Do you accept that?
A. I think in my previous statement I said G4S accepted the recommendations of the -- you know, of the Verita report.
Q. Yes, well, it was your word "broadly" which I was asking you about. If we go back to page -- we are still on page 2. Do you see the large paragraph in the centre there, just below, towards the end of it:
"With the announced departures of Peter Needen,

Jerry Petherick and Paul Kempster, G4S will have replaced the entire management chain who may be regarded as having presided over the Panorama events."
This document is dated January 2019.
Jerry Petherick, had he remained in post to help with the post-Panorama fallout or had he gone fairly quickly; do you remember?
A. Jerry was in post, post Panorama, absolutely.
Q. No, but how long did he remain?
A. I am not sure of his exact departure date, but he was certainly in post for a period after Panorama.
Q. Yes. With all of this in mind, Mr Brockington, can we look at your witness statement at paragraph 62. Your first witness statement. Perhaps we ought to start at paragraph 61. Let's put this up on screen <CJS0074041>, page 15.
Right at the top:
"The Verita report ... noted that they had ..."
And you quote here:
"... 'cause to question the quality and content of some of the training offered to new recruits on the ITC and to staff as refresher training. We found that not all those delivering the ITC and refresher courses were appropriately qualified'."
That is a reference to paragraph 1.38 in the Verita

report.
You say at 62:
"The company does not accept this conclusion."
Why not?
A. So in relation to training, I think it is quite important to lay out the training protocols we had in place at the IRC. The ITC, the initial training course, the contents were actually quite helpfully laid out in the Shaw report of 2018 -- I believe it is section 6 -- where it lays out the contents of what we agreed collaboratively and mutually with the Home Office in terms of the content of the training of the ITC. So I think with specific reference to the ITC, we have worked with our customer to devise and deploy the ITC, in order for all frontline officers to receive their certification aligned with being a fit and proper person, so they were certified by the Secretary of State to be a frontline officer. So, in our view, the ITC was devised and deployed collaboratively in accordance with our Home Office customer and the training was fit for purpose.
Q. Let's look at the Verita report, please. <CJS005923> at page 36. Let me know when you get there, please.
I am struggling to understand, Mr Brockington, in light of what you said in your witness statement, why,

then, the company accepted recommendation 9 and -- we'll come to it in a second -- recommendation 40.

Recommendation 9:

"The SMT and G4S managers should undertake regular and systematic evaluation and quality assurance of the training provided at Gatwick IRCs to ensure that staff receive training of a consistently high standard; that it meets the operational needs of the IRCs, trains and develops staff appropriately and promotes appropriate values."

So when Verita had cause to question the quality and content of some of the training, there is a recommendation that deals with it. In your witness statement, you say the company doesn't accept the conclusion but it accepted the recommendation.

How does that work?

A. I think it is a sign of a healthy business that we would consistently review our training requirements. I take some comfort -- although we have our own governance in place, I take some comfort that the HMIP inspection of 2019 showed we had improved training in place, and I would also say the Stephen Shaw findings of 2016, one of the recommendations said that we should deliver mandatory Safer Training on an annual basis, and we included that into our annual training.

We also deployed annual refresher training in areas such as C&R, first aid, respiratory protective equipment and equality and diversity, to name a few examples, so my personal view is I see this as a sign of a healthy business, that we consistently review our training, and we deploy our training -- the initial training course, as explained in the Shaw report and in full sight of the customer, working with the customer to make sure the training is fit for purpose and then we deploy ongoing training on an annual basis in certain areas as well, so that is where I conclude my position in the statement.

Q. Let's look on to recommendation 40 on page 37 because this deals with the second criticism, which you say the company doesn't accept, recommendation 40:

"The SMT in consultation with the local safeguarding boards must ensure that all staff receive appropriate annual safeguarding refresher training."

That was accepted without qualification by the company. So, again, one struggles to understand why, at paragraph 62, you say the company didn't accept the conclusion that Verita had arrived at. It is the same point, isn't it?

A. So, with specific reference to safeguarding, the Stephen Shaw report of 2016 stated clearly that we needed to act -- sorry, the 2016 HMIP inspection in

relation to the Stephen Shaw report stated we needed to act and we needed effective training for Adults at Risk and that was incorporated into the consolidated action plan of 2016. And the HMIP inspection of 2019 showed improvements and that was also reflected in the Shaw report.

We worked closely with the West Sussex Social Services Vulnerable Adults Board and, working with them, we developed annual refresher training. So, again, I think it is a sign of a healthy business, where we consistently review, based on external feedback, and we adapt and change in accordance with that feedback that we have received. So, again, that is where I conclude this position in the -- in my statement.

Q. The trouble is, Mr Brockington, that doesn't really answer the question. My question is -- and I know you are the mouthpiece for the company, and you are here to answer questions on behalf of the company and you weren't directly involved in these matters, as you make clear, at the time, but here is the company accepting recommendations in the Verita report, and I've pointed out, so far, two in particular. The Home Office clearly understood, by January 2019, that G4S had not only accepted all of the recommendations without qualification, but was actioning them, and here you are,

in 2022, saying the company doesn't accept the positions which I have just put to you. I think people will struggle to understand, although we hear your answer, that the company listens to feedback and it does all of these things, all fine and terrific, Mr Brockington, but there seems to be, in the passage I've read so far -- and I will come to another in a moment -- a resistance by G4S to accept what it accepted back in November 2018 or afterwards, once it received the final Verita report -- do you understand what I am saying?

A. I do understand what you are saying but I disagree with G4S's approach around the resistance.

The level of activity taken post Panorama -- and we have to look at this in terms of the timeframe. The Panorama programme was viewed, by us all, and the immediate action plan was taken -- was put in place and deployed. Those actions took immediate effect, and I can talk about those actions at some length, but we took a number of management interventions immediately, including the -- bringing in a new interim director; including increasing DCOs from two to three on the wings; including increasing the DCMs on the wings; bolstering the SMT; and improving the fabric of the establishment. So we took a number of specific management interventions immediately as part of the

Panorama action plan.

Those then -- as part of -- a further action of the Panorama action plan was to work with Verita, so -- but Verita took a period to compile their report and then put out their recommendations, so we have to look at this in the context of the timeline. A number of those actions were already completed by the time that Verita issued their report, so that is why, come January '19, 40 of the recommendations had already been completed and 12 were outstanding, of which, I believe, broadly five were dependent on work the Home Office and ourselves needed to do together. So that is our position.

But I categorically say there is absolutely no resistance from G4S, as a business, to deliver what was needed to be done.

Q. I am just wondering, Mr Brockington, why wouldn't it have been easier for you to say that in your witness statement, rather than saying, "The company does not accept the conclusions"?

A. If that was an oversight -- so, that is my position, that is the evidence I am giving the inquiry today.

Q. It is not the only one because, if we look at your first witness statement at 98, for example, if we can put that up, please, <CJS0074041> at page 22, you then say at the top, paragraph 97:

"The Verita report also concluded: 'The lack of visible, supportive management, managers' heavy-handed approach to performance issues, and a lack of confidence in the arrangements for reporting and dealing with concerns, has meant staff have tended to rely on each other for support and guidance. These management shortcomings have discouraged staff from raising concerns, including those about the behaviour of colleagues and managers'."

At 98, you say:

"The company does not fully accept these conclusions. DCMs were constantly 'on the floor', although, prior to the profiling mentioned above [something you deal with in your statement; reprofiling of staff], they would have covered two residential wings, so would not have been visible to all staff all of the time."

What was it you didn't fully accept?

A. I think what we -- the actions we took immediately post Panorama, as I have just described to the inquiry, is we brought in a new interim director, and the interim director was very clear in his views that we needed to increase the number of DCOs on the floor from two to three and DCMs to one per wing. Amongst other things which I -- some of which I have just previously

described.

So there is a recognition in our action plan that there was a requirement to bolster both the DCO and DCM resource within the establishment. I think it is quite important to add that G4S took that action and cost for the period up to the extension. That then translated -- that profile then translated into the two-year extension, which we delivered, and that also translated into the new tender in 2020, which is now being delivered by the new provider.

Q. Serco?

A. Indeed.

Q. Let's look at what you say at 99:

"The company does not fully accept the conclusions for the reason given earlier. A key point is that just because senior managers (SMT) were not visible all of the time did not take away the fact they were present. Notwithstanding, as already explained, the company does accept that senior managers could have been more visible, but it does not accept that any lack of visibility or actions discouraged staff from reporting concerns. The Verita report does not fully set out the reasons as to why it reached this view and the company was not involved in the investigation. Nor does it have knowledge or access to the underlying source material in

order to understand or consider the point further."

Who commissioned the Verita report?

A. We commissioned the Verita report.

Q. And if we look at their first recommendation, if we go back to the report, please, Zaynab, <CJS005923> at page 34, right at the bottom:

"The SMT should be more present in the centre and should consider how they can better engage with staff. (To be completed as a matter of urgency)."

Again, G4S accepted this recommendation, and yet, here we have three paragraphs with you on behalf of the company seeking to undermine some of it. How do you explain that?

A. So we are not undermining that at all, from my perspective. I think we have been very clear in the fairly decisive actions that we took post Panorama, that we recognised there was a gap between the senior management team on site and the DCMs on site. What I would say is, to address that point, under the leadership and direction of the new interim director, we bolstered the SMT, we increased the DCMs, but we also engaged Corndell, which is a training provider, to increase the skills of the DCMs to create -- to ensure they had the right skills to be frontline managers and also to develop a career path for those DCMs.

So I -- what I am saying, through my response, is we took a number of actions to address the findings. And we took that, as it said, as a matter of urgency. That was one of the initial actions which we took as part of our action plan post Panorama.

Q. I was going to ask you, because the Verita report, which was commissioned, let's not forget -- and I have reminded you, and you have agreed -- by G4S, your company. Here it is, in recommendation 1, in its final report of November 2018, saying "(To be completed as a matter of urgency)". Doesn't that suggest to you that it hadn't been done?

A. No.

Q. It doesn't?

A. No. What I tried to explain earlier, perhaps clumsily, was there was a timeline of activity between Panorama and the issuing of the Verita recommendations.

The Panorama was -- the episode was shown, there was an action group, a project group, which was put in place to develop an action plan. The action plan was deployed and a significant number of management interventions, working collaboratively with our customer, working collaboratively with the Home Office at the time were deployed. As one of those actions, the Verita report was commissioned and the findings were subsequently

released in December 2018, some 14 or 15 months after the viewing of the programme. A number of those actions had been completed and, as you saw in your previous document which you just showed, which was the Shaw Programme Board of 10 January, 40 of the 52 recommendations had been completed by that stage. So we had done a lot of this stuff.

Q. Did G4S have any input to this final report before it went out, before it was published; in other words, did Kate Lampard and Ed Marsden send it to G4S to say, "Do you have any comments on the final draft before it is published"?

A. My only understanding of any intervention which we had was, I believe there was a slight redaction, due to GDPR, before G4S agreed to publish this document, and I have to say we agreed to publish in full, subject to certain GDPR redactions.

Q. Don't you find it a little odd, if we go through all these recommendations, the timelines are given to be completed as a matter of urgency. We see recommendation 32 to be completed within six months.

But if some of these had already been completed in the action plan that you have been telling us about, then why did the report go out like this, with a series of recommendations with timelines and deadlines which

were not required because these had been completed? Can you understand that?

A. I can understand the question. What I come back to is it was an independent report, albeit commissioned by ourselves and there is a lot of activity that happened between Panorama and Verita conducting their review, which took a period of time, compiling their report and issuing their recommendations. So -- and, as a business, we got on and did a lot of the actions that we were required to do and which we put in place as part of the initial Panorama action plan.

So I think, you know, we have to look at this in terms of the timeline, we have to look at this in terms of at a moment in time and, when the actions, or the recommendations, for the Verita report were subsequently issued in December 2018, as I said -- and, clearly, the Shaw Programme Board review of 10 January 2019 clearly states that we had completed, and it was agreed we had completed, 40 of the 52 recommendations.

Q. But that was January 2019.

A. Which is after the -- so one month after the recommendation.

Q. I accept that, it was two or three months after, at least, the date of this report which is November 2018.

Let's turn then to a different matter, please. Back

to your witness statement, please, at paragraph 6. We don't need it put it up on screen. But do you agree, Mr Brockington, under the heading "The Panorama programme" it says:

"I do not believe the company is in a position to comment or speculate on what the cause or causes of behaviour of the staff shown in the programme was or were."

Then you go on to express the company's views, that what they did was inconsistent with the company's values, that the behaviours had never been condoned and were not the behaviours expected of staff, which was to act at all times with integrity, professionalism and in accordance with trained and accepted practices.

You say:

"Given that I have no personal knowledge as to any matters raised by Panorama, or know any of the individuals identified, I do not feel that I can comment further on why they behaved in the way they did."

Do you agree you said that?

A. I believe that is from my statement, yes.

Q. So if we go on to paragraph 34, please, I just want to ask you why you said this, and it is on your page 9:

"The company does not believe that either staffing levels or turnover were a factor in the mistreatment of

detainees between April and August 2017."

That is a speculation which you were not prepared to speculate about, and I am just wondering why you have afforded yourself the luxury of doing so at paragraph 34, having said that you were not prepared to?

A. So I think I would like to just go back to your previous comments, in terms of the Panorama programme, and I want to go slightly further than what I put in the initial statement, in terms of, what we witnessed in the Panorama programme and the actions of an isolated number of individuals was abhorrent. There was absolutely no place for that in society in general, let alone working for G4S, so I do want to go a little bit further than I said in my statement.

However, coming to your second point, I don't believe there is a direct correlation between the turnover of staff -- profit, I think you stated -- and the isolated incidents of individuals acting wholly -- and I maintain "wholly" -- inappropriately. Individuals are trained. The frontline staff, all the frontline staff, are trained through the initial training course, the ITC programme, which I explained earlier is helpfully laid out in the Shaw report, at section 6, the detail of which is very visible, and we work collaboratively with the Home Office on the contents of

that. That then allows -- through the fit and proper persons process, and the initial training, allows the individuals to get a certification and become frontline officers.

So I think we train the individuals to do what they do and these individuals chose to act in the way that they did, so I see no correlation between staff turnover and profit.

Q. Paragraph 36, you say:

"To be clear, the company accepts that staffing levels and turnover at Brook House was an issue during the relevant period. The reasons for that were multi-factorial, and whilst it is accepted that they had an adverse impact on the centre and the regime, those are entirely separate and unrelated when it comes to the question of abuses."

How do you know that?

A. I have clearly done -- spoken to a lot of colleagues in preparation for this hearing. I think we recognise -- and I say in my statement -- we are very clear that the design of the establishment in relation to activities, you know, it wasn't designed for a significant amount of activities, and I think the turnover -- this is an area where, you know, I am not an expert, but I would say that, you know, certain activities -- the whole process

wasn't designed for a lot of activities at that time.

Q. You are not an expert, but Professor Mary Bosworth is?

A. Agreed.

Q. We heard from her two days ago. Did you read her evidence or watch her evidence?

A. I saw some of it, yes.

Q. Which part did you see?

A. The first part I ...

Q. The first part?

A. Yes.

Q. During which -- presumably you have read her report?

A. I haven't read her report.

Q. You haven't read it?

A. No.

Q. Why not?

A. To be honest -- I just haven't read her report.

Q. It is critical, isn't it?

She is one of three experts who have provided lengthy accounts to the inquiry within their fields of expertise; in her case, culture and staff culture. She wrote, I mean you have referred to the Shaw report, she was responsible for annex 5 in the January 2016 report of Stephen Shaw and she also wrote a literature review at annexes 10 and 11 in the Shaw report of July 2018. She is an expert in the field. She has been involved in

this environment for many years and is a well respected expert.

At length, not only did she write, in both reports, her views of staff culture and the impact of the environment, the physical environment, the fact, which is unavoidable, that detainees were being held in Brook House far longer than the place was designed for, or its purpose, and she had no doubt in telling us that, among the many things which were causative or contributory to the mistreatment of the detainees in that place during the relevant period in particular, were staffing levels, the turnover, retention and recruitment. All of those issues were part of the melting pot, to use your word "multifactors", which you cannot divorce from the abuse of those detainees within Brook House.

Now, why didn't you know that?

A. I hadn't read the report so --

Q. You should have done, shouldn't you, Mr Brockington?

A. We work very closely with academia across our broader estates. Perhaps I should have read the report, and I haven't read the report.

Q. Perhaps -- no, clearly not.

When you watched part of her evidence -- watched or read?

A. I watched a small part.

Q. A small part.
So she is one, as I say, of three experts who has told us that, really, just the whole environment, the whole effect and impact, not only on the detainees but staff, caused or attributed to what we are all here for now -- are you prepared to accept that?
A. Sorry, can I expand --
Q. Are you prepared to accept her evidence?
A. What I am -- what I say in my report is I don't believe there is a direct correlation between an isolated instance of abhorrent abuse and the overarching environment.
Q. She is an expert and says that there is; you are not an expert, and you say there is not. Who do you think the inquiry should listen to?
A. That is for the inquiry to decide.
My view is these were isolated incidents of dreadful behaviour that is contrary to the training which G4S provided. It is contrary to the certification obligations under -- to the Secretary of State, in order for their certification, so I believe they are.
My personal view is I don't believe there is a correlation. I think that these isolated incidents of abuse are -- are isolated.
Q. If we go back to your paragraph 34, let's, Zaynab, put

it back up on screen, <CJS0074041> page 9.
It is the second part of that paragraph:
"The company's view is regardless of the number of staff on site the small number of individuals concerned chose to conduct themselves as they did when they thought they were effectively acting 'out of sight'. If they were that way inclined, they would likely have behaved in such circumstances irrespective as to the overall staffing profile or numbers."
Out of sight of whom, Mr Brockington?
A. Out of sight of -- I am guessing cameras or senior management.
Q. So eyesight and earshot, presumably? Because it is not just physical abuse, it is language: derogatory, offensive, verbally abusive language. You know that?
A. Yes.
Q. Yes. And out of sight of whom, in particular?
A. As I said, out of sight of senior management and cameras.
Q. Well, out of sight of the SMT; yes?
A. Sorry, that is what I thought I just said, yes, the senior managers.
Q. You said "managers"; what do you mean by "managers"?
A. I said "senior management team".
Q. Senior management team?

A. Yes.
Q. Jerry Petherick, who was at Brook House, presumably, from time to time?
A. He was from time to time. I think in his evidence he said that he was there -- he tried to get to all of his sites monthly.
Q. It wasn't out of sight of other detainees. It wasn't out of sight of other officers, because it was often committed in front of other officers, DCOs and DCMs, and it wasn't out of sight of Callum Tulley, because he was able to record it all from 24 April 2017 until he left in early July.
What do you mean by "the small number of individuals concerned"? What do you regard as a small number of individuals?
A. We witnessed on the Panorama programme a number of individuals who conducted themselves wholly inappropriately. I put that in the context of the many, many, many thousands of hours that colleagues within my business deliver. We are a private -- you have heard from previous individuals giving evidence to the inquiry, we are a private sector company delivering public services. We deliver many, many, many thousands of hours of public service to care for those individuals in our case.

So when I talk about a small number, I put it in the context of, you know, thousands of colleagues on a day-to-day, hour-by-hour basis, delivering care to those in our care. That is what I mean. We witnessed a handful of people delivering abhorrent activities.
Q. That may be right, as far as the Panorama broadcast is concerned -- I assume you have watched that, haven't you?
A. I watched it live, or at the time, and I have watched it many times since.
Q. Yes, and have you watched any of the undisclosed -- the disclosed, unbroadcast footage?
A. Not much of it, no.
Q. How much?
A. Very -- minimal amounts.
Q. What does that mean?
A. Well, a couple of snippets, really. Not -- really not very much.
Q. A couple of snippets. Have you looked at some of the material disclosed by your own company?
A. Yes, I have.
Q. CCTV, and handheld and body-worn camera footage?
A. I have seen -- I have seen some of it, not a huge amount.
Q. No. Have you read some of the transcripts?

A. I have.
Q. How many?
A. I couldn't say.
Q. No. You see, just if one reads that paragraph, the company's view is:
"... regardless of the number of staff on site the small number of individuals concerned chose to conduct themselves as they did when they thought they were effectively acting 'out of sight'. If they were that way inclined, they would likely have behaved in such circumstances irrespective as to the overall staffing profile or numbers."
It just sounds a little trivialising, Mr Brockington. Presumably you don't mean that?
A. I couldn't -- I wholly disagree that that is trivialising this issue. This is a material issue and we have taken it, as an organisation, incredibly seriously.
The immediate actions that we took post Panorama, working with Sussex and West Sussex Police, working with the Home Office, working with the IMB, developing the action plan, delivering a number of management actions immediately and further actions ongoing, I don't, for one minute, see how you can conclude that we have taken it trivially. This is an incredibly important issue for

us, as an organisation, and we have taken it very seriously indeed.
Q. I mean the words "out of sight" are intended to suggest that the company, the senior management, never knew what was going on; is that the intention behind the wording?
A. That is not the intention behind the wording. I do agree with you that the senior management team were not sighted on these issues, otherwise, they would have acted accordingly.
Q. They had been going on since at least 2014. I know you tell us you didn't join the company until 2015, and you haven't been in the position you are in before November 2020, but were you aware that the mistreatment of detainees had been notified to the SMT as early as 2014? Were you aware of that?
A. I wasn't aware of that. What I would say is, in terms of sort of constant failings, the HMIP inspection of 2019 did state that they had no evidence to suggest that the 2016 inspection -- that they had missed any issues which were raised in Panorama.
So whilst I don't take sole acceptance from HMIP, what I do take is a degree of assurance from an independent inspection such as HMIP.
Q. Yes, but, Mr Brockington, we all know that an unannounced inspection of HMIP is not necessarily

going to provide the sort of information that was internally available to SMT members as early as 2014. You are talking about 2019, you refer back to the relevant report that covers the 2016 period, but we are not really interested in that, Mr Brockington. What we are interested in is what G4S knew, and that is why you are here.
Have you heard the name Stacie Dean?
A. I have.
Q. So you will know that Stacie Dean -- in fact, together with Michelle Brown, but Stacie Dean in particular -- first complained of the mistreatment of detainees some time before October 2014, and you should know that, because of that, Jerry Petherick became involved eventually. I am not going to go through the whole history, some of it has been ventilated during the course of the inquiry evidence, but she made a witness statement to the inquiry fairly recently. If we can put it up on screen, Zaynab, please, <INQ000172> at page 2. Tab 31, chair:
"I have been asked whether I raised concern about the treatment of detainees earlier than October 2014. I can't recall when I first raised concern about the treatment of detainees formally. I know I raised the matter (along with the culture of staff bullying) in

various meetings, as did other members of the SMT. I have been asked whether I have any further in relation to the complaint I made in 2015 and recall that regarding DCOs Instone-Brewer and Fagbo, I raised concern that it was a well discussed issue (at senior meetings) that assurances had been given that they would not be allowed to work together on the same wing and that they were bullying detainees, yet whenever I went to Brook House, they were always rostered together. Other than that, I have nothing further to raise on that point."
At paragraph 8 on the next page she says:
"Both myself and Ms Brown ..."
If we perhaps start at the beginning:
"I have been asked to respond to the point that Ms Brown raised concern in a SMT meeting at which I was present. I do recall regularly that Ms Brown was one of the SMT members who repeatedly raised concern about staff treatment of detainees. Both myself and Ms Brown were concerned that some members of staff, as well as detainees, were being regularly subjected to bullying behaviour from some staff. The response of the SMT was consistently uninterested. I do not recall specific dates or times, but do remember the general approach to any of us raising concern or complaint would be fairly

generic and non-committal and the lack of any action was frustrating. At times I think the view from some SMT members was that the situation was amusing, so it was far from taken seriously."

We know that she wrote an email dated 25 October 2015, both to Steve Skitt, who was the deputy director, and Ben Saunders, who was the centre director making similar complaints. Her complaints, in particular about mistreatment in relation to Instone-Brewer and Fagbo, was goading and antagonising detainees.

So it starts as early as around 2014, and certainly, by 2015, Jerry Petherick was involved. So it is hard to say that the company didn't know or individuals higher up the ladder didn't know; don't you agree? I mean, this is a precursor to what we see in 2017.

A. I really cannot comment further on these, and I am afraid I have nothing further to add on the evidence which you have just put in front of me.

Q. If we go to another statement, Nathan Ward -- that's a name that will be familiar to you, I suspect, Mr Brockington?

A. I don't know Nathan, but I do know the name.

Q. <DL0000154>, please, at page 2, and this is his second statement made to the inquiry. At paragraph 5, he

begins that paragraph by saying:

"Having reviewed the investigation ..."

Are you aware of the Cotter investigation?

A. I know of its existence. I -- nothing of its detail.

Q. Stephen Cotter, was asked to investigate any number of issues and grievances which arose between members of staff, following Nathan Ward's -- not only his exit interview, but as a result of -- he left in about 2014, but as a result of any number of other grievances, and in particular what he had to say to the Panorama programme.

Stephen Cotter wrote a lengthy report, it is dated 16 November 2017, and that is the investigation Nathan Ward is here talking about:

"Having reviewed the investigation, I believe the most important point to take away from it is that it shows, in the years building up to the abuse captured by Panorama, various complaints of bullying, mismanagement and failures at Brook House were made directly to Jerry Petherick but these repeated complaints -- whether by myself, Wayne Debnam, Stacie Dean or Michelle Brown (with the latter two in particular raising concerns about staff treatment of detainees) -- clearly did not result in any sufficient changes being made by the time of the relevant period in 2017. This can be the only

conclusion on any viewing of Panorama and the wider footage that has been provided by the BBC on the way staff treated detainees. The fact that officers such as DCO Instone-Brewer and DCO Fagbo, two officers accused not just of mistreating detainees but also dealing spice, were still in place by the relevant period is damning. Stacie Dean had raised concerns about these officers to Ben Saunders and Stephen Skitt as early as 2015."

That is the email I referred to a moment or two ago.

Do you agree it is damning, Mr Brockington?

A. I cannot conclude either way. I have nothing more to add to -- in relation to --

Q. Why not? You are the face of G4S. Why have you got nothing more to add?

A. I have no corporate memory or knowledge of these specific issues, so it would be inappropriate for me to add anything further.

Q. Do you need corporate memory to apologise, for example, to say this should never have happened, to say the company knew that there were issues as long ago as 2014/2015 and there is a causative link?

A. In relation to the specific Panorama programme, of course, I am exceptionally sorry. I thought I was pretty clear in my view a few moments ago when I said

that the actions which we witnessed in Panorama were, quite frankly, disgusting. And as an organisation, and as an individual managing director, I take full responsibility for the actions of my business. I am exceptionally sorry that those actions took place.

But on the specifics of the emails and the detail of which you have just put in front of me, I don't have anything further to add. What I reiterate is I am -- I was appalled by what I saw in Panorama and, of course, as an organisation, we are exceptionally sorry that that happened.

Q. Can we look at your paragraph 71 of your witness statement. We are back to <CJS0074041> at page 16. Under the heading "Management of Brook House", you say:

"The company does not believe that members of the senior management team of Brook House were aware of mistreatment of detainees of the type shown in Panorama."

What type did you have in mind? What was the qualification "of the type", what did you mean by that?

A. Literally, just referring to the appalling behaviour which we saw in the Panorama programme.

Q. Because it is clear from what I have just suggested to you that the management was aware years before that detainees were being mistreated.

You accept that, don't you?
A. No, I -- I responded to your question that I can't conclude either way.
Q. Or you are just not prepared to, Mr Brockington?
A. No, as I said, I can't conclude either way.
Q. Then at 72, at the top of the next page:
"The company is not aware of any evidence that suggests that senior managers ought to have been aware of such mistreatment."
Did you really mean that?
A. I would say that if senior managers were made aware of mistreatment, they would have acted appropriately. I can certainly refer to the business which I run today, and I would fully expect that, if any evidence of any suggestions of mistreatment occurred within the establishments which I run, we would absolutely take immediate action to investigate.
Q. Well, let's look at what the company did know. You have referred to the HMIP report for -- signed off by Peter Clarke in January 2017 but for the inspection window of 31 October to 11 November 2016. <CJS000761>, please, page 1 to begin with.
This is one of the reports you referred to, Mr Brockington, isn't it?
If we then go to page 20, were you aware that the

HMIP conducted a detainee survey?
A. I was aware, yes.
Q. Yes. If we look at 1.13 on page 20:
"In our survey, 37 per cent of detainees reported feeling unsafe, 21 per cent reported victimisation by other detainees and 18 per cent by staff. The Safer Community team had provided information in different languages to detainees about reporting concerns. Focus groups had been held to discuss victimisation and violence."
Then if we go to page 69, at the top, it is:
"Appendix IV: Summary of detainee survey responses" and, at the foot of the page, under the heading "Survey response":
"At the time of the survey on 31 October 2016, the detainee population of Brook House was 392. Using the [methodology they set out], questionnaires were distributed to a sample of 209 detainees.
"We received a total of 159 completed questionnaires, a response rate of 76 per cent. This included one questionnaire completed via interview. Nine respondents refused to complete a questionnaire and 41 questionnaires were not returned."
Can we go on, please, to page 76. Here you will see the questions and the responses which the HMIP received

in the course of their detainee survey. In particular, on page 76, we have, under section 7, towards the bottom, beginning with question 43:
"Do you have a member of staff at the centre you can turn to for help if you have a problem?", and so on.
There are four questions in that vein, concluding at question 46, at the top of the next page. And then a new section, "Section 8: Safety":
"Do you feel unsafe in this centre?"
Yes, 37 per cent; no, 63 per cent.
48:
"Has another detainee or group of detainees victimised, insulted or assaulted you here? "
Yes, 71 per cent; no, 79 per cent.
Question 49, further questions about victimisation by detainees or groups of detainees.
But let's look at question 50:
"Has a member of staff or group of staff victimised (['victimised' here meaning] insulted or assaulted) you here?"
Yes, 18 per cent; no, 82 per cent.
51:
"If you have felt victimised by a member of staff/group of staff, what did the incident(s) involve?...

"Physical abuse (being hit, kicked or assaulted), 3 per cent."
52:
"If you have been victimised by detainees or staff, did you report it?"
Yes, 12 per cent.
Skating over 53, question 54:
"Have you ever felt threatened or intimidated by a member of staff in here?"
Yes, 12 per cent.
Now, presumably, senior managers not just at SMT level, but at board level, would be privy to the contents of a report like this?
A. I would absolutely agree. I can't speak for my colleagues, but what I would say, in the business and the estate which I run, when we have an HMIP inspection, I would certainly read the contents of an HMIP inspection.
Q. Yes. Well, this one, as I have told you, was signed off by Peter Clarke, the chief inspector, in January 2017, so a matter of three months before the commencement of the relevant period, for the purposes of this inquiry.
Why doesn't a survey like this ring alarm bells, because here it is, writ large, that there are detainees who were prepared to take part in this survey and

prepared to tell HMIP that they were being insulted or assaulted, in particular physically abused, being hit, kicked or assaulted, and it had been reported.

You cannot tell this inquiry, Mr Brockington, that the company didn't know that there were problems, can you?

A. What I would say is the findings of Peter Clarke and his inspection team stated very clearly that the 2016 report, issued in 2017, the establishment was allocated a reasonably good overall assessment for the four and healthy establishment tests.

So whilst I agree there are specifics in there which would have formed part of the action plan, the overall assessment was reasonably good.

I would also go back to, and refer you to, the 2019 report, which is clearly after the second inspection, where HMIP also stated that there was no evidence to suggest in the 2016 inspection that any -- that they had missed any issues relating to what was subsequently seen in the Panorama.

Q. So the company takes comfort from two words, "Reasonably good" but, what, is prepared to excuse as acceptable the physical abuse even of 3 per cent of the detainee population by staff?

A. Sorry, that is not what I said.

Q. What are you saying, Mr Brockington, because it seems to me, and it may seem to others, that you are sidestepping the issue. You are relying on what Peter Clarke said or what HMIP said overall about the health of the establishment, but you are overlooking this detainee survey.

A. That is not the case.

When we receive -- I can only talk for today, but when we receive an HMIP inspection final report, we would review it in detail, and that forms the basis of an overarching action plan to constantly improve our establishments, because that is what we do.

We strive to improve constantly. This would have formed part of our thinking, undoubtedly at the time, so I am not sidestepping it based on two words. What I am actually saying is we hold HMIP inspections very, very seriously. They are absolute experts in their field, who have a full appreciation of both the custodial and the detained estate, who periodically come and assess us overall.

So we do take what they say incredibly seriously. We also take what the detainees say incredibly seriously. And this would form part of our overarching action plan. But I go back to the point that, whilst we and HMIP will have looked at this data very closely, the

overarching assessment of our establishment was reasonably good.

Q. I assume you will agree, Mr Brockington, that these figures are unacceptable?

A. I would agree that we -- when we review these, we need to take action.

Any form of -- any form of violence that is of staff against detainee or prisoner is wholly -- that falls outside of the formal training and process is wholly unacceptable.

Q. You made that clear, that under your tenure, if you heard of that sort of thing happening, you would deal with it. You said that earlier.

A. I would and I stand by that.

Q. What was done about this? Forget HMIP and forget, if I may say so, seeking refuge in the fact that Peter Clarke found the establishment "reasonably good", what I want to know is what was done about even unacceptable figures of physical abuse of detainees which was reported, what was done about it at the time?

A. I am afraid I wasn't privy to the specifics at the time, so I can't comment further on that specific question.

Q. What I am going to do, Mr Brockington, is to invite you, after you have completed your evidence, to find out and provide, if you would, a further statement to the

inquiry, please, telling us exactly what G4S did about the information in this detainee survey from 2017.

A. We would be delighted to do that.

Q. Going back to your witness statement in May, please, at paragraph 21, you say, "In terms of lessons learned" -- at paragraph 21 on page 5, Zaynab:

"In terms of lessons learned, the company would accept that the management team in place at the time spent a significant amount of their time dealing with paperwork, leaving insufficient time to be proactive and be 'out and about' in the centre. This changed following the Panorama programme and the implementation of the Project Board Action Plan."

At 22, you say:

"Managers were not close enough to the day-to-day goings on, which led to individuals taking too much direction from DCMs."

Are you accepting, so that we are clear, that there were failures at senior management level at the time?

A. What I am saying is there was -- after Panorama, when we brought in an interim -- an experienced interim director into the establishment, it was clear that there was a disconnect between the SMT and the DCMs on site. I think I mentioned earlier, but I will reiterate, as part of the action plan, under the leadership of the new

interim director, we bolstered the SMT, we increased the number of DCMs and we deployed training to the DCMs through engagement with Corndell to ensure they had the required training to deliver their role.

So we would accept, and I say in my statement, that there was a disconnect between the SMT and the frontline management.

Q. So coming back to my original question, are you prepared to accept that there were failures at senior management level at the time?

A. What I am saying is there was a disconnect between the two.

Q. Why won't you agree with me, Mr Brockington? Why are you not prepared to agree with the word "failure"?

A. What I am saying is the -- the senior management team were clearly focused in one area. There was -- as I said previously, there was a clearly a disconnect which was highlighted by the new interim director and we took approach actions to close that gap.

Q. So are you saying it wasn't a failure?

A. I am saying -- I am saying there was clearly a gap between the frontline management and the senior management team.

Q. So it is a "disconnect", it is a "gap", but the word "failure" you cannot bring to say; is that it

Mr Brockington? You are not prepared to characterise it as a failure?

A. I stand by what I have just said.

Q. You go on to say at paragraph 22:

"There was a perception that this environment bred bad habits and common practices developed which were not acceptable."

Whose perception did you have in mind?

A. That would be the perception of the frontline staff.

Q. By which you mean?

A. DCOs.

Q. So the DCOs perceived that the environment "bred bad habits and common practices developed which were not acceptable"? How did they breed bad habits? How did the DCOs breed bad habits, or are you saying the senior management bred bad habits?

A. I am afraid I would have no sight of what was happening on site at that time.

Q. Mr Brockington, these are your words. They are not my words. I am just reading back to you what you were prepared to sign off as a statement of truth.

So help us, why did you say this? What was the perception that the environment bred bad habits? That is what I want to know. These are your words, what did you mean?

A. I think there was just a general feeling, is my understanding from the work that I have done and talking to colleagues. My understanding there was, as I say, a disconnect between DCMs and the SMT on site and that was picked up by the staff on site.

Q. Who are the colleagues that you spoke to in order to produce these words in this paragraph of this statement? Who did you speak to? Who was your information from?

A. I have spoken to a number of people within the organisation.

Q. People who were at Brook House at the time?

A. People who had an understanding of Brook House.

Q. People who were at Brook House at the time?

A. It depends which period you are talking about.

Q. Well, the time is the relevant period for the purposes of this inquiry.

A. I have certainly spoken to the interim director who we had put in place.

Q. Who else?

A. The functional leads that were in post, not at Brook House but functional leads that have a recollection of that, the relevant period.

Q. You go on in that paragraph to say:

"This was limited to the staff members identified in the programme where processes and procedures were not

followed, namely, around the use of force, completing paperwork correctly, and the treating of detainees with dignity and respect."

So is it your suggestion that somehow Callum Tulley, on behalf of the BBC, conveniently managed to capture the entirety of the bad practices and abuse at Brook House at the time and that there was nothing more to see here; is that what you are trying to say here? It is limited to ...?

A. What I am saying is it is our understanding that these were isolated incidents, and I take -- I make that conclusion based on information which we have -- which we have internally but also information which was provided to the organisation from the IMB and the Home Office, et cetera, so I think, you know, we are not running this establishment in isolation. There are a number of third parties on site, so we are, you know -- of which I have no recollection of, you know, those parties raising these issues.

So, you know, I think it is important to stress that the centre did have a number of organisations on site, both the IMB -- as I said, the IMB, the Home Office, amongst others.

Q. So does G4S accept, or not accept, that these practices were ingrained and systemic?

A. I do not accept that they were ingrained and systemic.
Q. So, from your perspective, on behalf of the company, what we are seeing are isolated instances of the abuse of detainees, all, as it happens, captured by Callum Tulley, but, for the rest, the inquiry shouldn't be concerned that that kind of abuse, of that type, was going on outside that period; is that what we should understand from your evidence?
A. What I am saying is we believed these to be isolated incidents and we take a view, and that from our experience, from Home Office, IMB, other authorities, so we believe that they were isolated incidents. I would agree with your comment in specific relation to the isolatedness.
Q. You don't want to be agreeing with me, Mr Brockington, because all I am doing is putting questions to you. Don't take from anything that I say that I am vocalising an opinion.
Back to your statement at page 17, paragraph 73, you talk about the complaints system, and you say:
"In light of the fact that the significant incidents broadcast by Panorama were not reported to senior management by detainees or staff at the time, the company has been asked to comment on whether the complaints system and/or whistleblowing policy properly

accounted for potential barriers to disclosure. It is also the case that none of the matters appear to have been reported by any of the other multiple organisations that were in regular contact with detainees (certainly not in a way that would have permitted G4S to take action on the report). It is not entirely clear why this is. It may however be a manifestation of a general lack of trust within the detained population towards agencies of the state."
At 74:
"The complaints system [which you explain further below] ... but detainees had free and unfettered access to the complaints system. The company believes that the system itself was robust and transparent. The complaints system was however determined by the HO."
In other words, the Home Office.
Does the company, through you, Mr Brockington, take comfort from the fact that, at least during the relevant period, there were no official reports of mistreatment? Is that what we are to understand from what you say, "We, the company, take comfort, our whistleblowing processes were robust, our complaints system was robust and, therefore, the absence of complaints means there is an absence of evidence"?
A. I just need to be clear on the process for complaints in

the establishments. The IRCs had a very different complaints process to that of the custody estate, whereas the Home Office run a complaints process for the detainees.
In terms of our own complaints process and whistleblowing, we need to be very clear that, you know, we believe there was a robust process in place for staff to make complaints, but I also say in my personal statement, which you may or may not come on to, that, in this instance, it didn't work. The individuals who we witnessed on the Panorama programme chose not to use a whistleblowing process, which goes against the training, which we trained through the ITC programme, and it also goes against their obligation to the Secretary of State under their certification.
So it didn't work. We took a number of actions -- it didn't work because they chose not to use it. We took a number of actions post Panorama to reinforce the whistleblowing process.
The whistleblowing process, just to be clear, was a process which G4S established, working very closely with Public Concern at Work, who were -- are deemed to be experts in this field and, you know, advised BEIS(?), as an example, on whistleblowing processes, so we felt this was a global process which was designed by experts

and implemented across our business. After Panorama, we promoted it, we promoted it heavily, as part of our action plan, but, of course, these things are only -- only work if people choose to use them. Why people chose not to use them, which is contrary to their training, and is contrary to their obligations to Secretary of State under their certification, is -- I can't conclude as to why that happened.
Q. So you cannot account for the fact that it wasn't being used to capture and investigate the serious abuses that happened at Brook House during the period that we are concerned with?
A. What I am saying is I can't conclude why the individuals who we witnessed on the Panorama programme chose not to use a whistleblowing process, which is in contra to their training and contra to their obligation to the Secretary of State under their certification.
Q. I will come back to a couple of reasons in a moment. Before we break, there is one further document I would like to show you. <HOM0331707>, please. This, Mr Brockington, is an internal memorandum within the Home Office. It is dated 22 March. It should be 2018.
The name to whom it is sent is redacted, but I think I am at liberty to tell you who the name actually is. It is Patsy Wilkinson, who was the Second Permanent

Secretary, so this is as high up as this document went, and there is a list of other people to whom this document went at the foot of it, which probably, in this version, will be redacted, so we will not be able to see it.

"Panorama allegations against G4S staff at Brook House."

It is to do with a meeting, at paragraph 1, "to discuss Professional Standards Unit ... investigations and Brook House on 20 February". They undertook to provide her "with a definitive account of what the Home Office knew about the detainee custody officers ... against whom allegations were made and the outcome of associated investigations."

Paragraph 2:

"There were 17 members of G4S staff identified within the material Panorama provided before the broadcast, or from the broadcast footage, details of which were provided [separately]."

Under the heading, "Prior allegations:

"Of these 17, seven had been the subject of serious complaints in 2016 and 2017 and were investigated by PSU [table provided below]. These investigations were prior to and unconnected with the Panorama allegations. On the date on which we were made aware of Panorama's

allegation (24 August 2017) there were six outstanding investigations into the activities of five DCOs (highlighted in [the table]). None of these investigations were based on allegations that subsequently featured in the Panorama material."

So, of the 17 identified in the Panorama broadcast, seven of them had already been the subject of serious complaint in 2016 and 2017. Were you aware of that, Mr Brockington?

A. No, I wasn't.

Q. Surely G4S must have been?

A. I would expect, but I can't wholly conclude -- I can come back to the inquiry, if that would be helpful.

Q. Yes, please. But if it is right, whether they are allegations substantiated or unsubstantiated, they are serious. If you look down the list, they are all assaults, there are some sexual assaults, and one is assault and neglect. And we will see that the greater number are against a DCO by the name of Derek Murphy.

Do you agree that G4S should have considered these more closely before being exposed by the BBC? Or do you --

A. I am afraid, personally, I can't conclude either way on that. What I have committed to the inquiry is we will respond, if that would be helpful, but I can't add

anything further to your line of questioning, I am afraid.

MR ALTMAN: All right, Mr Brockington. It is 25 past, chair. Can I suggest a 15-minute break and come back at 11.40?

THE CHAIR: Thank you very much. Thank you.

(11.27 am)

(a short break)

(11.40 am)

THE CHAIR: Thank you very much. Please take a seat.

Mr Altman, thank you.

MR ALTMAN: Zaynab, could we put up on screen, please, Mr Brockington's first witness statement <CJS0074041> at page 11.

Here you are dealing with policies and procedures. At paragraph 45, you say:

"It is evident that certain staff members, and in particular Mr Callum Tulley, did not report their concerns on abuses and/or impropriety. This did put detainees at risk as it allowed abuses of the type shown in Panorama to continue. Such abuses would have been prevented had prompt reports been made, as they would have been acted on by the company. Mr Tulley stated in the programme that he did not report his concerns on the basis that he did not believe that they would have been

taken seriously. The company does not understand the basis of this assertion, given there was never any attempt by him to raise such concerns at any stage during his employment with the company through its whistleblowing policy or otherwise. The company is confident that, had he done so, such complaints would have been treated seriously."

Were you aware that "Speak Out" posters had been defaced in parts of Brook House, or a part of Brook House that was accessible by staff members, upon which was written words like "snitch" or "grass"; did you know that?

A. I did know that.

Q. So anybody reading that would understand pretty readily that speaking out, even within the company's global whistleblowing policy, would be met by difficulty, to say the least, amongst one's colleagues; do you agree?

A. I think there were a couple of posters that were defaced in that way, which is not acceptable.

So, yes, I would say that it is not acceptable to have that on the posters.

Q. Callum Tulley joined the company, if my memory serves me, in 2015, when he was 18, so by the time we are talking about, he was a young man of around 20.

Ironically, as you probably realise, Mr Brockington,

he was influenced to go to the BBC Panorama production team having watched, on 12 January 2016, the Panorama expose into Medway?

A. I was aware of that point.

Q. He was a 20-year old or thereabouts. But Owen Syred, he wasn't -- you have heard the name Owen Syred?

A. I have.

Q. If we put up on screen what he told us in his witness statement -- please, Zaynab <INN000007> at page 30. He was a mature man, a welfare officer, respected, listened to, and under the heading in his statement "Disciplinary and grievance process", between paragraphs 125 and 127, he tells the story of how someone by the name of Sam Gurney said to him -- you can see about half a dozen lines up -- when some of the detainees were being demanding, "I bloody hate this lot, no wonder I'm racist."

He made some comment about that. A couple of weeks later, he was in the wing office on C wing, talking to another DCO by the name of Liam Sharkey, who was eating a packet of plantain crisps, and he said:

"I asked Liam what they were and Sam interjected and said 'they are crisps for niggers'. I couldn't believe what he had said. I knew that I had to challenge the comment, but I didn't want to do it in front of the

detainees ..."

So two points. First of all, Gurney says what he says. Mr Syred, very sensibly, did not want to challenge the comment in front of detainees because, as he said, this could have caused disruption:

"A detainee was stood nearby and I wasn't sure if he had heard everything that had been said. The detainee said to me, 'did I hear what I thought I heard?'"

And he said:

"I told the detainee that I would deal with it and the detainee said 'I trust you to deal with it'."

So he did, he went to Conway Edwards, who was, I think, the diversity and inclusion manager, and took the complaint there. And, at paragraph 127:

"Following my report of this incident I started to receive Post-It notes stuck on my locker that said 'nigger lover' and 'grass' and for about a year afterwards, friends of Sam in the control room would follow me around by camera and raise bogus reports to try and get me into trouble, for example a complaint that I shaved in the barbers while on duty (which was false). I was also told by a colleague to watch my back and that people had it in for me because I had reported Sam. I reported this behaviour to the director, Ben Saunders, and recommended that future recruitment

should focus on more mature candidates."

If this sort of thing happened to somebody of the seniority of Owen Syred, what confidence could anybody have that whistleblowing would make any difference other than one which was to the detriment of the person who made the complaint?

A. Clearly, that sort of behaviour is horrendous. And I would absolutely not accept that behaviour in the estate, in the establishments which I am currently responsible for.

Q. What is the answer to the question, Mr Brockington?

A. You would conclude that, clearly, on a personal level -- and it is my personal view, in response to that question -- that, you know, younger men -- clearly, Callum Tulley was influenced by this and he made it clear in his statement.

Q. Well, my question was, what confidence could anybody have in making a complaint through the whistleblowing hotline or process, if the result is nothing other than detriment to the person who makes the complaint? That is my question. The answer is surely none, isn't it?

A. We were very clear in our training, through the ITCs and promoting the ITCs, that individuals should use the "Speak Out" and they should absolutely -- in accordance with their obligation under the certification to the

Secretary of State, they have an obligation to raise any concerns.

So to be honest, I can't conclude either way. What I can say is we trained our staff to speak out when they found areas of concern, and either through line management, which would be our primary option, or by whistleblowing if they chose not to use the line management reporting process.

So, you know -- and we emphasised that further after Panorama. So it was -- they had an obligation to us under the training, and they had an obligation to the Secretary of State as well.

Q. Which is all fine and dandy, Mr Brockington, but you talk about reporting to line managers if you don't want to use the formal hotline. Well, because Callum Tulley was a DCO, his line managers were DCMs and he made it perfectly clear to us, when he gave evidence in the first phase of this inquiry, that the principal reason he reported none of this to other DCMs was because the DCMs were involved in it themselves that. That is a fair point, isn't it?

A. I can't comment on what was happening on site at the time. What I can say is that the organisation which I am managing director of and I am responsible for, I believe has a culture where, if those feel they cannot

report to their line management, they can escalate that and I am very clear that anybody can escalate any issues to myself.

So whilst I can't comment on during this period at the IRC, what I can say is that is certainly the culture which I have in my organisation.

Q. Owen Syred talks about the culture at paragraph 129 which is still on screen:

"The culture within the organisation was that they did not want to make waves and did not want to generate publicity."

Is that right, Mr Brockington?

A. As I said in my previous statement, I can't comment at that point in time, at that establishment. What I can say is that is certainly not an environment which I recognise in the establishments and business which I currently run.

Q. If we go to what Callum Tulley had to say in his inquiry witness statement, <INQ000052> at page 42, paragraph 168, and start at 167:

"In the majority of examples outlined in this statement, members of staff were present during mistreatment of detainees and for admissions of abuse and malpractice who were otherwise well behaving officers. This underlines the lack of confidence staff

had in raising complaints about such behaviour."

At 168:

"This culture of silence across the work force at Brook House coupled with a lack of demonstrable oversight, interest and engagement from Ben Saunders and his senior management team allowed the abusive culture in Brook House to fester and go unchecked. The confidence that officers and managers had to, in front of other members of staff, flagrantly brag and joke about abuse or speak in derogatory or even racist terms about detainees demonstrated their faith in the culture of silence which allowed the abuse to persist."

Do you want to disagree with that?

A. What I would say to that point is we operated the site but not in a silo; we operated the site with onsite engagement from the Home Office and IMB, amongst others.

This was not raised to -- is my understanding -- it was not raised to the IMB, the Home Office or ourselves during that period.

So that is what I conclude from that. Clearly, this statement shows a culture of silence, but I wasn't privy to the site at the time, so I would be surmising to more conclusively respond to your question. But I do stand by what I say in terms of we were on site with the IMB and the Home Office and, to my understanding, it

wasn't raised to them either.

Q. Yes, because it was a culture of silence. That is the whole point, isn't it, Mr Brockington?

A. As I said, I can't conclude. I would be surmising.

Q. Let's turn to another paragraph of yours, please, in your first witness statement, back to that, please, Zaynab, <CJS0074041> at page 35 and paragraph 173:

"All use of force incidents were reported directly to the Home Office as required under the terms of the contract."

Do you want to rethink that sentence, Mr Brockington? Is there anything about it that is not accurate, do you think?

A. That is my understanding, when I submitted the statement to the inquiry.

Q. Well, what about the incidents which resulted in the strangulation of D1527 on 25 April, when there was a failure by anyone to bring to anyone's attention that assault on him on that date, let alone -- forget the Home Office, let alone to G4S. It is not right, is it, this sentence?

You know what I am talking about, don't you?

A. Of course I do.

Q. Yes, there was a complete cover-up, which involved every officer who was involved in the illegitimate use of

force on D1527 in room 7 of E Wing at around 7.00 in the evening on 25 April 2017. Callum Tulley tells us, and we have it on transcript, and on video, that after it happened, Yan Paschali, who was the principal involved in this, told Callum Tulley, "As it stands, no use of force". In other words, no report was to be compiled and, as you may know, if you had followed the evidence, Yan Paschali claims that he did complete an incident report for the final of the three aspects of the incident with D1527 on 25 April, left it on a desk by a pigeon hole, but somehow, magically, it disappeared. And his claim to this inquiry, at the beginning of this set of hearings, was that Callum Tulley had, for reasons of his own, made it disappear.

In the end, there wasn't a single report that he had been strangled on that evening by Yan Paschali, let alone that Paschali had whispered to him "You fucking piece of shit, because I am going to put you to fucking sleep".

Now, when you think about all of that, how does it come about, Mr Brockington, that, at paragraph 173 of your corporate statement, you tell this inquiry, in a witness statement said to be a statement of truth, that all use of force incidents were reported directly to the Home Office as required under the terms of the

contract?
A. The reports were made -- I would expect the reports to be made. In all honesty, I can't comment further on what we have said. I understand the point that you have made.
Q. Yes. It is wrong, isn't it?
A. I understand the point that you have made.
Q. It is wrong, isn't it?
A. In that instance, that incident was not reported.
Q. The sentence is wrong, isn't it?
A. I would agree.
Q. Thank you. You see, if Callum Tulley, who you criticise, had not filmed the event, no one would be any the wiser, would they?
A. For those specific incidents, they weren't -- the reports, for whatever reason, were not filed.
Q. Do you not think, just standing back for a second, Mr Brockington, that in singling out Callum Tulley, as you do in your witness statement, for criticism, in fact, the only person who, in fact, did anything about the abuse on that day -- and other abuses; not just that, but this one in particular -- rather than any member of staff or management of G4S, don't you think this continues to send out a signal as to how "snitches" or "grasses" will be treated by the company?

A. My response is we would expect all frontline officers -- in fact, all staff, who have completed the ITC, to report incidents such as this. Perhaps an oversight to single out Callum Tulley. He was one of a number of individuals who were present, who witnessed these abhorrent activities, and all of the staff who witnessed that have an obligation to us under the training which we deploy, and to the Secretary of State under the terms of their certification, to report such incidents. All of them failed to do so.
Q. Let me ask you a few things about what you say on the subject of the use of force.
Before I do, have you read Jon Collier's report on use of force -- he gave evidence to this inquiry yesterday, but have you read his reports?
A. I haven't read his report.
Q. Why not?
A. Others have, but I haven't.
Q. Many others in this room have. Why didn't you?
A. I just haven't read the report.
Q. We know that, you have said that three times. Why not? You knew about them presumably?
A. I did, I just haven't read them.
Q. Why didn't you?
A. I just haven't read the report, I am afraid.

Q. Did you appreciate that he identified 27 incidents of use of force during the relevant period which, to him, were incidents of significant concern, in various ways, in that they either involved an excess of the use of force, they were wholly disproportionate, or that they were provoking or punitive in nature; in other words to punish the detainee. Were you even aware of that?
A. I wasn't sighted on that, no.
Q. Now you are, what do you think about it?
A. All our frontline officers are trained to deliver C&R. And we, at the time, did -- we also did annual refresher training, so I would expect -- and certainly in the establishments where -- that I currently run, we have very clear governance around the deployment of C&R, reviews, feedback. What was happening at the time, I can't comment on; what I can comment on is what we currently have in place, and I have full confidence in my very experienced leadership teams that we have governance structures in place to measure and monitor C&R.
Q. Well, presumably, if you'd sat here in July 2017, you would have said "I have full confidence in my senior experienced leadership team". Presumably, you wouldn't have had that level of confidence, had you sat here in July 2017, knowing what we now know?

A. I would be speculating to answer that.
Q. Yes. You deal with a particular issue, which you seem to have taken exception about, at paragraph 184 of your witness statement on page 37:
"The inquiry has stated that it seems that many of the 'report of injury to detainee' (F213) forms attached to UoF forms were left blank, or such forms were not attached to the UoF forms.
"The company does not accept that many of the forms were left blank. The F213 is a general document used to record all injuries to detainees, however they are sustained. It is not specifically designed for use of force incident reporting; it is a separate stand-alone document which was adopted into the use of force packs."
Did you realise, Mr Brockington that, out of 106 use of force incidents, where we have the documentation, 62 F213s are incomplete or missing, and I can break that down for you: 28 of them were missing, so that is almost 50 per cent. None were left totally blank, but in 28 reports, the reporting officer did not fill out section 2s, which are the details and the description of the incident and seven reports were missing the second page which contains the medical assessment.
One of that number falls within two categories; in other words, section 2 was not completed and the second

page was missing.
As to why they were missing, do you not agree that all documents were preserved or should have been preserved? What is your understanding of the documentation from the period?
A. My view is that --
Q. Not your view. I don't want your view. I want what the facts are, Mr Brockington.
A. I can't conclude what happened at the time. I would be surmising. But what we have said in my statement is that there were areas which were missing.
Q. You will agree with this, I hope, that all documents should have been preserved; do you accept that much?
A. Yes, I do.
Q. There was a police investigation after all, which started fairly swiftly?
A. Correct.
Q. Lampard started, when, around November 2017?
A. That is broadly my recollection, yes.
Q. Then there was a judicial review brought by two of the formerly detained people, which started in January 2018.
So all the documentation should have been preserved. Have you any explanation for why it has not been?
A. I don't.
Q. At your paragraph 186, which is still up on screen, you

say:
"It is acknowledged that on some of the F213 forms, sections 1 to 3 were not always completed, however, the information asked was duplicative of the information already set out and provided in the preceding DCF-2 documentation. This information is not therefore missing from the pack."
Are you saying it didn't really have a separate purpose? What does the use of the word "duplicative" mean?
A. What I am saying in that statement is that some areas were duplicated in the F213 and the DCF-2, and that might be one reason for them not being completed correctly.
Q. I am going to put up an example, just so everybody can see what I am talking about and what you were talking about here in the witness statement.
Can we put up, please, Zaynab, <CJS005534>, starting at page 1.
This happens to be in relation to D1527 for 25 April but this is the first part of, in effect, a three-part incident.
You can see the time use of force commenced. According to this document, 19.09 and completed at 10 minutes past.

If we go on, please, to page 5, here we see a document which apparently was completed by Jo Buss, who was the nurse, headed "Injury sustained and healthcare involvement". In the box "A F213 or equivalent form was completed by ..." it says "Name: Jo Buss".
"Did the detainee sustain any injuries at the time?" and "Yes" is checked.
Can we go on, please, to page 7. Here we find the annex A statement of Steve Loughton, a DCM who went to D1527's aid when he was alerted to the fact by a DCO that he had put a ligature around his neck. If we can go to the next page, we can see the narrative:
"At approximately 19.08 I was checking the daily food refusals and I was on Eden Wing. I was just about to check a detainee by the name of ... who was currently on a constant supervision and rule 40 and was residing in room E/007. I was told by the officer who was watching him DCO Fraser that he had just gone into the toilet area and he couldn't see him properly. I entered the room and called his name but had no answer, I then went into the toilet area which is where I saw D1527 curled up around the toilet area with what looked like a ripped T-shirt around his neck which he was holding on to. I attempted to loose the ligature but D1527 was

holding on to it so I asked DCO Fraser to pass me his fish knife and I managed to cut the ligature off , I then pulled D1527 out of the toilet area and asked him to sit on the bed which he did and I called for medical assistance on my radio."
So all we have so far, would you agree, Mr Brockington, is a narrative account from Loughton which says nothing about any injury. We have a check box ticked which said that the detainee did suffer injury, but no detail; do you agree so far?
A. I would agree so far.
Q. Right. If we go, please, to page 11 -- actually, back to page 10, sorry.
Here is the report of injury to detainee. This is the F213. Surname ciphered as D1527. Section 2(a), time and date of incident, 25 April 2017 at 1900 hours.
The rest is not completed. Section 2(b), "Brief report of circumstances in which injury was sustained. (To be completed by the incident reporting officer)", completely blank. Could you scroll down, Zaynab, please? Do you agree, nothing there?
A. I would agree there is nothing there, yes.
Q. Then, on the next page, section 3, "Healthcare report. (To be completed by medical staff)":
"Seen on E Wing room by RGN [I think it is] Jo."

That must be Jo Buss:

"Detainee had placed a ligature around his neck, removed by staff. After that he went to toilet and attempt to self-strangulate -- [something] removed from his neck. Slightly redness noted on his neck."

There we see, if we scroll down a little more, an indicator around his neck, "Slight redness on his neck", and let's just scroll back up.

What this document doesn't tell you is how the redness noted on his neck arose, because, first of all, it refers to a ligature and then it refers to an attempt to self-strangulate.

The order of events here is important, Mr Brockington, because the first of this three-part incident was the ligature, when indeed Steve Loughton went in, being alerted to the fact that he was trying to strangulate himself with a ligature, and removed the ligature with a fish knife. Matters then calmed down when he placed in or around his mouth a battery from a mobile phone -- were you appreciative of that?

A. I was, yes. Or I was appreciative of the evidence that was given in relation to that point.

Q. Yes, and then, as you will know, the third part of the incident is when he attempted to self-strangulate with his hands.

I think reading this, then, probably the last words on that third line are "Hands removed from his neck". What this does not tell us is what Yan Paschali did; do you agree?

A. I would agree, yes.

Q. What this doesn't tell us is the whole series of events that led to Yan Paschali doing as he did or, for that matter, saying what he did; do you agree?

A. I do agree with that, yes.

Q. And then, if you read this at face value, "Slight redness noted on his neck", you would have no idea -- minor injuries though they may be, you would have no idea whether those injuries might have been caused by Yan Paschali digging his thumbs into his neck, would you?

A. I agree with what you are saying, I do.

Q. Yes. This is part of the cover-up that I was suggesting to you a little earlier.

Let me ask you now, please, something about your interview with Kate Lampard, please. Can we put up on screen <VER000255>. This is your interview on 9 March 2018. Was it just Kate Lampard or both her and Ed Marsden?

A. It was her and Ed.

Q. If we go to page 10, you say at 121, and I am just

picking up the numbers in the left-hand margin, you are talking about contracts, and you say, towards the end of that passage, "Rest assured, the vast majority of government tendering, regardless of whether it says it is 50-50 price quality, it is price, let's face facts."

Are you talking about what the focal point of any government contract in this environment is?

A. No. I need to be really clear on this. When -- if I can just explain the tendering process, if it might be helpful for the inquiry, the -- when an organisation, a customer, whether in the private sector or public sector -- in this instance the public sector; the Home Office -- want to reissue a service, and they look to outsource, they issue an invitation to tender.

An invitation to tender is a set of criteria and requirements that, in this instance, the private sector would then -- us and competitors would then respond to.

When they set out that criteria and list of requirements, they also set out the contract, they set out KPIs, KPTs, they also set out how it is going to be measured; ie, is it going to be measured on the quality submission, which is, "How are we going to do this?", or is it going to be measured on the price, ie what price we are going to deliver it for.

What I can say, harping back to, probably, 2007,

I think there was a far bigger drive by government to get a low price, which I would argue isn't necessarily value for money; I think that is a very different question.

So the 50-50 ratio which I refer to is, when they score the contract, they are scoring it half on the quality of our solution and half on the price which we are prepared to deliver it for.

So in that, what I was saying is different organisations apply different weightings to quality or price.

Now, whilst, in 2007, I believe the general thrust from government was to get a cheaper price, what I can say is that has demonstrably changed since that period and there is a far bigger drive by government for value for money and quality.

Q. Yes, but therein lies the flaw with the contract under which G4S operated Brook House during the period, because the focal point was on price rather than welfare, wasn't it?

A. So I think a couple of points on that.

It was a contract which, yes, we ended up delivering, but we lost at the tender process to GSL, and of course we inherited the contract through the acquisition, and it is set by government. It is set by

the customer, the -- how they -- their list of requirements, their list of measurements and the ratio of how they decide to score it, so I think that is probably quite clear.

Q. Except this, we don't perhaps need to put it up on screen now, but you will have seen a series of presentation documents which were created, I think, by Mr Schoenenberger who became the head of the DEPMU in due course. Do you remember reading -- for the record, chair, but I am going to deal with this through another witness, <DL0000140> at page 47. The Home Office's own internal assessment of the bids said -- and you will remember this:

"An ethos of cutting corners and meeting basic standards was evident from much of what we have read and we are especially disappointed at the extended lockdown hours proposed by these four bidders. This appears to be a desperate attempt to reduce costs at the expense of welfare."

GSL was one of the four bidders, wasn't it?

A. It was, in my understanding, yes. In fact, they won it.

Q. They did.

Therefore, it is not just about the Home Office, because all four companies, including GSL, were cutting corners in order to win the contract, weren't they?

A. I can't comment. I can't comment on the submission of a competitor at the time. What I can say is the process for tendering is the authority -- the Home Office, in this case -- sets out the criteria and the private sector, in this case, responds with a solution which needs to be sustainable on a number of metrics.

Q. And it wasn't just GSL, I mean G4S bid for the contract as well. So you were one of the four bidders who the assessor was complaining about trying to cut corners?

A. I really cannot comment on something back in 2007.

Q. You have seen the documents, haven't you?

A. The tender documents --

Q. Yes.

A. -- the specific tender documents? No, I haven't seen the specific tender documents, because they go back to 2007.

Q. You haven't looked at them? Because they were in your pack. Have you not looked at them?

A. Not in detail.

Q. Any detail, by the sound of it, no.

A. No.

Q. Coming back to your interview with Verita, which is still up on screen, if we look down the page, please, at 125, Mr Marsden is continuing:

"In trading reviews, I think the financials come

first --"

And you say:

"No, never, health and safety always comes first."

He says:

"Okay, that's interesting, someone told me that."

You say:

"Never."

At the top of the next page:

"Interesting", he says.

You say:

"Agenda point 1 on every ExCom is health and safety."

Explain what ExCom is?

A. It is the executive committee.

Q. What does the executive committee of G4S do, what is its raison d'etre?

A. At the specific time, it was to manage the regional business.

Q. Yes. If we move on, please, to page 18.

Says the questioner, at 241, who may be Kate Lampard:

"Can I just ask you about the chain of reporting on all of this: you've described how trading reviews focus on this matrix, balanced score card, all that sort of thing, and then it gets up to ExCom and ExCom will drill

down if there are evident things that are out of kilter and look absurd. By the time it gets to the board, one question Ashley asked us is, you have HMIP reporting, you have local IMB reporting, you have trading reviews, why did nobody tell him that people were behaving like brutes in Brook House?

"There are indicators for that, aren't there? I can't write a thesis on what the line is, but understaffed place, staff under pressure, not enough managers, not enough time off, not enough training and development, all of that stuff. What's your answer as to why that didn't come through to your board?."

You answer:

"Clearly, something isn't working."

Then you say:

"We have whistleblowing ..."

And you are asked:

"Is that something that's on the metrics too, on the formal reporting?

"Yes, I don't see that but Peter sees every single whistleblowing."

That's Peter Neden, presumably?

A. Yes.

Q. Who is the "Ashley"?

A. Our chief exec.

Q. What was not working, do you think? What were you telling Verita wasn't working?

A. What I was saying in -- what I was trying to get across, and it appears quite clumsy, was the -- the way that the trading reports were -- you have heard of different names for this through the inquiry -- I have heard them called "trading reports", I've heard them called "business reports". I personally call them "performance reports", because they are absolutely -- I think "trading" builds a picture of just commercial view.

These were absolutely not that. These were business reviews, where we looked at all aspects of health and safety, but I include use of force, I include violence on detainee or violence on -- prisoner-on-prisoner, in my current business, self-harm, recruitment, HR, the list goes on to cover all aspects of the business, and we also -- at the end, we cover facilities management as an example and then on to commercials.

So, you know, these are full business reviews and I stand by, you know, in my current business, what I review, with a very high-level of scrutiny and governance on a monthly basis with the -- the sites is all these areas.

So -- and I stand by what I say, that the whistleblowing process, I think, Peter did say in his

evidence that he did see the whistleblowing reports.

Q. At page 12 at 148, you are asked:

"I suppose what I am asking is not so much the actual mechanics of whether or not they breached a fundamental agreement, it is what sort of pressure are they put under to perform better than that bald agreed sum? Do you rate your directors one against the other on how much more they are able to get out of a contract?"

You say:

"Categorically not, we don't rate them one against one. We apply measured commercial pressure to them to deliver a number of components of their contract. If you look at it in terms of -- this is all a bit nonsensey -- if you look at it in terms of a balanced scorecard, we measure them on their health and safety performance, we measure them on their profitability, we measure them on their KPIs. These are all linked together, so if you fail your KPIs you're probably going to get financial penalties, which probably means your profitability is going to go down.

"The other really important thing about that is they are all leading indicators, so if you have a safe contract, and your team are engaged, and you are not hurting people, and you're delivering all those lead

indicators such as health and safety, the chances are your profitability is going to be good as well, because you are running a really good contract, you're a really good management team. We measure lead indicators which ultimately drive profitability. It is one component of a few, all of which are linked, but clearly we want them to make more money, not to the detriment of all the other indicators."

Then, just picking up on a few themes here, Mr Brockington, at line 157 at the bottom, you are asked:

"But your recollection of the contract was that it was not financially troublesome?"

You say "No, correct."

You also agree, on page 14, if we go over to page 14, at the top of 170, where you are asked:

"I suppose what I am really asking you is, if you have any experience of the sort of pressure that that person from the Home Office who sits on the ground at Gatwick and is the interface between the Home Office and the operation, if your experience is, as ours is, that really the thing they are focused on is pleasing the masters about people in and people out, and we have got the local person to admit that that is the case -- does that accord with your experience?"

You say:

"Yes, I think so. I think they will be driving what their boss is interested in."

So let me ask you, against the background of those questions and answers, and I am asking this on behalf of several of the core participants in this inquiry, Mr Brockington, do you accept that, in order for this model of performance monitoring to work, it is essential that the KPIs, and the imposition of financial penalties imposed on you by whoever purchases G4S's services, takes account of detainee welfare?

A. As I explained, or tried to explain, in my previous comments around the tender process, the customer, the Home Office in this case, puts out to the market a list of requirements in the invitation to tender.

Included in that is their requirements, their -- what they want to achieve, their strategic objectives, but also that includes, more often than not, a list of key performance indicators. These are designed by the customer and we respond to those in the tender.

So I am afraid, whilst I don't want to appear to be skirting this, because I am absolutely not, this is -- in all instances that I have been -- for many years, been engaged with procurement in the public sector, the KPTs and KPIs, whatever you choose to call them, are

designed and established and set out by the customer, and we respond and we build a sustainable model and service delivery model to respond to ensure we deliver a service as required by the customer, and we also ensure our adherence to the specific KPT measures.

Q. Secondly, do you accept that it is also essential for the Home Office to insist on adequate financial penalties to ensure that there is sufficient impact on your profitability to incentivise the centre director to take action?

A. In my experience over, say, a significant number of years, bidding for work within the public sector, KPTs are one measure that the authority measures us against.

The financial penalties vary between organisations, and the application of the quantum varies, depending on KPT and depending on customers.

So again, it is back to -- I am afraid it is back to the Home Office. They set the criteria in terms of what is to be measured and the final -- the financial penalty regime which sits alongside that.

Q. Who is ultimately responsible here, Mr Brockington, for what happened?

A. In terms of?

Q. In terms of the abuse? Who do you think is ultimately responsible?

A. As an organisation, and in the organisation which I am responsible for, in terms of our care and rehabilitation business, if this was to happen in the business that I run today, I would be responsible.

Q. Yes. Who was responsible, in your view, for what happened between April and the end of August 2017?

A. I believe the individuals who -- to be honest, I can't conclude either way. What I can say is -- because I can't conclude for that point in time, but what I can say is, for the business that I run, I would hold myself responsible if this was to happen in my business.

Q. Well, that is terrific, because we are not asking you about what is going on now. I am asking you about what happened in the spring to the summer of 2017.

Now, you have not come here, Mr Brockington without having some understanding of what G4S's position is on this. Are you telling us that you have no position to state publicly about whether G4S holds its hands up, as it were, and accepts its responsibility, not perhaps full responsibility, but, in part, its responsibility for what happened during those months?

A. I would accept we hold a degree of responsibility.

Q. Yes.

A. Absolutely.

Q. Because, for one moment, it sounded like you were not prepared to accept even that much.

A. If that is what has come across to the inquiry, that is wrong. I have said, as an organisation, and as an individual, as a -- responsible for this business now, I would hold myself wholly responsible for these abhorrent behaviours. I couldn't be clearer on that.

I think the inquiry will, of course, deliver the findings of the inquiry, based on the evidence that has been given, but I hope I am very clear in my openness to the inquiry around the fact that we take these matters incredibly seriously and have actioned a significant amount of -- all the areas covered, and we will continue to do so and continue to -- within the prison environment now, clearly not the detained environment, because we no longer operate within that environment, but I hope my position is now clear.

Q. A couple of final topics for you, Mr Brockington. First of all, can we go back to your witness statement at paragraph 182, which is on page 36, and it is up on screen. You say:

"Following a use of force event, detainees will sometimes be relocated to the CSU, if deemed appropriate, usually as a result of continued aggressive behaviour (to staff or others). Removal was therefore either for their protection or that of others."

You go on to say at 183:

"The Suicide and Prevention of Self-harm Policy would have been followed in CSU where appropriate, although this would not impact on the use of force event itself."

Then, if we can go forwards, please, to paragraph 200, which we find on page 40, and I want to go, really, to the end of that paragraph, which is on page 41 at the top:

"A number of detainees were also struggling to adapt to detention and several spent prolonged periods on rule 40 awaiting transfer to mental health facilities or to the prison estate."

Do you accept from everything you know, Mr Brockington, that vulnerable detainees who were suffering from serious illness or self-harming risk were routinely relocated to the CSU under rule 40 during the period?

A. What I would say is, where rule 40 occurred -- and rule 42, but we're talking about rule 40 -- there was a very different process for -- sometimes, arguably, a different process, under planned and unplanned.

In the event of a planned use of rule 40, there would be pre-authorisation by the Secretary of State's representative. In an unplanned use of rule 40, the

duty manager, and we would call that a case of urgency, the duty manager could authorise, initially, the rule 40, and then be followed up immediately, pretty much immediately, by the authority representative from the Secretary of State.

So when we used rule 40 and rule 42, it was within full sight of, and authorisation of, the Secretary of State's representative within the Home Office.

That was also -- I have referred on a few occasions to us not working in isolation at the immigration removal centre, because, of course, we reported the use of these to the Home Office on a daily basis at the 0800 meeting, daily reports, weekly reports and also to the IMB.

So what we did in those circumstances was fully authorised by the Home Office on --

Q. Did you not realise that in a huge amount of cases, it was DCMs themselves who were authorising in cases of urgency; did you know that?

A. It was our view that the duty manager would authorise.

Q. I know what was your view, but what I am asking you is whether you knew DCMs were, in fact, giving authorisation?

A. I didn't know that, I wasn't around at the time, so --

Q. Well, is this news to you now? Have you not heard this

before?

A. No, I am aware.

Q. You are aware.

A. Yes.

Q. So what do you think about it?

A. My understanding is -- I can't comment fully on anything further, but what I can say is the authorisation was followed up by the -- the Home Office's authorisation.

Q. Are you prepared to accept that the use of the rule 40 mechanism for relocating vulnerable detainees to the CSU, though suffering from serious illness or at risk of self-harm, their routine relocation was inappropriate to manage their mental health; do you accept that?

A. I can't conclude either way.

Q. Or are you just not prepared to?

A. It is not that I am not prepared to; I can't conclude, I have no detailed knowledge of it.

Q. Finally, a question on occupancy. You know that Brook House was built to the specification of a category B prison?

A. I do.

Q. Albeit without the sort of activities a category prison would or should have, holding prisoners who were serving perhaps relatively short-term sentences.

This was a building, we understand, which was

designed for short-term holding of up to 72 hours, but, unfortunately, if that was the intention, it was never, or rarely, complied with.

You know that?

A. I was fully aware of that, yes.

Q. Yes.

The HMIP report for Tinsley House in 2018 confirms that Tinsley House was closed for refurbishment between September 2016 and May 2017 -- presumably you know that?

A. I do.

Q. And a number of staff was transferred over to Brook House at the time, you will appreciate that too?

A. I do appreciate that.

Q. Yes. In your second witness statement, paragraph 9, we don't need to put it up, perhaps, but you say this:

"I was not involved in any discussions around this matter ..."

Now, the matter you refer to is the heading "Increase in operational capacity":

"... but on 25 January 2017 [you say], the Home Office issued a formal change request to CJS ..."

Which is Custodial and Justice Services?

A. At the time, yes.

Q. That is, what, part of the moniker of the company or the

division?

A. It was part of the division of G4S.

Q. "... requiring it to increase the operation capacity of Brook House from 448 to 508 ... This was then effected through a contractual change notice from the Home Office on 27 January 2017 ..."

We know that, we don't have to put up the documents, but we have seen two documents in that regard; for the record, <CJS0074084>, which is the service provider request form dated 25 January, signed off, although it is draft, but with Jerry Petherick's name on it for the extra 60 beds, and the Home Office notice of change document dated 27 January is <HOM000859>. The idea was that these beds would be operational with effect from 1 April 2017, the extra 60 beds, although we understand they may have been in place or built at least by the end of 2016.

Now, given that most of the Tinsley House staff were working at Brook House from around September 2016 onwards, until their return there back from Brook House, are you able to say whether or not there were staff shortages at Brook House in the period from around September 2016 to, give or take, November/December 2016, the time after HMIP had completed their inspection?

A. So my understanding is we delivered to the contractual requirements as set out in the contract, in terms of resourcing at that time.
Q. So the answer is, what, you don't know or you cannot say or there were no staff shortages?
A. What I am saying is we fulfilled our contract.
Q. What does that mean?
A. We -- so there is a minimum staffing level set out in the contract and we were broadly compliant to the terms of that contract.
Q. Let me ask it another way. Do you know whether G4S incurred any contractual penalties in that period for failing to meet the minimum staffing requirements? What are you referring to there, Mr Brockington? I see you have got something in the witness box with you, is it an aide-memoire, of some kind?
A. I have just got a couple of notes.
Q. It looks like a lot of notes from where I am standing.
A. It's just a couple of notes to help me answer your questions fully. I cannot confirm, but I will make a response to the inquiry to cover that point.
Q. Can you add this to it: how did staffing levels in the period, say, from about September to December 2016, compare to staffing levels during the relevant period? Are you able to help us with that?

A. Of course, we would be delighted to.
Q. Let's just put up on the screen please, I think finally, the HMIP report, again, <CJS000761> at page 5.
If we look at the penultimate paragraph on the screen:
"This report makes a number of detailed recommendations about the treatment of detainees and the conditions in which they are held. I would add a cautionary note on an issue that is not the subject of a specific recommendation but has the potential to adversely affect the conditions in which some detainees are held: the proposal to bring into use the third bed which has been installed in 60 of the two person cells. Many staff and detainees were of the view this would lead to a decline in living standards. This is a view shared by inspectors."
What did the company do about that?
A. My understanding of the process at the time, we worked closely with our -- with the customer, and my understanding is the initial view was we -- the Home Office wanted to increase the numbers by more than 60. We worked collaboratively with the customer to agree 60. A risk assessment was done at the time and it was concluded, albeit I wasn't privy to those conversations, so I can't comment further. It was

concluded by the site team at the time that 60 -- with the Home Office that 60 would be appropriate.
I am afraid I can't comment further because I was not privy to further conversations.
Q. In a moment, I am going to invite the chair to see if she has any questions for you, Mr Brockington, but before I do, I am going to invite you to consider whether there is anything you want to say to the detainees, not only those who have given live evidence before this inquiry, but those who were not able to, those whose statements and other material was adduced before the inquiry in respect of the mistreatment, physical and verbal, that was meted out to them during the course of the relevant period?
A. And I would like to take this opportunity, on behalf of G4S, to apologise for those who suffered mistreatment, as witnessed in the Panorama programme. What we saw on the Panorama programme was, as I said previously, abhorrent behaviour. We believe it to be isolated. And we look forward to receiving the conclusions of the inquiry.
MR ALTMAN: Thank you.
THE CHAIR: I have no questions. Thank you very much for your evidence, Mr Brockington. Thank you.
MR ALTMAN: Chair, it is 12.45. Rather than start the next

witness, can I suggest we have an early lunch and return in an hour at 1.45?
THE CHAIR: Thank you very much. Thank you Mr Brockington. Thank you.
(12.47 pm)
(The short adjournment)
(1.45 pm)
THE CHAIR: Thank you.
MS SIMCOCK: The next witness is Philip Dove.
MR PHILIP CHARLES DOVE (sworn)
Examination by MS SIMCOCK
MS SIMCOCK: Thank you, can you give your full name to the inquiry, please?
A. Philip Charles Dove.
Q. Mr Dove, you have provided a statement to the inquiry, that is at <CJS0074040>. I am going to ask you some questions about various topics within that statement, but I am not going to take you through it line by line, because I am going to ask that the entirety of it is adduced into evidence.
You, I don't think, were employed by G4S Health Services as managing director during the relevant period; is that right?
A. That's correct.
Q. What is your current job title?

A. Managing Director of Facilities Management and Public Services.
Q. Are you also director of G4S Health Services UK, Limited?
A. I am a director of G4S Health Services, but I also have a managing director running the business.
Q. Thank you. What does that role entail?
A. My role?
Q. Yes.
A. I run a number of disparate businesses, including Health Services for G4S.
Q. You are the corporate witness that has been put forward by G4S Health Services to provide evidence to this inquiry; is that right?
A. That's correct.
Q. You are here to answer questions on behalf of the company about the relevant period and about the current position; is that right?
A. That's correct.
Q. You say, at paragraph 2 of your statement:
"I have no personal knowledge as to any of the matters identified in the BBC Panorama programme. I also have no first-hand knowledge of the management of healthcare at Brook House between April and August 2017, or about the contractual/commissioning arrangements

between the Home Office, G4S and NHS England during this time."
Is that right?
A. That's correct, I didn't join G4S until November 2017 and had no responsibility whatsoever for the Health Services business until January 2019.
Q. Yes. At paragraphs 30 and 101 of your statement, you say that you are "unable to comment on lessons learned due to a lack of personal knowledge and a loss of staff."
A number of other times in your statement you refer to a "loss" or a "lack" of knowledge in the company, at paragraphs 22, 105, 107, 112 and 172, to explain why you have been unable to answer questions posed of you by the inquiry.
In those circumstances, how well placed are you to provide the corporate evidence on behalf of G4S Health Services to this inquiry?
A. I think I am the best current employee of G4S to provide the corporate statement. However, I would imagine that the statements you have received from other people who used to work for G4S at the time will be more relevant to the period; which -- at the relevant period.
Q. Is G4S Health Services committed to learning lessons as an organisation?

A. G4S is always trying to learn lessons.
Q. And is G4S Health Services committed to learning lessons from what was shown on the Panorama programme?
A. Yes, I believe it was. And continues to be so.
Q. And committed to learning lessons from this inquiry?
A. Yes, where relevant.
Q. Because, of course, the importance of learning lessons is to prevent past problems or failures occurring again in the future?
A. Indeed.
Q. And in this case, that was -- that led to mistreatment of vulnerable detainees. So important to prevent those failures and problems occurring again?
A. Indeed.
Q. Does your inability to comment in some of those respects suggest that G4S Health Services has, or at least had, no system in place to ensure that lessons learned were passed on from predecessors?
A. No, I think a considerable time has passed, it is five years since the relevant period. I think businesses evolve and change and I think that I would hope that lessons were learned, and I believe that they were, and I believe there was an intense period of reflection and action immediately after the Panorama programme. As such, I believe that processes are in place to

continue learning and to continue to develop.
Q. Are processes now in place to prevent the loss of company knowledge that you have referred to in your statement?
A. I think some of the questions here are so very specific to such very specific matters that it is difficult to say that you will not lose that knowledge, because it is so -- such a detailed question that is being asked. I think the general principles are understood and hopefully have been commented on.
Q. What about systems of auditing and documentation?
A. I think that there were systems of auditing. I think that we constantly evolve auditing and documentation. And although there are some gaps that are talked about, I think there is a good quantity of documentation that is available and has been reviewed and submitted.
Q. At paragraph 3 of your witness statement, you state that you have made the statement "on the basis of information provided by inquiries and/or of review of the company's documents and records."
Have you spoken to people who were in post during the relevant period?
A. I have spoken to Sandra Calver; otherwise, no.
Q. Why not, other than Sandra Calver?
A. I hadn't got access to other people other than

Sandra Calver.

Q. You say that you have spoken to Sandra Calver. She clearly had first-hand knowledge of the healthcare provision in Brook House during the relevant period and she provided written, and indeed live, evidence to the inquiry. Did you review her statements?

A. I did read her statements, yes.

Q. Did you listen to her give live evidence to the inquiry?

A. Not the entirety of it, but some of it, yes.

Q. Are there any aspects of her evidence with which you disagree?

A. Not that I recall specifically.

Q. At paragraph 14 of your statement, you say:

"This is a corporate statement for the company. It would not therefore be appropriate to comment or speculate on the causes of behaviours of staff employed by other organisations. It is also difficult for me to comment on the causes of staff behaviour in general terms. The conduct of different staff members will likely have been driven by different factors, causes and considerations. Where appropriate, I comment below in relation to particular staff and events."

You did feel able to comment at paragraph 31:

"The issues identified in relation to Ms [Joanne] Buss were in connection with her personal conduct, not

systems or policy failures. Nor, to the best of the company's knowledge and belief, were there any issues raised that extended to potential wider issues concerning the company's employees."

Is that right?

A. That is what is stated, certainly.

Q. Did you listen to Jo Buss's evidence to the inquiry?

A. Yes.

Q. Have you listened to Dr Hard's evidence to the inquiry?

A. Not all of it.

Q. But some of it?

A. But some of it.

Q. Have you read his two reports?

A. Yes.

Q. Do you still think -- having listened to and heard that evidence and read his reports, do you still think that there were no systems or policy failures leading to the mistreatment of vulnerable detainees in Brook House in 2017?

A. I am not a medical expert, and I wasn't there in 2017. I think it is very difficult for me to conclude whether what Dr Hard is saying from his desktop review in 2022, is correct or incorrect with regards to exactly what was going on in 2017.

Q. There has been a large amount of evidence from various

sources to the inquiry that various safeguards and policy implementation in relation to the safeguarding of vulnerable detainees was failing. Do you disagree with that evidence?

A. I am not sure to exactly what you are referring.

Q. Maybe we will come to it in more detail in a moment.

Do you have any comment on the evidence that Jo Buss gave that she had heard and not challenged and not reported inappropriate behaviour by detention staff in relation to the incident with D1527 on 25 April?

A. I -- that appears, as represented in the programme, to be shocking and Sandra Calver appears to have said that she was extremely shocked by Jo Buss's behaviour as well.

Q. Jo Buss gave evidence that seemed to suggest that that type of conduct by her and others was commonplace and that, effectively, staff had become, including her, immune to it. Does that indicate a system or policy failure in your view or does that still relate to individual conduct?

A. I certainly heard Jo Buss refer to it about her own behaviour. I don't recall her specifically suggesting that that was commonplace.

Q. We know from the BBC footage filmed by Callum Tulley, including some that was broadcast on Panorama, that

various staff members made mocking or derogatory comments in relation to detainees intoxicated by spice; were you aware of that?

A. I have seen that comment.

Q. And that -- that is not just by one individual, Jo Buss, it was by other members of healthcare. Again, does that indicate a more widespread culture or systemic problem at the time?

A. It certainly is inappropriate behaviour; whether that indicates that's a systemic problem or a lack of understanding of the impact of somebody's behaviour or comments on other people, whether that is a systemic failing, I think I couldn't comment on, I wasn't there.

Q. Paragraphs 43 to 45 of your statement, you state that staffing levels, turnover and the use of agency staff didn't contribute to the mistreatment of detainees.

How were you able to come to that view, given that the company and its senior management were not aware of the mistreatment at the time?

A. I have talked to the current leadership of our medical business about the way in which contracts, including ones like this one, are staffed; and I understand that it is commonplace across all NHS contracts, including in the NHS itself, for a core of permanent staff to be supported by bank and temporary staff, and in this

environment, of course, people couldn't just come in off the street to work, they would have to be inducted anyway, in order to work in a secure environment.

Q. At paragraph 67, you state that training failures didn't contribute to the mistreatment of detainees. Again, how were you able to come to that view?

A. I think there is a variety of insights into what was -- how the facility was being run at the time. I think that you would have the IMB report and the Her Majesty's Prisons' report supported by the CQC, and I would have expected, particularly in that case, that the CQC would have talked and required action, if they felt training to be inadequate. I don't believe that there was any inference from the HMIP report at the time that there was training inadequacies and there was certainly no specific action with regards to improving training.

Q. Dr Hard, in both of his reports, and in his live evidence, confirmed that in his view, there were various inadequacies in the training regarding the Adults at Risk policy rule 35, ACDTs and the use of force which led to failures in the safeguards, leading to detainees remaining in detention subject to segregation, committing acts of self-harm and having force used against them, including, for example, in D1527's case, the assault by Yan Paschali. Doesn't that indicate

training failures at the time in 2017, would you agree?

A. Not sure that Dr Hard taking a desktop view, in 2022, of a situation in 2017 necessarily leads directly to that conclusion. I would have thought that if there were significant failings in the view of the NHS, the Home Office, the IMB, and HMIP, that training was such a problem that, in one way or another, there would have been a significant impact and requirement for the business to change the training methods or improve it.

Q. Sandra Calver gave evidence that the training in relation to rule 35 wasn't sufficient and that she had pushed for more training at the time; were you aware of that?

A. From the research that I have done with regards to this hearing, it seems to me that rule 35 is a very complex area and there are many opinions around the way in which it, at the time, was being implemented and the way that it should still be implemented today. I am aware, obviously, that there was discussion around the training and I am also aware from the evidence that I have seen that the doctors were keen to discuss rule 35 with the Home Office and to make sure there was clarity in its implementation and training.

So it was clearly an area that wasn't totally crystal in the way in which it was to be implemented and

used.

Q. We will come to it perhaps in a little more detail in a moment, but at paragraph 75 of your statement, you state that no management failings contributed to the mistreatment of detainees. Again, how were you able to come to that view?

A. I think, with regards to the incidents shown in the Panorama programme, I don't believe that there has been question with regards to Sandra Calver in particular and her oversight of Nurse Buss. She appeared to have been incredibly shocked by her behaviour and I don't believe that any other issue had been raised with regards to Nurse Buss. Thereby, I think that is how I would conclude that it didn't appear there were any management failings around that matter.

Q. Are you now aware of Dr Hard's evidence that management failings led indirectly to the mistreatment of detainees through the failure of the safeguards under rules 34 and 35. Do you have any comment on that?

A. I am not a medical expert and I wasn't there at the time but, as I have said, it would appear that rule 34 and 35 weren't entirely clear at the time and Dr Hard's view, at this time, may or may not have been in line with the view that anybody may have held at that time.

Q. Coming, then, to rules 34 and 35, specifically, do you,

as a result of your preparation for this inquiry, have an understanding of the interaction between the two rules?

A. I have read a variety of documents and tried to understand and listen to Dr Hard and read relevant documents at the time. I think I have a desktop understanding, but I am not a medical expert and I wasn't there at the time, so my understanding will be very limited compared to many other people who would be able to provide a view.

Q. Rule 34 requires that every detainee have a medical examination, a physical and mental examination, within 24 hours of admission to a detention centre. You are aware of that?

A. I am.

Q. And rule 35(1) requires a report on anyone where detention is likely to injuriously affect their healthy, including their mental health, are you aware of that?

A. I am.

Q. In relation to rule 35(2), that requires a report on anyone suspected of having suicidal intentions; are you aware of that?

A. Yes.

Q. Where those thresholds are met, a rule 35 report should be completed as a direct consequence of the rule 34

examination at the outset of detention; are you aware of that?

A. Yes.

Q. And so, in that way, the two rules are meant to work together to safeguard vulnerable detainees at the outset of detention; is that your understanding?

A. Yes.

Q. Sandra Calver accepted in her evidence a failure of rule 34, her explanation being that, largely, there were inadequate resources allowed to give everyone the kind of examination required by the rule, and in particular that the appointment was very brief, being only five minutes long.

Are you aware of that evidence that she gave?

A. I am aware of that evidence. I think at the time, from what I have read, the interpretation shown by Dr Hard and talked about in this inquiry of a substantive mental assessment of every individual arriving at the IRC does not seem to be consistent with what the NHS were talking about at the time, a needs assessment, where they even commented that the need to see a GP for every detainee entering may be putting an unnecessary burden on GPs, so I find it difficult to square that the NHS, who commissioned the service, were suggesting that there was an unnecessary burden, first, as Dr Hard is suggesting

that there should have been a full mental health assessment of every detainee, so I wasn't there and I can't quite understand how those two things mesh together.

Q. It is not Dr Hard who was suggesting there should be a mental and physical examination; it is the wording of the rule, isn't it?

Rule 34 requires mental and physical examination of every detainee within 24 hours of arrival at the IRC; is that your understanding?

A. My understanding is that, within 24 hours, the detainee should see a GP.

Q. For a mental and physical examination.

A. For a mental and physical examination.

What I am unclear of, or what I kind of look at and try to process is, what was the intention and how long should that appointment have been; was it not to assess whether any further assessment was required and it would appear to me that that was what they were trying to achieve in seeing someone to assess whether they felt that a further follow-up appointment was required to assess their potential to need to put a rule 35 report together.

Q. That is clearly what was happening in practice on the ground in 2017. What the rules require, though, is for

a rule 35 report to be completed in appropriate circumstances, as a result of the rule 34 appointment, in order to safeguard vulnerable detainees by identifying them to the Home Office at the outset of detention; that's right, isn't it?

A. If that is the case, as your reading of the rule suggests, then I find it interesting that, still to this day, Sandra Calver gave the evidence that there still are only ten-minute appointments five years later.

Q. Indeed, but the rule clearly was being breached at the time, and may well still be being breached now. That is the significance of that evidence, isn't it?

A. If the interpretation of the rule is correct, then of course it is. But I guess what I struggle, as a layman, to work out is, why, five years later, with all of the focus on this area that there has been -- and with all of the interested bodies that are engaged in this, why would a change not have been made if that interpretation of the rule is, in fact, accurate and the way in which it should be implemented?

Q. So, Dr Oozeerally had confirmed that the rule 34 appointments were not leading to rule 35 reports; instead, as you have said, there was a period where, if a disclosure was made or another concern was raised about a vulnerability, a further appointment was booked

for a rule 35 assessment and that built in delay, and he described it as being almost like triage. Does G4S Health Services consider there were adequate GP resources provided at the time to fulfil the requirements of rule 34?

A. I think that the resources provided were in line with the contract let by the NHS and were in line with the resources available in the wider IRC estate -- pardon me -- and met the needs as people appeared to see them at that time. That may not be the need as you are defining rule 34 at this time, but appear to be consistent with it across the whole estate.

Q. Dr Oozeerally gave evidence that there was one rule 35 appointment available a day. Again, did G4S Health Services consider that to be adequate at the time, in order to fulfil the requirements of rules 34 and 35 working together?

A. It would seem that there was considerable discussion around rule 34 and 35 at the time; that there was active comparison between Brook House and other IRCs and that the approach was consistent and typical of the wider estate.

Q. The G4S document, at the time, on detainee reception procedures, was inaccurate in suggesting that detainees must require or request to see a doctor within 24 hours.

Would you agree that that is not in accordance with the rule and, therefore, that document was inaccurate and therefore inadequate?

A. Sorry, I believe the document that you describe is inaccurate; my understanding of the process was that a detainee on arrival would be seen by a nurse and that, at that point, the nurse would make an appointment for them to see the doctor.

So if the document did not reflect that process, then it would appear that the document was not reflecting what was done at the time.

Q. Yes.

There was some evidence the inquiry has heard from Medical Justice, from their case work experience, that detainees were not always seen for a rule 34 appointment within 24 hours and that, sometimes, even where a disclosure, such as being a victim of torture, was made, a rule 35 assessment was not booked for them.

Again, that would have been inadequate at the time to comply with the rules, wouldn't it?

A. If the detainee wasn't seen within 24 hours, indeed the rule does say "within 24 hours". In terms of if someone has disclosed torture, I am not clear that that necessarily directly leads to a rule 35 assessment, because, if there is no fear of the mental wellbeing of

the individual from their behaviour and state, would that necessarily lead there? I am not an expert, I wasn't there and I am not sure that that would necessarily happen.

Q. If someone had disclosed they were a victim of torture, you don't think it was necessary for them to be assessed under rule 35(3) at the time?

A. My understanding of rule 35 -- and it may be my misunderstanding -- was that the purpose of rule 35(3) was to raise that as a reason that the individuals should be released from detention because further detention would further harm them.

I am not clear that that is always the case of somebody who has suffered historic torture, but I am not an expert.

Q. Would you accept, from the evidence that the inquiry has heard from various sources, that the rules weren't working at the outset of detention to identify to the Home Office those who were vulnerable and at risk of harm in detention, and so were not safeguarding detainees at that stage?

A. I don't know that I can comment.

Q. Was senior management aware of how the rules were operating at the time on the ground in 2017?

A. I am not sure what I can point to to establish what

level of conversation was or wasn't going on with regards to those specific matters in 2017. Obviously, there were a number of reports produced and reviews undertaken and I don't remember in my reading of any of those reports it to have been something which was of significant concern, or record, that created substantive action. Therefore, I am not sure that it would necessarily have been something which was high on the agenda for discussion at a senior level.

Q. Stephen Shaw had, in his January 2016 report, looked at rules 34 and 35 and had noted that they were intended to be a key safeguard in ensuring that vulnerabilities were identified in detainees to the Home Office, but that it was abundantly clear that rule 35 was not fit for purpose and was failing to protect vulnerable people who find themselves in detention.

Was G4S Health Services, at a senior management level, aware of those findings in the Shaw report at the time?

A. I, unfortunately, wasn't there at the time of the Shaw report, and I haven't been able to speak to anybody who was there to know the answer to that question.

Q. Do you know if anything was done by G4S Health Services to respond to the failures that a rule 34 and 35 process identified by Mr Shaw in that review?

A. I don't know with specific reference to the Shaw review. I do, of course, know from Dr Oozeerally's evidence that he was trying to engage with the Home Office to discuss the effectiveness of rule 35.

Q. He is not senior management in G4S Health Services though, is he, Dr Oozeerally?

A. No.

Q. Do you know of any action taken by senior management in G4S Health Services to respond to those findings by Mr Shaw in 2016?

A. No, I -- I don't believe -- I haven't spoken to anyone who was in senior management at that time and I don't know what action was or wasn't taken, with regards to that report.

Q. There is nothing apparent from your review of the documentation?

A. My review concentrated on the relevant period. I didn't review anything particularly unless I was guided to it outside of the relevant period.

Q. You state, at paragraph 181 of your statement, that the majority of self-harm incidents did not meet the threshold for a rule 35(2) report of real suicidal intent.

What is the basis of that statement?

A. I understand that a doctor would talk to the individual

and assess, in his medical opinion, the intent and likelihood of further harm from such action.

I believe that that is what I refer to in my statement, this point.

Q. If we could show on screen, please, <CJS006120>, these are the Detention Centre Rules. If we could go to page 11, please. Rule 35 is in the middle. At rule 35(2):

"Requires the medical practitioner to report to the manager on the case of any detained person he suspects of having suicidal intentions."

The rule requires only a suspicion of suicidal intention, doesn't it?

A. It does.

Q. Your statement, at paragraph 181, that the majority of self-harm incidents did not meet the threshold for rule 35(2) of real suicidal intent, doesn't, though, address the very low numbers of rule 35(1) reports, does it?

A. And the fact that they would be injuriously affected by continued detention, no.

Q. Because rule 35(1) only requires a likelihood of harm, not even actual harm, to have been caused, and we see that from the rule, don't we?

A. We do.

Q. We know that there were only eight rule 35(1) reports in 2017, only two in the relevant period, and we know there were no rule 35(2) reports at all in 2017, and we know that, despite high-levels of self-harm and a large number of open ACDTs, 248 in 2017, evidence heard by the inquiry from Sandra Calver indicated that she, and indeed her staff, hadn't understood the rule 35 process and were applying too high a threshold for rule 35 reports to be completed.

Are you aware of that evidence?

A. I am not aware of that particular piece of evidence from Sandra. I am aware of the concern that you are talking of there. From my reading of the documentation around that, it would appear that that concern was discussed at the IRC forums and that the relative numbers were comparable with the numbers reported across the wider IRC estate at the time.

I am also cognisant of the evidence from Dr Oozeerally, where he talks about his use of part C, rather than 35(1) or (2). It appears, from what I have seen him talk about, that he felt that that was a quicker way to gain attention and discussion of specific instances.

Q. Part C, though, of course, does not require a review of detention, does it, by the Home Office; rule 35 does.

Were you aware of that?

A. I think, as I say, this is a complex area. I am not an expert in the area and it is difficult for me to make clear commentary on it. All I can say is that, as an observer, and listening to Dr Oozeerally, he seemed to have the opinion at the time that completing a part C and sending it to the same Home Office inbox as a rule 35, that it would be read by the same person and generate action.

Obviously, I can fully understand that there is a different interpretation and a requirement of action from rule 35 as talked about here. I guess there is a difference of interpretation versus practice at the time and I would normally have expected engagement between the Home Office, the NHS and other bodies to have brought that to the fore, and brought that as an improvement point which didn't appear to be happening for some reason.

Q. What evidence are you aware of that senior management at G4S Health Services were raising that issue with anyone?

A. I am not aware.

Q. Sandra Calver accepted that, regarding rule 35(1) and rule 35(2) that there should have been significantly more of both of those types of reporting in 2017 and that the safeguards had failed; do you agree with her?

A. I don't recall that particular piece of Sandra's evidence. I can certainly see, from the interpretations being taken here, that it would be reasonable to have expected higher numbers. As I said, it would appear that the numbers that were reported at Brook House were not inconsistent with the numbers reported across the wider estate and, as such, I would have expected there to have been considerable effort from other parties to have raised this and to be taking action, if it was, in fact, a problem that was only at Brook House.

Q. Whether or not there were failures in the safeguards at other IRCs, do you accept that they were failing, in 2017, in Brook House?

A. I think it is -- I guess the reason that I am labouring this is I am trying to look back five years and apply the lens of what was considered to be acceptable and normal five years ago, versus what might be considered to be a lens of a review and detailed desktop questioning today. I am not sure that a view that would be taken today in this room would necessarily have been the exact same view and interpretation taken by people actually operating the service at the time in 2017.

Q. Whether or not it was their view that they were operating it acceptably, do you accept now that the rules were not being complied with in 2017, in terms of

the reporting under rule 35(1) and rule 35(2) to the Home Office?

A. By the definitions of which you are interpreting those rules, I can see how you reach that conclusion. I find it difficult to understand why, if those rules were being so blatantly missed, why is it that the inspections of the IMB, Her Majesty's' Inspectorate and the CQC did not raise these as being serious failings at the time? I would have fully expected that level of oversight and the regular reviews that we undertake on a quarterly partnership and the quality meetings to have been raising those as serious issues.

So the sheer fact that so many other modes of oversight were not raising it, makes it, for me, as a layman, at this time a confusing picture to try and dissect.

Q. The statement that the majority of self-harm incidents in 2017 didn't meet the threshold criteria for rule 35(2), doesn't address the fact that there were, in fact, no rule 35(2) reports in 2017, does it? You are not suggesting that there were no detainees in 2017 in Brook House about whom there was a suspicion that they had suicidal intentions, are you?

A. No, I don't believe that Dr Oozeerally suggested that. I believe that he suggested, from what I have seen in

his evidence, that he'd rather use part C, and as you are saying, that may not have been the intention of the rules at the time, but appears to have been how he interpreted it.

Q. Because we know there were a number of detainees who the inquiry has heard about -- for example, D1527, D1914 and D687 -- who were identified as having made a statement or an attempt to kill themselves and were managed on constant supervision on an ACDT indicating a high risk of suicide.

Are you aware of that?

A. Yes.

Q. And so, in those types of -- in those cases and those types of cases, there should have been a rule 35(2) report completed at the time, shouldn't there -- do you accept that now?

A. By that interpretation, yes, I am not sure whether a part C was completed for those cases which would have been the evidence from Dr Oozeerally of the approach he would typically have taken at the time.

Q. But whether or not a part C was or was not completed, the rules require a report where there is a suspicion of suicidal intention and, in those cases where detainees were managed on constant supervision, that threshold was met, wasn't it?

A. I am not sure.

Q. Are you aware now as to whether, at the time, in 2017, senior management in G4S Health Services were indeed aware of the low numbers of 35(1) reports and that there were no rule 35(2) reports undertaken? Are you able to say whether they were or were not aware?

A. I don't know.

Q. Your explanation for the lack of those reports was that there was an understanding by those at the time, accepted in the knowledge of the Home Office, that that is the way it was done and so it wasn't a problem?

A. That is the only inference that I can take from the lack of it being raised through any other channel as being an important matter to resolve, because, otherwise, as you suggest, it looks obvious that there was a problem, but if there was a problem of the scale that has been described, I continue to struggle to understand why it wasn't being brought to the attention of everybody as a serious failing, because there was no lack of oversight, of detailed reporting and of review of what was going on in the establishment at the time.

Q. If senior management weren't aware of the low numbers indicating a lack of compliance with the rules, they should have been, shouldn't they, at the time?

A. As I said, I would expect that they would have been, but

I can't evidence whether they did or whether they didn't. I don't know what reports they read or what level of insight they had into the detail of what was going on at Brook House at the time.

Q. Some responsibility for compliance with the rules by those on the ground rests with senior management of the company, doesn't it?

A. Yes, it does. As I say, I reiterate, I don't know whether they did or whether they didn't. And I don't know what action they took.

Q. Given the evidence the inquiry has heard that healthcare staff, including the head of healthcare and clinical lead, leadership roles in healthcare, didn't understand how to apply the rules, and GPs on the ground were not applying them under rules 35(1) and (2), would you accept there was a failure of senior management in that regard?

A. I am afraid I find -- I find it difficult in such an environment, in a medical environment, where the medical director and clinical people would be in constant touch with the NHS, the Home Office, and other oversight bodies, the CQC, that, if this was such a well understood and well -- and documented in a way that creates such an expectation, then I am sure that it would have been a point of discussion and action would

have thereby flowed from it. I am not sure that I can infer, due to the lack of action and required action from any of those oversights, that I would expect there, therefore, to have been any action taken by the senior leadership of health services.

Q. Wasn't it senior management's responsibility, irrespective of what any other body was doing, to ensure that its staff were complying with their statutory obligations under the rules?

A. Yes, of course. But if, at the time the rules were being interpreted and enacted in a certain way across the whole IRC estate, which was understood from forums and other actions, then that would have been the interpretation of the rule at the time.

If, with hindsight, and five years on, we now consider that to be an incorrect interpretation, that could well be so, but that was not necessarily the view taken by any organisation at that time.

Q. Did G4S Health Services monitor the training being given to staff on rule 35?

A. I believe that there was a training matrix and that, as in all medical settings, training was important, and I would believe that rule 35 training would have been monitored in the same way as other training.

Q. Was there any monitoring from senior management of

compliance with rule 35? Was that audited at the time?

A. I haven't seen the detail of any audits documents.

Q. How, then, were the senior management of G4S Health Services ensuring that the legal duties under that rule were being complied with on the ground?

A. I don't know.

Q. You say, at paragraph 57 of your statement, that there were no contract compliance issues with DoctorPA Limited, who provided the GP services in Brook House at the time.

Did G4S Health Services review DoctorPA or the GPs' compliance with rule 35 at the time in 2017?

A. I believe there was a close working relationship between DoctorPA and the Health Services business, that there were daily reviews of practice, that there were quarterly quality reviews and there were quarterly partnership reviews which were attended by oversight bodies.

I am not aware as to -- across all of those different reviews and audits, as to what specifically was reviewed with regards to rule 35. It would be surprising if it wasn't covered in some way through that amount of oversight and engagement.

Q. Because it doesn't appear, that oversight and engagement, to have picked up a complete lack of

rule 35(2) reports and only eight rule 35(1) reports in the whole of 2017, does it? Does that suggest a failure of that oversight mechanism of the contract compliance in relation to the GPs at Brook House in 2017?

A. No, I don't think it does. I think it further points to the interpretation of rule 35 at the time, across the whole estate, because what -- if, as you suggest, there was such a failing, I cannot see how the CQC, the NHS or Her Majesty's Inspectorate, none of them decided that there was a significant failing that required action in this matter.

They were also aware of the number of reports, as they were of the number of reports across the wider IRC estate, and I understand that the number that were quoted out of Brook House were not untypical.

In fact, in the wider use of rule 35, I believe that Brook House had more reports converted into detainees being released than anywhere else.

Q. You say, at paragraph 56, that any significant performance issues or complaints concerning GPs were referred to the company's medical director. Were there any complaints about Dr Oozeerally or Dr Chaudhary concerning rule 35 reports or the lack thereof?

A. Not that I am aware of in the relevant period.

Q. Was it picked up as a performance issue by senior

management at G4S Health Services?

A. As I reiterate, I don't believe it was picked up by anybody as being a failing.

Q. But it should have been by senior management, shouldn't it, they did bear some responsibility for those on the ground complying with their obligations under the rules?

You can't just blame it all on everyone else.

A. I am not blaming everyone else. I am trying to consider the environment, that if the way in which the rule at the time was interpreted was consistent with as was expected by the oversight bodies and as was expected and seen in the wider IRC estate, then why would we then seek to interpret it in a different way? It is clear that there was discussion about rule 35, and that Dr Oozeerally gave evidence talking about wanting to engage with the Home Office about rule 35, so there was clearly some issue and discussion around it.

So on the basis that there was issue and discussion around it, and that there was training which was subsequently provided in 2018, it is obvious there was engagement and there was real discussion happening. So in that sense, it would suggest that there was action and awareness.

As to exactly how that was being interpreted, and how that was being reported and whether that, therefore,

could create an inference that there was a failing, I am not sure that I can join the dots that create a failing from that, because there was so much talk around it. It is not like it was ignored, is what I am saying.

Q. But that didn't result in compliance with the rules; would you accept that?

A. As the rule is defined today, in 2022, and as it can be read --

Q. It has not changed, since 2017.

A. No, but we are now in version 7 of a document that was in version 4 in 2017, so there is clearly a lot gone on around the whole rule 35 thing and continues to be so, and the fact we have been talking about it for so long.

Q. But the wording of the rule remained the same in 2017 as it does now, and whatever discussion there was between senior management and any other body, it didn't result in compliance with the rules, did it, in 2017?

A. I think it is about the way in which the rule was being interpreted and implemented. I think, from what I could infer, that -- from Dr Oozeerally's evidence, as I saw it, he talked about the use of part C. Now, that may not have been appropriate, that may not have been in line with the rule, but that would appear to be the way in which he interpreted it in what he did.

Q. Do you think senior management in G4S Health Services

was aware of that practice at the time?

A. I couldn't conclusively evidence that to be the case. However, there was a close working relationship between G4S and DoctorPA and I would be surprised if they weren't aware of that.

Q. Sandra Calver gave evidence that, along with herself as head of healthcare, the Home Office bore some responsibility for failings within the rule 35 process, in that they had been aware of the practice being undertaken in Brook House through her involvement with the IRC forums, as you have alluded to.

Do you agree with her that the Home Office bears responsibility as well?

A. I think this is a complex matter and I think the lack of clarity has certainly -- it certainly didn't help.

Q. Sandra Calver gave evidence that, as a result of the lack of rule 35(2) reports being completed, she created a rule 35(2) pathway document, and that she brought that to the attention of the Home Office and IRC forum, who approved it. Was senior management at G4S Health Services aware of the use of that pathway at the time?

A. I can't evidence that to be the case but I would assume so.

Q. On what basis?

A. That Sandra has talked about it in the manner in which she did. And that she felt the need to create the document, to bring, again, consistency. It was obviously a point of discussion.

Q. She accepted in evidence that it didn't comply strictly with the rule because it built in a delay in reporting with a step of a nurse referral prior to a GP being seen seven days after the detainee was put on an ACDT.

Were you aware, as were G4S Health Services' senior management aware at the time, that that pathway didn't comply with the wording of the rule?

A. I don't know. But I think it is taking the rule strictly -- I can see how you suggest the pathway doesn't apply to the rule. However, if the individual is already on an ACDT, and is being -- or is under constant supervision, then I guess that, from what I can understand from the intent there was, was to understand whether the individual was at genuine risk of a suicide attempt.

And I don't think it was strictly seven days, was it? It was up to seven days. It was trying to assess the individual, from my reading of that, but my reading may be wrong and I may have misinterpreted it.

Q. Can I look at the use of force, please. At paragraph 172 of your witness statement, you deal with

the F213 form and that some forms were missing or not completed during the relevant period, and you speculated there as to the possible reasons for that.

Has G4S Health Services taken any steps to ascertain the actual reasons that they were missing or not completed at the time? Was there any investigation of that?

A. No, I don't believe there was.

I think we are -- of course, as we have said in there, we are five years on, and they are documents amongst many and, as I understand it, of all the documents requested by the inquiry in terms of the F213, less than ten were missing, so it wouldn't suggest that there was a serious issue of a complete lack of documentation.

Q. Has there been any audit of the use of force paperwork undertaken to ascertain if healthcare were completing the forms on all occasions?

A. I don't know, that would have been done by CJS.

Q. Or as to the quality of the entries?

A. Again, I don't know.

Q. Because isn't the healthcare aspect of those forms important and the responsibility of senior management of G4S Health Services, as opposed to Care and Justice?

A. The quality of all the documentation to do with health

is important. It is to do with an individual's welfare and, as such, of course it is important.

Q. So wasn't it important to audit the quality of those entries? The healthcare entry on the use of force form?

A. I am sure that the quality of all health documentation is important, and I would be surprised if it wasn't audited in some way, shape or form.

Q. In the minutes from a meeting on 27 October 2016, it was stated that rule 42s and 213s are still not being completed on all occasions; are you aware of what action G4S Health Services took as a result of that being minuted in that meeting in relation to a failure to complete the forms?

A. Sorry, October -- sorry, can you just repeat that?

Q. In the minutes of a meeting from 27 October 2016, it was stated that rule 40s, rule 42s and 213s are still not being completed all occasions; I was asking whether you were aware of any action taken by G4S Health Services in relation to the failure to complete those forms?

A. No, unfortunately, I wasn't around in 2016.

Q. And there is no documentation available as to what action, if any, was taken by G4S Health Services, as a result of it being recorded in a meeting that that was the case?

A. I don't remember reviewing documentation from 2016.

Q. Dr Oozeerally, on 27 May 2017, within the relevant period, completed a fitness-to-fly letter in relation to D1914, and in that letter he stated:

"The above detainee is fit to fly and fit for detention. He will need a medical escort due to the nature of his medical condition. I am happy for reasonable force to be used (C&R) in order to facilitate the removal."

Was the senior management of G4S Health Services aware of the practice of GPs in providing such letters to the Home Office in 2017?

A. I don't know the specifics of operational detail at that level.

Q. That would have been a concern at the time, wouldn't it?

A. In what way?

Q. Wouldn't it be important for senior management at G4S Health Services to be aware of the practice of GPs of completing such letters for the Home Office in relation to patients?

A. I don't know.

Q. Dr Oozeerally, as I have said, stated there that he was happy for reasonable force to be used, which, effectively, approves or sanctions the use of force on D1914 to effect his removal; would you agree?

A. That could be inferred from what you read.

Q. It certainly goes beyond expressing a concern or a contraindication, a reason not to use force, doesn't it? Yes?

A. Yes.

Q. Indeed he doesn't raise any concerns or contraindications, reasons not to use force.

Was senior management in G4S Health Services aware of that practice by GPs in 2017, that there was an effective approval of use of force on detainees?

A. I don't know.

Q. If they were, would that have been of concern?

A. I guess I don't understand the context in which the letter was written. I don't see what questions were asked and I don't know what he was responding to. So in the context in which you ask the question, yes, of course it is concerning; but, not understanding the wider context around why was that written in that way at that time with respect to that particular individual, I don't know.

Q. Have you reviewed the evidence of Dr Bingham and Dr Hard on this issue to this inquiry?

A. I can't bring it immediately to mind.

Q. They certainly said that this went beyond what was appropriate for a doctor and that here, Dr Oozeerally should have been raising concerns and contraindications

due to both his physical and mental health history. You were not aware of that?

A. No, obviously they are qualified doctors, providing medical opinions about another doctor. I haven't seen the detail. I don't know what detail they have seen to have reached that conclusion either.

Q. Are you aware of how many times the medical emergency hands off instruction was used by healthcare staff in 2017?

A. No.

Q. Why not? Was that not something you expect to be recorded?

A. I don't know whether it was recorded. I certainly haven't seen any registers as such. I am aware it was the action that was expected to be taken if there was a problem with use of force.

Q. There wasn't any audit of how many times and in what circumstances those instructions were required to be being used by healthcare staff in 2017?

A. I don't know.

Q. What action did senior management in G4S Health Services take to follow up on such an instruction, having been given during a use of force?

A. I understand that there would have been a debrief and a review.

Q. What action would senior management take as a result of that?
A. I don't know what specific action they would have taken. I don't know because I haven't got any record of it happening or what action would have been taken.
Q. Are you aware of any other support other than the debrief being offered to healthcare staff who were required to issue such instructions, at the time?
A. No, I do remember some reference to it in a document, but I don't recall the detail of that. I am sorry.
Q. How was G4S senior management learning lessons from such situations?
A. I don't know how senior management were learning lessons. Sandra Calver comes across to me as being a very credible and caring manager and I would have thought that, as the manager on site, and with the regular reviews of her staff and continual development of them, that there would have been discussion around those areas, and I think we probably saw it in some of the minutes of some of the staff meetings, about talking about a variety of issues.
Q. Was any training provided to healthcare staff about their particular role in a use of force by G4S Health Services?
A. I think this is an area that we relied on CJS to provide

training and insight into. As I recall from the information, that that is the way in which individuals would have been trained, would have been to have been trained by CJS.
Q. But they are not healthcare professionals with healthcare expertise, are they? How would they provide training to healthcare staff on their particular role in a use of force?
A. I don't know.
Q. In relation to the authorisation of use of force and the authorisation of removal from association under rule 40 and authorisation of temporary confinement under rule 42, what is your understanding of who was able to authorise those aspects under those rules?
A. I think, from my understanding, that rule 40 and rule 42 were enacted by CJS.
Q. The relevant DSO suggests that, in normal circumstances, use of rule 40 or of 42 must be authorised by a manager from the compliance team at the Home Office, but in cases of urgency in which it is impractical to seek authority from the Home Office, it could be done by G4S. And "urgency" was defined as, for example, "to protect life and/or the security of the centre, for example, a fight or an assault on another detained individual or member of staff."

As far as you are aware, at the time, was that what happened?
A. I haven't seen anything to the contrary.
Q. In what circumstances would it have been impractical to seek authorisation or authority from the Home Office?
A. I don't know. I am not aware of just how close and available the Home Office was to the day-to-day operation.
Q. Do you have an understanding of who would seek such an authority from the Home Office?
A. No.
Q. Was it your understanding that detention centre managers could authorise force, removal from association and temporary confinement under these rules?
A. As you have just read them, yes, I believe that to be the case, if there was a particular and immediate immediate.
Q. You state in your second witness statement, at paragraph 4, that three different organisations bid for the GP contract, and that the doctors to be provided by DoctorPA were the same doctors who were delivering services within Saxonbrook, so this provided for an element of consistency and continuity of service; is that right?
A. Yes.

Q. What other factors influenced you in choosing that bid? Or influenced G4S Health Services, I should say, at the time?
A. I wasn't there and I don't know the detail of the tender. I know there were two other organisations that tendered. I would imagine that there would have been a mix of factors which would have generated the decision.
Q. Such as?
A. I would imagine, in any tender of its type, there would be a blend of quality, capability and price considerations.
Q. The 2016 IMB report had raised issues about the rule 35 process in Brook House. At paragraph 5.4.10, they said:
"It is surprising that there are so few reports by GPs about detainees whose health is likely to be affected by continuing detention or suspecting that a detainee has suicidal intentions, given that reporting from G4S showed an average of 11 incidents of self-harm attempts per month in 2016."
So there we have an example of the IMB, in 2016, raising issues with the number of reports under rule 35, would you agree?
A. Yes.
Q. Did that, to your knowledge, raise any concerns within

G4S Health Services about giving the contract to the company owned by the two existing GPs in Brook House at that time?

A. I am not aware that it did, no, remembering those GPs were not just working in Brook House, but were working in the wider IRC estate.

Q. Should that have been a concern, in awarding them the contract, what the IMB have recorded there?

A. As I have said, I don't think, from what I have read and understood, that the practice was inconsistent with the practice in the wider IRC estate at the time. Whether it was right or not, obviously, we are discussing and I don't know, but if it was consistent with the wider practice in the wider IRC estate, then I am not sure why it would have been a cautionary point with regards to the appointment of the doctors.

Q. You mentioned earlier in your evidence that there was clearly a reliance upon the IMB not raising concerns, and we see that they did, in fact, raise concerns, didn't they?

A. They raised a note of surprise, didn't they, that that is somewhat short of raising a direct concern around the performance of the organisation.

Q. Are you aware of whether or not that note of surprise was raised at all with the GPs from DoctorPA Limited by

G4S Health Services at the time?

A. I have no evidence to suggest whether that was true or not. I would be very surprised if a report of that type wasn't raised in both the quality -- the quarterly quality meeting and the partnering meeting, especially with the wider attendance at the partnering meetings, but I haven't reviewed any minutes of any of those meetings to be able to confirm or deny that.

Q. At paragraph 120 of your first statement, in relation to the Lampard report, which reported on the nature of the nature of detainee complaints concerning healthcare, you stated that, "The company cannot respond to specific comments without knowledge of the detainees, their medical history or the context of the discussions."

Does G4S Health Services accept that there was any substance to detainee complaints about healthcare in 2017?

A. Sorry, can you repeat the question?

Q. Does G4S Health Services accept that there was any substance to detainees' complaints about healthcare in 2017?

A. From what I can understand, we took complaints seriously, and each complaint was reviewed by an independent reviewer, so it would seem that we were taking complaints seriously.

Q. On some of the footage we have seen, both on Panorama and on the unbroadcast footage, there was evidence of a mocking and derogatory attitude by some healthcare staff towards detainees who were unwell, particularly intoxicated with spice, and Sandra Calver certainly accepted in her evidence that those comments were inappropriate.

Was G4S Health Services senior management aware of that type of behaviour from some members of healthcare towards detainees in 2017?

A. I can't comment on whether it was aware. It was clearly unacceptable.

Q. Some formerly detained persons have given evidence to the inquiry of rude or dismissive or abusive attitudes by healthcare staff to them; do you have any comment upon that?

A. I think there is no place for unacceptable behaviour by healthcare staff in -- towards any patient. I think that the line that must be drawn, however, is the concept around dismissive or brusque; that could be regarding a style rather than an actual intent. So I think anything that is rude is -- and inappropriate, is completely unacceptable.

However, I think the inference about somebody who is busy, who is trying to do many things, appearing to be

brusque, is not, maybe, the best example of how you would hope that somebody would conduct themselves, but isn't necessarily a reference to their intent or ability to deliver a healthcare service.

Q. Did G4S Health Services, at the time, seek to investigate the nature of detainees' complaints to ascertain whether any action was needed at a systemic level?

A. I believe that the complaints were taken seriously and reviewed at quarterly complaints reviews in the quality meetings, so I would be very surprised if there wasn't a systematic and systemic review of those, but I have no evidence to prove that that would be the case.

Q. In a complaints audit undertaken by the company in 2020, it is recorded that the majority of complaints at Gatwick IRCs related to the failure to treat, with the second most common reason being staff attitude, and it stated, "Considering a complaint, do we actively listen, seek and act on feedback?" The report records no evidence that complaints were being reviewed at quality or board meetings.

Were complaints being reviewed at quality or board meetings?

A. If that is the view taken in the 2020 report, then, at that time, they cannot have been. Obviously, I don't

know whether that was the case in 2017. We obviously had a managing director in 2017, a different managing director in 2019, who, unfortunately, passed away, and we were on the third leadership at the time, so it may be something that was done and had passed. I know that following that report, a full review was taken of the complaints process and a number of items that have been brought up on that report have since been rectified and the whole complaints procedure across the business has been changed.

Q. The report says that there wasn't any formal collation of complaint outcomes and triangulation with patient safety and patient experience data; is that something that has changed now?

A. I believe so. That report does not make good reading. I believe that the only thing I took from reading that report was that, actually, Gatwick was probably the best performing of our establishments with regards to complaints.

Q. At paragraphs 21 and 22 of your statement, you deal with the root cause analysis investigation that was carried out following the Panorama programme, and you say that the company was required to submit a root cause analysis, which is an NHS-led document reporting tool designed to capture serious incidents:

"Its purpose is to demonstrate good governance and safety and to also demonstrate lessons learned."

The report was delayed, because of the ongoing police investigation, and you then say:

"Due to loss of knowledge, and healthcare's limited role in the police investigation (which was led primarily through CJS), the company is unable to say when clearance to proceed was given, but following this, Ms Hill was commissioned to conduct the required RCA investigation. However, following her departure from the company, it was identified that this did not appear to have been done."

Ms Hill, was she the director of nursing?

A. She was.

Q. Do you know when she was commissioned to undertake the RCA investigation?

A. No, I don't.

Q. What were her qualifications and experience?

A. I am afraid I don't know.

Q. She left the company in November 2018. She reported to Tom Tuppen(?), who was the managing director at the time; is that right?

A. That's correct.

Q. Why didn't he follow up on the RCA before she left; do you know?

A. No.

Q. The RCA was belatedly carried out by two other senior members of staff arbitration a report dated May 2019 was submitted.

Was that the only review carried out by G4S Health Services as a result of the Panorama programme?

A. I don't know. I do find it very surprising that Ms Hill didn't do the RCA, but obviously we cannot evidence it because we cannot find the document. So I don't know what other reviews may or may not have been undertaken.

Obviously, health services were involved in all of the activities in G4S with regards to reviewing the Panorama programme and actions afterwards.

Q. The RCA report found that contributory factors to the failure to treat detainees with respect and dignity included lack of attention to dignity and respect systemically across the IRC, and it identified root causes as staff cultural institutionalisation across the IRC more widely led to patients not being treated with dignity and respect. Staff were not supported to deliver safe and compassionate care. There was a failure of speaking up and reporting concerns or complaint systems and a dysfunctional atmosphere and culture that enabled bullying and blame systemically across the IRC.

Does the company accept the findings of the RCA?

A. The RCA was conducted in 2019 by two senior managers who I think were seeking to do -- well, the mode of the RCA took a much wider review of both the healthcare and the functioning of the IRC from what I can see through interviewing everybody. It is clear that its view about the wider IRC, and where it was, was an important observation and I believe action followed.

Q. The question was, does the company accept the findings of the RCA?

A. I think we accept the findings. I think it is in the context of it being an RCA that I struggle with.

Q. It went wider than just looking at the particular incidents?

A. Yes.

Q. But the findings were nevertheless accepted?

A. I believe so.

Q. What action was taken to address those contributory factors and root causes by the senior management of G4S Health Services as a result of that RCA?

A. I believe Mr Cook continued to work with Sandra regarding the outcomes, but, to be honest, I can't remember in detail.

Q. I want to look at staffing briefly. Did

G4S Health Services, in 2017, have any system in place for documenting and monitoring the staffing levels in healthcare in each separate institution?

A. They -- there is a document that has been submitted that showed the rostering by staff type in Tinsley and Brook House, if that is what you mean?

Q. Was there a system for auditing or monitoring the care and treatment received by detained people by agency nurses as opposed to permanent members of staff?

A. I don't believe so.

Q. In 2017, some nurses didn't have training on the role of a nurse during control & restraint because the instructors of those courses had been suspended or dismissed because of their conduct captured in the Panorama programme.

Did any review take place of whether those who had received that training from those people who had been suspended or dismissed take place to see if they needed repeat training?

A. I don't know, I do remember, from some minutes in October 2017, that the deputy director of the prison undertook some training with all of the healthcare staff.

Q. That was Steve Skitt, the deputy director; is that right?

A. I believe so.

Q. Was the deputy director sufficiently qualified to give that training, in your view, given he is not a qualified nurse or a use of force instructor?

A. I don't know. I think he was trying to fill a gap, because there was a gap, because of the people that had been suspended and left the organisation. And ...

Q. In relation to HMIP, the HMIP Service Improvement Plan, in 2017, made recommendations that there should be a health needs analysis and a centre health and wellbeing strategy.

Do you consider that there had been a failure by G4S to not already have identified that need previously?

A. I think the health needs analysis was conducted by the NHS. I think there had previously been a health needs analysis in 2015. I don't know what the expected frequency of a health needs analysis would be, I am afraid, in a medical setting.

Q. At paragraph 126 of your witness statement, you say that in relation to the oversight of healthcare at Brook House by HMIP:

"All healthcare actions from the HMIP inspections from 2016 and 2019 were completed."

Is that right?

A. I believe that is what I stated.

Q. In 2016, the HMIP report, at paragraph 1.71, stated that the rule 35 reports they reviewed did not provide an adequate safeguard for detainees with post-traumatic stress disorder and no formal assessment of PTSD had been carried out in any case. And a recommendation was made at paragraph 1.80 stating that, where a detainee claims that they had been tortured, the rule 35 report should include an assessment of PTSD.

Were you aware of that finding and recommendation?

A. Not in detail.

Q. On page 36, at paragraph 2.37 in that same report, it was stated that complaints about health services were submitted through the general centre system and forwarded to NHS England, which then returned them to healthcare for investigation. This compromised medical confidentiality and led to unnecessary delays in responses, so that some detainees had left before the responses arrived, and a recommendation was made in that regard, on the same page, at paragraph 2.42, stating that the healthcare complaint system should maintain medical confidentiality.

Were you aware of that finding and recommendation in the 2016 report?

A. Not in detail.

Q. On page 36 at paragraph 2.38, it was stated there was no

centre wellbeing strategy, but health promotion information was displayed in the health centre, largely in English:

"We were told that some information could be provided in other languages. There was no self-care and wellbeing guidance in the library in any language."

And a recommendation was made:

"Detainees who do not speak or read English well should have reasonable access to translated information about health services and health and wellbeing."

Were you aware of that?

A. Yes, I believe that we submitted a number of documents that were in a variety of languages.

Q. And as a result, some leaflets were published in other languages; is that right?

A. I believe so.

Q. Why had G4S Health Services not identified that as a need previously?

A. I don't know.

Q. It seems like a relatively obvious proposition that detainees should have access to information in a form they can understand, doesn't it?

A. I would accept that. I do believe that the main reliance was on translation services, in order to engage with detainees in their language, and I believe we used

two different translation services and that that was the primary way in which we ensured communication in an appropriate language.

Q. In relation to the statement that all actions from the 2016 report were completed, as you say at paragraph 126, they were assessed in the 2019 HMIP report.

On page 61, it was stated in relation to progress from recommendations from the previous report:

"Where a detainee claims they have been tortured, the rule 35 report should include an assessment of PTSD; where there is independent evidence of torture, the Home Office should only detain in very exceptional circumstances. Reasons for maintaining detention in such cases should be comprehensive."

And it was recorded, "Not achieved".

Were you aware of that?

A. That is in the 2019 report, I should say, yes.

Q. On page 61, it also stated:

"The healthcare complaints system should maintain medical confidentiality."

And it stated "Partially achieved".

Were you aware of that?

A. Yes.

Q. On page 62:

"Detainees who do not speak or read English well

should have reasonable access to translated information about health services and health and wellbeing."

Again, "partially achieved".

Again, in those circumstances, is it really correct to say, as you do at paragraph 126, that all actions from both reports have been completed?

A. Well, I guess, in terms of the last one, the company clearly didn't reach the level at which the IMB expected us to have reached in completing that.

However, as you have commented on, the company had completed leaflets and made sure that both translation services were available. I guess that that would be the company's interpretation at the time versus the expectation to meet the need.

Q. At paragraph 122 of your first statement, you say:

"Some detainees would seek to get fast tracked through the NHS to get on to a hospital waiting list for treatment, on the assumption that being on such a waiting list would prevent deportation until the treatment had been provided and/or seek to stay in the UK until the treatment had been provided."

Would there also have been occasions when there was a genuine need for the assessment and treatment of detainees?

A. Indeed, and I think the doctors were trying to meet the

need of the detainees as much as possible.

Q. On what evidence did you base the statement that they were seeking to get treatment solely to prevent or delay deportation?

A. I believe that would have been an assertion made from my inquiries with Sandra.

Q. In relation to complaints, serious matters for concern were raised with NHS England in terms of complaints. If a complaint was serious, it would be passed on to NHS England to investigate. Are you aware of how many there were, in 2017, passed to NHS England?

A. I don't think any were in 2017.

Q. Was there any policy to guide the use of the discretion about when there should be a referral of serious concerns by the head of healthcare to NHS England, what guidance was given as to the threshold.

A. I don't know.

Q. Was any training provided?

(Technical problem)

MS SIMCOCK: Chair, given we have to pause, that may be a good opportunity to have our afternoon short break.

THE CHAIR: Good idea.

MS SIMCOCK: Can I say 3.35, please?

THE CHAIR: Thank you very much. Thank you.

(3.20 pm)

(A short break)

(3.35 pm)

MS SIMCOCK: Thank you, Mr Dove, were you aware that when the clinical lead, Chrissie Williams, would conduct investigations into complaints in Brook House in 2017, that she wouldn't speak to the detained person that made the complaint, but would only speak to staff members?

A. No, I was not aware.

Q. And that she wouldn't always require any formal statement to be taken, only if it was a serious issue, were you aware of that in 2017?

A. No.

Q. Do you think that is an appropriate way to conduct complaints investigations?

A. I think, depending on the nature of the complaint, where, if it is a complaint that just requires the review of some documentation, or an approach, then it may be appropriate, but I can imagine, in many cases, that there would be a point at which speaking to the detained individual would be very useful.

But I don't know what the policy was at the time.

Q. In relation to Medical Justice, G4S Health Services received a number of clinical letters and medico-legal reports in relation to their clients in the relevant period. Do you know if G4S Health Services ever

responded to any of those to Medical Justice?
A. No, I don't know.
Q. Do you know if G4S Health Services ever approached Medical Justice as an organisation to discuss any aspect of the recurring issues that arose in those letters of medico-legal reports?
A. No, I don't know.
Q. If they didn't, would you have any knowledge of the reasons why they didn't?
A. No, I would have no knowledge at all.
Q. Brook House was, and indeed is, a closed institution, so, of course, Medical Justice wouldn't have any access to documentation at Brook House, including medical documentation, beyond the individual cases that they were involved in, would they?
A. I believe not.
Q. I just want to ask you what you mean, at paragraph 147 of your report, by saying the company would have welcomed such input, meaningful input, from external bodies, which would have improved effective oversight and governance, and it is disappointing that such bodies, in which you included Medical Justice, didn't provide any such meaningful input.
What input could they have given in the circumstances that would have been more meaningful than

what they were already doing?
A. I don't know.
Q. You say, at paragraph 155 of your statement, that there was a disconnect between Medical Justice statements on fitness for detention and observed behaviour of detainees; what do you mean by that?
A. I think that an opinion provided by Medical Justice wasn't consistent with the opinion provided by the doctors.
Q. Do you mean that, from their behaviour, detainees seemed well, but Medical Justice were reporting that they were unwell?
A. I am not sure that it is about well and unwell, is it? I think it is about fitness to detain -- somebody may not be completely well, but they could still be perfectly fit to be detained, is my understanding.
Q. You are not implying any level of dishonesty on the part of Medical Justice, are you --
A. No.
Q. -- or on the part of detainees --
A. No.
Q. -- that they were seeking to misuse the system?
A. No, I think it is about perception, isn't it, when something you perceive to be a bad headache or a bad problem may not be perceived to be a bad problem by

somebody else.
Q. I see. I just want to ask you, lastly, a couple of questions about E wing and the use of segregation.
You said in paragraph 161 of your statement that E wing and CSU were generally quieter due to having less people and they were therefore better suited for those requiring constant watch due to suicide or self-harm risk.
Did you understand that E wing was used for segregating violent detainees or refractory detainees and those resisting their removal?
A. That was certainly part of E wing, wasn't it?
Q. The inquiry has heard a considerable amount of evidence that E wing wasn't a very quiet place. Why did you consider that it was, given you weren't there at the time?
A. I understand that the wider IRC was very busy and very noisy. E wing was a much smaller facility with far less cells in it and far greater oversight from both the custodial services and the health services, and I believe that they also had better vision into the cells, such that it was a place that was better controlled, maybe not ideal, but probably the best option in the establishment as it was configured.
Q. Did G4S Health Services give consideration at a policy

level to the impact of segregation on a detainee with mental illness at the time?
A. I couldn't evidence whether they did or they didn't.
Q. Does healthcare have a responsibility to assess the likely impact of being in CSU on a detained person, as far as you are concerned?
A. I think that healthcare has got to be concerned and medical professionals are, in my experience, extremely concerned about the wellbeing of individuals.
I guess it is the choices that have to be made about what the best balanced options are in the environments in which they exist and, thus, although not ideal, my understanding is that the decisions were made on the basis that E wing was a better option than leaving individuals out in the wider establishment, which could be noisy, busy, and not necessarily have the oversight you would hope for for the individual.
Q. What was your understanding of the role of a GP under rules 40 and 42 in relation to removal from association and temporary confinement?
A. I am not sure the GP had a role in rule 40 and 42.
Q. Well, rule 47 says:
"The manager may arrange, at his discretion, for such a detained person as aforesaid to resume association with other detained persons and shall do so

if, in any case, the medical practitioner so advises on medical grounds."

That was a role of a GP, wasn't it?

A. Yes.

Q. And under subsection 9:

"The manager, the medical practitioner and, at a contracted-out detention centre, an officer of the Secretary of State, shall visit all detained persons who have been removed from association at least once each day for as long as they remain so removed."

So a medical practitioner had to visit every day if a person was on rule 40. Again, that is a rule particular to a GP in an IRC, isn't it?

A. Yes.

Q. The purpose of those visits and there is a similar provision under rule 42 was to ensure the detained person's welfare, so a safeguarding role, would you agree?

A. Yes.

Q. How was G4S Health Services senior management monitoring whether the GPs in Brook House were fulfilling that safeguarding of the detainees' welfare under those rules in 2017?

A. I don't know. However, I do know there were daily meetings between healthcare and the doctors. I would

have assumed it was covered in that.

MS SIMCOCK: Thank you. Chair, I have no further questions for this witness. Do you have any questions?

THE CHAIR: Thank you very much, Ms Simcock.

I have no questions for you, Mr Dove. Thank you for coming to give your evidence today. I appreciate it.

A. Thank you very much.

MS SIMCOCK: Chair, we are going to do a quick change over, given the time and that we have already had our afternoon break, so if Mr Dove can step down and we will proceed with the next witness, who is Luke Wells.

THE CHAIR: Thank you.

MR LUKE ANDREW WELLS (affirmed)

Examination by MS SIMCOCK

THE CHAIR: Please take a seat, Mr Wells, thank you.

MS SIMCOCK: Thank you. Can you give your full name to the inquiry, please?

A. Yes, it is Luke Andrew Wells.

Q. Mr Wells, you have made a statement for the purposes of the inquiry, which is at <PPG000169>, and I am going to ask that that statement is adduced in full. What that means is that I do not have to take you to every line of your statement or everything in it, but I am going to ask you some questions about particular topics for your evidence on them.

First of all, what is your role at PPG?

A. So I am the service director for our health industry service line.

Q. What does that role entail?

A. Ultimately, responsible for the operations of the services that we have got across England, so we run healthcare in 50 prisons and immigration removal centres or places of secure -- secure environments.

Q. Who do you report to?

A. I report to the managing director for our primary care business.

Q. And he reports, I think, to the chief executive?

A. That's correct.

Q. In the context of the IRCs at Gatwick, you line manage, I think, the regional director for the south region of which that service forms a part; is that right?

A. That's correct.

Q. You say that you have worked in the Health in Justice sector since 2007, and have held a number of management and leadership roles during this time. Just very briefly, what type of roles have you had over that period of time?

A. So all operational roles, so heading up services, regional management roles, regional director roles and, more latterly, my current role as service director.

Q. You say you joined PPG in June 2016, and you commenced in your current role in January 2021; is that right?

A. That's correct.

Q. Can you just briefly explain what PPG, as a company, experience is of working in IRCs as opposed to prisons?

A. We have had some previous experience of working within immigration removal centres. They're not particularly services that I have personally been involved in before, but I believe the Verne was previously an immigration removal centre before it became a prison and Campsfield House, I think, was another.

Q. Thank you. As you say, you have, as a company, greater experience previously in relation to healthcare in prisons; is that right?

A. That's correct.

Q. Would you accept that an IRC operates a different detention environment to a prison because detainees in an IRC are not there by order of a court, but, rather, because of an administrative power being exercised by the Home Office?

A. Yes, that's correct. There are obviously some similarities between the two environments. But they are -- they do serve a different purpose, yes.

Q. And of course, there is no time limit to immigration detention in contrast to that in prisons; is that right?

A. In most instances, yes.
Q. So the role of healthcare in an IRC is, therefore, not just to provide primary healthcare to detainees, but also to provide important clinical safeguards which identify who is vulnerable to harm in detention and to notify the Home Office of those people, so that their continued detention can be promptly reviewed and that they might be removed from detention; is that right?
A. That's correct.
Q. You, in terms of the company, were reliant upon the existing healthcare staff transferring over from G4S Health Services to PPG when you took over the contract in relation to Brook House; is that right?
A. So, for staff that are specifically delivering service on the ground, yes, largely that is the case, supported by a team of bank and agency staff as well.
Q. At paragraph 9 of your witness statement, you say:
"The most senior individual employed by PPG based at the IRC in Gatwick is the head of healthcare ... who is also the CQC registered manager responsible for the service. This individual holds primary responsibility for the running of the service and partnership working with the operator and the Home Office, taking the lead on local meetings and daily briefings."
Is that right?

A. Correct.
Q. That was -- as it was in 2017, that is now Sandra Calver; is that right?
A. Yes.
Q. And so she holds primary responsibility for making sure that PPG complies with the safeguards required to be operated in Brook House; is that right?
A. Yes, not in isolation, so there is obviously a team that support her with that, but, yes, primarily speaking, on a day-to-day basis, that would be Sandra.
Q. In relation to the GPs, DoctorPA Limited, who PPG subcontracts to provide primary care services, those are the same now as they were in 2017, Dr Oozeerally and Dr Chaudhary; is that right?
A. That's correct. They don't -- they only provide the GP part of the primary care service, though. The rest of it would be provided directly by our employed nurses.
Q. You say in your statements that you are transitioning away from subcontracting to DoctorPA Limited to a mixture of both subcontracted and employed doctors; is that right?
A. Yes, so I think the intention is to take a phased approach to this, whereby, over time, we would reduce the involvement of DoctorPA within these services, with an aim to eventually run the services with full-time,

employed GPs.
Q. But, at the moment, they are still the subcontracted GP service; is that right?
A. That's correct.
Q. And, as you say, you will take a phased approach to, first of all, employing some GPs but also subcontracting to them?
A. Yes, that's correct.
Q. Just pausing there, for a moment, what are the reasons for moving towards employing GPs directly rather than subcontracting that service, what are the benefits to doing that?
A. I think, organisationally, that is always our preference. I think we tend to find that GPs that we employ directly can, at times, be more engaged with services, they certainly feel more embedded at times with the team. I also think it helps us in terms of supporting their professional development, we invest heavily in our GP workforce, so, when it comes to things like training, it offers us a greater flexibility to support them with that.
Q. I see. But, currently, at any rate, and for the immediate foreseeable future, the current arrangements for healthcare provision by PPG have been informed by both Sandra Calver, as head of healthcare, and by

Drs Oozeerally and Chaudhary as DoctorPA Limited; is that right?
A. That's correct.
Q. The inquiry has heard evidence from the three of them. Did you hear their evidence?
A. I have heard Sandra Calver's evidence, but I didn't hear either of the GP evidence.
Q. Why not?
A. Largely because, when we originally were invited to give evidence, we decided to split down our evidence, so I am here for more of an operational perspective and my colleague Dr Sarah Bromley(?) is here from more of a medical perspective, so it felt more suitable that we divvy out the evidence -- observing the evidence --
Q. So if there are --
A. -- on this (overspeaking).
Q. -- points that come directly out of their evidence that you cannot answer, then she will be able to answer those for us?
A. Hopefully so, yes.
Q. Does -- given you have heard the evidence of Sandra Calver, does her evidence cause you any concern on the part of PPG about her continuation as head of healthcare at all?
A. No, I think it is clear from Sandra Calver's evidence

that there is some work that needs to be done, certainly around things such as rule 35. However, as an individual, I believe Sandra Calver is a registered clinician. We have had no concerns in terms of her professional practice. She appears, from what we have known of her for a very short period of time, to be quite caring and compassionate and seeks to do the right thing in the interests of our patient group.

Q. You have confidence in her to fulfil her obligations and responsibilities in relation to her role in Brook House?

A. Yes, I think, obviously, with training and support -- for additional training and support from the wider PPG organisation.

Q. You -- yes, so let's look at, please, then, rules 34 and 35 of the Detention Centre Rules. Are you aware of the content of those rules?

A. Yes.

Q. Rule 34 requires a physical and mental examination, used to identify vulnerabilities in detainees and it could, and should, result in a rule 35 report, where appropriate, so that the Home Office is notified promptly, at the outset of detention, of those vulnerabilities and that detained person's detention reviewed. Is that your understanding of the rule?

A. Correct.

Q. That is particularly important as a rule because the Home Office doesn't have any pre-detention medical screening tool to identify vulnerabilities before detaining a detained person; would you agree with that?

A. Largely speaking, the Home Office may not. We may sometimes have prior information based on -- depending on where the detainees come from. So, for example, if they are transferred from prison, their prison healthcare records will transfer with them, so we may have more background information than the Home Office would.

Q. That information would help to inform you in the rule 34 process of vulnerabilities as being the first opportunity for assessing those vulnerabilities in immigration detention; is that right?

A. Yes, that information would be readily available to the GPs undertaking those assessments and the nurses who do the initial screening.

Q. So as a rule, it is, therefore, vital in functioning effectively so that people particularly at risk of being harmed in detention can be identified and removed from detention, where appropriate, at the outset, at that first arrival into detention. Is that your understanding?

A. That is, I think, the intention. What I would say is

I think the notion that to carry out an assessment on somebody within their first 24 hours when they are likely to be very vulnerable, very emotional and have a lack of -- a lack of trust, really, in people of authority, I would suggest that is quite a difficult assessment to do in such an early point in which somebody has been detained, but, yes, I understand that is the purpose and that was the thinking behind the rule being written.

Q. Yes. You will be aware from listening to Sandra Calver's evidence but we heard from her that the GP appointments carried out within the first 24 hours were, at the time, five minutes long and are now ten minutes long, and that that really is not enough time to do a fully-compliant rule 34 medical examination, which requires a full physical and mental examination. Would you agree with that?

A. I think it is a very difficult question to fully answer. I think the wording of the rule is not very specific around the extent to which an assessment is required. So, for example, for a mental health assessment, that could involve a whole hour's appointment with the psychiatrist, for example, that is one extreme, so I think it is unclear and I think it is fair to have heard evidence over the last few days that there is

a bit of a lack of understanding around the purpose of rule 34.

Q. Dr Oozeerally also said in his evidence that it was not possible to do the sort of physical and mental state examination required at that initial GP appointment and he described it as being really only triage. Would you agree with that?

A. Yes, I would, yes.

Q. And he gave evidence that if there had been a disclosure, for example, of torture in that initial appointment, or something else raised, which meant there should be consideration of a rule 35 report, instead of completing a report immediately, which he wasn't doing, and indeed isn't doing, a further, longer appointment was made, sometimes some time later, and that that built in some delay. Would you agree that that is the practice even now in Brook House in relation to that initial rule 34 and then further rule 35 assessment?

A. Yes, that's correct.

Q. So given the importance that you have agreed of the rule 34 examination in leading to a rule 35 report, where appropriate, in that it is to screen people out of detention by notifying them to the Home Office of their vulnerability, why is it that there is insufficient provision made to ensure that rule 34 can be properly

complied with, so that a rule 34 -- rule 35 report can be done immediately as a result of that appointment?

A. So I think our understanding previously would have been that the spirit of rule 34 was around identifying immediate risk and then ensuring that there is follow-up action to be taken.

I think, when you consider the evidence of Dr Hard, whereby he stated that these would need to be significantly longer appointments, at the moment, within the service, we would not have the capacity to do that to any great extent, so I think, operationally, we are trying to make the best we can of the safeguards we have got within the resources available to us.

Q. Those initial appointments, as Dr Oozeerally confirmed in his evidence, are clearly not leading to rule 35 reports directly as a result of those first appointments. Do you accept that at least one reason for that is that they are so short? It is simply not possible to complete the examination and a report within a ten-minute appointment?

A. I am not sure I completely agree with that. I think, for me, there is clearly learning to be done around rule 35, and I think, with better education and understanding around rule 35, whilst the current process may not be ideal, it would still serve a purpose, given,

as I have already said, the context of the resources available to us and the volume of patients that we would be required to see.

Q. But it does build in delay, doesn't it? The Home Office are certainly not being informed, at the outset of detention, about these people; they are continuing to be detained because their detention is not being reviewed, there are effectively delays built in to those arrangements, aren't there?

A. Yes, so a follow-up rule 35 appointment would be roughly two days, so I accept that creates an element of delay. But, as I mentioned before, I think, to some degree, there is also some benefit in having a slight time lag between people arriving and that assessment taking place, if needs be, because it allows you to try and build up a greater level of trust with the individual so you get a more open and honest and transparent consultation.

Q. That might occur in some cases, but there is at least also the possibility, isn't there, as the rules are designed to prevent, that someone remains in detention and deteriorates during that time, isn't there?

A. Yeah, that is absolutely possible and there are other safeguards in place to try and identify those individuals and make sure we manage them as best we can

within the constraints of the service.

Q. So it is still a case of trying to manage those people in detention, as opposed to using the statutory mechanism to have their detention reviewed by the Home Office; is that right?

A. Yes, I think it is around the delivery of healthcare rather than just the Home Office process, that's correct.

Q. Is the Home Office aware from PPG that only ten minutes are allocated to those rule 34 appointments?

A. I could neither confirm nor deny what they are or are not aware of. My understanding is they are very closely involved with the service, so I would be very surprised if they didn't, but that would probably need to be a question for the Home Office.

Q. Have you raised with them that those appointments are only ten minutes and, therefore, cannot comply with the rule 34 full mental and physical examination, potentially leading to a rule 35 report?

A. No, I personally haven't, no.

Q. Have they ever raised any concerns with you or PPG, to your knowledge, about the length or the provision generally of those appointments?

A. I don't believe so, no.

Q. Are you taking any steps to allow for more time to be

afforded to those initial appointments?

A. So we are currently in the process of undertaking a review of our pathway for rule 35. So that is a piece of work that will take place in April.

Obviously, from that, we will make decisions around what we need to do if we need to extend those appointments, and that may need to be a conversation that we have with NHS England as our commissioning body.

Q. Yes, because PPG subcontracts the GP services to DoctorPA Limited, so it would be within PPG's power to obtain more resources from them, in terms of either the time the GPs who are there are using to undertake those appointments or to require more GPs to carry out the service?

A. So I believe there is scope within the contract for us to negotiate around the amount of time that the doctors would spend on site, yes.

Q. Has there been any review of the contract in order to make compliance with rule 35 and 34 something that is front and centre in the contract in terms of being a KPI or having penalties applied if those rules are not complied with?

A. So, at this stage, no. We are seeking to engage with DoctorPA, so, as I said, there is a workshop that Dr Bromley will be chairing in April. DoctorPA have

been invited to attend that, so we would like to use some of their knowledge as well, in terms of informing our pathway and our processes, in order to develop a PPG, I suppose, operating procedure, really, around rule 34 and rule 35. Once that piece of work has been conducted, then, if needs be, we can review the contract with DoctorPA, yes, but I think we would seek to work in the spirit of partnership with them and try to work and educate them rather than impose financial penalties.

Q. Has there been, or is there intended to be, any review as to whether DoctorPA Limited, in the form of Drs Oozeerally and Chaudhary should retain the contract and should continue to be working at Brook House at all?

A. At this stage, no. As I said, we would seek to work with the doctors involved. I think it is fair to say -- as I said, there has been quite widespread misunderstandings, shall we say, around the application of those particular rules and, therefore, I think we need to seek and clarify a PPG position first, and then, you know, have very clear expectations with the doctors that work in the service that they would be expected to follow up those processes.

Q. You mentioned that there is going to be a phasing out of the subcontracting services. In relation to the individuals, though, Dr Oozeerally and Dr Chaudhary, is

there consideration being given to employing them directly in PPG, in the future, in Brook House?

A. So my understanding is that we would have explored that option with both GPs prior to the service going live. I don't believe that that was something that they were keen to explore further with us.

Q. I see. In relation to rule 35, Sandra Calver accepted in her evidence that, in 2017, she had a misunderstanding of the thresholds to be applied under rule 35(1) and rule 35(2) and that she was applying too high a threshold. She gave some evidence that she had thought that a rule 35(2) report was a report stating a detainee was severely suicidal and not suitable for detention. She accepted that that threshold could be risky and potentially dangerous and wasn't in accordance with the rule. Were you aware of that?

A. Of her evidence, yes.

Q. She also thought that a rule 35(1) report was a report stating a detainee had a severe or unstable medical condition, which meant they were not suitable for detention.

She gave evidence that she, and indeed her staff, didn't have a good understanding of rule 35(1) and (2) and that that was a significant gap in knowledge, both then, in 2017, and now.

Were you aware of that?

A. Well, I was, at the point at which that evidence was given. I wasn't aware of that previously.

Q. That is a concern, isn't it, if it is still a continuing situation?

A. Yes, and, as I said, that is why we have put in place plans to mitigate that risk. So, organisationally, we want to take an organisational position rather than this be based on the experience of one or two individuals.

I think, as I said, it does appear, from having conversations with Sandra and other IRC heads of healthcare, that there is a broad lack of understanding around this, so I think we would also be seeking to work with the Home Office to understand what their expectations are.

Q. In circumstances where rule 35(2) reports were not being completed in Brook House, she drafted the G4S pathway for rule 35(2) that didn't meet the technical requirements of rule 35(2) because it built in an extra step of a nurse and a delay.

That pathway, we understand, from PPG's witness statement evidence is still in place in Brook House. Does that concern you?

A. Yes, it is of concern, but I think it is also important to set the context for this service. So, as you know,

this service went live with PPG on 1 September. The service has been declared an outbreak by the UK HSA throughout that period of time, which means our ability to access the site has been somewhat limited, and it also means that, unfortunately, staff have had to take up some extra responsibilities caring for those patients who are -- could be positive, and the extra monitoring involved, and plus the mass testing events.

So I think this is not, probably, our standard approach to mobilisation, I would suggest. So I would've really expected us to have been working through some of these issues earlier than we are at the moment, but, I think, nonetheless, as I said, we do have plans in place to work to address this.

I also think the priority was also around ensuring that we enhanced the service offering as well, so Dr Hard gave some evidence, didn't he, around the conflict around delivering healthcare and managing some of those processes and I think, organisationally, probably, our focus was on looking at the healthcare side and improving the offering in terms of things like mental health and additional ancillary services.

Q. Do you accept that the clinical safeguards that operate under the rules are as, if not more, important than the provision of primary healthcare in an IRC because of

their role in safeguarding vulnerable detainees by rooting them out of detention where they are likely to be harmed by detention?

A. I wouldn't say they are more important, because I think, if you are running a service that purely only manages risk and isn't effectively treating people, then it is reasonable to assume that people will deteriorate; therefore, that is not good for their health either. So I think both need to be taken in equal measure.

Q. What action does PPG intend to take, in particular in relation to the rule 35(2) pathway drafted by Sandra Calver?

A. The purpose of the workshop is to agree what our pathways will be going forward. So a new policy will be written around that. That will be a national policy and we will expect the service (inaudible) at Gatwick to be compliant with that policy.

Q. Is there a need for a pathway when the rules are clear themselves, the rules require notification under the three different limbs when the threshold is met?

A. So yes, I think there is a need for a pathway, and the reason for that is that rule 35 -- you know, the process, itself, is probably more simple, but actually, as we have heard in evidence, it requires staff identifying patients and making the GPs aware of them,

so this is not just about a simple process with the Home Office, it is about trying to change a culture and change the attitude and beliefs of the people that work in the wider service.

Q. Sandra Calver accepted that there was a failing in relation to the safeguards in two different respects: firstly, that nurses clearly were applying the too high a threshold that she accepted, so that they were not referring detainees to the GPs when -- for consideration of rule 35(1) and (2) reports; and she also said that, even when referred, or when GPs were seeing patients and the threshold was met, the GPs simply were not completing rule 35(1) reports, or only on very rare occasions, or rule 35(2) reports, we know, at all, in 2017, and indeed since.

She had tried to ensure with the GPs that they were completing rule 35(2) reports, partly through the pathway and -- but they simply weren't.

We know from your colleague Sarah Bromley's statement that rule 35(2)s are still not being done and there are very few rule 35(1)s. Only one in September -- from September 2021 to January 2022.

So this failure in the safeguards remains a significant concern at present, doesn't it?

A. I would agree, yes.

Q. You have talked about developing the pathways in order -- and liaising with the Home Office in order to address this issue. Is there anything else that PPG is doing to ensure that reports are being completed when they should be under the rules, in circumstances where, even up to January of this year, they are not being?

A. So I think, once the pathway is agreed and is formalised -- and we are not a particularly bureaucratic organisation, so that shouldn't take a significant amount of time -- we are quite confident, after the workshops are held, that can be written up. The expectation would be that that would be audited so that we can ensure compliance.

Q. And audited how and by whom?

A. Primarily, audits would be undertaken by the site. But I think, given the significance of the rule 35 and the level of scrutiny it has come under, then it may well be that we decide to audit that at a regional level with the regional medical lead who is a GP responsible for GP services within that region.

Q. In paragraph 15 of your first witness statement, you say that provision is made for two rule 35 appointments per day, then that is over and above the provision that PPG has made for primary care services.

Do you consider that to be sufficient provision?

A. I think that decision has been based on the previous ways of working and interpreting those rules. It may well be that we do need to review that following the outcome of the workshop and understand what provision needs to be ring-fenced for rule 35.

Q. Yes, because it doesn't take account, does it, that every detainee should have a rule 34 appointment for a physical and mental examination within 24 hours of arrival, which could, and should, if appropriate, lead to a rule 35 report?

A. Yes, the rule 34 appointments will be separate to that, so that is not included within those appointments.

Q. What provision is there going to be for rule 34 appointments that could, and should, lead to a rule 35 report, if appropriate?

A. So rule 34s are seen currently within the 24 hours.

Q. But, again, is the intention still only to afford every detainee a ten-minute appointment going forward?

A. I think we need to seek further clarity from the Home Office before making a commitment around what level of resource that would require.

Q. Because that is not enough time, is it, to complete a rule 35 report, if appropriate, it still would build in the delay for a further longer appointment to be booked at a later date within those two appointments per

day?
A. Yes, I think the challenge is what is practical as well, so, obviously, not every patient that is reviewed under rule 34 will need a rule 35. Therefore, it is an ineffective use of a GP's time for a rule -- or an appointment length that would facilitate a rule 35 appointment to be offered to every single individual and that, I think, is the balance that we are trying to understand and work through.
Q. Would you agree that a high proportion of detainees in immigration detention have clinically significant levels of depression, PTSD and anxiety as Dr Bingham gave evidence about?
A. Yes.
Q. And are you aware that PTSD is frequently linked with a history of torture or other forms of serious ill-treatment?
A. Yes, I am.
Q. Would you agree that detention is likely to precipitate significant deterioration of mental health in the majority of cases?
A. I would have to be led by experts in that area but it seems reasonable to me that detention could pose as a trigger for patients who have a diagnosis of PTSD, yes.

Q. And detention can also, for example, increase self-harm and suicidal ideation?
A. Yes.
Q. Given the high prevalence of people with PTSD and of people who are likely to have a history of torture, and who are therefore likely to be harmed in detention, their prompt identification to the Home Office is essential?
A. Yes. I would agree.
Q. Because prompt identification can lead to rule 35, which might -- may lead to their release from detention?
A. Yes.
Q. Dr Oozeerally gave some evidence that there are currently delays in getting through the number of rule 35 reports that need to be done and there is a waiting list.
He said there was only one rule 35 appointment a day. Can you account for the discrepancy between that evidence and the two appointments you say are available a day?
A. So in preparing my evidence, I consulted Sandra Calver, who is the head of healthcare and responsible for that service, and the regional manager, and they were very clear with me that it was two appointments a day. However, I am very happy to go back and investigate that

further and report back to the inquiry.
Q. Thank you. Would you accept, though, that whether it is one or two appointments a day, given the prevalence of the conditions we have just talked about and their link with vulnerabilities and, therefore, the necessity for the safeguards to apply, that that is likely to be inadequate provision going forwards, in terms of rule 35 appointments?
A. Yes, as we discussed, there are certain elements of the rule 35 that appear to be non-compliant at this moment in time. Therefore, that may increase demand for that particular part of the service.
Q. Yes. Were you aware of the IMB report of 2021 that reported on the year from January 2020 to December 2020?
A. I have seen that report, yes.
Q. Appreciating that that was before PPG took over the contract because you started, as you said, in September 2021, it would have been important for PPG to understand what the situation had been in the period prior to taking over, wouldn't it?
A. Yes.
Q. That report described the lack of any rule 35(2) reports to be puzzling in the light of the scale of self-harm and suicide threats made during the latter part of 2020, when there were compressed charter flights and the IMB

said, "We cannot reconcile the evidence of frequent suicidal ideation with there being absolutely no rule 35(2) reports". You would agree that is of significant concern?
A. I would agree that is of significant concern, yes. I don't believe that IMB report was made available to us as part of the tendering process, though, so normally you would receive a health needs analysis that is commissioned by NHS England that would indicate the current level of provision and gaps in service provision. I can't absolutely categorically state, but, from memory, I don't recall any documentation to suggest that that provision was inadequate at the point at which we were tendering for the service.
Q. PPG statistics on ACDTs indicate that 73 were opened with 45 on a constant watch for the period of September 2021 to December 2021.
So that is since PPG took over, were you aware of that?
A. I wasn't aware of that, no.
Q. Would you accept, as Sandra Calver did, that someone being on a constant watch indicates that there is a high risk of suicide?
A. Absolutely, yes.
Q. And clearly, there were still no rule 35(2) reports in

that period -- so in the period from September 2021 to December 2021 -- despite the 45 constant watch ACDTs.

Dr Oozeerally, as I have mentioned, gave evidence that he is still not completing rule 35(2) reports, and he gave evidence now over two weeks ago. Has PPG taken any steps immediately to address that discrepancy?

A. No, I think we took a conscious decision that we wanted to ensure that we had a full and robust process and policy in place rather than just making an immediate snap decision to put something right. As I said, I think this is about a whole system approach review rather than just putting in place, for want of a better phrase, a sticking plaster over an issue.

Q. Isn't the risk of that, though, Mr Wells, that detainees are remaining in detention with suicidal ideation, meaning the threshold for a rule 35(2) report has been reached but hasn't been completed, exposing them to a risk of further harm in detention because their case has not been notified and, therefore, reviewed by the Home Office?

A. I accept that, and I think, as I said, the lack of rule 35 doesn't necessarily mean that they are not receiving any healthcare provision or any treatment, but in terms of their detention or their potential release from detention, that is currently a gap that we are

seeking to address.

Q. At paragraph 32 of your witness statement, you say:

"Due to the nature of how IRCs operate, high volumes of patients arriving at once, especially during the night, can place a strain on staffing levels, however we have in place appropriate mechanisms to support our staff during such peak periods of demand by utilising a shortened version of the initial reception screen."

Again, in relation to that, isn't there a greater risk that that will contribute to further delays in identifying vulnerabilities.

A. No, I don't believe so. I think there are a couple of observations on that particular point. Firstly, since we took over the service, we have actually increased the staffing on a night from that of the previous profile so we have an additional nurse that works over at Tinsley House.

So I think, largely speaking, the rule 34 nurse assessment would be done still within a couple of hours, but it may not meet the initial two-hour threshold, which is why we would want to do an immediate safety risk to ensure that patients are as safe as they can be in the interim.

Q. The IMB, in their 2021 report, also said that, in September, the board asked the Home Office if there

would be provision for extra mental health resource, which could allow focus on preventative measures to alleviate stress and anxiety. The response, in other words, from the Home Office, was that healthcare staff had not requested any additional resource. Does your existing contract allow you to ask for more resources if you need them?

A. So we can ask for more resources if we need them, yes. That would be via NHS England rather than the Home Office because they are responsible for commissioning and funding the provision of healthcare, but what I would say is I think our model is different from the model that was previously on offer under the previous provider and I think we have already built into that an element of delivering proactive healthcare, so things, for example, such as talking therapies, our Making Sense Programme, which is a trauma-informed programme aiming to support people with low-level anxiety, managing low-level mental health conditions. So I think we have already made provision for that within our existing contract, but if we felt that that was not sufficient, then we would engage in a conversation with NHS England to explore that further.

Q. What about exploring further resource for the rule 34 and 35 appointments in circumstances where reports still

are not being completed under two limbs of the rule in circumstances where there are high-levels of self-harm and suicidal ideation?

A. So that may well be a route that we need to take. I think, obviously, we are conscious of use of the public purse and we would look to seek to understand what else we could do to redesign our services to accommodate that. So, for example, I do believe that there is more that the nursing team could do to take some of the workload away from the GPs. We also have a nurse that is undergoing advanced clinical practice, so we will be able to deliver a significant chunk of what currently sits with the GP. So it may be that we can reconfigure some of our existing services, but if we have reached the point whereby the service is no longer tenable in that regard, then we would be having conversations with NHS England about that.

Q. I appreciate freeing up GP time by transferring some duties to nurses may assist in GPs doing rule 34 and rule 35 appointments, but nurses certainly cannot take that responsibility under the rules, can they?

A. No, not currently, so that would still have to be done by the GPs. It is more around the delivery of what we would call routine healthcare or primary healthcare.

Q. The period that the IMB was reporting on in their 2021

report was at a time when there were substantially fewer detained people at Brook House. In quarter 3 in 2020, there were 339 detained persons, and in quarter 4, 254; whereas, in 2021, in the same period, there were 574 and 464 detainees respectively.

Again, the problems are likely to be compounded, are they, with greater numbers of detained people in Brook House?

A. Yes, absolutely. That is common sense really. I think what we would say is our experience of the service thus far has been on a significantly lower operational -- not capacity, I can't think of the word I am looking for, but the role, in essence, has been lower. Therefore, that has been our experience thus far, but we are very adapt to changing services when the need arises. So, for example, if a -- a change of purpose in two of our prisons, for example, where courts have been closed and we have had to take significantly more new arrivals, we have the ability to amend our services at relatively short notice.

Q. Is that also a consideration that PPG are planning to review the allocation of resources to the rule 35 process, given an uptake in the number of detainees?

A. Yes, so as part of our modelling, as I have said, I think we need to understand the process that we are

endorsing, first of all, in conjunction with the Home Office, and then we would need to look at what level of resource would be needed to meet the service demand in that area, both now and as the service continues to grow.

Q. The IMB also noted that there were examples, in 2020, of removals whilst detainees were in a state of distress or injury following self-harm, which the IMB called inhumane and put detainees at further risk, and they also criticised the absence of any arrangements for briefings from healthcare to the Home Office about those most vulnerable detainees.

Were you aware of that in that report?

A. I had seen it in that report. I wasn't aware of it being an issue prior.

Q. Are there now arrangements for such briefings from healthcare to the Home Office about those types of vulnerable detainees?

A. I can't answer that, unfortunately, I am not sure. Again, I would be happy to report back to the inquiry on that particular matter. I only received the IMB report quite recently, so I have not had a chance to explore that further.

Q. We would be very grateful. In relation to use of force, the IMB report also expressed concerns about the high

incidence of use of force being used to deal with incidents of self-harm. Were you aware of that?

A. Yes.

Q. And they also noted proportionately large numbers of the use of rule 40 and constant watch to manage vulnerable detainees; were you aware of that?

A. Yes.

Q. Sandra Calver confirmed in her evidence that use of force is still used for relocation of detainees to E wing and segregation is still used for managing mental health issues, suicide risk and for detainees on a constant watch, and there is no clinical risk assessment for those not going to the CSU but going to segregation on E wing.

Are those matters for concern for PPG?

A. They are, yes. I think warrant further exploration, yes.

Q. Use of force risks exacerbating and damaging further the mental health of a vulnerable detainee; do you agree that use of force shouldn't be occurring in relation to vulnerable detainees unless it is immediately to prevent a risk to life?

A. I think if it is a planned use of force, then there should be a discussion that is held in conjunction with healthcare so that the centre management can make

a decision as to the appropriate way forward with our advice. I don't think it could ever be categorically ruled out but I think certainly, generally, our advice would be that it should be avoided wherever possible.

Q. It is certainly a last resort?

A. Yes, I would agree it's a last resort.

Q. It is a concern if it's still being used as a custodial risk management tool to respond to incidents of self-harm, isn't it?

A. It is of concern. I can see to some extent why there is a challenge to the officers that are responding to these incidents, in that often they may be with good intent trying to preserve life, but I accept that there has got to be a balance between that and weighing up the impact on a detainee's mental health.

Q. Because the risk, of course, is that deficiencies in the safeguards, meaning vulnerable people are not rooted out of detention but remain in detention, being managed, and the use of force and segregation in this way as a risk management tool risks another situation like there was in late 2020, where the whole detainee population, the IMB found, were subject to inhumane treatment; would you agree?

A. Sorry, can you just repeat that question for me again?

Q. So the danger is the risk is that, where there are

deficiencies in the safeguards, so people are being manage indeed detention and not rooted out of detention because of delays in the rule 34 and 35 process, and where there is use of force and segregation to manage incidents of self-harm, there risks a situation like there was in late 2020 which the IMB described as subjecting the whole detainee population to inhumane treatment?

A. So I think I would go back to my earlier comment really around rule 35, so accepting that there is an element of non-compliance with rule 35, and that does present a risk, I still think that there are safeguards in place, ie we understand these patients, we understand their needs and therefore we should still be in position to advise detention officers on the appropriate use of force.

Q. That situation that the IMB found, that Brook House wasn't a safe place for vulnerable detainees and that the circumstances there amounted to inhumane treatment of the whole detainee population, happened under the watch of Sandra Calver as head of healthcare and of the doctors that you subcontract to currently. Isn't that of concern to you?

A. So, yes, I think it is.

I think what I would say is inhumane is subjective.

I do believe that vulnerable -- you know, an Immigration Removal Centre is probably not the right location for certain vulnerable individuals in general. So I don't believe these people should be there to start with. I am not sure quite how much of that realistically is within our gift to manage.

I accept that there is more work we can do in that regard.

Q. In particular in relation to rule 34 and 35?

A. Correct.

Q. The IMB recommended a systematic and ongoing review of vulnerable detainees to monitor the effect of continued detention on their wellbeing. Dr Hard gave some evidence that it was his opinion that there was a need for such a system of ongoing review of vulnerable detainees in detention.

Has there been the introduction of a systematic and ongoing review of vulnerable detainees in detention?

A. So vulnerable individuals would be reviewed as part of the delivery of healthcare services. So, for example, those with severe mental health would be assigned a caseworker within the mental health team that would meet with the individual regularly and, obviously, as part of their assessment would understand if people were deteriorating. I accept the fact that -- what I don't

believe is happening is that that is triggering a further rule 35 review in most cases at least.

Q. So does PPG plan to address that gap?

A. Yes. So as part of the rule 35 pathway review, that will also consider what work needs to be done to understand there are regular follow ups or reviews.

I think there are already processes in place to flag whereby we have concerns around an individual, we run a multi-professional complex case conferences on a weekly basis. Those kinds of things could be discussed there, but also we have things like a duty mental health worker who could flag any immediate concerns and bring those to the attention of the head of healthcare and, if necessary, the GPs.

Q. Yes.

Did you watch the Panorama programme?

A. I did watch it, yes.

Q. You are aware then of the involvement of some healthcare staff in making derogatory and mocking comments about detainees. You would presumably agree that those types of comments have no place from healthcare staff in an IRC?

A. I agree with that question.

Q. And with Sandra Calver that they are completely inappropriate and would be of concern if you were aware

of them?

A. That's correct.

Q. Does it concern you that at the time, as head of healthcare, she was unaware of them?

A. So I think it is -- it is a difficult question to answer in some ways. Can we hold an individual, even though they are the head of healthcare, responsible for the actions of individuals? Some would argue yes; some perhaps no.

I think the reality is that -- I think in evidence Sandra Calver said she was very surprised about that. It is a very small team who work in a very small and confined environment and by virtue of the fact it is a secure environment that means that people are pretty much on top of each other, if I am honest. So I would have been very surprised, having got to know Sandra a little bit since she has joined the organisation, if she had any concerns or suspicions that the behaviour of staff was not in line with what she would expect, that she wouldn't have addressed that.

Q. What steps have or are PPG taking with regard to ensuring a culture of dehumanising and degrading detainees doesn't persist in Brook House?

A. There are a couple of things really.

I think, firstly, we are very keen on ensuring that

clinical supervision is embedded with our clinical team. That is not just to review incidents, it is about talking around reflective practice, having discussions around things like compassion fatigue and, really, having a safe space for people to be honest about some of the things that they are struggling with and the challenges that they have.

I think on a broader scale we are currently working with an external organisation to look at how we better embed trauma informed care within that service and there are four themes to that really: one is around a general level of training that you would expect anybody to have, if I am honest even the detention custody officers -- we are very happy to open up that training to them. That is around basic awareness of trauma informed, looking at things like adverse childhood experiences, those kinds of things.

The second is around a more detailed training that is given to healthcare professionals so they can understand or better identify signs of trauma but also, working within the course of their general duties, be able to assess for trauma. So that is another point.

I think there are some bigger ambitions that we have but that will require further work with Serco, as the operator, for us to implement. So that will be around

the leadership team unitedly challenging things like language and behaviours, and then the fourth element, which is quite aspirational but nonetheless is one that we want to pursue, is around understanding what elements of detention can re-trigger people around their trauma and trying to avoid those.

So it is a four-pronged approach that we are looking to develop to try and prevent the exact scenario that you would have seen on the Panorama documentary.

Q. I just want to finally then ask you about some of Dr Hard's recommendations, particularly in relation to training and various aspects.

Would you agree with him that better training is needed for both detention and healthcare staff in the use of force?

A. Yes, absolutely. In fact we have also taken steps to address that ourselves.

So for the last year -- because use of force is equally used within our prison establishments, so the principles are exactly the same. So we have been working with -- there is no off-the-shelf training, it is very clear. So we have been working with our director of nursing, consulting with colleagues who offer things like C&R training, for example, so nurses are absolutely clear what their role is within any use

of force and that has been ruled out across our whole organisation. I think it is about to commence in a site and will be on a phased roll out.

Q. Yes, because it is clear they didn't understand that in 2017; would you agree?

A. Either they didn't understand it or chose not to enforce their role, yes.

Q. And appreciating that force is of course used sometimes in prisons, the difference in the population is that you have a particularly vulnerable population in IRCs in terms of underlying mental ill-health or experiences of trauma, particularly in relation to being victims of torture, would you agree?

A. I don't think it is always unique. So, for example, HMP Huntercombe, which is a prison, is used to house foreign nationals. So I think there are definitely some transferable skills within the prison estate that we can bring to the Immigration Removal Centre setting.

Q. But those aspects of the population certainly need to be particularly considered in relation to training in relation to use of force, would you agree?

A. So every prison is unique, or every Immigration Removal Centre is unique, and it needs to cater for the needs of the people that are detained there.

Q. Would you agree with Dr Hard that there needs to be

better training in relation to healthcare's role in the ACDT process, and in particular that there needs to be some understanding of the link between those who are on ACDTs and the safeguards under rule 35 applying?

A. So I don't necessarily agree that there needs to be further ACDT training. My understanding is that is an annual training programme that is delivered by Serco, who are the operator, and the feedback is that that generally appears to be very good and comprehensive. I think the issue is around the link to rule 35 and it is really training around rule 35 that we need to resolve.

Q. That would address that link?

A. Yes.

Q. Including in relation to food and fluid refusal and the link between those who refuse food and fluids and, potentially, the applying of the safeguards under rule 35?

A. Yes.

Q. Would you agree with him that training ought to be provided aimed at addressing compassion fatigue and desensitisation of staff as to what they encounter at Brook House?

A. Yes, as I have already said, I think that will be included in the trauma informed training that we are looking to roll out.

Q. You have already addressed that there should be better training in relation to rule 35, as Dr Hard also agrees.

Do you consider it is PPG who should be supplying that training or some other organisation?

A. I think it is a joint responsibility. I think it is really evident that there is a lack of clarity around rule 35. Therefore my view is that there should be some training that is delivered by the Home Office, as it is a Home Office policy or ruling; but that equally should then be followed up -- as I said, it is not just around the process for rule 35, it is a whole system approach around the identification of people and the pathway then that those people need to go through in order to get their appropriate assessment.

So I think it is a joint responsibility and it has two elements to it.

MS SIMCOCK: Thank you.

Chair, those are all the questions that I have for this witness. Do you have any questions?

THE CHAIR: Thank you, Ms Simcock.

I do have a couple of questions for you, Mr Wells, thank you.

Questions from THE CHAIR

THE CHAIR: I wonder if you could tell me a little about the timeframes for the review of the pathway, the rule 35

pathway that you are undertaking?

A. When you say --

THE CHAIR: The timeframe, so when did you start it, when will it be concluded?

A. It is commencing on 20 April.

THE CHAIR: The 20th?

A. Yes.

THE CHAIR: When is it due to conclude?

A. We haven't got -- obviously, it depends what falls out of that event. As I said, we are not particularly bureaucratic, so I would hope that we'd have a better-informed policy, at least, within a few weeks of that taking place. Obviously, depending on what the findings are from that particular piece of work, if that does involve, you know, service redesign or conversations with our Commissioners, then that could extend that period.

So it is a little difficult to give you a definitive, but I would expect, at least, that we would have a policy on it by the end of the month.

THE CHAIR: End of ...?

A. End of April, sorry.

THE CHAIR: End of April. Okay, thank you.

In response to one of the questions that Ms Simcock asked you around the ten-minute appointment that is

currently being offered, you said that you would need to seek further clarity from the Home Office before making a commitment around the level of resource that might be required to offer more than a ten-minute appointment.

Do you intend to have that conversation with the Home Office?

A. Absolutely. My understanding is the Home Office have already suggested locally to Brook House that there needs to be some form of either further training or review of that, so I would expect that is a good forum in which we could explore further discussion around what exactly is involved -- or what is their understanding of what exactly is involved by the term "assessment" within that ruling.

THE CHAIR: Okay, thank you.

Then finally, again, Ms Simcock asked you some questions around this, the discrepancy in the numbers of people on constant watches towards the end of 2021, in contrast to the lack of rule 35(2) reports and, obviously, I understand, from what you have told us about some of the reviews, that you are going to be commencing and looking at that as an issue, and your answer to Ms Simcock was you didn't want to make any immediate snap decisions around that.

Have you given any consideration to the potential

issue that there are people now in detention currently, who are not going to be going to be referred for rule 35(2) appointments where there has been suicidal ideation expressed?

A. Yes, I think so. I have discussed that with Dr Bromley, and I think our view is clear, whilst we accept that there is an element of risk within that, I think there is also an element of risk, in terms of bringing in a series of changes to working practice which can be confusing to staff and, given that this is a long-standing issue, it is not a new issue that has been operating for some time, I personally am in favour of an approach whereby we take a very clear approach. Whilst that will involve, you know, roughly a three- or four-week wait, I think it is a much better way forward than us to go out with a number of different directives to the team that are trying to deliver these services.

THE CHAIR: Thank you. I have no other questions, I am grateful for your evidence and I am sorry we have kept you a little late, but it has been important to hear from you, so thank you.

A. Thank you.

MS SIMCOCK: Chair, in the evidence of Mr Dove, I neglected to ask for his second witness statement to be adduced, so I just do that now, it is at <CJS0074042>.

THE CHAIR: Thank you.
MS SIMCOCK: Thank you. 10.00 am tomorrow.
THE CHAIR: 10.00 am tomorrow. Thank you.
(4.45 pm)
(The inquiry adjourned until 10.00 am the following day)

I N D E X

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