

<p>1 Thursday, 31 March 2022</p> <p>2 (10.00 am)</p> <p>3 THE CHAIR: Good morning, thank you very much.</p> <p>4 Mr Altman, good morning.</p> <p>5 MR GORDON COLIN BROCKINGTON (sworn)</p> <p>6 Examination by MR ALTMAN</p> <p>7 MR ALTMAN: Thank you, Mr Brockington, give us your full</p> <p>8 name, please.</p> <p>9 A. Gordon Colin Brockington.</p> <p>10 Q. Mr Brockington, tell us, please, first of all, what your</p> <p>11 position is with G4S?</p> <p>12 A. My current role is Managing Director of Justice and the</p> <p>13 Government Chief Commercial Officer.</p> <p>14 Q. And since how long have you been in that role?</p> <p>15 A. Since November 9, 2020.</p> <p>16 Q. You said that is your current role. How long have you</p> <p>17 worked with G4S?</p> <p>18 A. I joined G4S in March 2015, and I have held a number of</p> <p>19 roles in G4S throughout that time.</p> <p>20 Q. So you were an employee of G4S during the period that we</p> <p>21 are interested in, April through to August 2017. Where</p> <p>22 were you at the time?</p> <p>23 A. At the time, I was the regional business development</p> <p>24 director.</p> <p>25 Q. Head office?</p> <p style="text-align: center;">Page 1</p>	<p>1 Q. When you talk about a project team, was a team</p> <p>2 especially set up in order to deal with the matter?</p> <p>3 A. Absolutely. The immediate actions and the action plan</p> <p>4 were compiled by a specific project team immediately</p> <p>5 after Panorama, amongst other things, which we look</p> <p>6 immediate action on.</p> <p>7 Q. Who headed the team; do you remember now?</p> <p>8 A. I believe initial investigations were taken place by</p> <p>9 Lee Hanford and Pete Small, and then the project team</p> <p>10 was put together to develop the actions required, in</p> <p>11 collaboration with the Home Office and others, and then</p> <p>12 the action plan was then put in place and deployed.</p> <p>13 Q. Who did the project team report to on the board?</p> <p>14 A. I believe that would have been Jerry Petherick at the</p> <p>15 time.</p> <p>16 Q. But he left, didn't he?</p> <p>17 A. Jerry Petherick?</p> <p>18 Q. Yes. Didn't he leave G4S?</p> <p>19 A. He did, but not at the time, not immediately</p> <p>20 post Panorama.</p> <p>21 Q. We will look at a document in a moment and I will ask</p> <p>22 you about it then.</p> <p>23 At your paragraph 77 of your first witness</p> <p>24 statement, of which you made two -- we will come to that</p> <p>25 in a second and I will ask the chair if we can adduce</p> <p style="text-align: center;">Page 3</p>
<p>1 A. Head office, correct.</p> <p>2 Q. Which is where?</p> <p>3 A. Victoria.</p> <p>4 Q. And presumably you were aware, even though remote, from</p> <p>5 the allegations that arose through the Panorama</p> <p>6 recording of incidents during that period, April</p> <p>7 to August, presumably wasn't much of a secret at G4S; is</p> <p>8 that correct?</p> <p>9 A. That is absolutely correct. I was fully sighted. I saw</p> <p>10 the Panorama programme and I was based in head office at</p> <p>11 the time.</p> <p>12 Q. Yes. Were you on the board at the time?</p> <p>13 A. I wasn't on the board, no.</p> <p>14 Q. No. Were you privy to any of the meetings which took</p> <p>15 place, or must have taken place, about what Panorama had</p> <p>16 shown?</p> <p>17 A. Limited meetings.</p> <p>18 Q. Yes. But, clearly, directors like you would have been</p> <p>19 sighted on the issues which Panorama exposed?</p> <p>20 A. Not clearly. We were sighted on what was -- at the</p> <p>21 time, what we saw on Panorama, but a lot of the meetings</p> <p>22 that were held in relation to the Panorama were held by</p> <p>23 the project team, were held by the senior execs at the</p> <p>24 time and the operations team responsible for the</p> <p>25 Gatwick IRC.</p> <p style="text-align: center;">Page 2</p>	<p>1 both of the statements, respectively <CJS0074041> and</p> <p>2 <CJS0074043>, and you will confirm you made two witness</p> <p>3 statements to the inquiry, Mr Brockington: the first on</p> <p>4 7 February of this year, I think; and the second on</p> <p>5 10 February. Is that correct?</p> <p>6 A. I can confirm that is correct.</p> <p>7 Q. Yes. Let's look at what you say at paragraph 77 of your</p> <p>8 first witness statement -- we don't have to put it up on</p> <p>9 screen, but you say:</p> <p>10 "Following the broadcast, the company sent a clear</p> <p>11 message to all employees that the behaviours witnessed</p> <p>12 in the programme were unacceptable and would not be</p> <p>13 tolerated. The message was reinforced by the swift</p> <p>14 suspensions that followed, together with the subsequent</p> <p>15 investigations and cooperation and engagement with</p> <p>16 Sussex Police."</p> <p>17 So that was the message that the company sent out;</p> <p>18 yes?</p> <p>19 A. That is correct. That came from Peter Neden.</p> <p>20 Q. Came from ...?</p> <p>21 A. Peter Neden. That is where I saw it; in an email from</p> <p>22 Peter Neden.</p> <p>23 Q. Did G4S, as you understand it, accept all of the Lampard</p> <p>24 findings and recommendations, the Verita?</p> <p>25 A. We did, so of the 52 recommendations in the Verita</p> <p style="text-align: center;">Page 4</p>

<p>1 report -- clearly that came some time after.</p> <p>2 Q. Yes, that was -- the final report was November the</p> <p>3 following year.</p> <p>4 A. Yes, absolutely. So we broadly accepted the</p> <p>5 52 recommendations; that is correct.</p> <p>6 Q. When you say "broadly", what does that mean?</p> <p>7 A. In essence, we accepted the 52 findings. When it came</p> <p>8 out in the final report some time after, of course,</p> <p>9 I believe late in -- December 2018.</p> <p>10 Q. Yes. Let's look at a document. It is dated</p> <p>11 10 January 2019, and it is one which has been disclosed</p> <p>12 to you, so I hope you have had an opportunity to look at</p> <p>13 it <HOM005917>. Chair, it's tab 29 -- 30 for you,</p> <p>14 sorry.</p> <p>15 This is a Home Office document; headed "Shaw</p> <p>16 Programme Board", 10 January 2019. It is in relation to</p> <p>17 the Verita report on Brook House. At the bottom, it</p> <p>18 gives a summary of it. We don't need to go through</p> <p>19 that.</p> <p>20 Over the page, under "The Recommendations", it tells</p> <p>21 us:</p> <p>22 "There are 52 recommendations under seven broad</p> <p>23 headings. G4S have recently shared their internal</p> <p>24 response (attached at annex A) ..."</p> <p>25 Although it is not attached to the document in your</p> <p style="text-align: center;">Page 5</p>	<p>1 Jerry Petherick and Paul Kempster, G4S will have</p> <p>2 replaced the entire management chain who may be regarded</p> <p>3 as having presided over the Panorama events."</p> <p>4 This document is dated January 2019.</p> <p>5 Jerry Petherick, had he remained in post to help with</p> <p>6 the post-Panorama fallout or had he gone fairly quickly;</p> <p>7 do you remember?</p> <p>8 A. Jerry was in post, post Panorama, absolutely.</p> <p>9 Q. No, but how long did he remain?</p> <p>10 A. I am not sure of his exact departure date, but he was</p> <p>11 certainly in post for a period after Panorama.</p> <p>12 Q. Yes. With all of this in mind, Mr Brockington, can we</p> <p>13 look at your witness statement at paragraph 62. Your</p> <p>14 first witness statement. Perhaps we ought to start at</p> <p>15 paragraph 61. Let's put this up on screen <CJS0074041>,</p> <p>16 page 15.</p> <p>17 Right at the top:</p> <p>18 "The Verita report ... noted that they had ..."</p> <p>19 And you quote here:</p> <p>20 "... 'cause to question the quality and content of</p> <p>21 some of the training offered to new recruits on the ITC</p> <p>22 and to staff as refresher training. We found that not</p> <p>23 all those delivering the ITC and refresher courses were</p> <p>24 appropriately qualified'."</p> <p>25 That is a reference to paragraph 1.38 in the Verita</p> <p style="text-align: center;">Page 7</p>
<p>1 bundle:</p> <p>2 "... indicating that they have accepted all of the</p> <p>3 recommendations. They are showing 40 as having been</p> <p>4 completed, with the other 12 either in progress or under</p> <p>5 consideration.</p> <p>6 "At face value their response appears appropriate</p> <p>7 although lacking in dates for actions that remain</p> <p>8 outstanding."</p> <p>9 And there is some further text there.</p> <p>10 So, first of all, the Home Office's understanding --</p> <p>11 and this is a document, if we look to the bottom of the</p> <p>12 next page, which is under the authorship of Phil Riley,</p> <p>13 who we will be hearing from next week, and is dated</p> <p>14 2 January 2019, but, clearly, the Home Office's</p> <p>15 understanding is that the 52 recommendations under the</p> <p>16 seven broad headings had been accepted by G4S without</p> <p>17 qualification? Do you accept that?</p> <p>18 A. I think in my previous statement I said G4S accepted the</p> <p>19 recommendations of the -- you know, of the Verita</p> <p>20 report.</p> <p>21 Q. Yes, well, it was your word "broadly" which I was asking</p> <p>22 you about. If we go back to page -- we are still on</p> <p>23 page 2. Do you see the large paragraph in the centre</p> <p>24 there, just below, towards the end of it:</p> <p>25 "With the announced departures of Peter Needen,</p> <p style="text-align: center;">Page 6</p>	<p>1 report.</p> <p>2 You say at 62:</p> <p>3 "The company does not accept this conclusion."</p> <p>4 Why not?</p> <p>5 A. So in relation to training, I think it is quite</p> <p>6 important to lay out the training protocols we had in</p> <p>7 place at the IRC. The ITC, the initial training course,</p> <p>8 the contents were actually quite helpfully laid out in</p> <p>9 the Shaw report of 2018 -- I believe it is section 6 --</p> <p>10 where it lays out the contents of what we agreed</p> <p>11 collaboratively and mutually with the Home Office in</p> <p>12 terms of the content of the training of the ITC. So</p> <p>13 I think with specific reference to the ITC, we have</p> <p>14 worked with our customer to devise and deploy the ITC,</p> <p>15 in order for all frontline officers to receive their</p> <p>16 certification aligned with being a fit and proper</p> <p>17 person, so they were certified by the Secretary of State</p> <p>18 to be a frontline officer. So, in our view, the ITC was</p> <p>19 devised and deployed collaboratively in accordance with</p> <p>20 our Home Office customer and the training was fit for</p> <p>21 purpose.</p> <p>22 Q. Let's look at the Verita report, please. <CJS005923> at</p> <p>23 page 36. Let me know when you get there, please.</p> <p>24 I am struggling to understand, Mr Brockington, in</p> <p>25 light of what you said in your witness statement, why,</p> <p style="text-align: center;">Page 8</p>

<p>1 then, the company accepted recommendation 9 and -- we'll</p> <p>2 come to it in a second -- recommendation 40.</p> <p>3 Recommendation 9:</p> <p>4 "The SMT and G4S managers should undertake regular</p> <p>5 and systematic evaluation and quality assurance of the</p> <p>6 training provided at Gatwick IRCs to ensure that staff</p> <p>7 receive training of a consistently high standard; that</p> <p>8 it meets the operational needs of the IRCs, trains and</p> <p>9 develops staff appropriately and promotes appropriate</p> <p>10 values."</p> <p>11 So when Verita had cause to question the quality and</p> <p>12 content of some of the training, there is</p> <p>13 a recommendation that deals with it. In your witness</p> <p>14 statement, you say the company doesn't accept the</p> <p>15 conclusion but it accepted the recommendation.</p> <p>16 How does that work?</p> <p>17 A. I think it is a sign of a healthy business that we would</p> <p>18 consistently review our training requirements. I take</p> <p>19 some comfort -- although we have our own governance in</p> <p>20 place, I take some comfort that the HMIP inspection of</p> <p>21 2019 showed we had improved training in place, and</p> <p>22 I would also say the Stephen Shaw findings of 2016, one</p> <p>23 of the recommendations said that we should deliver</p> <p>24 mandatory Safer Training on an annual basis, and we</p> <p>25 included that into our annual training.</p> <p style="text-align: center;">Page 9</p>	<p>1 relation to the Stephen Shaw report stated we needed to</p> <p>2 act and we needed effective training for Adults at Risk</p> <p>3 and that was incorporated into the consolidated action</p> <p>4 plan of 2016. And the HMIP inspection of 2019 showed</p> <p>5 improvements and that was also reflected in the Shaw</p> <p>6 report.</p> <p>7 We worked closely with the West Sussex Social</p> <p>8 Services Vulnerable Adults Board and, working with them,</p> <p>9 we developed annual refresher training. So, again,</p> <p>10 I think it is a sign of a healthy business, where we</p> <p>11 consistently review, based on external feedback, and we</p> <p>12 adapt and change in accordance with that feedback that</p> <p>13 we have received. So, again, that is where I conclude</p> <p>14 this position in the -- in my statement.</p> <p>15 Q. The trouble is, Mr Brockington, that doesn't really</p> <p>16 answer the question. My question is -- and I know you</p> <p>17 are the mouthpiece for the company, and you are here to</p> <p>18 answer questions on behalf of the company and you</p> <p>19 weren't directly involved in these matters, as you make</p> <p>20 clear, at the time, but here is the company accepting</p> <p>21 recommendations in the Verita report, and I've pointed</p> <p>22 out, so far, two in particular. The Home Office clearly</p> <p>23 understood, by January 2019, that G4S had not only</p> <p>24 accepted all of the recommendations without</p> <p>25 qualification, but was actioning them, and here you are,</p> <p style="text-align: center;">Page 11</p>
<p>1 We also deployed annual refresher training in areas</p> <p>2 such as C&R, first aid, respiratory protective equipment</p> <p>3 and equality and diversity, to name a few examples, so</p> <p>4 my personal view is I see this as a sign of a healthy</p> <p>5 business, that we consistently review our training, and</p> <p>6 we deploy our training -- the initial training course,</p> <p>7 as explained in the Shaw report and in full sight of the</p> <p>8 customer, working with the customer to make sure the</p> <p>9 training is fit for purpose and then we deploy ongoing</p> <p>10 training on an annual basis in certain areas as well, so</p> <p>11 that is where I conclude my position in the statement.</p> <p>12 Q. Let's look on to recommendation 40 on page 37 because</p> <p>13 this deals with the second criticism, which you say the</p> <p>14 company doesn't accept, recommendation 40:</p> <p>15 "The SMT in consultation with the local safeguarding</p> <p>16 boards must ensure that all staff receive appropriate</p> <p>17 annual safeguarding refresher training."</p> <p>18 That was accepted without qualification by the</p> <p>19 company. So, again, one struggles to understand why, at</p> <p>20 paragraph 62, you say the company didn't accept the</p> <p>21 conclusion that Verita had arrived at. It is the same</p> <p>22 point, isn't it?</p> <p>23 A. So, with specific reference to safeguarding, the</p> <p>24 Stephen Shaw report of 2016 stated clearly that we</p> <p>25 needed to act -- sorry, the 2016 HMIP inspection in</p> <p style="text-align: center;">Page 10</p>	<p>1 in 2022, saying the company doesn't accept the positions</p> <p>2 which I have just put to you. I think people will</p> <p>3 struggle to understand, although we hear your answer,</p> <p>4 that the company listens to feedback and it does all of</p> <p>5 these things, all fine and terrific, Mr Brockington, but</p> <p>6 there seems to be, in the passage I've read so far --</p> <p>7 and I will come to another in a moment -- a resistance</p> <p>8 by G4S to accept what it accepted back in November 2018</p> <p>9 or afterwards, once it received the final Verita</p> <p>10 report -- do you understand what I am saying?</p> <p>11 A. I do understand what you are saying but I disagree with</p> <p>12 G4S's approach around the resistance.</p> <p>13 The level of activity taken post Panorama -- and we</p> <p>14 have to look at this in terms of the timeframe. The</p> <p>15 Panorama programme was viewed, by us all, and the</p> <p>16 immediate action plan was taken -- was put in place and</p> <p>17 deployed. Those actions took immediate effect, and</p> <p>18 I can talk about those actions at some length, but</p> <p>19 we took a number of management interventions</p> <p>20 immediately, including the -- bringing in a new interim</p> <p>21 director; including increasing DCOs from two to three on</p> <p>22 the wings; including increasing the DCMs on the wings;</p> <p>23 bolstering the SMT; and improving the fabric of the</p> <p>24 establishment. So we took a number of specific</p> <p>25 management interventions immediately as part of the</p> <p style="text-align: center;">Page 12</p>

<p>1 Panorama action plan.</p> <p>2 Those then -- as part of -- a further action of the</p> <p>3 Panorama action plan was to work with Verita, so -- but</p> <p>4 Verita took a period to compile their report and then</p> <p>5 put out their recommendations, so we have to look at</p> <p>6 this in the context of the timeline. A number of those</p> <p>7 actions were already completed by the time that Verita</p> <p>8 issued their report, so that is why, come January '19,</p> <p>9 40 of the recommendations had already been completed and</p> <p>10 12 were outstanding, of which, I believe, broadly five</p> <p>11 were dependent on work the Home Office and ourselves</p> <p>12 needed to do together. So that is our position.</p> <p>13 But I categorically say there is absolutely no</p> <p>14 resistance from G4S, as a business, to deliver what was</p> <p>15 needed to be done.</p> <p>16 Q. I am just wondering, Mr Brockington, why wouldn't it</p> <p>17 have been easier for you to say that in your witness</p> <p>18 statement, rather than saying, "The company does not</p> <p>19 accept the conclusions"?</p> <p>20 A. If that was an oversight -- so, that is my position,</p> <p>21 that is the evidence I am giving the inquiry today.</p> <p>22 Q. It is not the only one because, if we look at your first</p> <p>23 witness statement at 98, for example, if we can put that</p> <p>24 up, please, <CJS0074041> at page 22, you then say at the</p> <p>25 top, paragraph 97:</p> <p style="text-align: center;">Page 13</p>	<p>1 described.</p> <p>2 So there is a recognition in our action plan that</p> <p>3 there was a requirement to bolster both the DCO and DCM</p> <p>4 resource within the establishment. I think it is quite</p> <p>5 important to add that G4S took that action and cost for</p> <p>6 the period up to the extension. That then translated --</p> <p>7 that profile then translated into the two-year</p> <p>8 extension, which we delivered, and that also translated</p> <p>9 into the new tender in 2020, which is now being</p> <p>10 delivered by the new provider.</p> <p>11 Q. Serco?</p> <p>12 A. Indeed.</p> <p>13 Q. Let's look at what you say at 99:</p> <p>14 "The company does not fully accept the conclusions</p> <p>15 for the reason given earlier. A key point is that just</p> <p>16 because senior managers (SMT) were not visible all of</p> <p>17 the time did not take away the fact they were present.</p> <p>18 Notwithstanding, as already explained, the company does</p> <p>19 accept that senior managers could have been more</p> <p>20 visible, but it does not accept that any lack of</p> <p>21 visibility or actions discouraged staff from reporting</p> <p>22 concerns. The Verita report does not fully set out the</p> <p>23 reasons as to why it reached this view and the company</p> <p>24 was not involved in the investigation. Nor does it have</p> <p>25 knowledge or access to the underlying source material in</p> <p style="text-align: center;">Page 15</p>
<p>1 "The Verita report also concluded: 'The lack of</p> <p>2 visible, supportive management, managers' heavy-handed</p> <p>3 approach to performance issues, and a lack of confidence</p> <p>4 in the arrangements for reporting and dealing with</p> <p>5 concerns, has meant staff have tended to rely on each</p> <p>6 other for support and guidance. These management</p> <p>7 shortcomings have discouraged staff from raising</p> <p>8 concerns, including those about the behaviour of</p> <p>9 colleagues and managers'."</p> <p>10 At 98, you say:</p> <p>11 "The company does not fully accept these</p> <p>12 conclusions. DCMs were constantly 'on the floor',</p> <p>13 although, prior to the profiling mentioned above</p> <p>14 [something you deal with in your statement; reprofiling</p> <p>15 of staff], they would have covered two residential</p> <p>16 wings, so would not have been visible to all staff all</p> <p>17 of the time."</p> <p>18 What was it you didn't fully accept?</p> <p>19 A. I think what we -- the actions we took immediately</p> <p>20 post Panorama, as I have just described to the inquiry,</p> <p>21 is we brought in a new interim director, and the interim</p> <p>22 director was very clear in his views that we needed to</p> <p>23 increase the number of DCOs on the floor from two to</p> <p>24 three and DCMs to one per wing. Amongst other things</p> <p>25 which I -- some of which I have just previously</p> <p style="text-align: center;">Page 14</p>	<p>1 order to understand or consider the point further."</p> <p>2 Who commissioned the Verita report?</p> <p>3 A. We commissioned the Verita report.</p> <p>4 Q. And if we look at their first recommendation, if we go</p> <p>5 back to the report, please, Zaynab, <CJS005923> at</p> <p>6 page 34, right at the bottom:</p> <p>7 "The SMT should be more present in the centre and</p> <p>8 should consider how they can better engage with staff.</p> <p>9 (To be completed as a matter of urgency)."</p> <p>10 Again, G4S accepted this recommendation, and yet,</p> <p>11 here we have three paragraphs with you on behalf of the</p> <p>12 company seeking to undermine some of it. How do you</p> <p>13 explain that?</p> <p>14 A. So we are not undermining that at all, from my</p> <p>15 perspective. I think we have been very clear in the</p> <p>16 fairly decisive actions that we took post Panorama, that</p> <p>17 we recognised there was a gap between the senior</p> <p>18 management team on site and the DCMs on site. What</p> <p>19 I would say is, to address that point, under the</p> <p>20 leadership and direction of the new interim director, we</p> <p>21 bolstered the SMT, we increased the DCMs, but we also</p> <p>22 engaged Cornnell, which is a training provider, to</p> <p>23 increase the skills of the DCMs to create -- to ensure</p> <p>24 they had the right skills to be frontline managers and</p> <p>25 also to develop a career path for those DCMs.</p> <p style="text-align: center;">Page 16</p>

<p>1 So I -- what I am saying, through my response, is we 2 took a number of actions to address the findings. And 3 we took that, as it said, as a matter of urgency. That 4 was one of the initial actions which we took as part of 5 our action plan post Panorama. 6 Q. I was going to ask you, because the Verita report, which 7 was commissioned, let's not forget -- and I have 8 reminded you, and you have agreed -- by G4S, your 9 company. Here it is, in recommendation 1, in its final 10 report of November 2018, saying "(To be completed as 11 a matter of urgency)". Doesn't that suggest to you that 12 it hadn't been done? 13 A. No. 14 Q. It doesn't? 15 A. No. What I tried to explain earlier, perhaps clumsily, 16 was there was a timeline of activity between Panorama 17 and the issuing of the Verita recommendations. 18 The Panorama was -- the episode was shown, there was 19 an action group, a project group, which was put in place 20 to develop an action plan. The action plan was deployed 21 and a significant number of management interventions, 22 working collaboratively with our customer, working 23 collaboratively with the Home Office at the time were 24 deployed. As one of those actions, the Verita report 25 was commissioned and the findings were subsequently</p> <p style="text-align: right;">Page 17</p>	<p>1 were not required because these had been completed? Can 2 you understand that? 3 A. I can understand the question. What I come back to is 4 it was an independent report, albeit commissioned by 5 ourselves and there is a lot of activity that happened 6 between Panorama and Verita conducting their review, 7 which took a period of time, compiling their report and 8 issuing their recommendations. So -- and, as 9 a business, we got on and did a lot of the actions that 10 we were required to do and which we put in place as part 11 of the initial Panorama action plan. 12 So I think, you know, we have to look at this in 13 terms of the timeline, we have to look at this in terms 14 of at a moment in time and, when the actions, or the 15 recommendations, for the Verita report were subsequently 16 issued in December 2018, as I said -- and, clearly, the 17 Shaw Programme Board review of 10 January 2019 clearly 18 states that we had completed, and it was agreed we had 19 completed, 40 of the 52 recommendations. 20 Q. But that was January 2019. 21 A. Which is after the -- so one month after the 22 recommendation. 23 Q. I accept that, it was two or three months after, at 24 least, the date of this report which is November 2018. 25 Let's turn then to a different matter, please. Back</p> <p style="text-align: right;">Page 19</p>
<p>1 released in December 2018, some 14 or 15 months after 2 the viewing of the programme. A number of those actions 3 had been completed and, as you saw in your previous 4 document which you just showed, which was the Shaw 5 Programme Board of 10 January, 40 of the 52 6 recommendations had been completed by that stage. So we 7 had done a lot of this stuff. 8 Q. Did G4S have any input to this final report before it 9 went out, before it was published; in other words, did 10 Kate Lampard and Ed Marsden send it to G4S to say, "Do 11 you have any comments on the final draft before it is 12 published"? 13 A. My only understanding of any intervention which we had 14 was, I believe there was a slight redaction, due to 15 GDPR, before G4S agreed to publish this document, and 16 I have to say we agreed to publish in full, subject to 17 certain GDPR redactions. 18 Q. Don't you find it a little odd, if we go through all 19 these recommendations, the timelines are given to be 20 completed as a matter of urgency. We see 21 recommendation 32 to be completed within six months. 22 But if some of these had already been completed in 23 the action plan that you have been telling us about, 24 then why did the report go out like this, with a series 25 of recommendations with timelines and deadlines which</p> <p style="text-align: right;">Page 18</p>	<p>1 to your witness statement, please, at paragraph 6. We 2 don't need it put it up on screen. But do you agree, 3 Mr Brockington, under the heading "The Panorama 4 programme" it says: 5 "I do not believe the company is in a position to 6 comment or speculate on what the cause or causes of 7 behaviour of the staff shown in the programme was or 8 were." 9 Then you go on to express the company's views, that 10 what they did was inconsistent with the company's 11 values, that the behaviours had never been condoned and 12 were not the behaviours expected of staff, which was to 13 act at all times with integrity, professionalism and in 14 accordance with trained and accepted practices. 15 You say: 16 "Given that I have no personal knowledge as to any 17 matters raised by Panorama, or know any of the 18 individuals identified, I do not feel that I can comment 19 further on why they behaved in the way they did." 20 Do you agree you said that? 21 A. I believe that is from my statement, yes. 22 Q. So if we go on to paragraph 34, please, I just want to 23 ask you why you said this, and it is on your page 9: 24 "The company does not believe that either staffing 25 levels or turnover were a factor in the mistreatment of</p> <p style="text-align: right;">Page 20</p>

<p>1 detainees between April and August 2017."</p> <p>2 That is a speculation which you were not prepared to</p> <p>3 speculate about, and I am just wondering why you have</p> <p>4 afforded yourself the luxury of doing so at</p> <p>5 paragraph 34, having said that you were not prepared to?</p> <p>6 A. So I think I would like to just go back to your previous</p> <p>7 comments, in terms of the Panorama programme, and I want</p> <p>8 to go slightly further than what I put in the initial</p> <p>9 statement, in terms of, what we witnessed in the</p> <p>10 Panorama programme and the actions of an isolated number</p> <p>11 of individuals was abhorrent. There was absolutely no</p> <p>12 place for that in society in general, let alone working</p> <p>13 for G4S, so I do want to go a little bit further than</p> <p>14 I said in my statement.</p> <p>15 However, coming to your second point, I don't</p> <p>16 believe there is a direct correlation between the</p> <p>17 turnover of staff -- profit, I think you stated -- and</p> <p>18 the isolated incidents of individuals acting wholly --</p> <p>19 and I maintain "wholly" -- inappropriately. Individuals</p> <p>20 are trained. The frontline staff, all the frontline</p> <p>21 staff, are trained through the initial training course,</p> <p>22 the ITC programme, which I explained earlier is</p> <p>23 helpfully laid out in the Shaw report, at section 6, the</p> <p>24 detail of which is very visible, and we work</p> <p>25 collaboratively with the Home Office on the contents of</p> <p style="text-align: center;">Page 21</p>	<p>1 wasn't designed for a lot of activities at that time.</p> <p>2 Q. You are not an expert, but Professor Mary Bosworth is?</p> <p>3 A. Agreed.</p> <p>4 Q. We heard from her two days ago. Did you read her</p> <p>5 evidence or watch her evidence?</p> <p>6 A. I saw some of it, yes.</p> <p>7 Q. Which part did you see?</p> <p>8 A. The first part I ...</p> <p>9 Q. The first part?</p> <p>10 A. Yes.</p> <p>11 Q. During which -- presumably you have read her report?</p> <p>12 A. I haven't read her report.</p> <p>13 Q. You haven't read it?</p> <p>14 A. No.</p> <p>15 Q. Why not?</p> <p>16 A. To be honest -- I just haven't read her report.</p> <p>17 Q. It is critical, isn't it?</p> <p>18 She is one of three experts who have provided</p> <p>19 lengthy accounts to the inquiry within their fields of</p> <p>20 expertise; in her case, culture and staff culture. She</p> <p>21 wrote, I mean you have referred to the Shaw report, she</p> <p>22 was responsible for annex 5 in the January 2016 report</p> <p>23 of Stephen Shaw and she also wrote a literature review</p> <p>24 at annexes 10 and 11 in the Shaw report of July 2018.</p> <p>25 She is an expert in the field. She has been involved in</p> <p style="text-align: center;">Page 23</p>
<p>1 that. That then allows -- through the fit and proper</p> <p>2 persons process, and the initial training, allows the</p> <p>3 individuals to get a certification and become frontline</p> <p>4 officers.</p> <p>5 So I think we train the individuals to do what they</p> <p>6 do and these individuals chose to act in the way that</p> <p>7 they did, so I see no correlation between staff turnover</p> <p>8 and profit.</p> <p>9 Q. Paragraph 36, you say:</p> <p>10 "To be clear, the company accepts that staffing</p> <p>11 levels and turnover at Brook House was an issue during</p> <p>12 the relevant period. The reasons for that were</p> <p>13 multi-factorial, and whilst it is accepted that they had</p> <p>14 an adverse impact on the centre and the regime, those</p> <p>15 are entirely separate and unrelated when it comes to the</p> <p>16 question of abuses."</p> <p>17 How do you know that?</p> <p>18 A. I have clearly done -- spoken to a lot of colleagues in</p> <p>19 preparation for this hearing. I think we recognise --</p> <p>20 and I say in my statement -- we are very clear that the</p> <p>21 design of the establishment in relation to activities,</p> <p>22 you know, it wasn't designed for a significant amount of</p> <p>23 activities, and I think the turnover -- this is an area</p> <p>24 where, you know, I am not an expert, but I would say</p> <p>25 that, you know, certain activities -- the whole process</p> <p style="text-align: center;">Page 22</p>	<p>1 this environment for many years and is a well respected</p> <p>2 expert.</p> <p>3 At length, not only did she write, in both reports,</p> <p>4 her views of staff culture and the impact of the</p> <p>5 environment, the physical environment, the fact, which</p> <p>6 is unavoidable, that detainees were being held in Brook</p> <p>7 House far longer than the place was designed for, or its</p> <p>8 purpose, and she had no doubt in telling us that, among</p> <p>9 the many things which were causative or contributory to</p> <p>10 the mistreatment of the detainees in that place during</p> <p>11 the relevant period in particular, were staffing levels,</p> <p>12 the turnover, retention and recruitment. All of those</p> <p>13 issues were part of the melting pot, to use your word</p> <p>14 "multifactors", which you cannot divorce from the abuse</p> <p>15 of those detainees within Brook House.</p> <p>16 Now, why didn't you know that?</p> <p>17 A. I hadn't read the report so --</p> <p>18 Q. You should have done, shouldn't you, Mr Brockington?</p> <p>19 A. We work very closely with academia across our broader</p> <p>20 estates. Perhaps I should have read the report, and</p> <p>21 I haven't read the report.</p> <p>22 Q. Perhaps -- no, clearly not.</p> <p>23 When you watched part of her evidence -- watched or</p> <p>24 read?</p> <p>25 A. I watched a small part.</p> <p style="text-align: center;">Page 24</p>

<p>1 Q. A small part.</p> <p>2 So she is one, as I say, of three experts who has</p> <p>3 told us that, really, just the whole environment, the</p> <p>4 whole effect and impact, not only on the detainees but</p> <p>5 staff, caused or attributed to what we are all here for</p> <p>6 now -- are you prepared to accept that?</p> <p>7 A. Sorry, can I expand --</p> <p>8 Q. Are you prepared to accept her evidence?</p> <p>9 A. What I am -- what I say in my report is I don't believe</p> <p>10 there is a direct correlation between an isolated</p> <p>11 instance of abhorrent abuse and the overarching</p> <p>12 environment.</p> <p>13 Q. She is an expert and says that there is; you are not</p> <p>14 an expert, and you say there is not. Who do you think</p> <p>15 the inquiry should listen to?</p> <p>16 A. That is for the inquiry to decide.</p> <p>17 My view is these were isolated incidents of dreadful</p> <p>18 behaviour that is contrary to the training which G4S</p> <p>19 provided. It is contrary to the certification</p> <p>20 obligations under -- to the Secretary of State, in order</p> <p>21 for their certification, so I believe they are.</p> <p>22 My personal view is I don't believe there is</p> <p>23 a correlation. I think that these isolated incidents of</p> <p>24 abuse are -- are isolated.</p> <p>25 Q. If we go back to your paragraph 34, let's, Zaynab, put</p> <p style="text-align: center;">Page 25</p>	<p>1 A. Yes.</p> <p>2 Q. Jerry Petherick, who was at Brook House, presumably,</p> <p>3 from time to time?</p> <p>4 A. He was from time to time. I think in his evidence he</p> <p>5 said that he was there -- he tried to get to all of his</p> <p>6 sites monthly.</p> <p>7 Q. It wasn't out of sight of other detainees. It wasn't</p> <p>8 out of sight of other officers, because it was often</p> <p>9 committed in front of other officers, DCOs and DCMs, and</p> <p>10 it wasn't out of sight of Callum Tulley, because he was</p> <p>11 able to record it all from 24 April 2017 until he left</p> <p>12 in early July.</p> <p>13 What do you mean by "the small number of individuals</p> <p>14 concerned"? What do you regard as a small number of</p> <p>15 individuals?</p> <p>16 A. We witnessed on the Panorama programme a number of</p> <p>17 individuals who conducted themselves wholly</p> <p>18 inappropriately. I put that in the context of the many,</p> <p>19 many, many thousands of hours that colleagues within my</p> <p>20 business deliver. We are a private -- you have heard</p> <p>21 from previous individuals giving evidence to the</p> <p>22 inquiry, we are a private sector company delivering</p> <p>23 public services. We deliver many, many, many thousands</p> <p>24 of hours of public service to care for those individuals</p> <p>25 in our case.</p> <p style="text-align: center;">Page 27</p>
<p>1 it back up on screen, <CJS0074041> page 9.</p> <p>2 It is the second part of that paragraph:</p> <p>3 "The company's view is regardless of the number of</p> <p>4 staff on site the small number of individuals concerned</p> <p>5 chose to conduct themselves as they did when they</p> <p>6 thought they were effectively acting 'out of sight'. If</p> <p>7 they were that way inclined, they would likely have</p> <p>8 behaved in such circumstances irrespective as to the</p> <p>9 overall staffing profile or numbers."</p> <p>10 Out of sight of whom, Mr Brockington?</p> <p>11 A. Out of sight of -- I am guessing cameras or senior</p> <p>12 management.</p> <p>13 Q. So eyesight and earshot, presumably? Because it is not</p> <p>14 just physical abuse, it is language: derogatory,</p> <p>15 offensive, verbally abusive language. You know that?</p> <p>16 A. Yes.</p> <p>17 Q. Yes. And out of sight of whom, in particular?</p> <p>18 A. As I said, out of sight of senior management and</p> <p>19 cameras.</p> <p>20 Q. Well, out of sight of the SMT; yes?</p> <p>21 A. Sorry, that is what I thought I just said, yes, the</p> <p>22 senior managers.</p> <p>23 Q. You said "managers"; what do you mean by "managers"?</p> <p>24 A. I said "senior management team".</p> <p>25 Q. Senior management team?</p> <p style="text-align: center;">Page 26</p>	<p>1 So when I talk about a small number, I put it in the</p> <p>2 context of, you know, thousands of colleagues on</p> <p>3 a day-to-day, hour-by-hour basis, delivering care to</p> <p>4 those in our care. That is what I mean. We witnessed</p> <p>5 a handful of people delivering abhorrent activities.</p> <p>6 Q. That may be right, as far as the Panorama broadcast is</p> <p>7 concerned -- I assume you have watched that, haven't</p> <p>8 you?</p> <p>9 A. I watched it live, or at the time, and I have watched it</p> <p>10 many times since.</p> <p>11 Q. Yes, and have you watched any of the undisclosed -- the</p> <p>12 disclosed, unbroadcast footage?</p> <p>13 A. Not much of it, no.</p> <p>14 Q. How much?</p> <p>15 A. Very -- minimal amounts.</p> <p>16 Q. What does that mean?</p> <p>17 A. Well, a couple of snippets, really. Not -- really not</p> <p>18 very much.</p> <p>19 Q. A couple of snippets. Have you looked at some of the</p> <p>20 material disclosed by your own company?</p> <p>21 A. Yes, I have.</p> <p>22 Q. CCTV, and handheld and body-worn camera footage?</p> <p>23 A. I have seen -- I have seen some of it, not a huge</p> <p>24 amount.</p> <p>25 Q. No. Have you read some of the transcripts?</p> <p style="text-align: center;">Page 28</p>

<p>1 A. I have.</p> <p>2 Q. How many?</p> <p>3 A. I couldn't say.</p> <p>4 Q. No. You see, just if one reads that paragraph, the</p> <p>5 company's view is:</p> <p>6 "... regardless of the number of staff on site the</p> <p>7 small number of individuals concerned chose to conduct</p> <p>8 themselves as they did when they thought they were</p> <p>9 effectively acting 'out of sight'. If they were that</p> <p>10 way inclined, they would likely have behaved in such</p> <p>11 circumstances irrespective as to the overall staffing</p> <p>12 profile or numbers."</p> <p>13 It just sounds a little trivialising,</p> <p>14 Mr Brockington. Presumably you don't mean that?</p> <p>15 A. I couldn't -- I wholly disagree that that is</p> <p>16 trivialising this issue. This is a material issue and</p> <p>17 we have taken it, as an organisation, incredibly</p> <p>18 seriously.</p> <p>19 The immediate actions that we took post Panorama,</p> <p>20 working with Sussex and West Sussex Police, working with</p> <p>21 the Home Office, working with the IMB, developing the</p> <p>22 action plan, delivering a number of management actions</p> <p>23 immediately and further actions ongoing, I don't, for</p> <p>24 one minute, see how you can conclude that we have taken</p> <p>25 it trivially. This is an incredibly important issue for</p> <p style="text-align: center;">Page 29</p>	<p>1 going to provide the sort of information that was</p> <p>2 internally available to SMT members as early as 2014.</p> <p>3 You are talking about 2019, you refer back to the</p> <p>4 relevant report that covers the 2016 period, but we are</p> <p>5 not really interested in that, Mr Brockington. What we</p> <p>6 are interested in is what G4S knew, and that is why you</p> <p>7 are here.</p> <p>8 Have you heard the name Stacie Dean?</p> <p>9 A. I have.</p> <p>10 Q. So you will know that Stacie Dean -- in fact, together</p> <p>11 with Michelle Brown, but Stacie Dean in particular --</p> <p>12 first complained of the mistreatment of detainees some</p> <p>13 time before October 2014, and you should know that,</p> <p>14 because of that, Jerry Petherick became involved</p> <p>15 eventually. I am not going to go through the whole</p> <p>16 history, some of it has been ventilated during the</p> <p>17 course of the inquiry evidence, but she made a witness</p> <p>18 statement to the inquiry fairly recently. If we can put</p> <p>19 it up on screen, Zaynab, please, <INQ000172> at page 2.</p> <p>20 Tab 31, chair:</p> <p>21 "I have been asked whether I raised concern about</p> <p>22 the treatment of detainees earlier than October 2014.</p> <p>23 I can't recall when I first raised concern about the</p> <p>24 treatment of detainees formally. I know I raised the</p> <p>25 matter (along with the culture of staff bullying) in</p> <p style="text-align: center;">Page 31</p>
<p>1 us, as an organisation, and we have taken it very</p> <p>2 seriously indeed.</p> <p>3 Q. I mean the words "out of sight" are intended to suggest</p> <p>4 that the company, the senior management, never knew what</p> <p>5 was going on; is that the intention behind the wording?</p> <p>6 A. That is not the intention behind the wording. I do</p> <p>7 agree with you that the senior management team were not</p> <p>8 sighted on these issues, otherwise, they would have</p> <p>9 acted accordingly.</p> <p>10 Q. They had been going on since at least 2014. I know you</p> <p>11 tell us you didn't join the company until 2015, and you</p> <p>12 haven't been in the position you are in</p> <p>13 before November 2020, but were you aware that the</p> <p>14 mistreatment of detainees had been notified to the SMT</p> <p>15 as early as 2014? Were you aware of that?</p> <p>16 A. I wasn't aware of that. What I would say is, in terms</p> <p>17 of sort of constant failings, the HMIP inspection of</p> <p>18 2019 did state that they had no evidence to suggest that</p> <p>19 the 2016 inspection -- that they had missed any issues</p> <p>20 which were raised in Panorama.</p> <p>21 So whilst I don't take sole acceptance from HMIP,</p> <p>22 what I do take is a degree of assurance from</p> <p>23 an independent inspection such as HMIP.</p> <p>24 Q. Yes, but, Mr Brockington, we all know that</p> <p>25 an unannounced inspection of HMIP is not necessarily</p> <p style="text-align: center;">Page 30</p>	<p>1 various meetings, as did other members of the SMT.</p> <p>2 I have been asked whether I have any further in relation</p> <p>3 to the complaint I made in 2015 and recall that</p> <p>4 regarding DCOs Instone-Brewer and Fagbo, I raised</p> <p>5 concern that it was a well discussed issue (at senior</p> <p>6 meetings) that assurances had been given that they would</p> <p>7 not be allowed to work together on the same wing and</p> <p>8 that they were bullying detainees, yet whenever I went</p> <p>9 to Brook House, they were always rostered together.</p> <p>10 Other than that, I have nothing further to raise on that</p> <p>11 point."</p> <p>12 At paragraph 8 on the next page she says:</p> <p>13 "Both myself and Ms Brown ..."</p> <p>14 If we perhaps start at the beginning:</p> <p>15 "I have been asked to respond to the point that</p> <p>16 Ms Brown raised concern in a SMT meeting at which I was</p> <p>17 present. I do recall regularly that Ms Brown was one of</p> <p>18 the SMT members who repeatedly raised concern about</p> <p>19 staff treatment of detainees. Both myself and Ms Brown</p> <p>20 were concerned that some members of staff, as well as</p> <p>21 detainees, were being regularly subjected to bullying</p> <p>22 behaviour from some staff. The response of the SMT was</p> <p>23 consistently uninterested. I do not recall specific</p> <p>24 dates or times, but do remember the general approach to</p> <p>25 any of us raising concern or complaint would be fairly</p> <p style="text-align: center;">Page 32</p>

<p>1 generic and non-committal and the lack of any action was 2 frustrating. At times I think the view from some SMT 3 members was that the situation was amusing, so it was 4 far from taken seriously."</p> <p>5 We know that she wrote an email dated 6 25 October 2015, both to Steve Skitt, who was the deputy 7 director, and Ben Saunders, who was the centre director 8 making similar complaints. Her complaints, in 9 particular about mistreatment in relation to 10 Instone-Brewer and Fagbo, was goading and antagonising 11 detainees.</p> <p>12 So it starts as early as around 2014, and certainly, 13 by 2015, Jerry Petherick was involved. So it is hard to 14 say that the company didn't know or individuals higher 15 up the ladder didn't know; don't you agree? I mean, 16 this is a precursor to what we see in 2017.</p> <p>17 A. I really cannot comment further on these, and I am 18 afraid I have nothing further to add on the evidence 19 which you have just put in front of me.</p> <p>20 Q. If we go to another statement, Nathan Ward -- that's 21 a name that will be familiar to you, I suspect, 22 Mr Brockington?</p> <p>23 A. I don't know Nathan, but I do know the name.</p> <p>24 Q. <DL0000154>, please, at page 2, and this is his second 25 statement made to the inquiry. At paragraph 5, he</p> <p style="text-align: center;">Page 33</p>	<p>1 conclusion on any viewing of Panorama and the wider 2 footage that has been provided by the BBC on the way 3 staff treated detainees. The fact that officers such as 4 DCO Instone-Brewer and DCO Fagbo, two officers accused 5 not just of mistreating detainees but also dealing 6 spice, were still in place by the relevant period is 7 damning. Stacie Dean had raised concerns about these 8 officers to Ben Saunders and Stephen Skitt as early as 9 2015."</p> <p>10 That is the email I referred to a moment or two ago. 11 Do you agree it is damning, Mr Brockington?</p> <p>12 A. I cannot conclude either way. I have nothing more to 13 add to -- in relation to --</p> <p>14 Q. Why not? You are the face of G4S. Why have you got 15 nothing more to add?</p> <p>16 A. I have no corporate memory or knowledge of these 17 specific issues, so it would be inappropriate for me to 18 add anything further.</p> <p>19 Q. Do you need corporate memory to apologise, for example, 20 to say this should never have happened, to say the 21 company knew that there were issues as long ago as 22 2014/2015 and there is a causative link?</p> <p>23 A. In relation to the specific Panorama programme, of 24 course, I am exceptionally sorry. I thought I was 25 pretty clear in my view a few moments ago when I said</p> <p style="text-align: center;">Page 35</p>
<p>1 begins that paragraph by saying: 2 "Having reviewed the investigation ..." 3 Are you aware of the Cotter investigation?</p> <p>4 A. I know of its existence. I -- nothing of its detail.</p> <p>5 Q. Stephen Cotter, was asked to investigate any number of 6 issues and grievances which arose between members of 7 staff, following Nathan Ward's -- not only his exit 8 interview, but as a result of -- he left in about 2014, 9 but as a result of any number of other grievances, and 10 in particular what he had to say to the Panorama 11 programme.</p> <p>12 Stephen Cotter wrote a lengthy report, it is dated 13 16 November 2017, and that is the investigation 14 Nathan Ward is here talking about: 15 "Having reviewed the investigation, I believe the 16 most important point to take away from it is that it 17 shows, in the years building up to the abuse captured by 18 Panorama, various complaints of bullying, mismanagement 19 and failures at Brook House were made directly to 20 Jerry Petherick but these repeated complaints -- whether 21 by myself, Wayne Debnam, Stacie Dean or Michelle Brown 22 (with the latter two in particular raising concerns 23 about staff treatment of detainees) -- clearly did not 24 result in any sufficient changes being made by the time 25 of the relevant period in 2017. This can be the only</p> <p style="text-align: center;">Page 34</p>	<p>1 that the actions which we witnessed in Panorama were, 2 quite frankly, disgusting. And as an organisation, and 3 as an individual managing director, I take full 4 responsibility for the actions of my business. I am 5 exceptionally sorry that those actions took place.</p> <p>6 But on the specifics of the emails and the detail of 7 which you have just put in front of me, I don't have 8 anything further to add. What I reiterate is I am -- 9 I was appalled by what I saw in Panorama and, of course, 10 as an organisation, we are exceptionally sorry that that 11 happened.</p> <p>12 Q. Can we look at your paragraph 71 of your witness 13 statement. We are back to <CJS0074041> at page 16. 14 Under the heading "Management of Brook House", you say: 15 "The company does not believe that members of the 16 senior management team of Brook House were aware of 17 mistreatment of detainees of the type shown in 18 Panorama." 19 What type did you have in mind? What was the 20 qualification "of the type", what did you mean by that?</p> <p>21 A. Literally, just referring to the appalling behaviour 22 which we saw in the Panorama programme.</p> <p>23 Q. Because it is clear from what I have just suggested to 24 you that the management was aware years before that 25 detainees were being mistreated.</p> <p style="text-align: center;">Page 36</p>

<p>1 You accept that, don't you?</p> <p>2 A. No, I -- I responded to your question that I can't</p> <p>3 conclude either way.</p> <p>4 Q. Or you are just not prepared to, Mr Brockington?</p> <p>5 A. No, as I said, I can't conclude either way.</p> <p>6 Q. Then at 72, at the top of the next page:</p> <p>7 "The company is not aware of any evidence that</p> <p>8 suggests that senior managers ought to have been aware</p> <p>9 of such mistreatment."</p> <p>10 Did you really mean that?</p> <p>11 A. I would say that if senior managers were made aware of</p> <p>12 mistreatment, they would have acted appropriately.</p> <p>13 I can certainly refer to the business which I run today,</p> <p>14 and I would fully expect that, if any evidence of any</p> <p>15 suggestions of mistreatment occurred within the</p> <p>16 establishments which I run, we would absolutely take</p> <p>17 immediate action to investigate.</p> <p>18 Q. Well, let's look at what the company did know. You have</p> <p>19 referred to the HMIP report for -- signed off by</p> <p>20 Peter Clarke in January 2017 but for the inspection</p> <p>21 window of 31 October to 11 November 2016. <CJS000761>,</p> <p>22 please, page 1 to begin with.</p> <p>23 This is one of the reports you referred to,</p> <p>24 Mr Brockington, isn't it?</p> <p>25 If we then go to page 20, were you aware that the</p> <p style="text-align: center;">Page 37</p>	<p>1 in the course of their detainee survey. In particular,</p> <p>2 on page 76, we have, under section 7, towards the</p> <p>3 bottom, beginning with question 43:</p> <p>4 "Do you have a member of staff at the centre you can</p> <p>5 turn to for help if you have a problem?", and so on.</p> <p>6 There are four questions in that vein, concluding at</p> <p>7 question 46, at the top of the next page. And then</p> <p>8 a new section, "Section 8: Safety":</p> <p>9 "Do you feel unsafe in this centre?"</p> <p>10 Yes, 37 per cent; no, 63 per cent.</p> <p>11 48:</p> <p>12 "Has another detainee or group of detainees</p> <p>13 victimised, insulted or assaulted you here? "</p> <p>14 Yes, 71 per cent; no, 79 per cent.</p> <p>15 Question 49, further questions about victimisation</p> <p>16 by detainees or groups of detainees.</p> <p>17 But let's look at question 50:</p> <p>18 "Has a member of staff or group of staff victimised</p> <p>19 (['victimised' here meaning] insulted or assaulted) you</p> <p>20 here?"</p> <p>21 Yes, 18 per cent; no, 82 per cent.</p> <p>22 51:</p> <p>23 "If you have felt victimised by a member of</p> <p>24 staff/group of staff, what did the incident(s)</p> <p>25 involve?...</p> <p style="text-align: center;">Page 39</p>
<p>1 HMIP conducted a detainee survey?</p> <p>2 A. I was aware, yes.</p> <p>3 Q. Yes. If we look at 1.13 on page 20:</p> <p>4 "In our survey, 37 per cent of detainees reported</p> <p>5 feeling unsafe, 21 per cent reported victimisation by</p> <p>6 other detainees and 18 per cent by staff. The Safer</p> <p>7 Community team had provided information in different</p> <p>8 languages to detainees about reporting concerns. Focus</p> <p>9 groups had been held to discuss victimisation and</p> <p>10 violence."</p> <p>11 Then if we go to page 69, at the top, it is:</p> <p>12 "Appendix IV: Summary of detainee survey responses"</p> <p>13 and, at the foot of the page, under the heading "Survey</p> <p>14 response":</p> <p>15 "At the time of the survey on 31 October 2016, the</p> <p>16 detainee population of Brook House was 392. Using the</p> <p>17 [methodology they set out], questionnaires were</p> <p>18 distributed to a sample of 209 detainees.</p> <p>19 "We received a total of 159 completed</p> <p>20 questionnaires, a response rate of 76 per cent. This</p> <p>21 included one questionnaire completed via interview.</p> <p>22 Nine respondents refused to complete a questionnaire and</p> <p>23 41 questionnaires were not returned."</p> <p>24 Can we go on, please, to page 76. Here you will see</p> <p>25 the questions and the responses which the HMIP received</p> <p style="text-align: center;">Page 38</p>	<p>1 "Physical abuse (being hit, kicked or assaulted),</p> <p>2 3 per cent."</p> <p>3 52:</p> <p>4 "If you have been victimised by detainees or staff,</p> <p>5 did you report it?"</p> <p>6 Yes, 12 per cent.</p> <p>7 Skating over 53, question 54:</p> <p>8 "Have you ever felt threatened or intimidated by</p> <p>9 a member of staff in here?"</p> <p>10 Yes, 12 per cent.</p> <p>11 Now, presumably, senior managers not just at SMT</p> <p>12 level, but at board level, would be privy to the</p> <p>13 contents of a report like this?</p> <p>14 A. I would absolutely agree. I can't speak for my</p> <p>15 colleagues, but what I would say, in the business and</p> <p>16 the estate which I run, when we have an HMIP inspection,</p> <p>17 I would certainly read the contents of an HMIP</p> <p>18 inspection.</p> <p>19 Q. Yes. Well, this one, as I have told you, was signed off</p> <p>20 by Peter Clarke, the chief inspector, in January 2017,</p> <p>21 so a matter of three months before the commencement of</p> <p>22 the relevant period, for the purposes of this inquiry.</p> <p>23 Why doesn't a survey like this ring alarm bells,</p> <p>24 because here it is, writ large, that there are detainees</p> <p>25 who were prepared to take part in this survey and</p> <p style="text-align: center;">Page 40</p>

<p>1 prepared to tell HMIP that they were being insulted or</p> <p>2 assaulted, in particular physically abused, being hit,</p> <p>3 kicked or assaulted, and it had been reported.</p> <p>4 You cannot tell this inquiry, Mr Brockington, that</p> <p>5 the company didn't know that there were problems, can</p> <p>6 you?</p> <p>7 A. What I would say is the findings of Peter Clarke and his</p> <p>8 inspection team stated very clearly that the 2016</p> <p>9 report, issued in 2017, the establishment was allocated</p> <p>10 a reasonably good overall assessment for the four and</p> <p>11 healthy establishment tests.</p> <p>12 So whilst I agree there are specifics in there which</p> <p>13 would have formed part of the action plan, the overall</p> <p>14 assessment was reasonably good.</p> <p>15 I would also go back to, and refer you to, the 2019</p> <p>16 report, which is clearly after the second inspection,</p> <p>17 where HMIP also stated that there was no evidence to</p> <p>18 suggest in the 2016 inspection that any -- that they had</p> <p>19 missed any issues relating to what was subsequently seen</p> <p>20 in the Panorama.</p> <p>21 Q. So the company takes comfort from two words, "Reasonably</p> <p>22 good" but, what, is prepared to excuse as acceptable the</p> <p>23 physical abuse even of 3 per cent of the detainee</p> <p>24 population by staff?</p> <p>25 A. Sorry, that is not what I said.</p> <p style="text-align: center;">Page 41</p>	<p>1 overarching assessment of our establishment was</p> <p>2 reasonably good.</p> <p>3 Q. I assume you will agree, Mr Brockington, that these</p> <p>4 figures are unacceptable?</p> <p>5 A. I would agree that we -- when we review these, we need</p> <p>6 to take action.</p> <p>7 Any form of -- any form of violence that is of staff</p> <p>8 against detainee or prisoner is wholly -- that falls</p> <p>9 outside of the formal training and process is wholly</p> <p>10 unacceptable.</p> <p>11 Q. You made that clear, that under your tenure, if you</p> <p>12 heard of that sort of thing happening, you would deal</p> <p>13 with it. You said that earlier.</p> <p>14 A. I would and I stand by that.</p> <p>15 Q. What was done about this? Forget HMIP and forget, if</p> <p>16 I may say so, seeking refuge in the fact that</p> <p>17 Peter Clarke found the establishment "reasonably good",</p> <p>18 what I want to know is what was done about even</p> <p>19 unacceptable figures of physical abuse of detainees</p> <p>20 which was reported, what was done about it at the time?</p> <p>21 A. I am afraid I wasn't privy to the specifics at the time,</p> <p>22 so I can't comment further on that specific question.</p> <p>23 Q. What I am going to do, Mr Brockington, is to invite you,</p> <p>24 after you have completed your evidence, to find out and</p> <p>25 provide, if you would, a further statement to the</p> <p style="text-align: center;">Page 43</p>
<p>1 Q. What are you saying, Mr Brockington, because it seems to</p> <p>2 me, and it may seem to others, that you are sidestepping</p> <p>3 the issue. You are relying on what Peter Clarke said or</p> <p>4 what HMIP said overall about the health of the</p> <p>5 establishment, but you are overlooking this detainee</p> <p>6 survey.</p> <p>7 A. That is not the case.</p> <p>8 When we receive -- I can only talk for today, but</p> <p>9 when we receive an HMIP inspection final report, we</p> <p>10 would review it in detail, and that forms the basis of</p> <p>11 an overarching action plan to constantly improve our</p> <p>12 establishments, because that is what we do.</p> <p>13 We strive to improve constantly. This would have</p> <p>14 formed part of our thinking, undoubtedly at the time, so</p> <p>15 I am not sidestepping it based on two words. What I am</p> <p>16 actually saying is we hold HMIP inspections very, very</p> <p>17 seriously. They are absolute experts in their field,</p> <p>18 who have a full appreciation of both the custodial and</p> <p>19 the detained estate, who periodically come and assess us</p> <p>20 overall.</p> <p>21 So we do take what they say incredibly seriously.</p> <p>22 We also take what the detainees say incredibly</p> <p>23 seriously. And this would form part of our overarching</p> <p>24 action plan. But I go back to the point that, whilst we</p> <p>25 and HMIP will have looked at this data very closely, the</p> <p style="text-align: center;">Page 42</p>	<p>1 inquiry, please, telling us exactly what G4S did about</p> <p>2 the information in this detainee survey from 2017.</p> <p>3 A. We would be delighted to do that.</p> <p>4 Q. Going back to your witness statement in May, please, at</p> <p>5 paragraph 21, you say, "In terms of lessons learned" --</p> <p>6 at paragraph 21 on page 5, Zaynab:</p> <p>7 "In terms of lessons learned, the company would</p> <p>8 accept that the management team in place at the time</p> <p>9 spent a significant amount of their time dealing with</p> <p>10 paperwork, leaving insufficient time to be proactive and</p> <p>11 be 'out and about' in the centre. This changed</p> <p>12 following the Panorama programme and the implementation</p> <p>13 of the Project Board Action Plan."</p> <p>14 At 22, you say:</p> <p>15 "Managers were not close enough to the day-to-day</p> <p>16 goings on, which led to individuals taking too much</p> <p>17 direction from DCMs."</p> <p>18 Are you accepting, so that we are clear, that there</p> <p>19 were failures at senior management level at the time?</p> <p>20 A. What I am saying is there was -- after Panorama, when we</p> <p>21 brought in an interim -- an experienced interim director</p> <p>22 into the establishment, it was clear that there was</p> <p>23 a disconnect between the SMT and the DCMs on site.</p> <p>24 I think I mentioned earlier, but I will reiterate, as</p> <p>25 part of the action plan, under the leadership of the new</p> <p style="text-align: center;">Page 44</p>

<p>1 interim director, we bolstered the SMT, we increased the</p> <p>2 number of DCMs and we deployed training to the DCMs</p> <p>3 through engagement with Corndell to ensure they had the</p> <p>4 required training to deliver their role.</p> <p>5 So we would accept, and I say in my statement, that</p> <p>6 there was a disconnect between the SMT and the frontline</p> <p>7 management.</p> <p>8 Q. So coming back to my original question, are you prepared</p> <p>9 to accept that there were failures at senior management</p> <p>10 level at the time?</p> <p>11 A. What I am saying is there was a disconnect between the</p> <p>12 two.</p> <p>13 Q. Why won't you agree with me, Mr Brockington? Why are</p> <p>14 you not prepared to agree with the word "failure"?</p> <p>15 A. What I am saying is the -- the senior management team</p> <p>16 were clearly focused in one area. There was -- as</p> <p>17 I said previously, there was a clearly a disconnect</p> <p>18 which was highlighted by the new interim director and we</p> <p>19 took approach actions to close that gap.</p> <p>20 Q. So are you saying it wasn't a failure?</p> <p>21 A. I am saying -- I am saying there was clearly a gap</p> <p>22 between the frontline management and the senior</p> <p>23 management team.</p> <p>24 Q. So it is a "disconnect", it is a "gap", but the word</p> <p>25 "failure" you cannot bring to say; is that it</p> <p style="text-align: center;">Page 45</p>	<p>1 A. I think there was just a general feeling, is my</p> <p>2 understanding from the work that I have done and talking</p> <p>3 to colleagues. My understanding there was, as I say,</p> <p>4 a disconnect between DCMs and the SMT on site and that</p> <p>5 was picked up by the staff on site.</p> <p>6 Q. Who are the colleagues that you spoke to in order to</p> <p>7 produce these words in this paragraph of this statement?</p> <p>8 Who did you speak to? Who was your information from?</p> <p>9 A. I have spoken to a number of people within the</p> <p>10 organisation.</p> <p>11 Q. People who were at Brook House at the time?</p> <p>12 A. People who had an understanding of Brook House.</p> <p>13 Q. People who were at Brook House at the time?</p> <p>14 A. It depends which period you are talking about.</p> <p>15 Q. Well, the time is the relevant period for the purposes</p> <p>16 of this inquiry.</p> <p>17 A. I have certainly spoken to the interim director who we</p> <p>18 had put in place.</p> <p>19 Q. Who else?</p> <p>20 A. The functional leads that were in post, not at</p> <p>21 Brook House but functional leads that have</p> <p>22 a recollection of that, the relevant period.</p> <p>23 Q. You go on in that paragraph to say:</p> <p>24 "This was limited to the staff members identified in</p> <p>25 the programme where processes and procedures were not</p> <p style="text-align: center;">Page 47</p>
<p>1 Mr Brockington? You are not prepared to characterise it</p> <p>2 as a failure?</p> <p>3 A. I stand by what I have just said.</p> <p>4 Q. You go on to say at paragraph 22:</p> <p>5 "There was a perception that this environment bred</p> <p>6 bad habits and common practices developed which were not</p> <p>7 acceptable."</p> <p>8 Whose perception did you have in mind?</p> <p>9 A. That would be the perception of the frontline staff.</p> <p>10 Q. By which you mean?</p> <p>11 A. DCOs.</p> <p>12 Q. So the DCOs perceived that the environment "bred bad</p> <p>13 habits and common practices developed which were not</p> <p>14 acceptable"? How did they breed bad habits? How did</p> <p>15 the DCOs breed bad habits, or are you saying the senior</p> <p>16 management bred bad habits?</p> <p>17 A. I am afraid I would have no sight of what was happening</p> <p>18 on site at that time.</p> <p>19 Q. Mr Brockington, these are your words. They are not my</p> <p>20 words. I am just reading back to you what you were</p> <p>21 prepared to sign off as a statement of truth.</p> <p>22 So help us, why did you say this? What was the</p> <p>23 perception that the environment bred bad habits? That</p> <p>24 is what I want to know. These are your words, what did</p> <p>25 you mean?</p> <p style="text-align: center;">Page 46</p>	<p>1 followed, namely, around the use of force, completing</p> <p>2 paperwork correctly, and the treating of detainees with</p> <p>3 dignity and respect."</p> <p>4 So is it your suggestion that somehow Callum Tulley,</p> <p>5 on behalf of the BBC, conveniently managed to capture</p> <p>6 the entirety of the bad practices and abuse at</p> <p>7 Brook House at the time and that there was nothing more</p> <p>8 to see here; is that what you are trying to say here?</p> <p>9 It is limited to ...?</p> <p>10 A. What I am saying is it is our understanding that these</p> <p>11 were isolated incidents, and I take -- I make that</p> <p>12 conclusion based on information which we have -- which</p> <p>13 we have internally but also information which was</p> <p>14 provided to the organisation from the IMB and the</p> <p>15 Home Office, et cetera, so I think, you know, we are not</p> <p>16 running this establishment in isolation. There are</p> <p>17 a number of third parties on site, so we are, you</p> <p>18 know -- of which I have no recollection of, you know,</p> <p>19 those parties raising these issues.</p> <p>20 So, you know, I think it is important to stress that</p> <p>21 the centre did have a number of organisations on site,</p> <p>22 both the IMB -- as I said, the IMB, the Home Office,</p> <p>23 amongst others.</p> <p>24 Q. So does G4S accept, or not accept, that these practices</p> <p>25 were ingrained and systemic?</p> <p style="text-align: center;">Page 48</p>

<p>1 A. I do not accept that they were ingrained and systemic.</p> <p>2 Q. So, from your perspective, on behalf of the company,</p> <p>3 what we are seeing are isolated instances of the abuse</p> <p>4 of detainees, all, as it happens, captured by</p> <p>5 Callum Tulley, but, for the rest, the inquiry shouldn't</p> <p>6 be concerned that that kind of abuse, of that type, was</p> <p>7 going on outside that period; is that what we should</p> <p>8 understand from your evidence?</p> <p>9 A. What I am saying is we believed these to be isolated</p> <p>10 incidents and we take a view, and that from our</p> <p>11 experience, from Home Office, IMB, other authorities, so</p> <p>12 we believe that they were isolated incidents. I would</p> <p>13 agree with your comment in specific relation to the</p> <p>14 isolatedness.</p> <p>15 Q. You don't want to be agreeing with me, Mr Brockington,</p> <p>16 because all I am doing is putting questions to you.</p> <p>17 Don't take from anything that I say that I am vocalising</p> <p>18 an opinion.</p> <p>19 Back to your statement at page 17, paragraph 73, you</p> <p>20 talk about the complaints system, and you say:</p> <p>21 "In light of the fact that the significant incidents</p> <p>22 broadcast by Panorama were not reported to senior</p> <p>23 management by detainees or staff at the time, the</p> <p>24 company has been asked to comment on whether the</p> <p>25 complaints system and/or whistleblowing policy properly</p> <p style="text-align: center;">Page 49</p>	<p>1 the establishments. The IRCs had a very different</p> <p>2 complaints process to that of the custody estate,</p> <p>3 whereas the Home Office run a complaints process for the</p> <p>4 detainees.</p> <p>5 In terms of our own complaints process and</p> <p>6 whistleblowing, we need to be very clear that, you know,</p> <p>7 we believe there was a robust process in place for staff</p> <p>8 to make complaints, but I also say in my personal</p> <p>9 statement, which you may or may not come on to, that, in</p> <p>10 this instance, it didn't work. The individuals who we</p> <p>11 witnessed on the Panorama programme chose not to use</p> <p>12 a whistleblowing process, which goes against the</p> <p>13 training, which we trained through the ITC programme,</p> <p>14 and it also goes against their obligation to the</p> <p>15 Secretary of State under their certification.</p> <p>16 So it didn't work. We took a number of actions --</p> <p>17 it didn't work because they chose not to use it. We</p> <p>18 took a number of actions post Panorama to reinforce the</p> <p>19 whistleblowing process.</p> <p>20 The whistleblowing process, just to be clear, was</p> <p>21 a process which G4S established, working very closely</p> <p>22 with Public Concern at Work, who were -- are deemed to</p> <p>23 be experts in this field and, you know, advised BEIS(?),</p> <p>24 as an example, on whistleblowing processes, so we felt</p> <p>25 this was a global process which was designed by experts</p> <p style="text-align: center;">Page 51</p>
<p>1 accounted for potential barriers to disclosure. It is</p> <p>2 also the case that none of the matters appear to have</p> <p>3 been reported by any of the other multiple organisations</p> <p>4 that were in regular contact with detainees (certainly</p> <p>5 not in a way that would have permitted G4S to take</p> <p>6 action on the report). It is not entirely clear why</p> <p>7 this is. It may however be a manifestation of a general</p> <p>8 lack of trust within the detained population towards</p> <p>9 agencies of the state."</p> <p>10 At 74:</p> <p>11 "The complaints system [which you explain further</p> <p>12 below] ... but detainees had free and unfettered access</p> <p>13 to the complaints system. The company believes that the</p> <p>14 system itself was robust and transparent. The</p> <p>15 complaints system was however determined by the HO."</p> <p>16 In other words, the Home Office.</p> <p>17 Does the company, through you, Mr Brockington, take</p> <p>18 comfort from the fact that, at least during the relevant</p> <p>19 period, there were no official reports of mistreatment?</p> <p>20 Is that what we are to understand from what you say,</p> <p>21 "We, the company, take comfort, our whistleblowing</p> <p>22 processes were robust, our complaints system was robust</p> <p>23 and, therefore, the absence of complaints means there is</p> <p>24 an absence of evidence"?</p> <p>25 A. I just need to be clear on the process for complaints in</p> <p style="text-align: center;">Page 50</p>	<p>1 and implemented across our business. After Panorama, we</p> <p>2 promoted it, we promoted it heavily, as part of our</p> <p>3 action plan, but, of course, these things are only --</p> <p>4 only work if people choose to use them. Why people</p> <p>5 chose not to use them, which is contrary to their</p> <p>6 training, and is contrary to their obligations to</p> <p>7 Secretary of State under their certification, is --</p> <p>8 I can't conclude as to why that happened.</p> <p>9 Q. So you cannot account for the fact that it wasn't being</p> <p>10 used to capture and investigate the serious abuses that</p> <p>11 happened at Brook House during the period that we are</p> <p>12 concerned with?</p> <p>13 A. What I am saying is I can't conclude why the individuals</p> <p>14 who we witnessed on the Panorama programme chose not to</p> <p>15 use a whistleblowing process, which is in contra to</p> <p>16 their training and contra to their obligation to the</p> <p>17 Secretary of State under their certification.</p> <p>18 Q. I will come back to a couple of reasons in a moment.</p> <p>19 Before we break, there is one further document I would</p> <p>20 like to show you. <HOM0331707>, please. This,</p> <p>21 Mr Brockington, is an internal memorandum within the</p> <p>22 Home Office. It is dated 22 March. It should be 2018.</p> <p>23 The name to whom it is sent is redacted, but I think</p> <p>24 I am at liberty to tell you who the name actually is.</p> <p>25 It is Patsy Wilkinson, who was the Second Permanent</p> <p style="text-align: center;">Page 52</p>

<p>1 Secretary, so this is as high up as this document went, 2 and there is a list of other people to whom this 3 document went at the foot of it, which probably, in this 4 version, will be redacted, so we will not be able to see 5 it. 6 "Panorama allegations against G4S staff at 7 Brook House." 8 It is to do with a meeting, at paragraph 1, "to 9 discuss Professional Standards Unit ... investigations 10 and Brook House on 20 February". They undertook to 11 provide her "with a definitive account of what the 12 Home Office knew about the detainee custody officers ... 13 against whom allegations were made and the outcome of 14 associated investigations." 15 Paragraph 2: 16 "There were 17 members of G4S staff identified 17 within the material Panorama provided before the 18 broadcast, or from the broadcast footage, details of 19 which were provided [separately]." 20 Under the heading, "Prior allegations: 21 "Of these 17, seven had been the subject of serious 22 complaints in 2016 and 2017 and were investigated by PSU 23 [table provided below]. These investigations were prior 24 to and unconnected with the Panorama allegations. On 25 the date on which we were made aware of Panorama's</p> <p style="text-align: center;">Page 53</p>	<p>1 anything further to your line of questioning, I am 2 afraid. 3 MR ALTMAN: All right, Mr Brockington. It is 25 past, 4 chair. Can I suggest a 15-minute break and come back at 5 11.40? 6 THE CHAIR: Thank you very much. Thank you. 7 (11.27 am) 8 (a short break) 9 (11.40 am) 10 THE CHAIR: Thank you very much. Please take a seat. 11 Mr Altman, thank you. 12 MR ALTMAN: Zaynab, could we put up on screen, please, 13 Mr Brockington's first witness statement <CJS0074041> at 14 page 11. 15 Here you are dealing with policies and procedures. 16 At paragraph 45, you say: 17 "It is evident that certain staff members, and in 18 particular Mr Callum Tulley, did not report their 19 concerns on abuses and/or impropriety. This did put 20 detainees at risk as it allowed abuses of the type shown 21 in Panorama to continue. Such abuses would have been 22 prevented had prompt reports been made, as they would 23 have been acted on by the company. Mr Tulley stated in 24 the programme that he did not report his concerns on the 25 basis that he did not believe that they would have been</p> <p style="text-align: center;">Page 55</p>
<p>1 allegation (24 August 2017) there were six outstanding 2 investigations into the activities of five DCOs 3 (highlighted in [the table]). None of these 4 investigations were based on allegations that 5 subsequently featured in the Panorama material." 6 So, of the 17 identified in the Panorama broadcast, 7 seven of them had already been the subject of serious 8 complaint in 2016 and 2017. Were you aware of that, 9 Mr Brockington? 10 A. No, I wasn't. 11 Q. Surely G4S must have been? 12 A. I would expect, but I can't wholly conclude -- I can 13 come back to the inquiry, if that would be helpful. 14 Q. Yes, please. But if it is right, whether they are 15 allegations substantiated or unsubstantiated, they are 16 serious. If you look down the list, they are all 17 assaults, there are some sexual assaults, and one is 18 assault and neglect. And we will see that the greater 19 number are against a DCO by the name of Derek Murphy. 20 Do you agree that G4S should have considered these 21 more closely before being exposed by the BBC? Or do 22 you -- 23 A. I am afraid, personally, I can't conclude either way on 24 that. What I have committed to the inquiry is we will 25 respond, if that would be helpful, but I can't add</p> <p style="text-align: center;">Page 54</p>	<p>1 taken seriously. The company does not understand the 2 basis of this assertion, given there was never any 3 attempt by him to raise such concerns at any stage 4 during his employment with the company through its 5 whistleblowing policy or otherwise. The company is 6 confident that, had he done so, such complaints would 7 have been treated seriously." 8 Were you aware that "Speak Out" posters had been 9 defaced in parts of Brook House, or a part of 10 Brook House that was accessible by staff members, upon 11 which was written words like "snitch" or "grass"; did 12 you know that? 13 A. I did know that. 14 Q. So anybody reading that would understand pretty readily 15 that speaking out, even within the company's global 16 whistleblowing policy, would be met by difficulty, to 17 say the least, amongst one's colleagues; do you agree? 18 A. I think there were a couple of posters that were defaced 19 in that way, which is not acceptable. 20 So, yes, I would say that it is not acceptable to 21 have that on the posters. 22 Q. Callum Tulley joined the company, if my memory serves 23 me, in 2015, when he was 18, so by the time we are 24 talking about, he was a young man of around 20. 25 Ironically, as you probably realise, Mr Brockington,</p> <p style="text-align: center;">Page 56</p>

<p>1 he was influenced to go to the BBC Panorama production</p> <p>2 team having watched, on 12 January 2016, the Panorama</p> <p>3 expose into Medway?</p> <p>4 A. I was aware of that point.</p> <p>5 Q. He was a 20-year old or thereabouts. But Owen Syred, he</p> <p>6 wasn't -- you have heard the name Owen Syred?</p> <p>7 A. I have.</p> <p>8 Q. If we put up on screen what he told us in his witness</p> <p>9 statement -- please, Zaynab <INN000007> at page 30. He</p> <p>10 was a mature man, a welfare officer, respected, listened</p> <p>11 to, and under the heading in his statement "Disciplinary</p> <p>12 and grievance process", between paragraphs 125 and 127,</p> <p>13 he tells the story of how someone by the name of</p> <p>14 Sam Gurney said to him -- you can see about half a dozen</p> <p>15 lines up -- when some of the detainees were being</p> <p>16 demanding, "I bloody hate this lot, no wonder I'm</p> <p>17 racist."</p> <p>18 He made some comment about that. A couple of weeks</p> <p>19 later, he was in the wing office on C wing, talking to</p> <p>20 another DCO by the name of Liam Sharkey, who was eating</p> <p>21 a packet of plantain crisps, and he said:</p> <p>22 "I asked Liam what they were and Sam interjected and</p> <p>23 said 'they are crisps for niggers'. I couldn't believe</p> <p>24 what he had said. I knew that I had to challenge the</p> <p>25 comment, but I didn't want to do it in front of the</p> <p style="text-align: center;">Page 57</p>	<p>1 should focus on more mature candidates."</p> <p>2 If this sort of thing happened to somebody of the</p> <p>3 seniority of Owen Syred, what confidence could anybody</p> <p>4 have that whistleblowing would make any difference other</p> <p>5 than one which was to the detriment of the person who</p> <p>6 made the complaint?</p> <p>7 A. Clearly, that sort of behaviour is horrendous. And</p> <p>8 I would absolutely not accept that behaviour in the</p> <p>9 estate, in the establishments which I am currently</p> <p>10 responsible for.</p> <p>11 Q. What is the answer to the question, Mr Brockington?</p> <p>12 A. You would conclude that, clearly, on a personal level --</p> <p>13 and it is my personal view, in response to that</p> <p>14 question -- that, you know, younger men -- clearly,</p> <p>15 Callum Tulley was influenced by this and he made it</p> <p>16 clear in his statement.</p> <p>17 Q. Well, my question was, what confidence could anybody</p> <p>18 have in making a complaint through the whistleblowing</p> <p>19 hotline or process, if the result is nothing other than</p> <p>20 detriment to the person who makes the complaint? That</p> <p>21 is my question. The answer is surely none, isn't it?</p> <p>22 A. We were very clear in our training, through the ITCs and</p> <p>23 promoting the ITCs, that individuals should use the</p> <p>24 "Speak Out" and they should absolutely -- in accordance</p> <p>25 with their obligation under the certification to the</p> <p style="text-align: center;">Page 59</p>
<p>1 detainees ..."</p> <p>2 So two points. First of all, Gurney says what he</p> <p>3 says. Mr Syred, very sensibly, did not want to</p> <p>4 challenge the comment in front of detainees because, as</p> <p>5 he said, this could have caused disruption:</p> <p>6 "A detainee was stood nearby and I wasn't sure if he</p> <p>7 had heard everything that had been said. The detainee</p> <p>8 said to me, 'did I hear what I thought I heard?'"</p> <p>9 And he said:</p> <p>10 "I told the detainee that I would deal with it and</p> <p>11 the detainee said 'I trust you to deal with it.'"</p> <p>12 So he did, he went to Conway Edwards, who was,</p> <p>13 I think, the diversity and inclusion manager, and took</p> <p>14 the complaint there. And, at paragraph 127:</p> <p>15 "Following my report of this incident I started to</p> <p>16 receive Post-It notes stuck on my locker that said</p> <p>17 'nigger lover' and 'grass' and for about a year</p> <p>18 afterwards, friends of Sam in the control room would</p> <p>19 follow me around by camera and raise bogus reports to</p> <p>20 try and get me into trouble, for example a complaint</p> <p>21 that I shaved in the barbers while on duty (which was</p> <p>22 false). I was also told by a colleague to watch my back</p> <p>23 and that people had it in for me because I had reported</p> <p>24 Sam. I reported this behaviour to the director,</p> <p>25 Ben Saunders, and recommended that future recruitment</p> <p style="text-align: center;">Page 58</p>	<p>1 Secretary of State, they have an obligation to raise any</p> <p>2 concerns.</p> <p>3 So to be honest, I can't conclude either way. What</p> <p>4 I can say is we trained our staff to speak out when they</p> <p>5 found areas of concern, and either through line</p> <p>6 management, which would be our primary option, or by</p> <p>7 whistleblowing if they chose not to use the line</p> <p>8 management reporting process.</p> <p>9 So, you know -- and we emphasised that further after</p> <p>10 Panorama. So it was -- they had an obligation to us</p> <p>11 under the training, and they had an obligation to the</p> <p>12 Secretary of State as well.</p> <p>13 Q. Which is all fine and dandy, Mr Brockington, but you</p> <p>14 talk about reporting to line managers if you don't want</p> <p>15 to use the formal hotline. Well, because Callum Tulley</p> <p>16 was a DCO, his line managers were DCMs and he made it</p> <p>17 perfectly clear to us, when he gave evidence in the</p> <p>18 first phase of this inquiry, that the principal reason</p> <p>19 he reported none of this to other DCMs was because the</p> <p>20 DCMs were involved in it themselves that. That is</p> <p>21 a fair point, isn't it?</p> <p>22 A. I can't comment on what was happening on site at the</p> <p>23 time. What I can say is that the organisation which</p> <p>24 I am managing director of and I am responsible for,</p> <p>25 I believe has a culture where, if those feel they cannot</p> <p style="text-align: center;">Page 60</p>

15 (Pages 57 to 60)

<p>1 report to their line management, they can escalate that</p> <p>2 and I am very clear that anybody can escalate any issues</p> <p>3 to myself.</p> <p>4 So whilst I can't comment on during this period at</p> <p>5 the IRC, what I can say is that is certainly the culture</p> <p>6 which I have in my organisation.</p> <p>7 Q. Owen Syred talks about the culture at paragraph 129</p> <p>8 which is still on screen:</p> <p>9 "The culture within the organisation was that they</p> <p>10 did not want to make waves and did not want to generate</p> <p>11 publicity."</p> <p>12 Is that right, Mr Brockington?</p> <p>13 A. As I said in my previous statement, I can't comment at</p> <p>14 that point in time, at that establishment. What I can</p> <p>15 say is that is certainly not an environment which</p> <p>16 I recognise in the establishments and business which</p> <p>17 I currently run.</p> <p>18 Q. If we go to what Callum Tulley had to say in his inquiry</p> <p>19 witness statement, <INQ000052> at page 42,</p> <p>20 paragraph 168, and start at 167:</p> <p>21 "In the majority of examples outlined in this</p> <p>22 statement, members of staff were present during</p> <p>23 mistreatment of detainees and for admissions of abuse</p> <p>24 and malpractice who were otherwise well behaving</p> <p>25 officers. This underlines the lack of confidence staff</p> <p style="text-align: center;">Page 61</p>	<p>1 wasn't raised to them either.</p> <p>2 Q. Yes, because it was a culture of silence. That is the</p> <p>3 whole point, isn't it, Mr Brockington?</p> <p>4 A. As I said, I can't conclude. I would be surmising.</p> <p>5 Q. Let's turn to another paragraph of yours, please, in</p> <p>6 your first witness statement, back to that, please,</p> <p>7 Zaynab, <CJS0074041> at page 35 and paragraph 173:</p> <p>8 "All use of force incidents were reported directly</p> <p>9 to the Home Office as required under the terms of the</p> <p>10 contract."</p> <p>11 Do you want to rethink that sentence,</p> <p>12 Mr Brockington? Is there anything about it that is not</p> <p>13 accurate, do you think?</p> <p>14 A. That is my understanding, when I submitted the statement</p> <p>15 to the inquiry.</p> <p>16 Q. Well, what about the incidents which resulted in the</p> <p>17 strangulation of D1527 on 25 April, when there was</p> <p>18 a failure by anyone to bring to anyone's attention that</p> <p>19 assault on him on that date, let alone -- forget the</p> <p>20 Home Office, let alone to G4S. It is not right, is it,</p> <p>21 this sentence?</p> <p>22 You know what I am talking about, don't you?</p> <p>23 A. Of course I do.</p> <p>24 Q. Yes, there was a complete cover-up, which involved every</p> <p>25 officer who was involved in the illegitimate use of</p> <p style="text-align: center;">Page 63</p>
<p>1 had in raising complaints about such behaviour."</p> <p>2 At 168:</p> <p>3 "This culture of silence across the work force at</p> <p>4 Brook House coupled with a lack of demonstrable</p> <p>5 oversight, interest and engagement from Ben Saunders and</p> <p>6 his senior management team allowed the abusive culture</p> <p>7 in Brook House to fester and go unchecked. The</p> <p>8 confidence that officers and managers had to, in front</p> <p>9 of other members of staff, flagrantly brag and joke</p> <p>10 about abuse or speak in derogatory or even racist terms</p> <p>11 about detainees demonstrated their faith in the culture</p> <p>12 of silence which allowed the abuse to persist."</p> <p>13 Do you want to disagree with that?</p> <p>14 A. What I would say to that point is we operated the site</p> <p>15 but not in a silo; we operated the site with onsite</p> <p>16 engagement from the Home Office and IMB, amongst others.</p> <p>17 This was not raised to -- is my understanding -- it</p> <p>18 was not raised to the IMB, the Home Office or ourselves</p> <p>19 during that period.</p> <p>20 So that is what I conclude from that. Clearly, this</p> <p>21 statement shows a culture of silence, but I wasn't privy</p> <p>22 to the site at the time, so I would be surmising to more</p> <p>23 conclusively respond to your question. But I do</p> <p>24 stand by what I say in terms of we were on site with the</p> <p>25 IMB and the Home Office and, to my understanding, it</p> <p style="text-align: center;">Page 62</p>	<p>1 force on D1527 in room 7 of E Wing at around 7.00 in the</p> <p>2 evening on 25 April 2017. Callum Tulley tells us, and</p> <p>3 we have it on transcript, and on video, that after it</p> <p>4 happened, Yan Paschali, who was the principal involved</p> <p>5 in this, told Callum Tulley, "As it stands, no use of</p> <p>6 force". In other words, no report was to be compiled</p> <p>7 and, as you may know, if you had followed the evidence,</p> <p>8 Yan Paschali claims that he did complete an incident</p> <p>9 report for the final of the three aspects of the</p> <p>10 incident with D1527 on 25 April, left it on a desk by</p> <p>11 a pigeon hole, but somehow, magically, it disappeared.</p> <p>12 And his claim to this inquiry, at the beginning of this</p> <p>13 set of hearings, was that Callum Tulley had, for reasons</p> <p>14 of his own, made it disappear.</p> <p>15 In the end, there wasn't a single report that he had</p> <p>16 been strangled on that evening by Yan Paschali, let</p> <p>17 alone that Paschali had whispered to him "You fucking</p> <p>18 piece of shit, because I am going to put you to fucking</p> <p>19 sleep".</p> <p>20 Now, when you think about all of that, how does it</p> <p>21 come about, Mr Brockington, that, at paragraph 173 of</p> <p>22 your corporate statement, you tell this inquiry, in</p> <p>23 a witness statement said to be a statement of truth,</p> <p>24 that all use of force incidents were reported directly</p> <p>25 to the Home Office as required under the terms of the</p> <p style="text-align: center;">Page 64</p>

<p>1 contract?</p> <p>2 A. The reports were made -- I would expect the reports to</p> <p>3 be made. In all honesty, I can't comment further on</p> <p>4 what we have said. I understand the point that you have</p> <p>5 made.</p> <p>6 Q. Yes. It is wrong, isn't it?</p> <p>7 A. I understand the point that you have made.</p> <p>8 Q. It is wrong, isn't it?</p> <p>9 A. In that instance, that incident was not reported.</p> <p>10 Q. The sentence is wrong, isn't it?</p> <p>11 A. I would agree.</p> <p>12 Q. Thank you. You see, if Callum Tulley, who you</p> <p>13 criticise, had not filmed the event, no one would be any</p> <p>14 the wiser, would they?</p> <p>15 A. For those specific incidents, they weren't -- the</p> <p>16 reports, for whatever reason, were not filed.</p> <p>17 Q. Do you not think, just standing back for a second,</p> <p>18 Mr Brockington, that in singling out Callum Tulley, as</p> <p>19 you do in your witness statement, for criticism, in</p> <p>20 fact, the only person who, in fact, did anything about</p> <p>21 the abuse on that day -- and other abuses; not just</p> <p>22 that, but this one in particular -- rather than any</p> <p>23 member of staff or management of G4S, don't you think</p> <p>24 this continues to send out a signal as to how "snitches"</p> <p>25 or "grasses" will be treated by the company?</p> <p style="text-align: center;">Page 65</p>	<p>1 Q. Did you appreciate that he identified 27 incidents of</p> <p>2 use of force during the relevant period which, to him,</p> <p>3 were incidents of significant concern, in various ways,</p> <p>4 in that they either involved an excess of the use of</p> <p>5 force, they were wholly disproportionate, or that they</p> <p>6 were provoking or punitive in nature; in other words to</p> <p>7 punish the detainee. Were you even aware of that?</p> <p>8 A. I wasn't sighted on that, no.</p> <p>9 Q. Now you are, what do you think about it?</p> <p>10 A. All our frontline officers are trained to deliver C&R.</p> <p>11 And we, at the time, did -- we also did annual refresher</p> <p>12 training, so I would expect -- and certainly in the</p> <p>13 establishments where -- that I currently run, we have</p> <p>14 very clear governance around the deployment of C&R,</p> <p>15 reviews, feedback. What was happening at the time,</p> <p>16 I can't comment on; what I can comment on is what we</p> <p>17 currently have in place, and I have full confidence in</p> <p>18 my very experienced leadership teams that we have</p> <p>19 governance structures in place to measure and monitor</p> <p>20 C&R.</p> <p>21 Q. Well, presumably, if you'd sat here in July 2017, you</p> <p>22 would have said "I have full confidence in my senior</p> <p>23 experienced leadership team". Presumably, you wouldn't</p> <p>24 have had that level of confidence, had you sat here</p> <p>25 in July 2017, knowing what we now know?</p> <p style="text-align: center;">Page 67</p>
<p>1 A. My response is we would expect all frontline officers --</p> <p>2 in fact, all staff, who have completed the ITC, to</p> <p>3 report incidents such as this. Perhaps an oversight to</p> <p>4 single out Callum Tulley. He was one of a number of</p> <p>5 individuals who were present, who witnessed these</p> <p>6 abhorrent activities, and all of the staff who witnessed</p> <p>7 that have an obligation to us under the training which</p> <p>8 we deploy, and to the Secretary of State under the terms</p> <p>9 of their certification, to report such incidents. All</p> <p>10 of them failed to do so.</p> <p>11 Q. Let me ask you a few things about what you say on the</p> <p>12 subject of the use of force.</p> <p>13 Before I do, have you read Jon Collier's report on</p> <p>14 use of force -- he gave evidence to this inquiry</p> <p>15 yesterday, but have you read his reports?</p> <p>16 A. I haven't read his report.</p> <p>17 Q. Why not?</p> <p>18 A. Others have, but I haven't.</p> <p>19 Q. Many others in this room have. Why didn't you?</p> <p>20 A. I just haven't read the report.</p> <p>21 Q. We know that, you have said that three times. Why not?</p> <p>22 You knew about them presumably?</p> <p>23 A. I did, I just haven't read them.</p> <p>24 Q. Why didn't you?</p> <p>25 A. I just haven't read the report, I am afraid.</p> <p style="text-align: center;">Page 66</p>	<p>1 A. I would be speculating to answer that.</p> <p>2 Q. Yes. You deal with a particular issue, which you seem</p> <p>3 to have taken exception about, at paragraph 184 of your</p> <p>4 witness statement on page 37:</p> <p>5 "The inquiry has stated that it seems that many of</p> <p>6 the 'report of injury to detainee' (F213) forms attached</p> <p>7 to UoF forms were left blank, or such forms were not</p> <p>8 attached to the UoF forms.</p> <p>9 "The company does not accept that many of the forms</p> <p>10 were left blank. The F213 is a general document used to</p> <p>11 record all injuries to detainees, however they are</p> <p>12 sustained. It is not specifically designed for use of</p> <p>13 force incident reporting; it is a separate stand-alone</p> <p>14 document which was adopted into the use of force packs."</p> <p>15 Did you realise, Mr Brockington that, out of 106 use</p> <p>16 of force incidents, where we have the documentation,</p> <p>17 62 F213s are incomplete or missing, and I can break that</p> <p>18 down for you: 28 of them were missing, so that is almost</p> <p>19 50 per cent. None were left totally blank, but in</p> <p>20 28 reports, the reporting officer did not fill out</p> <p>21 section 2s, which are the details and the description of</p> <p>22 the incident and seven reports were missing the second</p> <p>23 page which contains the medical assessment.</p> <p>24 One of that number falls within two categories; in</p> <p>25 other words, section 2 was not completed and the second</p> <p style="text-align: center;">Page 68</p>

17 (Pages 65 to 68)

<p>1 page was missing.</p> <p>2 As to why they were missing, do you not agree that</p> <p>3 all documents were preserved or should have been</p> <p>4 preserved? What is your understanding of the</p> <p>5 documentation from the period?</p> <p>6 A. My view is that --</p> <p>7 Q. Not your view. I don't want your view. I want what the</p> <p>8 facts are, Mr Brockington.</p> <p>9 A. I can't conclude what happened at the time. I would be</p> <p>10 surmising. But what we have said in my statement is</p> <p>11 that there were areas which were missing.</p> <p>12 Q. You will agree with this, I hope, that all documents</p> <p>13 should have been preserved; do you accept that much?</p> <p>14 A. Yes, I do.</p> <p>15 Q. There was a police investigation after all, which</p> <p>16 started fairly swiftly?</p> <p>17 A. Correct.</p> <p>18 Q. Lampard started, when, around November 2017?</p> <p>19 A. That is broadly my recollection, yes.</p> <p>20 Q. Then there was a judicial review brought by two of the</p> <p>21 formerly detained people, which started in January 2018.</p> <p>22 So all the documentation should have been preserved.</p> <p>23 Have you any explanation for why it has not been?</p> <p>24 A. I don't.</p> <p>25 Q. At your paragraph 186, which is still up on screen, you</p> <p style="text-align: center;">Page 69</p>	<p>1 If we go on, please, to page 5, here we see</p> <p>2 a document which apparently was completed by Jo Buss,</p> <p>3 who was the nurse, headed "Injury sustained and</p> <p>4 healthcare involvement". In the box "A F213 or</p> <p>5 equivalent form was completed by ..." it says "Name:</p> <p>6 Jo Buss".</p> <p>7 "Did the detainee sustain any injuries at the time?"</p> <p>8 and "Yes" is checked.</p> <p>9 Can we go on, please, to page 7. Here we find the</p> <p>10 annex A statement of Steve Loughton, a DCM who went to</p> <p>11 D1527's aid when he was alerted to the fact by a DCO</p> <p>12 that he had put a ligature around his neck. If we can</p> <p>13 go to the next page, we can see the narrative:</p> <p>14 "At approximately 19.08 I was checking the daily</p> <p>15 food refusals and I was on Eden Wing. I was just about</p> <p>16 to check a detainee by the name of ... who was currently</p> <p>17 on a constant supervision and rule 40 and was residing</p> <p>18 in room E/007. I was told by the officer who was</p> <p>19 watching him DCO Fraser that he had just gone into the</p> <p>20 toilet area and he couldn't see him properly. I entered</p> <p>21 the room and called his name but had no answer, I then</p> <p>22 went into the toilet area which is where I saw D1527</p> <p>23 curled up around the toilet area with what looked like</p> <p>24 a ripped T-shirt around his neck which he was holding on</p> <p>25 to. I attempted to loose the ligature but D1527 was</p> <p style="text-align: center;">Page 71</p>
<p>1 say:</p> <p>2 "It is acknowledged that on some of the F213 forms,</p> <p>3 sections 1 to 3 were not always completed, however, the</p> <p>4 information asked was duplicative of the information</p> <p>5 already set out and provided in the preceding DCF-2</p> <p>6 documentation. This information is not therefore</p> <p>7 missing from the pack."</p> <p>8 Are you saying it didn't really have a separate</p> <p>9 purpose? What does the use of the word "duplicative"</p> <p>10 mean?</p> <p>11 A. What I am saying in that statement is that some areas</p> <p>12 were duplicated in the F213 and the DCF-2, and that</p> <p>13 might be one reason for them not being completed</p> <p>14 correctly.</p> <p>15 Q. I am going to put up an example, just so everybody can</p> <p>16 see what I am talking about and what you were talking</p> <p>17 about here in the witness statement.</p> <p>18 Can we put up, please, Zaynab, <CJS005534>, starting</p> <p>19 at page 1.</p> <p>20 This happens to be in relation to D1527 for 25 April</p> <p>21 but this is the first part of, in effect, a three-part</p> <p>22 incident.</p> <p>23 You can see the time use of force commenced.</p> <p>24 According to this document, 19.09 and completed at</p> <p>25 10 minutes past.</p> <p style="text-align: center;">Page 70</p>	<p>1 holding on to it so I asked DCO Fraser to pass me his</p> <p>2 fish knife and I managed to cut the ligature off ,</p> <p>3 I then pulled D1527 out of the toilet area and asked him</p> <p>4 to sit on the bed which he did and I called for medical</p> <p>5 assistance on my radio."</p> <p>6 So all we have so far, would you agree,</p> <p>7 Mr Brockington, is a narrative account from Loughton</p> <p>8 which says nothing about any injury. We have a check</p> <p>9 box ticked which said that the detainee did suffer</p> <p>10 injury, but no detail; do you agree so far?</p> <p>11 A. I would agree so far.</p> <p>12 Q. Right. If we go, please, to page 11 -- actually, back</p> <p>13 to page 10, sorry.</p> <p>14 Here is the report of injury to detainee. This is</p> <p>15 the F213. Surname ciphered as D1527. Section 2(a),</p> <p>16 time and date of incident, 25 April 2017 at 1900 hours.</p> <p>17 The rest is not completed. Section 2(b), "Brief</p> <p>18 report of circumstances in which injury was sustained.</p> <p>19 (To be completed by the incident reporting officer)",</p> <p>20 completely blank. Could you scroll down, Zaynab,</p> <p>21 please? Do you agree, nothing there?</p> <p>22 A. I would agree there is nothing there, yes.</p> <p>23 Q. Then, on the next page, section 3, "Healthcare report.</p> <p>24 (To be completed by medical staff)":</p> <p>25 "Seen on E Wing room by RGN [I think it is] Jo."</p> <p style="text-align: center;">Page 72</p>

<p>1 That must be Jo Buss:</p> <p>2 "Detainee had placed a ligature around his neck,</p> <p>3 removed by staff. After that he went to toilet and</p> <p>4 attempt to self-strangulate -- [something] removed from</p> <p>5 his neck. Slightly redness noted on his neck."</p> <p>6 There we see, if we scroll down a little more,</p> <p>7 an indicator around his neck, "Slight redness on his</p> <p>8 neck", and let's just scroll back up.</p> <p>9 What this document doesn't tell you is how the</p> <p>10 redness noted on his neck arose, because, first of all,</p> <p>11 it refers to a ligature and then it refers to an attempt</p> <p>12 to self-strangulate.</p> <p>13 The order of events here is important,</p> <p>14 Mr Brockington, because the first of this three-part</p> <p>15 incident was the ligature, when indeed Steve Loughton</p> <p>16 went in, being alerted to the fact that he was trying to</p> <p>17 strangulate himself with a ligature, and removed the</p> <p>18 ligature with a fish knife. Matters then calmed down</p> <p>19 when he placed in or around his mouth a battery from</p> <p>20 a mobile phone -- were you appreciative of that?</p> <p>21 A. I was, yes. Or I was appreciative of the evidence that</p> <p>22 was given in relation to that point.</p> <p>23 Q. Yes, and then, as you will know, the third part of the</p> <p>24 incident is when he attempted to self-strangulate with</p> <p>25 his hands.</p> <p style="text-align: right;">Page 73</p>	<p>1 picking up the numbers in the left-hand margin, you are</p> <p>2 talking about contracts, and you say, towards the end of</p> <p>3 that passage, "Rest assured, the vast majority of</p> <p>4 government tendering, regardless of whether it says it</p> <p>5 is 50-50 price quality, it is price, let's face facts."</p> <p>6 Are you talking about what the focal point of any</p> <p>7 government contract in this environment is?</p> <p>8 A. No. I need to be really clear on this. When -- if</p> <p>9 I can just explain the tendering process, if it might be</p> <p>10 helpful for the inquiry, the -- when an organisation,</p> <p>11 a customer, whether in the private sector or public</p> <p>12 sector -- in this instance the public sector; the</p> <p>13 Home Office -- want to reissue a service, and they look</p> <p>14 to outsource, they issue an invitation to tender.</p> <p>15 An invitation to tender is a set of criteria and</p> <p>16 requirements that, in this instance, the private sector</p> <p>17 would then -- us and competitors would then respond to.</p> <p>18 When they set out that criteria and list of</p> <p>19 requirements, they also set out the contract, they set</p> <p>20 out KPIs, KPTs, they also set out how it is going to be</p> <p>21 measured; ie, is it going to be measured on the quality</p> <p>22 submission, which is, "How are we going to do this?", or</p> <p>23 is it going to be measured on the price, ie what price</p> <p>24 we are going to deliver it for.</p> <p>25 What I can say, harping back to, probably, 2007,</p> <p style="text-align: right;">Page 75</p>
<p>1 I think reading this, then, probably the last words</p> <p>2 on that third line are "Hands removed from his neck".</p> <p>3 What this does not tell us is what Yan Paschali did; do</p> <p>4 you agree?</p> <p>5 A. I would agree, yes.</p> <p>6 Q. What this doesn't tell us is the whole series of events</p> <p>7 that led to Yan Paschali doing as he did or, for that</p> <p>8 matter, saying what he did; do you agree?</p> <p>9 A. I do agree with that, yes.</p> <p>10 Q. And then, if you read this at face value, "Slight</p> <p>11 redness noted on his neck", you would have no idea --</p> <p>12 minor injuries though they may be, you would have no</p> <p>13 idea whether those injuries might have been caused by</p> <p>14 Yan Paschali digging his thumbs into his neck, would</p> <p>15 you?</p> <p>16 A. I agree with what you are saying, I do.</p> <p>17 Q. Yes. This is part of the cover-up that I was suggesting</p> <p>18 to you a little earlier.</p> <p>19 Let me ask you now, please, something about your</p> <p>20 interview with Kate Lampard, please. Can we put up on</p> <p>21 screen <VER000255>. This is your interview on</p> <p>22 9 March 2018. Was it just Kate Lampard or both her and</p> <p>23 Ed Marsden?</p> <p>24 A. It was her and Ed.</p> <p>25 Q. If we go to page 10, you say at 121, and I am just</p> <p style="text-align: right;">Page 74</p>	<p>1 I think there was a far bigger drive by government to</p> <p>2 get a low price, which I would argue isn't necessarily</p> <p>3 value for money; I think that is a very different</p> <p>4 question.</p> <p>5 So the 50-50 ratio which I refer to is, when they</p> <p>6 score the contract, they are scoring it half on the</p> <p>7 quality of our solution and half on the price which we</p> <p>8 are prepared to deliver it for.</p> <p>9 So in that, what I was saying is different</p> <p>10 organisations apply different weightings to quality or</p> <p>11 price.</p> <p>12 Now, whilst, in 2007, I believe the general thrust</p> <p>13 from government was to get a cheaper price, what I can</p> <p>14 say is that has demonstrably changed since that period</p> <p>15 and there is a far bigger drive by government for value</p> <p>16 for money and quality.</p> <p>17 Q. Yes, but therein lies the flaw with the contract under</p> <p>18 which G4S operated Brook House during the period,</p> <p>19 because the focal point was on price rather than</p> <p>20 welfare, wasn't it?</p> <p>21 A. So I think a couple of points on that.</p> <p>22 It was a contract which, yes, we ended up</p> <p>23 delivering, but we lost at the tender process to GSL,</p> <p>24 and of course we inherited the contract through the</p> <p>25 acquisition, and it is set by government. It is set by</p> <p style="text-align: right;">Page 76</p>

<p>1 the customer, the -- how they -- their list of 2 requirements, their list of measurements and the ratio 3 of how they decide to score it, so I think that is 4 probably quite clear. 5 Q. Except this, we don't perhaps need to put it up on 6 screen now, but you will have seen a series of 7 presentation documents which were created, I think, by 8 Mr Schoenenberger who became the head of the DEPMU in 9 due course. Do you remember reading -- for the record, 10 chair, but I am going to deal with this through another 11 witness, <DL0000140> at page 47. The Home Office's own 12 internal assessment of the bids said -- and you will 13 remember this: 14 "An ethos of cutting corners and meeting basic 15 standards was evident from much of what we have read and 16 we are especially disappointed at the extended lockdown 17 hours proposed by these four bidders. This appears to 18 be a desperate attempt to reduce costs at the expense of 19 welfare." 20 GSL was one of the four bidders, wasn't it? 21 A. It was, in my understanding, yes. In fact, they won it. 22 Q. They did. 23 Therefore, it is not just about the Home Office, 24 because all four companies, including GSL, were cutting 25 corners in order to win the contract, weren't they?</p> <p style="text-align: center;">Page 77</p>	<p>1 first --" 2 And you say: 3 "No, never, health and safety always comes first." 4 He says: 5 "Okay, that's interesting, someone told me that." 6 You say: 7 "Never." 8 At the top of the next page: 9 "Interesting", he says. 10 You say: 11 "Agenda point 1 on every ExCom is health and 12 safety." 13 Explain what ExCom is? 14 A. It is the executive committee. 15 Q. What does the executive committee of G4S do, what is its 16 raison d'etre? 17 A. At the specific time, it was to manage the regional 18 business. 19 Q. Yes. If we move on, please, to page 18. 20 Says the questioner, at 241, who may be 21 Kate Lampard: 22 "Can I just ask you about the chain of reporting on 23 all of this: you've described how trading reviews focus 24 on this matrix, balanced score card, all that sort of 25 thing, and then it gets up to ExCom and ExCom will drill</p> <p style="text-align: center;">Page 79</p>
<p>1 A. I can't comment. I can't comment on the submission of 2 a competitor at the time. What I can say is the process 3 for tendering is the authority -- the Home Office, in 4 this case -- sets out the criteria and the private 5 sector, in this case, responds with a solution which 6 needs to be sustainable on a number of metrics. 7 Q. And it wasn't just GSL, I mean G4S bid for the contract 8 as well. So you were one of the four bidders who the 9 assessor was complaining about trying to cut corners? 10 A. I really cannot comment on something back in 2007. 11 Q. You have seen the documents, haven't you? 12 A. The tender documents -- 13 Q. Yes. 14 A. -- the specific tender documents? No, I haven't seen 15 the specific tender documents, because they go back to 16 2007. 17 Q. You haven't looked at them? Because they were in your 18 pack. Have you not looked at them? 19 A. Not in detail. 20 Q. Any detail, by the sound of it, no. 21 A. No. 22 Q. Coming back to your interview with Verita, which is 23 still up on screen, if we look down the page, please, at 24 125, Mr Marsden is continuing: 25 "In trading reviews, I think the financials come</p> <p style="text-align: center;">Page 78</p>	<p>1 down if there are evident things that are out of kilter 2 and look absurd. By the time it gets to the board, one 3 question Ashley asked us is, you have HMIP reporting, 4 you have local IMB reporting, you have trading reviews, 5 why did nobody tell him that people were behaving like 6 brutes in Brook House? 7 "There are indicators for that, aren't there?" 8 I can't write a thesis on what the line is, but 9 understaffed place, staff under pressure, not enough 10 managers, not enough time off, not enough training and 11 development, all of that stuff. What's your answer as 12 to why that didn't come through to your board?." 13 You answer: 14 "Clearly, something isn't working." 15 Then you say: 16 "We have whistleblowing ..." 17 And you are asked: 18 "Is that something that's on the metrics too, on the 19 formal reporting?" 20 "Yes, I don't see that but Peter sees every single 21 whistleblowing." 22 That's Peter Neden, presumably? 23 A. Yes. 24 Q. Who is the "Ashley"? 25 A. Our chief exec.</p> <p style="text-align: center;">Page 80</p>

20 (Pages 77 to 80)

<p>1 Q. What was not working, do you think? What were you 2 telling Verita wasn't working?</p> <p>3 A. What I was saying in -- what I was trying to get across, 4 and it appears quite clumsy, was the -- the way that the 5 trading reports were -- you have heard of different 6 names for this through the inquiry -- I have heard them 7 called "trading reports", I've heard them called 8 "business reports". I personally call them "performance 9 reports", because they are absolutely -- I think 10 "trading" builds a picture of just commercial view.</p> <p>11 These were absolutely not that. These were business 12 reviews, where we looked at all aspects of health and 13 safety, but I include use of force, I include violence 14 on detainee or violence on -- prisoner-on-prisoner, in 15 my current business, self-harm, recruitment, HR, the 16 list goes on to cover all aspects of the business, and 17 we also -- at the end, we cover facilities management as 18 an example and then on to commercials.</p> <p>19 So, you know, these are full business reviews and 20 I stand by, you know, in my current business, what 21 I review, with a very high-level of scrutiny and 22 governance on a monthly basis with the -- the sites is 23 all these areas.</p> <p>24 So -- and I stand by what I say, that the 25 whistleblowing process, I think, Peter did say in his</p> <p style="text-align: center;">Page 81</p>	<p>1 indicators such as health and safety, the chances are 2 your profitability is going to be good as well, because 3 you are running a really good contract, you're a really 4 good management team. We measure lead indicators which 5 ultimately drive profitability. It is one component of 6 a few, all of which are linked, but clearly we want them 7 to make more money, not to the detriment of all the 8 other indicators."</p> <p>9 Then, just picking up on a few themes here, 10 Mr Brockington, at line 157 at the bottom, you are 11 asked:</p> <p>12 "But your recollection of the contract was that it 13 was not financially troublesome?"</p> <p>14 You say "No, correct."</p> <p>15 You also agree, on page 14, if we go over to 16 page 14, at the top of 170, where you are asked:</p> <p>17 "I suppose what I am really asking you is, if you 18 have any experience of the sort of pressure that that 19 person from the Home Office who sits on the ground at 20 Gatwick and is the interface between the Home Office and 21 the operation, if your experience is, as ours is, that 22 really the thing they are focused on is pleasing the 23 masters about people in and people out, and we have got 24 the local person to admit that that is the case -- does 25 that accord with your experience?"</p> <p style="text-align: center;">Page 83</p>
<p>1 evidence that he did see the whistleblowing reports.</p> <p>2 Q. At page 12 at 148, you are asked:</p> <p>3 "I suppose what I am asking is not so much the 4 actual mechanics of whether or not they breached 5 a fundamental agreement, it is what sort of pressure are 6 they put under to perform better than that bald agreed 7 sum? Do you rate your directors one against the other 8 on how much more they are able to get out of 9 a contract?"</p> <p>10 You say:</p> <p>11 "Categorically not, we don't rate them one against 12 one. We apply measured commercial pressure to them to 13 deliver a number of components of their contract. If 14 you look at it in terms of -- this is all a bit 15 nonsense -- if you look at it in terms of a balanced 16 scorecard, we measure them on their health and safety 17 performance, we measure them on their profitability, we 18 measure them on their KPIs. These are all linked 19 together, so if you fail your KPIs you're probably going 20 to get financial penalties, which probably means your 21 profitability is going to go down.</p> <p>22 "The other really important thing about that is they 23 are all leading indicators, so if you have a safe 24 contract, and your team are engaged, and you are not 25 hurting people, and you're delivering all those lead</p> <p style="text-align: center;">Page 82</p>	<p>1 You say:</p> <p>2 "Yes, I think so. I think they will be driving what 3 their boss is interested in."</p> <p>4 So let me ask you, against the background of those 5 questions and answers, and I am asking this on behalf of 6 several of the core participants in this inquiry, 7 Mr Brockington, do you accept that, in order for this 8 model of performance monitoring to work, it is essential 9 that the KPIs, and the imposition of financial penalties 10 imposed on you by whoever purchases G4S's services, 11 takes account of detainee welfare?</p> <p>12 A. As I explained, or tried to explain, in my previous 13 comments around the tender process, the customer, the 14 Home Office in this case, puts out to the market a list 15 of requirements in the invitation to tender.</p> <p>16 Included in that is their requirements, their -- 17 what they want to achieve, their strategic objectives, 18 but also that includes, more often than not, a list of 19 key performance indicators. These are designed by the 20 customer and we respond to those in the tender.</p> <p>21 So I am afraid, whilst I don't want to appear to be 22 skirting this, because I am absolutely not, this is -- 23 in all instances that I have been -- for many years, 24 been engaged with procurement in the public sector, the 25 KPTs and KPIs, whatever you choose to call them, are</p> <p style="text-align: center;">Page 84</p>

<p>1 designed and established and set out by the customer, 2 and we respond and we build a sustainable model and 3 service delivery model to respond to ensure we deliver 4 a service as required by the customer, and we also 5 ensure our adherence to the specific KPT measures. 6 Q. Secondly, do you accept that it is also essential for 7 the Home Office to insist on adequate financial 8 penalties to ensure that there is sufficient impact on 9 your profitability to incentivise the centre director to 10 take action? 11 A. In my experience over, say, a significant number of 12 years, bidding for work within the public sector, KPTs 13 are one measure that the authority measures us against. 14 The financial penalties vary between organisations, 15 and the application of the quantum varies, depending on 16 KPT and depending on customers. 17 So again, it is back to – I am afraid it is back to 18 the Home Office. They set the criteria in terms of what 19 is to be measured and the final – the financial penalty 20 regime which sits alongside that. 21 Q. Who is ultimately responsible here, Mr Brockington, for 22 what happened? 23 A. In terms of? 24 Q. In terms of the abuse? Who do you think is ultimately 25 responsible?</p> <p style="text-align: center;">Page 85</p>	<p>1 prepared to accept even that much. 2 A. If that is what has come across to the inquiry, that is 3 wrong. I have said, as an organisation, and as 4 an individual, as a – responsible for this business 5 now, I would hold myself wholly responsible for these 6 abhorrent behaviours. I couldn't be clearer on that. 7 I think the inquiry will, of course, deliver the 8 findings of the inquiry, based on the evidence that has 9 been given, but I hope I am very clear in my openness to 10 the inquiry around the fact that we take these matters 11 incredibly seriously and have actioned a significant 12 amount of – all the areas covered, and we will continue 13 to do so and continue to – within the prison 14 environment now, clearly not the detained environment, 15 because we no longer operate within that environment, 16 but I hope my position is now clear. 17 Q. A couple of final topics for you, Mr Brockington. First 18 of all, can we go back to your witness statement at 19 paragraph 182, which is on page 36, and it is up on 20 screen. You say: 21 "Following a use of force event, detainees will 22 sometimes be relocated to the CSU, if deemed 23 appropriate, usually as a result of continued aggressive 24 behaviour (to staff or others). Removal was therefore 25 either for their protection or that of others."</p> <p style="text-align: center;">Page 87</p>
<p>1 A. As an organisation, and in the organisation which I am 2 responsible for, in terms of our care and rehabilitation 3 business, if this was to happen in the business that 4 I run today, I would be responsible. 5 Q. Yes. Who was responsible, in your view, for what 6 happened between April and the end of August 2017? 7 A. I believe the individuals who – to be honest, I can't 8 conclude either way. What I can say is – because 9 I can't conclude for that point in time, but what I can 10 say is, for the business that I run, I would hold myself 11 responsible if this was to happen in my business. 12 Q. Well, that is terrific, because we are not asking you 13 about what is going on now. I am asking you about what 14 happened in the spring to the summer of 2017. 15 Now, you have not come here, Mr Brockington without 16 having some understanding of what G4S's position is on 17 this. Are you telling us that you have no position to 18 state publicly about whether G4S holds its hands up, as 19 it were, and accepts its responsibility, not perhaps 20 full responsibility, but, in part, its responsibility 21 for what happened during those months? 22 A. I would accept we hold a degree of responsibility. 23 Q. Yes. 24 A. Absolutely. 25 Q. Because, for one moment, it sounded like you were not</p> <p style="text-align: center;">Page 86</p>	<p>1 You go on to say at 183: 2 "The Suicide and Prevention of Self-harm Policy 3 would have been followed in CSU where appropriate, 4 although this would not impact on the use of force event 5 itself." 6 Then, if we can go forwards, please, to 7 paragraph 200, which we find on page 40, and I want to 8 go, really, to the end of that paragraph, which is on 9 page 41 at the top: 10 "A number of detainees were also struggling to adapt 11 to detention and several spent prolonged periods on 12 rule 40 awaiting transfer to mental health facilities or 13 to the prison estate." 14 Do you accept from everything you know, 15 Mr Brockington, that vulnerable detainees who were 16 suffering from serious illness or self-harming risk were 17 routinely relocated to the CSU under rule 40 during the 18 period? 19 A. What I would say is, where rule 40 occurred – and 20 rule 42, but we're talking about rule 40 – there was 21 a very different process for – sometimes, arguably, 22 a different process, under planned and unplanned. 23 In the event of a planned use of rule 40, there 24 would be pre-authorisation by the Secretary of State's 25 representative. In an unplanned use of rule 40, the</p> <p style="text-align: center;">Page 88</p>

<p>1 duty manager, and we would call that a case of urgency,</p> <p>2 the duty manager could authorise, initially, the</p> <p>3 rule 40, and then be followed up immediately, pretty</p> <p>4 much immediately, by the authority representative from</p> <p>5 the Secretary of State.</p> <p>6 So when we used rule 40 and rule 42, it was within</p> <p>7 full sight of, and authorisation of, the Secretary of</p> <p>8 State's representative within the Home Office.</p> <p>9 That was also -- I have referred on a few occasions</p> <p>10 to us not working in isolation at the immigration</p> <p>11 removal centre, because, of course, we reported the use</p> <p>12 of these to the Home Office on a daily basis at the 0800</p> <p>13 meeting, daily reports, weekly reports and also to the</p> <p>14 IMB.</p> <p>15 So what we did in those circumstances was fully</p> <p>16 authorised by the Home Office on --</p> <p>17 Q. Did you not realise that in a huge amount of cases, it</p> <p>18 was DCMs themselves who were authorising in cases of</p> <p>19 urgency; did you know that?</p> <p>20 A. It was our view that the duty manager would authorise.</p> <p>21 Q. I know what was your view, but what I am asking you is</p> <p>22 whether you knew DCMs were, in fact, giving</p> <p>23 authorisation?</p> <p>24 A. I didn't know that, I wasn't around at the time, so --</p> <p>25 Q. Well, is this news to you now? Have you not heard this</p> <p style="text-align: center;">Page 89</p>	<p>1 designed for short-term holding of up to 72 hours, but,</p> <p>2 unfortunately, if that was the intention, it was never,</p> <p>3 or rarely, complied with.</p> <p>4 You know that?</p> <p>5 A. I was fully aware of that, yes.</p> <p>6 Q. Yes.</p> <p>7 The HMIP report for Tinsley House in 2018 confirms</p> <p>8 that Tinsley House was closed for refurbishment</p> <p>9 between September 2016 and May 2017 -- presumably you</p> <p>10 know that?</p> <p>11 A. I do.</p> <p>12 Q. And a number of staff was transferred over to</p> <p>13 Brook House at the time, you will appreciate that too?</p> <p>14 A. I do appreciate that.</p> <p>15 Q. Yes. In your second witness statement, paragraph 9, we</p> <p>16 don't need to put it up, perhaps, but you say this:</p> <p>17 "I was not involved in any discussions around this</p> <p>18 matter ..."</p> <p>19 Now, the matter you refer to is the heading</p> <p>20 "Increase in operational capacity":</p> <p>21 "... but on 25 January 2017 [you say], the</p> <p>22 Home Office issued a formal change request to CJS ..."</p> <p>23 Which is Custodial and Justice Services?</p> <p>24 A. At the time, yes.</p> <p>25 Q. That is, what, part of the moniker of the company or the</p> <p style="text-align: center;">Page 91</p>
<p>1 before?</p> <p>2 A. No, I am aware.</p> <p>3 Q. You are aware.</p> <p>4 A. Yes.</p> <p>5 Q. So what do you think about it?</p> <p>6 A. My understanding is -- I can't comment fully on anything</p> <p>7 further, but what I can say is the authorisation was</p> <p>8 followed up by the -- the Home Office's authorisation.</p> <p>9 Q. Are you prepared to accept that the use of the rule 40</p> <p>10 mechanism for relocating vulnerable detainees to the</p> <p>11 CSU, though suffering from serious illness or at risk of</p> <p>12 self-harm, their routine relocation was inappropriate to</p> <p>13 manage their mental health; do you accept that?</p> <p>14 A. I can't conclude either way.</p> <p>15 Q. Or are you just not prepared to?</p> <p>16 A. It is not that I am not prepared to; I can't conclude,</p> <p>17 I have no detailed knowledge of it.</p> <p>18 Q. Finally, a question on occupancy. You know that</p> <p>19 Brook House was built to the specification of</p> <p>20 a category B prison?</p> <p>21 A. I do.</p> <p>22 Q. Albeit without the sort of activities a category prison</p> <p>23 would or should have, holding prisoners who were serving</p> <p>24 perhaps relatively short-term sentences.</p> <p>25 This was a building, we understand, which was</p> <p style="text-align: center;">Page 90</p>	<p>1 division?</p> <p>2 A. It was part of the division of G4S.</p> <p>3 Q. "... requiring it to increase the operation capacity of</p> <p>4 Brook House from 448 to 508 ... This was then effected</p> <p>5 through a contractual change notice from the Home Office</p> <p>6 on 27 January 2017 ..."</p> <p>7 We know that, we don't have to put up the documents,</p> <p>8 but we have seen two documents in that regard; for the</p> <p>9 record, <CJS0074084>, which is the service provider</p> <p>10 request form dated 25 January, signed off, although it</p> <p>11 is draft, but with Jerry Petherick's name on it for the</p> <p>12 extra 60 beds, and the Home Office notice of change</p> <p>13 document dated 27 January is <HOM000859>. The idea was</p> <p>14 that these beds would be operational with effect from</p> <p>15 1 April 2017, the extra 60 beds, although we understand</p> <p>16 they may have been in place or built at least by the end</p> <p>17 of 2016.</p> <p>18 Now, given that most of the Tinsley House staff were</p> <p>19 working at Brook House from around September 2016</p> <p>20 onwards, until their return there back from Brook House,</p> <p>21 are you able to say whether or not there were staff</p> <p>22 shortages at Brook House in the period from</p> <p>23 around September 2016 to, give or take,</p> <p>24 November/December 2016, the time after HMIP had</p> <p>25 completed their inspection?</p> <p style="text-align: center;">Page 92</p>

<p>1 A. So my understanding is we delivered to the contractual</p> <p>2 requirements as set out in the contract, in terms of</p> <p>3 resourcing at that time.</p> <p>4 Q. So the answer is, what, you don't know or you cannot say</p> <p>5 or there were no staff shortages?</p> <p>6 A. What I am saying is we fulfilled our contract.</p> <p>7 Q. What does that mean?</p> <p>8 A. We -- so there is a minimum staffing level set out in</p> <p>9 the contract and we were broadly compliant to the terms</p> <p>10 of that contract.</p> <p>11 Q. Let me ask it another way. Do you know whether G4S</p> <p>12 incurred any contractual penalties in that period for</p> <p>13 failing to meet the minimum staffing requirements? What</p> <p>14 are you referring to there, Mr Brockington? I see you</p> <p>15 have got something in the witness box with you, is it</p> <p>16 an aide-memoire, of some kind?</p> <p>17 A. I have just got a couple of notes.</p> <p>18 Q. It looks like a lot of notes from where I am standing.</p> <p>19 A. It's just a couple of notes to help me answer your</p> <p>20 questions fully. I cannot confirm, but I will make</p> <p>21 a response to the inquiry to cover that point.</p> <p>22 Q. Can you add this to it: how did staffing levels in the</p> <p>23 period, say, from about September to December 2016,</p> <p>24 compare to staffing levels during the relevant period?</p> <p>25 Are you able to help us with that?</p> <p style="text-align: center;">Page 93</p>	<p>1 concluded by the site team at the time that 60 -- with</p> <p>2 the Home Office that 60 would be appropriate.</p> <p>3 I am afraid I can't comment further because I was</p> <p>4 not privy to further conversations.</p> <p>5 Q. In a moment, I am going to invite the chair to see if</p> <p>6 she has any questions for you, Mr Brockington, but</p> <p>7 before I do, I am going to invite you to consider</p> <p>8 whether there is anything you want to say to the</p> <p>9 detainees, not only those who have given live evidence</p> <p>10 before this inquiry, but those who were not able to,</p> <p>11 those whose statements and other material was adduced</p> <p>12 before the inquiry in respect of the mistreatment,</p> <p>13 physical and verbal, that was meted out to them during</p> <p>14 the course of the relevant period?</p> <p>15 A. And I would like to take this opportunity, on behalf of</p> <p>16 G4S, to apologise for those who suffered mistreatment,</p> <p>17 as witnessed in the Panorama programme. What we saw on</p> <p>18 the Panorama programme was, as I said previously,</p> <p>19 abhorrent behaviour. We believe it to be isolated. And</p> <p>20 we look forward to receiving the conclusions of the</p> <p>21 inquiry.</p> <p>22 MR ALTMAN: Thank you.</p> <p>23 THE CHAIR: I have no questions. Thank you very much for</p> <p>24 your evidence, Mr Brockington. Thank you.</p> <p>25 MR ALTMAN: Chair, it is 12.45. Rather than start the next</p> <p style="text-align: center;">Page 95</p>
<p>1 A. Of course, we would be delighted to.</p> <p>2 Q. Let's just put up on the screen please, I think finally,</p> <p>3 the HMIP report, again, <CJS000761> at page 5.</p> <p>4 If we look at the penultimate paragraph on the</p> <p>5 screen:</p> <p>6 "This report makes a number of detailed</p> <p>7 recommendations about the treatment of detainees and the</p> <p>8 conditions in which they are held. I would add</p> <p>9 a cautionary note on an issue that is not the subject of</p> <p>10 a specific recommendation but has the potential to</p> <p>11 adversely affect the conditions in which some detainees</p> <p>12 are held: the proposal to bring into use the third bed</p> <p>13 which has been installed in 60 of the two person cells.</p> <p>14 Many staff and detainees were of the view this would</p> <p>15 lead to a decline in living standards. This is a view</p> <p>16 shared by inspectors."</p> <p>17 What did the company do about that?</p> <p>18 A. My understanding of the process at the time, we worked</p> <p>19 closely with our -- with the customer, and my</p> <p>20 understanding is the initial view was we -- the</p> <p>21 Home Office wanted to increase the numbers by more than</p> <p>22 60. We worked collaboratively with the customer to</p> <p>23 agree 60. A risk assessment was done at the time and it</p> <p>24 was concluded, albeit I wasn't privy to those</p> <p>25 conversations, so I can't comment further. It was</p> <p style="text-align: center;">Page 94</p>	<p>1 witness, can I suggest we have an early lunch and return</p> <p>2 in an hour at 1.45?</p> <p>3 THE CHAIR: Thank you very much. Thank you Mr Brockington.</p> <p>4 Thank you.</p> <p>5 (12.47 pm)</p> <p>6 (The short adjournment)</p> <p>7 (1.45 pm)</p> <p>8 THE CHAIR: Thank you.</p> <p>9 MS SIMCOCK: The next witness is Philip Dove.</p> <p>10 MR PHILIP CHARLES DOVE (sworn)</p> <p>11 Examination by MS SIMCOCK</p> <p>12 MS SIMCOCK: Thank you, can you give your full name to the</p> <p>13 inquiry, please?</p> <p>14 A. Philip Charles Dove.</p> <p>15 Q. Mr Dove, you have provided a statement to the inquiry,</p> <p>16 that is at <CJS0074040>. I am going to ask you some</p> <p>17 questions about various topics within that statement,</p> <p>18 but I am not going to take you through it line by line,</p> <p>19 because I am going to ask that the entirety of it is</p> <p>20 adduced into evidence.</p> <p>21 You, I don't think, were employed by</p> <p>22 G4S Health Services as managing director during the</p> <p>23 relevant period; is that right?</p> <p>24 A. That's correct.</p> <p>25 Q. What is your current job title?</p> <p style="text-align: center;">Page 96</p>

<p>1 A. Managing Director of Facilities Management and Public 2 Services. 3 Q. Are you also director of G4S Health Services UK, 4 Limited? 5 A. I am a director of G4S Health Services, but I also have 6 a managing director running the business. 7 Q. Thank you. What does that role entail? 8 A. My role? 9 Q. Yes. 10 A. I run a number of disparate businesses, including 11 Health Services for G4S. 12 Q. You are the corporate witness that has been put forward 13 by G4S Health Services to provide evidence to this 14 inquiry; is that right? 15 A. That's correct. 16 Q. You are here to answer questions on behalf of the 17 company about the relevant period and about the current 18 position; is that right? 19 A. That's correct. 20 Q. You say, at paragraph 2 of your statement: 21 "I have no personal knowledge as to any of the 22 matters identified in the BBC Panorama programme. 23 I also have no first-hand knowledge of the management of 24 healthcare at Brook House between April and August 2017, 25 or about the contractual/commissioning arrangements</p> <p style="text-align: right;">Page 97</p>	<p>1 A. G4S is always trying to learn lessons. 2 Q. And is G4S Health Services committed to learning lessons 3 from what was shown on the Panorama programme? 4 A. Yes, I believe it was. And continues to be so. 5 Q. And committed to learning lessons from this inquiry? 6 A. Yes, where relevant. 7 Q. Because, of course, the importance of learning lessons 8 is to prevent past problems or failures occurring again 9 in the future? 10 A. Indeed. 11 Q. And in this case, that was -- that led to mistreatment 12 of vulnerable detainees. So important to prevent those 13 failures and problems occurring again? 14 A. Indeed. 15 Q. Does your inability to comment in some of those respects 16 suggest that G4S Health Services has, or at least had, 17 no system in place to ensure that lessons learned were 18 passed on from predecessors? 19 A. No, I think a considerable time has passed, it is five 20 years since the relevant period. I think businesses 21 evolve and change and I think that I would hope that 22 lessons were learned, and I believe that they were, and 23 I believe there was an intense period of reflection and 24 action immediately after the Panorama programme. 25 As such, I believe that processes are in place to</p> <p style="text-align: right;">Page 99</p>
<p>1 between the Home Office, G4S and NHS England during this 2 time." 3 Is that right? 4 A. That's correct, I didn't join G4S until November 2017 5 and had no responsibility whatsoever for the 6 Health Services business until January 2019. 7 Q. Yes. At paragraphs 30 and 101 of your statement, you 8 say that you are "unable to comment on lessons learned 9 due to a lack of personal knowledge and a loss of 10 staff." 11 A number of other times in your statement you refer 12 to a "loss" or a "lack" of knowledge in the company, at 13 paragraphs 22, 105, 107, 112 and 172, to explain why you 14 have been unable to answer questions posed of you by the 15 inquiry. 16 In those circumstances, how well placed are you to 17 provide the corporate evidence on behalf of 18 G4S Health Services to this inquiry? 19 A. I think I am the best current employee of G4S to provide 20 the corporate statement. However, I would imagine that 21 the statements you have received from other people who 22 used to work for G4S at the time will be more relevant 23 to the period; which -- at the relevant period. 24 Q. Is G4S Health Services committed to learning lessons as 25 an organisation?</p> <p style="text-align: right;">Page 98</p>	<p>1 continue learning and to continue to develop. 2 Q. Are processes now in place to prevent the loss of 3 company knowledge that you have referred to in your 4 statement? 5 A. I think some of the questions here are so very specific 6 to such very specific matters that it is difficult to 7 say that you will not lose that knowledge, because it is 8 so -- such a detailed question that is being asked. 9 I think the general principles are understood and 10 hopefully have been commented on. 11 Q. What about systems of auditing and documentation? 12 A. I think that there were systems of auditing. I think 13 that we constantly evolve auditing and documentation. 14 And although there are some gaps that are talked about, 15 I think there is a good quantity of documentation that 16 is available and has been reviewed and submitted. 17 Q. At paragraph 3 of your witness statement, you state that 18 you have made the statement "on the basis of information 19 provided by inquiries and/or of review of the company's 20 documents and records." 21 Have you spoken to people who were in post during 22 the relevant period? 23 A. I have spoken to Sandra Calver; otherwise, no. 24 Q. Why not, other than Sandra Calver? 25 A. I hadn't got access to other people other than</p> <p style="text-align: right;">Page 100</p>

25 (Pages 97 to 100)

<p>1 Sandra Calver.</p> <p>2 Q. You say that you have spoken to Sandra Calver. She</p> <p>3 clearly had first-hand knowledge of the healthcare</p> <p>4 provision in Brook House during the relevant period and</p> <p>5 she provided written, and indeed live, evidence to the</p> <p>6 inquiry. Did you review her statements?</p> <p>7 A. I did read her statements, yes.</p> <p>8 Q. Did you listen to her give live evidence to the inquiry?</p> <p>9 A. Not the entirety of it, but some of it, yes.</p> <p>10 Q. Are there any aspects of her evidence with which you</p> <p>11 disagree?</p> <p>12 A. Not that I recall specifically.</p> <p>13 Q. At paragraph 14 of your statement, you say:</p> <p>14 "This is a corporate statement for the company. It</p> <p>15 would not therefore be appropriate to comment or</p> <p>16 speculate on the causes of behaviours of staff employed</p> <p>17 by other organisations. It is also difficult for me to</p> <p>18 comment on the causes of staff behaviour in general</p> <p>19 terms. The conduct of different staff members will</p> <p>20 likely have been driven by different factors, causes and</p> <p>21 considerations. Where appropriate, I comment below in</p> <p>22 relation to particular staff and events."</p> <p>23 You did feel able to comment at paragraph 31:</p> <p>24 "The issues identified in relation to Ms [Joanne]</p> <p>25 Buss were in connection with her personal conduct, not</p> <p style="text-align: center;">Page 101</p>	<p>1 sources to the inquiry that various safeguards and</p> <p>2 policy implementation in relation to the safeguarding of</p> <p>3 vulnerable detainees was failing. Do you disagree with</p> <p>4 that evidence?</p> <p>5 A. I am not sure to exactly what you are referring.</p> <p>6 Q. Maybe we will come to it in more detail in a moment.</p> <p>7 Do you have any comment on the evidence that Jo Buss</p> <p>8 gave that she had heard and not challenged and not</p> <p>9 reported inappropriate behaviour by detention staff in</p> <p>10 relation to the incident with D1527 on 25 April?</p> <p>11 A. I -- that appears, as represented in the programme, to</p> <p>12 be shocking and Sandra Calver appears to have said that</p> <p>13 she was extremely shocked by Jo Buss's behaviour as</p> <p>14 well.</p> <p>15 Q. Jo Buss gave evidence that seemed to suggest that that</p> <p>16 type of conduct by her and others was commonplace and</p> <p>17 that, effectively, staff had become, including her,</p> <p>18 immune to it. Does that indicate a system or policy</p> <p>19 failure in your view or does that still relate to</p> <p>20 individual conduct?</p> <p>21 A. I certainly heard Jo Buss refer to it about her own</p> <p>22 behaviour. I don't recall her specifically suggesting</p> <p>23 that that was commonplace.</p> <p>24 Q. We know from the BBC footage filmed by Callum Tulley,</p> <p>25 including some that was broadcast on Panorama, that</p> <p style="text-align: center;">Page 103</p>
<p>1 systems or policy failures. Nor, to the best of the</p> <p>2 company's knowledge and belief, were there any issues</p> <p>3 raised that extended to potential wider issues</p> <p>4 concerning the company's employees."</p> <p>5 Is that right?</p> <p>6 A. That is what is stated, certainly.</p> <p>7 Q. Did you listen to Jo Buss's evidence to the inquiry?</p> <p>8 A. Yes.</p> <p>9 Q. Have you listened to Dr Hard's evidence to the inquiry?</p> <p>10 A. Not all of it.</p> <p>11 Q. But some of it?</p> <p>12 A. But some of it.</p> <p>13 Q. Have you read his two reports?</p> <p>14 A. Yes.</p> <p>15 Q. Do you still think -- having listened to and heard that</p> <p>16 evidence and read his reports, do you still think that</p> <p>17 there were no systems or policy failures leading to the</p> <p>18 mistreatment of vulnerable detainees in Brook House in</p> <p>19 2017?</p> <p>20 A. I am not a medical expert, and I wasn't there in 2017.</p> <p>21 I think it is very difficult for me to conclude whether</p> <p>22 what Dr Hard is saying from his desktop review in 2022,</p> <p>23 is correct or incorrect with regards to exactly what was</p> <p>24 going on in 2017.</p> <p>25 Q. There has been a large amount of evidence from various</p> <p style="text-align: center;">Page 102</p>	<p>1 various staff members made mocking or derogatory</p> <p>2 comments in relation to detainees intoxicated by spice;</p> <p>3 were you aware of that?</p> <p>4 A. I have seen that comment.</p> <p>5 Q. And that -- that is not just by one individual, Jo Buss,</p> <p>6 it was by other members of healthcare. Again, does that</p> <p>7 indicate a more widespread culture or systemic problem</p> <p>8 at the time?</p> <p>9 A. It certainly is inappropriate behaviour; whether that</p> <p>10 indicates that's a systemic problem or a lack of</p> <p>11 understanding of the impact of somebody's behaviour or</p> <p>12 comments on other people, whether that is a systemic</p> <p>13 failing, I think I couldn't comment on, I wasn't there.</p> <p>14 Q. Paragraphs 43 to 45 of your statement, you state that</p> <p>15 staffing levels, turnover and the use of agency staff</p> <p>16 didn't contribute to the mistreatment of detainees.</p> <p>17 How were you able to come to that view, given that</p> <p>18 the company and its senior management were not aware of</p> <p>19 the mistreatment at the time?</p> <p>20 A. I have talked to the current leadership of our medical</p> <p>21 business about the way in which contracts, including</p> <p>22 ones like this one, are staffed; and I understand that</p> <p>23 it is commonplace across all NHS contracts, including in</p> <p>24 the NHS itself, for a core of permanent staff to be</p> <p>25 supported by bank and temporary staff, and in this</p> <p style="text-align: center;">Page 104</p>

26 (Pages 101 to 104)

<p>1 environment, of course, people couldn't just come in off</p> <p>2 the street to work, they would have to be inducted</p> <p>3 anyway, in order to work in a secure environment.</p> <p>4 Q. At paragraph 67, you state that training failures didn't</p> <p>5 contribute to the mistreatment of detainees. Again, how</p> <p>6 were you able to come to that view?</p> <p>7 A. I think there is a variety of insights into what was --</p> <p>8 how the facility was being run at the time. I think</p> <p>9 that you would have the IMB report and the Her Majesty's</p> <p>10 Prisons' report supported by the CQC, and I would have</p> <p>11 expected, particularly in that case, that the CQC would</p> <p>12 have talked and required action, if they felt training</p> <p>13 to be inadequate. I don't believe that there was any</p> <p>14 inference from the HMIP report at the time that there</p> <p>15 was training inadequacies and there was certainly no</p> <p>16 specific action with regards to improving training.</p> <p>17 Q. Dr Hard, in both of his reports, and in his live</p> <p>18 evidence, confirmed that in his view, there were various</p> <p>19 inadequacies in the training regarding the Adults at</p> <p>20 Risk policy rule 35, ACDTs and the use of force which</p> <p>21 led to failures in the safeguards, leading to detainees</p> <p>22 remaining in detention subject to segregation,</p> <p>23 committing acts of self-harm and having force used</p> <p>24 against them, including, for example, in D1527's case,</p> <p>25 the assault by Yan Paschali. Doesn't that indicate</p> <p style="text-align: center;">Page 105</p>	<p>1 used.</p> <p>2 Q. We will come to it perhaps in a little more detail in</p> <p>3 a moment, but at paragraph 75 of your statement, you</p> <p>4 state that no management failings contributed to the</p> <p>5 mistreatment of detainees. Again, how were you able to</p> <p>6 come to that view?</p> <p>7 A. I think, with regards to the incidents shown in the</p> <p>8 Panorama programme, I don't believe that there has been</p> <p>9 question with regards to Sandra Calver in particular and</p> <p>10 her oversight of Nurse Buss. She appeared to have been</p> <p>11 incredibly shocked by her behaviour and I don't believe</p> <p>12 that any other issue had been raised with regards to</p> <p>13 Nurse Buss. Thereby, I think that is how I would</p> <p>14 conclude that it didn't appear there were any management</p> <p>15 failings around that matter.</p> <p>16 Q. Are you now aware of Dr Hard's evidence that management</p> <p>17 failings led indirectly to the mistreatment of detainees</p> <p>18 through the failure of the safeguards under rules 34</p> <p>19 and 35. Do you have any comment on that?</p> <p>20 A. I am not a medical expert and I wasn't there at the time</p> <p>21 but, as I have said, it would appear that rule 34 and 35</p> <p>22 weren't entirely clear at the time and Dr Hard's view,</p> <p>23 at this time, may or may not have been in line with the</p> <p>24 view that anybody may have held at that time.</p> <p>25 Q. Coming, then, to rules 34 and 35, specifically, do you,</p> <p style="text-align: center;">Page 107</p>
<p>1 training failures at the time in 2017, would you agree?</p> <p>2 A. Not sure that Dr Hard taking a desktop view, in 2022, of</p> <p>3 a situation in 2017 necessarily leads directly to that</p> <p>4 conclusion. I would have thought that if there were</p> <p>5 significant failings in the view of the NHS, the</p> <p>6 Home Office, the IMB, and HMIP, that training was such</p> <p>7 a problem that, in one way or another, there would have</p> <p>8 been a significant impact and requirement for the</p> <p>9 business to change the training methods or improve it.</p> <p>10 Q. Sandra Calver gave evidence that the training in</p> <p>11 relation to rule 35 wasn't sufficient and that she had</p> <p>12 pushed for more training at the time; were you aware of</p> <p>13 that?</p> <p>14 A. From the research that I have done with regards to this</p> <p>15 hearing, it seems to me that rule 35 is a very complex</p> <p>16 area and there are many opinions around the way in which</p> <p>17 it, at the time, was being implemented and the way that</p> <p>18 it should still be implemented today. I am aware,</p> <p>19 obviously, that there was discussion around the training</p> <p>20 and I am also aware from the evidence that I have seen</p> <p>21 that the doctors were keen to discuss rule 35 with the</p> <p>22 Home Office and to make sure there was clarity in its</p> <p>23 implementation and training.</p> <p>24 So it was clearly an area that wasn't totally</p> <p>25 crystal in the way in which it was to be implemented and</p> <p style="text-align: center;">Page 106</p>	<p>1 as a result of your preparation for this inquiry, have</p> <p>2 an understanding of the interaction between the two</p> <p>3 rules?</p> <p>4 A. I have read a variety of documents and tried to</p> <p>5 understand and listen to Dr Hard and read relevant</p> <p>6 documents at the time. I think I have a desktop</p> <p>7 understanding, but I am not a medical expert and</p> <p>8 I wasn't there at the time, so my understanding will be</p> <p>9 very limited compared to many other people who would be</p> <p>10 able to provide a view.</p> <p>11 Q. Rule 34 requires that every detainee have a medical</p> <p>12 examination, a physical and mental examination, within</p> <p>13 24 hours of admission to a detention centre. You are</p> <p>14 aware of that?</p> <p>15 A. I am.</p> <p>16 Q. And rule 35(1) requires a report on anyone where</p> <p>17 detention is likely to injuriously affect their healthy,</p> <p>18 including their mental health, are you aware of that?</p> <p>19 A. I am.</p> <p>20 Q. In relation to rule 35(2), that requires a report on</p> <p>21 anyone suspected of having suicidal intentions; are you</p> <p>22 aware of that?</p> <p>23 A. Yes.</p> <p>24 Q. Where those thresholds are met, a rule 35 report should</p> <p>25 be completed as a direct consequence of the rule 34</p> <p style="text-align: center;">Page 108</p>

<p>1 examination at the outset of detention; are you aware of</p> <p>2 that?</p> <p>3 A. Yes.</p> <p>4 Q. And so, in that way, the two rules are meant to work</p> <p>5 together to safeguard vulnerable detainees at the outset</p> <p>6 of detention; is that your understanding?</p> <p>7 A. Yes.</p> <p>8 Q. Sandra Calver accepted in her evidence a failure of</p> <p>9 rule 34, her explanation being that, largely, there were</p> <p>10 inadequate resources allowed to give everyone the kind</p> <p>11 of examination required by the rule, and in particular</p> <p>12 that the appointment was very brief, being only five</p> <p>13 minutes long.</p> <p>14 Are you aware of that evidence that she gave?</p> <p>15 A. I am aware of that evidence. I think at the time, from</p> <p>16 what I have read, the interpretation shown by Dr Hard</p> <p>17 and talked about in this inquiry of a substantive mental</p> <p>18 assessment of every individual arriving at the IRC does</p> <p>19 not seem to be consistent with what the NHS were talking</p> <p>20 about at the time, a needs assessment, where they even</p> <p>21 commented that the need to see a GP for every detainee</p> <p>22 entering may be putting an unnecessary burden on GPs, so</p> <p>23 I find it difficult to square that the NHS, who</p> <p>24 commissioned the service, were suggesting that there was</p> <p>25 an unnecessary burden, first, as Dr Hard is suggesting</p> <p style="text-align: center;">Page 109</p>	<p>1 a rule 35 report to be completed in appropriate</p> <p>2 circumstances, as a result of the rule 34 appointment,</p> <p>3 in order to safeguard vulnerable detainees by</p> <p>4 identifying them to the Home Office at the outset of</p> <p>5 detention; that's right, isn't it?</p> <p>6 A. If that is the case, as your reading of the rule</p> <p>7 suggests, then I find it interesting that, still to this</p> <p>8 day, Sandra Calver gave the evidence that there still</p> <p>9 are only ten-minute appointments five years later.</p> <p>10 Q. Indeed, but the rule clearly was being breached at the</p> <p>11 time, and may well still be being breached now. That is</p> <p>12 the significance of that evidence, isn't it?</p> <p>13 A. If the interpretation of the rule is correct, then of</p> <p>14 course it is. But I guess what I struggle, as a layman,</p> <p>15 to work out is, why, five years later, with all of the</p> <p>16 focus on this area that there has been -- and with all</p> <p>17 of the interested bodies that are engaged in this, why</p> <p>18 would a change not have been made if that interpretation</p> <p>19 of the rule is, in fact, accurate and the way in which</p> <p>20 it should be implemented?</p> <p>21 Q. So, Dr Oozeerally had confirmed that the rule 34</p> <p>22 appointments were not leading to rule 35 reports;</p> <p>23 instead, as you have said, there was a period where, if</p> <p>24 a disclosure was made or another concern was raised</p> <p>25 about a vulnerability, a further appointment was booked</p> <p style="text-align: center;">Page 111</p>
<p>1 that there should have been a full mental health</p> <p>2 assessment of every detainee, so I wasn't there and</p> <p>3 I can't quite understand how those two things mesh</p> <p>4 together.</p> <p>5 Q. It is not Dr Hard who was suggesting there should be</p> <p>6 a mental and physical examination; it is the wording of</p> <p>7 the rule, isn't it?</p> <p>8 Rule 34 requires mental and physical examination of</p> <p>9 every detainee within 24 hours of arrival at the IRC; is</p> <p>10 that your understanding?</p> <p>11 A. My understanding is that, within 24 hours, the detainee</p> <p>12 should see a GP.</p> <p>13 Q. For a mental and physical examination.</p> <p>14 A. For a mental and physical examination.</p> <p>15 What I am unclear of, or what I kind of look at and</p> <p>16 try to process is, what was the intention and how long</p> <p>17 should that appointment have been; was it not to assess</p> <p>18 whether any further assessment was required and it would</p> <p>19 appear to me that that was what they were trying to</p> <p>20 achieve in seeing someone to assess whether they felt</p> <p>21 that a further follow-up appointment was required to</p> <p>22 assess their potential to need to put a rule 35 report</p> <p>23 together.</p> <p>24 Q. That is clearly what was happening in practice on the</p> <p>25 ground in 2017. What the rules require, though, is for</p> <p style="text-align: center;">Page 110</p>	<p>1 for a rule 35 assessment and that built in delay, and he</p> <p>2 described it as being almost like triage. Does</p> <p>3 G4S Health Services consider there were adequate</p> <p>4 GP resources provided at the time to fulfil the</p> <p>5 requirements of rule 34?</p> <p>6 A. I think that the resources provided were in line with</p> <p>7 the contract let by the NHS and were in line with the</p> <p>8 resources available in the wider IRC estate -- pardon</p> <p>9 me -- and met the needs as people appeared to see them</p> <p>10 at that time. That may not be the need as you are</p> <p>11 defining rule 34 at this time, but appear to be</p> <p>12 consistent with it across the whole estate.</p> <p>13 Q. Dr Oozeerally gave evidence that there was one rule 35</p> <p>14 appointment available a day. Again, did</p> <p>15 G4S Health Services consider that to be adequate at the</p> <p>16 time, in order to fulfil the requirements of rules 34</p> <p>17 and 35 working together?</p> <p>18 A. It would seem that there was considerable discussion</p> <p>19 around rule 34 and 35 at the time; that there was active</p> <p>20 comparison between Brook House and other IRCs and that</p> <p>21 the approach was consistent and typical of the wider</p> <p>22 estate.</p> <p>23 Q. The G4S document, at the time, on detainee reception</p> <p>24 procedures, was inaccurate in suggesting that detainees</p> <p>25 must require or request to see a doctor within 24 hours.</p> <p style="text-align: center;">Page 112</p>

<p>1 Would you agree that that is not in accordance with</p> <p>2 the rule and, therefore, that document was inaccurate</p> <p>3 and therefore inadequate?</p> <p>4 A. Sorry, I believe the document that you describe is</p> <p>5 inaccurate; my understanding of the process was that</p> <p>6 a detainee on arrival would be seen by a nurse and that,</p> <p>7 at that point, the nurse would make an appointment for</p> <p>8 them to see the doctor.</p> <p>9 So if the document did not reflect that process,</p> <p>10 then it would appear that the document was not</p> <p>11 reflecting what was done at the time.</p> <p>12 Q. Yes.</p> <p>13 There was some evidence the inquiry has heard from</p> <p>14 Medical Justice, from their case work experience, that</p> <p>15 detainees were not always seen for a rule 34 appointment</p> <p>16 within 24 hours and that, sometimes, even where</p> <p>17 a disclosure, such as being a victim of torture, was</p> <p>18 made, a rule 35 assessment was not booked for them.</p> <p>19 Again, that would have been inadequate at the time</p> <p>20 to comply with the rules, wouldn't it?</p> <p>21 A. If the detainee wasn't seen within 24 hours, indeed the</p> <p>22 rule does say "within 24 hours". In terms of if someone</p> <p>23 has disclosed torture, I am not clear that that</p> <p>24 necessarily directly leads to a rule 35 assessment,</p> <p>25 because, if there is no fear of the mental wellbeing of</p> <p style="text-align: center;">Page 113</p>	<p>1 level of conversation was or wasn't going on with</p> <p>2 regards to those specific matters in 2017. Obviously,</p> <p>3 there were a number of reports produced and reviews</p> <p>4 undertaken and I don't remember in my reading of any of</p> <p>5 those reports it to have been something which was of</p> <p>6 significant concern, or record, that created substantive</p> <p>7 action. Therefore, I am not sure that it would</p> <p>8 necessarily have been something which was high on the</p> <p>9 agenda for discussion at a senior level.</p> <p>10 Q. Stephen Shaw had, in his January 2016 report, looked at</p> <p>11 rules 34 and 35 and had noted that they were intended to</p> <p>12 be a key safeguard in ensuring that vulnerabilities were</p> <p>13 identified in detainees to the Home Office, but that it</p> <p>14 was abundantly clear that rule 35 was not fit for</p> <p>15 purpose and was failing to protect vulnerable people who</p> <p>16 find themselves in detention.</p> <p>17 Was G4S Health Services, at a senior management</p> <p>18 level, aware of those findings in the Shaw report at the</p> <p>19 time?</p> <p>20 A. I, unfortunately, wasn't there at the time of the Shaw</p> <p>21 report, and I haven't been able to speak to anybody who</p> <p>22 was there to know the answer to that question.</p> <p>23 Q. Do you know if anything was done by G4S Health Services</p> <p>24 to respond to the failures that a rule 34 and 35 process</p> <p>25 identified by Mr Shaw in that review?</p> <p style="text-align: center;">Page 115</p>
<p>1 the individual from their behaviour and state, would</p> <p>2 that necessarily lead there? I am not an expert,</p> <p>3 I wasn't there and I am not sure that that would</p> <p>4 necessarily happen.</p> <p>5 Q. If someone had disclosed they were a victim of torture,</p> <p>6 you don't think it was necessary for them to be assessed</p> <p>7 under rule 35(3) at the time?</p> <p>8 A. My understanding of rule 35 -- and it may be my</p> <p>9 misunderstanding -- was that the purpose of rule 35(3)</p> <p>10 was to raise that as a reason that the individuals</p> <p>11 should be released from detention because further</p> <p>12 detention would further harm them.</p> <p>13 I am not clear that that is always the case of</p> <p>14 somebody who has suffered historic torture, but I am not</p> <p>15 an expert.</p> <p>16 Q. Would you accept, from the evidence that the inquiry has</p> <p>17 heard from various sources, that the rules weren't</p> <p>18 working at the outset of detention to identify to the</p> <p>19 Home Office those who were vulnerable and at risk of</p> <p>20 harm in detention, and so were not safeguarding</p> <p>21 detainees at that stage?</p> <p>22 A. I don't know that I can comment.</p> <p>23 Q. Was senior management aware of how the rules were</p> <p>24 operating at the time on the ground in 2017?</p> <p>25 A. I am not sure what I can point to to establish what</p> <p style="text-align: center;">Page 114</p>	<p>1 A. I don't know with specific reference to the Shaw review.</p> <p>2 I do, of course, know from Dr Oozeerally's evidence that</p> <p>3 he was trying to engage with the Home Office to discuss</p> <p>4 the effectiveness of rule 35.</p> <p>5 Q. He is not senior management in G4S Health Services</p> <p>6 though, is he, Dr Oozeerally?</p> <p>7 A. No.</p> <p>8 Q. Do you know of any action taken by senior management in</p> <p>9 G4S Health Services to respond to those findings by</p> <p>10 Mr Shaw in 2016?</p> <p>11 A. No, I -- I don't believe -- I haven't spoken to anyone</p> <p>12 who was in senior management at that time and I don't</p> <p>13 know what action was or wasn't taken, with regards to</p> <p>14 that report.</p> <p>15 Q. There is nothing apparent from your review of the</p> <p>16 documentation?</p> <p>17 A. My review concentrated on the relevant period. I didn't</p> <p>18 review anything particularly unless I was guided to it</p> <p>19 outside of the relevant period.</p> <p>20 Q. You state, at paragraph 181 of your statement, that the</p> <p>21 majority of self-harm incidents did not meet the</p> <p>22 threshold for a rule 35(2) report of real suicidal</p> <p>23 intent.</p> <p>24 What is the basis of that statement?</p> <p>25 A. I understand that a doctor would talk to the individual</p> <p style="text-align: center;">Page 116</p>

<p>1 and assess, in his medical opinion, the intent and</p> <p>2 likelihood of further harm from such action.</p> <p>3 I believe that that is what I refer to in my</p> <p>4 statement, this point.</p> <p>5 Q. If we could show on screen, please, <CJS006120>, these</p> <p>6 are the Detention Centre Rules. If we could go to</p> <p>7 page 11, please. Rule 35 is in the middle. At</p> <p>8 rule 35(2):</p> <p>9 "Requires the medical practitioner to report to the</p> <p>10 manager on the case of any detained person he suspects</p> <p>11 of having suicidal intentions."</p> <p>12 The rule requires only a suspicion of suicidal</p> <p>13 intention, doesn't it?</p> <p>14 A. It does.</p> <p>15 Q. Your statement, at paragraph 181, that the majority of</p> <p>16 self-harm incidents did not meet the threshold for</p> <p>17 rule 35(2) of real suicidal intent, doesn't, though,</p> <p>18 address the very low numbers of rule 35(1) reports, does</p> <p>19 it?</p> <p>20 A. And the fact that they would be injuriously affected by</p> <p>21 continued detention, no.</p> <p>22 Q. Because rule 35(1) only requires a likelihood of harm,</p> <p>23 not even actual harm, to have been caused, and we see</p> <p>24 that from the rule, don't we?</p> <p>25 A. We do.</p> <p style="text-align: center;">Page 117</p>	<p>1 Were you aware of that?</p> <p>2 A. I think, as I say, this is a complex area. I am not</p> <p>3 an expert in the area and it is difficult for me to make</p> <p>4 clear commentary on it. All I can say is that, as</p> <p>5 an observer, and listening to Dr Oozeerally, he seemed</p> <p>6 to have the opinion at the time that completing a part C</p> <p>7 and sending it to the same Home Office inbox as</p> <p>8 a rule 35, that it would be read by the same person and</p> <p>9 generate action.</p> <p>10 Obviously, I can fully understand that there is</p> <p>11 a different interpretation and a requirement of action</p> <p>12 from rule 35 as talked about here. I guess there is</p> <p>13 a difference of interpretation versus practice at the</p> <p>14 time and I would normally have expected engagement</p> <p>15 between the Home Office, the NHS and other bodies to</p> <p>16 have brought that to the fore, and brought that as</p> <p>17 an improvement point which didn't appear to be happening</p> <p>18 for some reason.</p> <p>19 Q. What evidence are you aware of that senior management at</p> <p>20 G4S Health Services were raising that issue with anyone?</p> <p>21 A. I am not aware.</p> <p>22 Q. Sandra Calver accepted that, regarding rule 35(1) and</p> <p>23 rule 35(2) that there should have been significantly</p> <p>24 more of both of those types of reporting in 2017 and</p> <p>25 that the safeguards had failed; do you agree with her?</p> <p style="text-align: center;">Page 119</p>
<p>1 Q. We know that there were only eight rule 35(1) reports in</p> <p>2 2017, only two in the relevant period, and we know there</p> <p>3 were no rule 35(2) reports at all in 2017, and we know</p> <p>4 that, despite high-levels of self-harm and a large</p> <p>5 number of open ACDTs, 248 in 2017, evidence heard by the</p> <p>6 inquiry from Sandra Calver indicated that she, and</p> <p>7 indeed her staff, hadn't understood the rule 35 process</p> <p>8 and were applying too high a threshold for rule 35</p> <p>9 reports to be completed.</p> <p>10 Are you aware of that evidence?</p> <p>11 A. I am not aware of that particular piece of evidence from</p> <p>12 Sandra. I am aware of the concern that you are talking</p> <p>13 of there. From my reading of the documentation around</p> <p>14 that, it would appear that that concern was discussed at</p> <p>15 the IRC forums and that the relative numbers were</p> <p>16 comparable with the numbers reported across the wider</p> <p>17 IRC estate at the time.</p> <p>18 I am also cognisant of the evidence from</p> <p>19 Dr Oozeerally, where he talks about his use of part C,</p> <p>20 rather than 35(1) or (2). It appears, from what I have</p> <p>21 seen him talk about, that he felt that that was</p> <p>22 a quicker way to gain attention and discussion of</p> <p>23 specific instances.</p> <p>24 Q. Part C, though, of course, does not require a review of</p> <p>25 detention, does it, by the Home Office; rule 35 does.</p> <p style="text-align: center;">Page 118</p>	<p>1 A. I don't recall that particular piece of Sandra's</p> <p>2 evidence. I can certainly see, from the interpretations</p> <p>3 being taken here, that it would be reasonable to have</p> <p>4 expected higher numbers. As I said, it would appear</p> <p>5 that the numbers that were reported at Brook House were</p> <p>6 not inconsistent with the numbers reported across the</p> <p>7 wider estate and, as such, I would have expected there</p> <p>8 to have been considerable effort from other parties to</p> <p>9 have raised this and to be taking action, if it was, in</p> <p>10 fact, a problem that was only at Brook House.</p> <p>11 Q. Whether or not there were failures in the safeguards at</p> <p>12 other IRCs, do you accept that they were failing, in</p> <p>13 2017, in Brook House?</p> <p>14 A. I think it is -- I guess the reason that I am labouring</p> <p>15 this is I am trying to look back five years and apply</p> <p>16 the lens of what was considered to be acceptable and</p> <p>17 normal five years ago, versus what might be considered</p> <p>18 to be a lens of a review and detailed desktop</p> <p>19 questioning today. I am not sure that a view that would</p> <p>20 be taken today in this room would necessarily have been</p> <p>21 the exact same view and interpretation taken by people</p> <p>22 actually operating the service at the time in 2017.</p> <p>23 Q. Whether or not it was their view that they were</p> <p>24 operating it acceptably, do you accept now that the</p> <p>25 rules were not being complied with in 2017, in terms of</p> <p style="text-align: center;">Page 120</p>

<p>1 the reporting under rule 35(1) and rule 35(2) to the</p> <p>2 Home Office?</p> <p>3 A. By the definitions of which you are interpreting those</p> <p>4 rules, I can see how you reach that conclusion. I find</p> <p>5 it difficult to understand why, if those rules were</p> <p>6 being so blatantly missed, why is it that the</p> <p>7 inspections of the IMB, Her Majesty's' Inspectorate and</p> <p>8 the CQC did not raise these as being serious failings at</p> <p>9 the time? I would have fully expected that level of</p> <p>10 oversight and the regular reviews that we undertake on</p> <p>11 a quarterly partnership and the quality meetings to have</p> <p>12 been raising those as serious issues.</p> <p>13 So the sheer fact that so many other modes of</p> <p>14 oversight were not raising it, makes it, for me, as</p> <p>15 a layman, at this time a confusing picture to try and</p> <p>16 dissect.</p> <p>17 Q. The statement that the majority of self-harm incidents</p> <p>18 in 2017 didn't meet the threshold criteria for</p> <p>19 rule 35(2), doesn't address the fact that there were, in</p> <p>20 fact, no rule 35(2) reports in 2017, does it? You are</p> <p>21 not suggesting that there were no detainees in 2017 in</p> <p>22 Brook House about whom there was a suspicion that they</p> <p>23 had suicidal intentions, are you?</p> <p>24 A. No, I don't believe that Dr Oozeerally suggested that.</p> <p>25 I believe that he suggested, from what I have seen in</p> <p style="text-align: center;">Page 121</p>	<p>1 A. I am not sure.</p> <p>2 Q. Are you aware now as to whether, at the time, in 2017,</p> <p>3 senior management in G4S Health Services were indeed</p> <p>4 aware of the low numbers of 35(1) reports and that there</p> <p>5 were no rule 35(2) reports undertaken? Are you able to</p> <p>6 say whether they were or were not aware?</p> <p>7 A. I don't know.</p> <p>8 Q. Your explanation for the lack of those reports was that</p> <p>9 there was an understanding by those at the time,</p> <p>10 accepted in the knowledge of the Home Office, that that</p> <p>11 is the way it was done and so it wasn't a problem?</p> <p>12 A. That is the only inference that I can take from the lack</p> <p>13 of it being raised through any other channel as being</p> <p>14 an important matter to resolve, because, otherwise, as</p> <p>15 you suggest, it looks obvious that there was a problem,</p> <p>16 but if there was a problem of the scale that has been</p> <p>17 described, I continue to struggle to understand why it</p> <p>18 wasn't being brought to the attention of everybody as</p> <p>19 a serious failing, because there was no lack of</p> <p>20 oversight, of detailed reporting and of review of what</p> <p>21 was going on in the establishment at the time.</p> <p>22 Q. If senior management weren't aware of the low numbers</p> <p>23 indicating a lack of compliance with the rules, they</p> <p>24 should have been, shouldn't they, at the time?</p> <p>25 A. As I said, I would expect that they would have been, but</p> <p style="text-align: center;">Page 123</p>
<p>1 his evidence, that he'd rather use part C, and as you</p> <p>2 are saying, that may not have been the intention of the</p> <p>3 rules at the time, but appears to have been how he</p> <p>4 interpreted it.</p> <p>5 Q. Because we know there were a number of detainees who the</p> <p>6 inquiry has heard about -- for example, D1527, D1914 and</p> <p>7 D687 -- who were identified as having made a statement</p> <p>8 or an attempt to kill themselves and were managed on</p> <p>9 constant supervision on an ACDT indicating a high risk</p> <p>10 of suicide.</p> <p>11 Are you aware of that?</p> <p>12 A. Yes.</p> <p>13 Q. And so, in those types of -- in those cases and those</p> <p>14 types of cases, there should have been a rule 35(2)</p> <p>15 report completed at the time, shouldn't there -- do you</p> <p>16 accept that now?</p> <p>17 A. By that interpretation, yes, I am not sure whether</p> <p>18 a part C was completed for those cases which would have</p> <p>19 been the evidence from Dr Oozeerally of the approach he</p> <p>20 would typically have taken at the time.</p> <p>21 Q. But whether or not a part C was or was not completed,</p> <p>22 the rules require a report where there is a suspicion of</p> <p>23 suicidal intention and, in those cases where detainees</p> <p>24 were managed on constant supervision, that threshold was</p> <p>25 met, wasn't it?</p> <p style="text-align: center;">Page 122</p>	<p>1 I can't evidence whether they did or whether they</p> <p>2 didn't. I don't know what reports they read or what</p> <p>3 level of insight they had into the detail of what was</p> <p>4 going on at Brook House at the time.</p> <p>5 Q. Some responsibility for compliance with the rules by</p> <p>6 those on the ground rests with senior management of the</p> <p>7 company, doesn't it?</p> <p>8 A. Yes, it does. As I say, I reiterate, I don't know</p> <p>9 whether they did or whether they didn't. And I don't</p> <p>10 know what action they took.</p> <p>11 Q. Given the evidence the inquiry has heard that healthcare</p> <p>12 staff, including the head of healthcare and clinical</p> <p>13 lead, leadership roles in healthcare, didn't understand</p> <p>14 how to apply the rules, and GPs on the ground were not</p> <p>15 applying them under rules 35(1) and (2), would you</p> <p>16 accept there was a failure of senior management in that</p> <p>17 regard?</p> <p>18 A. I am afraid I find -- I find it difficult in such an</p> <p>19 environment, in a medical environment, where the medical</p> <p>20 director and clinical people would be in constant touch</p> <p>21 with the NHS, the Home Office, and other oversight</p> <p>22 bodies, the CQC, that, if this was such a well</p> <p>23 understood and well -- and documented in a way that</p> <p>24 creates such an expectation, then I am sure that it</p> <p>25 would have been a point of discussion and action would</p> <p style="text-align: center;">Page 124</p>

<p>1 have thereby flowed from it. I am not sure that I can</p> <p>2 infer, due to the lack of action and required action</p> <p>3 from any of those oversights, that I would expect there,</p> <p>4 therefore, to have been any action taken by the senior</p> <p>5 leadership of health services.</p> <p>6 Q. Wasn't it senior management's responsibility,</p> <p>7 irrespective of what any other body was doing, to ensure</p> <p>8 that its staff were complying with their statutory</p> <p>9 obligations under the rules?</p> <p>10 A. Yes, of course. But if, at the time the rules were</p> <p>11 being interpreted and enacted in a certain way across</p> <p>12 the whole IRC estate, which was understood from forums</p> <p>13 and other actions, then that would have been the</p> <p>14 interpretation of the rule at the time.</p> <p>15 If, with hindsight, and five years on, we now</p> <p>16 consider that to be an incorrect interpretation, that</p> <p>17 could well be so, but that was not necessarily the view</p> <p>18 taken by any organisation at that time.</p> <p>19 Q. Did G4S Health Services monitor the training being given</p> <p>20 to staff on rule 35?</p> <p>21 A. I believe that there was a training matrix and that, as</p> <p>22 in all medical settings, training was important, and</p> <p>23 I would believe that rule 35 training would have been</p> <p>24 monitored in the same way as other training.</p> <p>25 Q. Was there any monitoring from senior management of</p> <p style="text-align: center;">Page 125</p>	<p>1 rule 35(2) reports and only eight rule 35(1) reports in</p> <p>2 the whole of 2017, does it? Does that suggest a failure</p> <p>3 of that oversight mechanism of the contract compliance</p> <p>4 in relation to the GPs at Brook House in 2017?</p> <p>5 A. No, I don't think it does. I think it further points to</p> <p>6 the interpretation of rule 35 at the time, across the</p> <p>7 whole estate, because what -- if, as you suggest, there</p> <p>8 was such a failing, I cannot see how the CQC, the NHS or</p> <p>9 Her Majesty's Inspectorate, none of them decided that</p> <p>10 there was a significant failing that required action in</p> <p>11 this matter.</p> <p>12 They were also aware of the number of reports, as</p> <p>13 they were of the number of reports across the wider IRC</p> <p>14 estate, and I understand that the number that were</p> <p>15 quoted out of Brook House were not untypical.</p> <p>16 In fact, in the wider use of rule 35, I believe that</p> <p>17 Brook House had more reports converted into detainees</p> <p>18 being released than anywhere else.</p> <p>19 Q. You say, at paragraph 56, that any significant</p> <p>20 performance issues or complaints concerning GPs were</p> <p>21 referred to the company's medical director. Were there</p> <p>22 any complaints about Dr Oozeerally or Dr Chaudhary</p> <p>23 concerning rule 35 reports or the lack thereof?</p> <p>24 A. Not that I am aware of in the relevant period.</p> <p>25 Q. Was it picked up as a performance issue by senior</p> <p style="text-align: center;">Page 127</p>
<p>1 compliance with rule 35? Was that audited at the time?</p> <p>2 A. I haven't seen the detail of any audits documents.</p> <p>3 Q. How, then, were the senior management of</p> <p>4 G4S Health Services ensuring that the legal duties under</p> <p>5 that rule were being complied with on the ground?</p> <p>6 A. I don't know.</p> <p>7 Q. You say, at paragraph 57 of your statement, that there</p> <p>8 were no contract compliance issues with</p> <p>9 DoctorPA Limited, who provided the GP services in</p> <p>10 Brook House at the time.</p> <p>11 Did G4S Health Services review DoctorPA or the GPs'</p> <p>12 compliance with rule 35 at the time in 2017?</p> <p>13 A. I believe there was a close working relationship between</p> <p>14 DoctorPA and the Health Services business, that there</p> <p>15 were daily reviews of practice, that there were</p> <p>16 quarterly quality reviews and there were quarterly</p> <p>17 partnership reviews which were attended by oversight</p> <p>18 bodies.</p> <p>19 I am not aware as to -- across all of those</p> <p>20 different reviews and audits, as to what specifically</p> <p>21 was reviewed with regards to rule 35. It would be</p> <p>22 surprising if it wasn't covered in some way through that</p> <p>23 amount of oversight and engagement.</p> <p>24 Q. Because it doesn't appear, that oversight and</p> <p>25 engagement, to have picked up a complete lack of</p> <p style="text-align: center;">Page 126</p>	<p>1 management at G4S Health Services?</p> <p>2 A. As I reiterate, I don't believe it was picked up by</p> <p>3 anybody as being a failing.</p> <p>4 Q. But it should have been by senior management, shouldn't</p> <p>5 it, they did bear some responsibility for those on the</p> <p>6 ground complying with their obligations under the rules?</p> <p>7 You can't just blame it all on everyone else.</p> <p>8 A. I am not blaming everyone else. I am trying to consider</p> <p>9 the environment, that if the way in which the rule at</p> <p>10 the time was interpreted was consistent with as was</p> <p>11 expected by the oversight bodies and as was expected and</p> <p>12 seen in the wider IRC estate, then why would we then</p> <p>13 seek to interpret it in a different way? It is clear</p> <p>14 that there was discussion about rule 35, and that</p> <p>15 Dr Oozeerally gave evidence talking about wanting to</p> <p>16 engage with the Home Office about rule 35, so there was</p> <p>17 clearly some issue and discussion around it.</p> <p>18 So on the basis that there was issue and discussion</p> <p>19 around it, and that there was training which was</p> <p>20 subsequently provided in 2018, it is obvious there was</p> <p>21 engagement and there was real discussion happening. So</p> <p>22 in that sense, it would suggest that there was action</p> <p>23 and awareness.</p> <p>24 As to exactly how that was being interpreted, and</p> <p>25 how that was being reported and whether that, therefore,</p> <p style="text-align: center;">Page 128</p>

<p>1 could create an inference that there was a failing, I am</p> <p>2 not sure that I can join the dots that create a failing</p> <p>3 from that, because there was so much talk around it. It</p> <p>4 is not like it was ignored, is what I am saying.</p> <p>5 Q. But that didn't result in compliance with the rules;</p> <p>6 would you accept that?</p> <p>7 A. As the rule is defined today, in 2022, and as it can be</p> <p>8 read --</p> <p>9 Q. It has not changed, since 2017.</p> <p>10 A. No, but we are now in version 7 of a document that was</p> <p>11 in version 4 in 2017, so there is clearly a lot gone on</p> <p>12 around the whole rule 35 thing and continues to be so,</p> <p>13 and the fact we have been talking about it for so long.</p> <p>14 Q. But the wording of the rule remained the same in 2017 as</p> <p>15 it does now, and whatever discussion there was between</p> <p>16 senior management and any other body, it didn't result</p> <p>17 in compliance with the rules, did it, in 2017?</p> <p>18 A. I think it is about the way in which the rule was being</p> <p>19 interpreted and implemented. I think, from what I could</p> <p>20 infer, that -- from Dr Oozeerally's evidence, as I saw</p> <p>21 it, he talked about the use of part C. Now, that may</p> <p>22 not have been appropriate, that may not have been in</p> <p>23 line with the rule, but that would appear to be the way</p> <p>24 in which he interpreted it in what he did.</p> <p>25 Q. Do you think senior management in G4S Health Services</p> <p style="text-align: center;">Page 129</p>	<p>1 A. That Sandra has talked about it in the manner in which</p> <p>2 she did. And that she felt the need to create the</p> <p>3 document, to bring, again, consistency. It was</p> <p>4 obviously a point of discussion.</p> <p>5 Q. She accepted in evidence that it didn't comply strictly</p> <p>6 with the rule because it built in a delay in reporting</p> <p>7 with a step of a nurse referral prior to a GP being seen</p> <p>8 seven days after the detainee was put on an ACDT.</p> <p>9 Were you aware, as were G4S Health Services' senior</p> <p>10 management aware at the time, that that pathway didn't</p> <p>11 comply with the wording of the rule?</p> <p>12 A. I don't know. But I think it is taking the rule</p> <p>13 strictly -- I can see how you suggest the pathway</p> <p>14 doesn't apply to the rule. However, if the individual</p> <p>15 is already on an ACDT, and is being -- or is under</p> <p>16 constant supervision, then I guess that, from what I can</p> <p>17 understand from the intent there was, was to understand</p> <p>18 whether the individual was at genuine risk of a suicide</p> <p>19 attempt.</p> <p>20 And I don't think it was strictly seven days, was</p> <p>21 it? It was up to seven days. It was trying to assess</p> <p>22 the individual, from my reading of that, but my reading</p> <p>23 may be wrong and I may have misinterpreted it.</p> <p>24 Q. Can I look at the use of force, please. At</p> <p>25 paragraph 172 of your witness statement, you deal with</p> <p style="text-align: center;">Page 131</p>
<p>1 was aware of that practice at the time?</p> <p>2 A. I couldn't conclusively evidence that to be the case.</p> <p>3 However, there was a close working relationship between</p> <p>4 G4S and DoctorPA and I would be surprised if they</p> <p>5 weren't aware of that.</p> <p>6 Q. Sandra Calver gave evidence that, along with herself as</p> <p>7 head of healthcare, the Home Office bore some</p> <p>8 responsibility for failings within the rule 35 process,</p> <p>9 in that they had been aware of the practice being</p> <p>10 undertaken in Brook House through her involvement with</p> <p>11 the IRC forums, as you have alluded to.</p> <p>12 Do you agree with her that the Home Office bears</p> <p>13 responsibility as well?</p> <p>14 A. I think this is a complex matter and I think the lack of</p> <p>15 clarity has certainly -- it certainly didn't help.</p> <p>16 Q. Sandra Calver gave evidence that, as a result of the</p> <p>17 lack of rule 35(2) reports being completed, she created</p> <p>18 a rule 35(2) pathway document, and that she brought that</p> <p>19 to the attention of the Home Office and IRC forum, who</p> <p>20 approved it. Was senior management at</p> <p>21 G4S Health Services aware of the use of that pathway at</p> <p>22 the time?</p> <p>23 A. I can't evidence that to be the case but I would assume</p> <p>24 so.</p> <p>25 Q. On what basis?</p> <p style="text-align: center;">Page 130</p>	<p>1 the F213 form and that some forms were missing or not</p> <p>2 completed during the relevant period, and you speculated</p> <p>3 there as to the possible reasons for that.</p> <p>4 Has G4S Health Services taken any steps to ascertain</p> <p>5 the actual reasons that they were missing or not</p> <p>6 completed at the time? Was there any investigation of</p> <p>7 that?</p> <p>8 A. No, I don't believe there was.</p> <p>9 I think we are -- of course, as we have said in</p> <p>10 there, we are five years on, and they are documents</p> <p>11 amongst many and, as I understand it, of all the</p> <p>12 documents requested by the inquiry in terms of the F213,</p> <p>13 less than ten were missing, so it wouldn't suggest that</p> <p>14 there was a serious issue of a complete lack of</p> <p>15 documentation.</p> <p>16 Q. Has there been any audit of the use of force paperwork</p> <p>17 undertaken to ascertain if healthcare were completing</p> <p>18 the forms on all occasions?</p> <p>19 A. I don't know, that would have been done by CJS.</p> <p>20 Q. Or as to the quality of the entries?</p> <p>21 A. Again, I don't know.</p> <p>22 Q. Because isn't the healthcare aspect of those forms</p> <p>23 important and the responsibility of senior management of</p> <p>24 G4S Health Services, as opposed to Care and Justice?</p> <p>25 A. The quality of all the documentation to do with health</p> <p style="text-align: center;">Page 132</p>

<p>1 is important. It is to do with an individual's welfare</p> <p>2 and, as such, of course it is important.</p> <p>3 Q. So wasn't it important to audit the quality of those</p> <p>4 entries? The healthcare entry on the use of force form?</p> <p>5 A. I am sure that the quality of all health documentation</p> <p>6 is important, and I would be surprised if it wasn't</p> <p>7 audited in some way, shape or form.</p> <p>8 Q. In the minutes from a meeting on 27 October 2016, it was</p> <p>9 stated that rule 42s and 213s are still not being</p> <p>10 completed on all occasions; are you aware of what action</p> <p>11 G4S Health Services took as a result of that being</p> <p>12 minuted in that meeting in relation to a failure to</p> <p>13 complete the forms?</p> <p>14 A. Sorry, October -- sorry, can you just repeat that?</p> <p>15 Q. In the minutes of a meeting from 27 October 2016, it was</p> <p>16 stated that rule 40s, rule 42s and 213s are still not</p> <p>17 being completed all occasions; I was asking whether you</p> <p>18 were aware of any action taken by G4S Health Services in</p> <p>19 relation to the failure to complete those forms?</p> <p>20 A. No, unfortunately, I wasn't around in 2016.</p> <p>21 Q. And there is no documentation available as to what</p> <p>22 action, if any, was taken by G4S Health Services, as</p> <p>23 a result of it being recorded in a meeting that that was</p> <p>24 the case?</p> <p>25 A. I don't remember reviewing documentation from 2016.</p> <p style="text-align: center;">Page 133</p>	<p>1 Q. It certainly goes beyond expressing a concern or</p> <p>2 a contraindication, a reason not to use force, doesn't</p> <p>3 it? Yes?</p> <p>4 A. Yes.</p> <p>5 Q. Indeed he doesn't raise any concerns or</p> <p>6 contraindications, reasons not to use force.</p> <p>7 Was senior management in G4S Health Services aware</p> <p>8 of that practice by GPs in 2017, that there was</p> <p>9 an effective approval of use of force on detainees?</p> <p>10 A. I don't know.</p> <p>11 Q. If they were, would that have been of concern?</p> <p>12 A. I guess I don't understand the context in which the</p> <p>13 letter was written. I don't see what questions were</p> <p>14 asked and I don't know what he was responding to. So in</p> <p>15 the context in which you ask the question, yes, of</p> <p>16 course it is concerning; but, not understanding the</p> <p>17 wider context around why was that written in that way at</p> <p>18 that time with respect to that particular individual,</p> <p>19 I don't know.</p> <p>20 Q. Have you reviewed the evidence of Dr Bingham and Dr Hard</p> <p>21 on this issue to this inquiry?</p> <p>22 A. I can't bring it immediately to mind.</p> <p>23 Q. They certainly said that this went beyond what was</p> <p>24 appropriate for a doctor and that here, Dr Oozeerally</p> <p>25 should have been raising concerns and contraindications</p> <p style="text-align: center;">Page 135</p>
<p>1 Q. Dr Oozeerally, on 27 May 2017, within the relevant</p> <p>2 period, completed a fitness-to-fly letter in relation to</p> <p>3 D1914, and in that letter he stated:</p> <p>4 "The above detainee is fit to fly and fit for</p> <p>5 detention. He will need a medical escort due to the</p> <p>6 nature of his medical condition. I am happy for</p> <p>7 reasonable force to be used (C&R) in order to facilitate</p> <p>8 the removal."</p> <p>9 Was the senior management of G4S Health Services</p> <p>10 aware of the practice of GPs in providing such letters</p> <p>11 to the Home Office in 2017?</p> <p>12 A. I don't know the specifics of operational detail at that</p> <p>13 level.</p> <p>14 Q. That would have been a concern at the time, wouldn't it?</p> <p>15 A. In what way?</p> <p>16 Q. Wouldn't it be important for senior management at</p> <p>17 G4S Health Services to be aware of the practice of GPs</p> <p>18 of completing such letters for the Home Office in</p> <p>19 relation to patients?</p> <p>20 A. I don't know.</p> <p>21 Q. Dr Oozeerally, as I have said, stated there that he was</p> <p>22 happy for reasonable force to be used, which,</p> <p>23 effectively, approves or sanctions the use of force on</p> <p>24 D1914 to effect his removal; would you agree?</p> <p>25 A. That could be inferred from what you read.</p> <p style="text-align: center;">Page 134</p>	<p>1 due to both his physical and mental health history. You</p> <p>2 were not aware of that?</p> <p>3 A. No, obviously they are qualified doctors, providing</p> <p>4 medical opinions about another doctor. I haven't seen</p> <p>5 the detail. I don't know what detail they have seen to</p> <p>6 have reached that conclusion either.</p> <p>7 Q. Are you aware of how many times the medical emergency</p> <p>8 hands off instruction was used by healthcare staff in</p> <p>9 2017?</p> <p>10 A. No.</p> <p>11 Q. Why not? Was that not something you expect to be</p> <p>12 recorded?</p> <p>13 A. I don't know whether it was recorded. I certainly</p> <p>14 haven't seen any registers as such. I am aware it was</p> <p>15 the action that was expected to be taken if there was</p> <p>16 a problem with use of force.</p> <p>17 Q. There wasn't any audit of how many times and in what</p> <p>18 circumstances those instructions were required to be</p> <p>19 being used by healthcare staff in 2017?</p> <p>20 A. I don't know.</p> <p>21 Q. What action did senior management in G4S Health Services</p> <p>22 take to follow up on such an instruction, having been</p> <p>23 given during a use of force?</p> <p>24 A. I understand that there would have been a debrief and</p> <p>25 a review.</p> <p style="text-align: center;">Page 136</p>

<p>1 Q. What action would senior management take as a result of</p> <p>2 that?</p> <p>3 A. I don't know what specific action they would have taken.</p> <p>4 I don't know because I haven't got any record of it</p> <p>5 happening or what action would have been taken.</p> <p>6 Q. Are you aware of any other support other than the</p> <p>7 debrief being offered to healthcare staff who were</p> <p>8 required to issue such instructions, at the time?</p> <p>9 A. No, I do remember some reference to it in a document,</p> <p>10 but I don't recall the detail of that. I am sorry.</p> <p>11 Q. How was G4S senior management learning lessons from such</p> <p>12 situations?</p> <p>13 A. I don't know how senior management were learning</p> <p>14 lessons. Sandra Calver comes across to me as being</p> <p>15 a very credible and caring manager and I would have</p> <p>16 thought that, as the manager on site, and with the</p> <p>17 regular reviews of her staff and continual development</p> <p>18 of them, that there would have been discussion around</p> <p>19 those areas, and I think we probably saw it in some of</p> <p>20 the minutes of some of the staff meetings, about talking</p> <p>21 about a variety of issues.</p> <p>22 Q. Was any training provided to healthcare staff about</p> <p>23 their particular role in a use of force by</p> <p>24 G4S Health Services?</p> <p>25 A. I think this is an area that we relied on CJS to provide</p> <p style="text-align: center;">Page 137</p>	<p>1 As far as you are aware, at the time, was that what</p> <p>2 happened?</p> <p>3 A. I haven't seen anything to the contrary.</p> <p>4 Q. In what circumstances would it have been impractical to</p> <p>5 seek authorisation or authority from the Home Office?</p> <p>6 A. I don't know. I am not aware of just how close and</p> <p>7 available the Home Office was to the day-to-day</p> <p>8 operation.</p> <p>9 Q. Do you have an understanding of who would seek such</p> <p>10 an authority from the Home Office?</p> <p>11 A. No.</p> <p>12 Q. Was it your understanding that detention centre managers</p> <p>13 could authorise force, removal from association and</p> <p>14 temporary confinement under these rules?</p> <p>15 A. As you have just read them, yes, I believe that to be</p> <p>16 the case, if there was a particular and immediate</p> <p>17 immediate.</p> <p>18 Q. You state in your second witness statement, at</p> <p>19 paragraph 4, that three different organisations bid for</p> <p>20 the GP contract, and that the doctors to be provided by</p> <p>21 DoctorPA were the same doctors who were delivering</p> <p>22 services within Saxonbrook, so this provided for</p> <p>23 an element of consistency and continuity of service; is</p> <p>24 that right?</p> <p>25 A. Yes.</p> <p style="text-align: center;">Page 139</p>
<p>1 training and insight into. As I recall from the</p> <p>2 information, that that is the way in which individuals</p> <p>3 would have been trained, would have been to have been</p> <p>4 trained by CJS.</p> <p>5 Q. But they are not healthcare professionals with</p> <p>6 healthcare expertise, are they? How would they provide</p> <p>7 training to healthcare staff on their particular role in</p> <p>8 a use of force?</p> <p>9 A. I don't know.</p> <p>10 Q. In relation to the authorisation of use of force and the</p> <p>11 authorisation of removal from association under rule 40</p> <p>12 and authorisation of temporary confinement under</p> <p>13 rule 42, what is your understanding of who was able to</p> <p>14 authorise those aspects under those rules?</p> <p>15 A. I think, from my understanding, that rule 40 and rule 42</p> <p>16 were enacted by CJS.</p> <p>17 Q. The relevant DSO suggests that, in normal circumstances,</p> <p>18 use of rule 40 or of 42 must be authorised by a manager</p> <p>19 from the compliance team at the Home Office, but in</p> <p>20 cases of urgency in which it is impractical to seek</p> <p>21 authority from the Home Office, it could be done by G4S.</p> <p>22 And "urgency" was defined as, for example, "to protect</p> <p>23 life and/or the security of the centre, for example,</p> <p>24 a fight or an assault on another detained individual or</p> <p>25 member of staff."</p> <p style="text-align: center;">Page 138</p>	<p>1 Q. What other factors influenced you in choosing that bid?</p> <p>2 Or influenced G4S Health Services, I should say, at the</p> <p>3 time?</p> <p>4 A. I wasn't there and I don't know the detail of the</p> <p>5 tender. I know there were two other organisations that</p> <p>6 tendered. I would imagine that there would have been</p> <p>7 a mix of factors which would have generated the</p> <p>8 decision.</p> <p>9 Q. Such as?</p> <p>10 A. I would imagine, in any tender of its type, there would</p> <p>11 be a blend of quality, capability and price</p> <p>12 considerations.</p> <p>13 Q. The 2016 IMB report had raised issues about the rule 35</p> <p>14 process in Brook House. At paragraph 5.4.10, they said:</p> <p>15 "It is surprising that there are so few reports by</p> <p>16 GPs about detainees whose health is likely to be</p> <p>17 affected by continuing detention or suspecting that</p> <p>18 a detainee has suicidal intentions, given that reporting</p> <p>19 from G4S showed an average of 11 incidents of self-harm</p> <p>20 attempts per month in 2016."</p> <p>21 So there we have an example of the IMB, in 2016,</p> <p>22 raising issues with the number of reports under rule 35,</p> <p>23 would you agree?</p> <p>24 A. Yes.</p> <p>25 Q. Did that, to your knowledge, raise any concerns within</p> <p style="text-align: center;">Page 140</p>

<p>1 G4S Health Services about giving the contract to the</p> <p>2 company owned by the two existing GPs in Brook House at</p> <p>3 that time?</p> <p>4 A. I am not aware that it did, no, remembering those GPs</p> <p>5 were not just working in Brook House, but were working</p> <p>6 in the wider IRC estate.</p> <p>7 Q. Should that have been a concern, in awarding them the</p> <p>8 contract, what the IMB have recorded there?</p> <p>9 A. As I have said, I don't think, from what I have read and</p> <p>10 understood, that the practice was inconsistent with the</p> <p>11 practice in the wider IRC estate at the time. Whether</p> <p>12 it was right or not, obviously, we are discussing and</p> <p>13 I don't know, but if it was consistent with the wider</p> <p>14 practice in the wider IRC estate, then I am not sure why</p> <p>15 it would have been a cautionary point with regards to</p> <p>16 the appointment of the doctors.</p> <p>17 Q. You mentioned earlier in your evidence that there was</p> <p>18 clearly a reliance upon the IMB not raising concerns,</p> <p>19 and we see that they did, in fact, raise concerns,</p> <p>20 didn't they?</p> <p>21 A. They raised a note of surprise, didn't they, that that</p> <p>22 is somewhat short of raising a direct concern around the</p> <p>23 performance of the organisation.</p> <p>24 Q. Are you aware of whether or not that note of surprise</p> <p>25 was raised at all with the GPs from DoctorPA Limited by</p> <p style="text-align: center;">Page 141</p>	<p>1 Q. On some of the footage we have seen, both on Panorama</p> <p>2 and on the unbroadcast footage, there was evidence of</p> <p>3 a mocking and derogatory attitude by some healthcare</p> <p>4 staff towards detainees who were unwell, particularly</p> <p>5 intoxicated with spice, and Sandra Calver certainly</p> <p>6 accepted in her evidence that those comments were</p> <p>7 inappropriate.</p> <p>8 Was G4S Health Services senior management aware of</p> <p>9 that type of behaviour from some members of healthcare</p> <p>10 towards detainees in 2017?</p> <p>11 A. I can't comment on whether it was aware. It was clearly</p> <p>12 unacceptable.</p> <p>13 Q. Some formerly detained persons have given evidence to</p> <p>14 the inquiry of rude or dismissive or abusive attitudes</p> <p>15 by healthcare staff to them; do you have any comment</p> <p>16 upon that?</p> <p>17 A. I think there is no place for unacceptable behaviour by</p> <p>18 healthcare staff in -- towards any patient. I think</p> <p>19 that the line that must be drawn, however, is the</p> <p>20 concept around dismissive or brusque; that could be</p> <p>21 regarding a style rather than an actual intent. So</p> <p>22 I think anything that is rude is -- and inappropriate,</p> <p>23 is completely unacceptable.</p> <p>24 However, I think the inference about somebody who is</p> <p>25 busy, who is trying to do many things, appearing to be</p> <p style="text-align: center;">Page 143</p>
<p>1 G4S Health Services at the time?</p> <p>2 A. I have no evidence to suggest whether that was true or</p> <p>3 not. I would be very surprised if a report of that type</p> <p>4 wasn't raised in both the quality -- the quarterly</p> <p>5 quality meeting and the partnering meeting, especially</p> <p>6 with the wider attendance at the partnering meetings,</p> <p>7 but I haven't reviewed any minutes of any of those</p> <p>8 meetings to be able to confirm or deny that.</p> <p>9 Q. At paragraph 120 of your first statement, in relation to</p> <p>10 the Lampard report, which reported on the nature of the</p> <p>11 nature of detainee complaints concerning healthcare, you</p> <p>12 stated that, "The company cannot respond to specific</p> <p>13 comments without knowledge of the detainees, their</p> <p>14 medical history or the context of the discussions."</p> <p>15 Does G4S Health Services accept that there was any</p> <p>16 substance to detainee complaints about healthcare in</p> <p>17 2017?</p> <p>18 A. Sorry, can you repeat the question?</p> <p>19 Q. Does G4S Health Services accept that there was any</p> <p>20 substance to detainees' complaints about healthcare in</p> <p>21 2017?</p> <p>22 A. From what I can understand, we took complaints</p> <p>23 seriously, and each complaint was reviewed by</p> <p>24 an independent reviewer, so it would seem that we were</p> <p>25 taking complaints seriously.</p> <p style="text-align: center;">Page 142</p>	<p>1 brusque, is not, maybe, the best example of how you</p> <p>2 would hope that somebody would conduct themselves, but</p> <p>3 isn't necessarily a reference to their intent or ability</p> <p>4 to deliver a healthcare service.</p> <p>5 Q. Did G4S Health Services, at the time, seek to</p> <p>6 investigate the nature of detainees' complaints to</p> <p>7 ascertain whether any action was needed at a systemic</p> <p>8 level?</p> <p>9 A. I believe that the complaints were taken seriously and</p> <p>10 reviewed at quarterly complaints reviews in the quality</p> <p>11 meetings, so I would be very surprised if there wasn't</p> <p>12 a systematic and systemic review of those, but I have no</p> <p>13 evidence to prove that that would be the case.</p> <p>14 Q. In a complaints audit undertaken by the company in 2020,</p> <p>15 it is recorded that the majority of complaints at</p> <p>16 Gatwick IRCs related to the failure to treat, with the</p> <p>17 second most common reason being staff attitude, and it</p> <p>18 stated, "Considering a complaint, do we actively listen,</p> <p>19 seek and act on feedback?" The report records no</p> <p>20 evidence that complaints were being reviewed at quality</p> <p>21 or board meetings.</p> <p>22 Were complaints being reviewed at quality or board</p> <p>23 meetings?</p> <p>24 A. If that is the view taken in the 2020 report, then, at</p> <p>25 that time, they cannot have been. Obviously, I don't</p> <p style="text-align: center;">Page 144</p>

<p>1 know whether that was the case in 2017. We obviously</p> <p>2 had a managing director in 2017, a different managing</p> <p>3 director in 2019, who, unfortunately, passed away, and</p> <p>4 we were on the third leadership at the time, so it may</p> <p>5 be something that was done and had passed. I know that</p> <p>6 following that report, a full review was taken of the</p> <p>7 complaints process and a number of items that have been</p> <p>8 brought up on that report have since been rectified and</p> <p>9 the whole complaints procedure across the business has</p> <p>10 been changed.</p> <p>11 Q. The report says that there wasn't any formal collation</p> <p>12 of complaint outcomes and triangulation with patient</p> <p>13 safety and patient experience data; is that something</p> <p>14 that has changed now?</p> <p>15 A. I believe so. That report does not make good reading.</p> <p>16 I believe that the only thing I took from reading that</p> <p>17 report was that, actually, Gatwick was probably the best</p> <p>18 performing of our establishments with regards to</p> <p>19 complaints.</p> <p>20 Q. At paragraphs 21 and 22 of your statement, you deal with</p> <p>21 the root cause analysis investigation that was carried</p> <p>22 out following the Panorama programme, and you say that</p> <p>23 the company was required to submit a root cause</p> <p>24 analysis, which is an NHS-led document reporting tool</p> <p>25 designed to capture serious incidents:</p> <p style="text-align: center;">Page 145</p>	<p>1 A. No.</p> <p>2 Q. The RCA was belatedly carried out by two other senior</p> <p>3 members of staff arbitration a report dated May 2019 was</p> <p>4 submitted.</p> <p>5 Was that the only review carried out by</p> <p>6 G4S Health Services as a result of the Panorama</p> <p>7 programme?</p> <p>8 A. I don't know. I do find it very surprising that Ms Hill</p> <p>9 didn't do the RCA, but obviously we cannot evidence it</p> <p>10 because we cannot find the document. So I don't know</p> <p>11 what other reviews may or may not have been undertaken.</p> <p>12 Obviously, health services were involved in all of</p> <p>13 the activities in G4S with regards to reviewing the</p> <p>14 Panorama programme and actions afterwards.</p> <p>15 Q. The RCA report found that contributory factors to the</p> <p>16 failure to treat detainees with respect and dignity</p> <p>17 included lack of attention to dignity and respect</p> <p>18 systemically across the IRC, and it identified root</p> <p>19 causes as staff cultural institutionalisation across the</p> <p>20 IRC more widely led to patients not being treated with</p> <p>21 dignity and respect. Staff were not supported to</p> <p>22 deliver safe and compassionate care. There was</p> <p>23 a failure of speaking up and reporting concerns or</p> <p>24 complaint systems and a dysfunctional atmosphere and</p> <p>25 culture that enabled bullying and blame systemically</p> <p style="text-align: center;">Page 147</p>
<p>1 "Its purpose is to demonstrate good governance and</p> <p>2 safety and to also demonstrate lessons learned."</p> <p>3 The report was delayed, because of the ongoing</p> <p>4 police investigation, and you then say:</p> <p>5 "Due to loss of knowledge, and healthcare's limited</p> <p>6 role in the police investigation (which was led</p> <p>7 primarily through CJS), the company is unable to say</p> <p>8 when clearance to proceed was given, but following this,</p> <p>9 Ms Hill was commissioned to conduct the required RCA</p> <p>10 investigation. However, following her departure from</p> <p>11 the company, it was identified that this did not appear</p> <p>12 to have been done."</p> <p>13 Ms Hill, was she the director of nursing?</p> <p>14 A. She was.</p> <p>15 Q. Do you know when she was commissioned to undertake the</p> <p>16 RCA investigation?</p> <p>17 A. No, I don't.</p> <p>18 Q. What were her qualifications and experience?</p> <p>19 A. I am afraid I don't know.</p> <p>20 Q. She left the company in November 2018. She reported to</p> <p>21 Tom Tuppen(?), who was the managing director at the</p> <p>22 time; is that right?</p> <p>23 A. That's correct.</p> <p>24 Q. Why didn't he follow up on the RCA before she left; do</p> <p>25 you know?</p> <p style="text-align: center;">Page 146</p>	<p>1 across the IRC.</p> <p>2 Does the company accept the findings of the RCA?</p> <p>3 A. The RCA was conducted in 2019 by two senior managers who</p> <p>4 I think were seeking to do -- well, the mode of the RCA</p> <p>5 took a much wider review of both the healthcare and the</p> <p>6 functioning of the IRC from what I can see through</p> <p>7 interviewing everybody. It is clear that its view about</p> <p>8 the wider IRC, and where it was, was an important</p> <p>9 observation and I believe action followed.</p> <p>10 Q. The question was, does the company accept the findings</p> <p>11 of the RCA?</p> <p>12 A. I think we accept the findings. I think it is in the</p> <p>13 context of it being an RCA that I struggle with.</p> <p>14 Q. It went wider than just looking at the particular</p> <p>15 incidents?</p> <p>16 A. Yes.</p> <p>17 Q. But the findings were nevertheless accepted?</p> <p>18 A. I believe so.</p> <p>19 Q. What action was taken to address those contributory</p> <p>20 factors and root causes by the senior management of</p> <p>21 G4S Health Services as a result of that RCA?</p> <p>22 A. I believe Mr Cook continued to work with Sandra</p> <p>23 regarding the outcomes, but, to be honest, I can't</p> <p>24 remember in detail.</p> <p>25 Q. I want to look at staffing briefly. Did</p> <p style="text-align: center;">Page 148</p>

<p>1 G4S Health Services, in 2017, have any system in place</p> <p>2 for documenting and monitoring the staffing levels in</p> <p>3 healthcare in each separate institution?</p> <p>4 A. They -- there is a document that has been submitted that</p> <p>5 showed the rostering by staff type in Tinsley and</p> <p>6 Brook House, if that is what you mean?</p> <p>7 Q. Was there a system for auditing or monitoring the care</p> <p>8 and treatment received by detained people by agency</p> <p>9 nurses as opposed to permanent members of staff?</p> <p>10 A. I don't believe so.</p> <p>11 Q. In 2017, some nurses didn't have training on the role of</p> <p>12 a nurse during control & restraint because the</p> <p>13 instructors of those courses had been suspended or</p> <p>14 dismissed because of their conduct captured in the</p> <p>15 Panorama programme.</p> <p>16 Did any review take place of whether those who had</p> <p>17 received that training from those people who had been</p> <p>18 suspended or dismissed take place to see if they needed</p> <p>19 repeat training?</p> <p>20 A. I don't know, I do remember, from some minutes</p> <p>21 in October 2017, that the deputy director of the prison</p> <p>22 undertook some training with all of the healthcare</p> <p>23 staff.</p> <p>24 Q. That was Steve Skitt, the deputy director; is that</p> <p>25 right?</p> <p style="text-align: center;">Page 149</p>	<p>1 Q. In 2016, the HMIP report, at paragraph 1.71, stated that</p> <p>2 the rule 35 reports they reviewed did not provide</p> <p>3 an adequate safeguard for detainees with post-traumatic</p> <p>4 stress disorder and no formal assessment of PTSD had</p> <p>5 been carried out in any case. And a recommendation was</p> <p>6 made at paragraph 1.80 stating that, where a detainee</p> <p>7 claims that they had been tortured, the rule 35 report</p> <p>8 should include an assessment of PTSD.</p> <p>9 Were you aware of that finding and recommendation?</p> <p>10 A. Not in detail.</p> <p>11 Q. On page 36, at paragraph 2.37 in that same report, it</p> <p>12 was stated that complaints about health services were</p> <p>13 submitted through the general centre system and</p> <p>14 forwarded to NHS England, which then returned them to</p> <p>15 healthcare for investigation. This compromised medical</p> <p>16 confidentiality and led to unnecessary delays in</p> <p>17 responses, so that some detainees had left before the</p> <p>18 responses arrived, and a recommendation was made in that</p> <p>19 regard, on the same page, at paragraph 2.42, stating</p> <p>20 that the healthcare complaint system should maintain</p> <p>21 medical confidentiality.</p> <p>22 Were you aware of that finding and recommendation in</p> <p>23 the 2016 report?</p> <p>24 A. Not in detail.</p> <p>25 Q. On page 36 at paragraph 2.38, it was stated there was no</p> <p style="text-align: center;">Page 151</p>
<p>1 A. I believe so.</p> <p>2 Q. Was the deputy director sufficiently qualified to give</p> <p>3 that training, in your view, given he is not a qualified</p> <p>4 nurse or a use of force instructor?</p> <p>5 A. I don't know. I think he was trying to fill a gap,</p> <p>6 because there was a gap, because of the people that had</p> <p>7 been suspended and left the organisation. And ...</p> <p>8 Q. In relation to HMIP, the HMIP Service Improvement Plan,</p> <p>9 in 2017, made recommendations that there should be</p> <p>10 a health needs analysis and a centre health and</p> <p>11 wellbeing strategy.</p> <p>12 Do you consider that there had been a failure by G4S</p> <p>13 to not already have identified that need previously?</p> <p>14 A. I think the health needs analysis was conducted by the</p> <p>15 NHS. I think there had previously been a health needs</p> <p>16 analysis in 2015. I don't know what the expected</p> <p>17 frequency of a health needs analysis would be, I am</p> <p>18 afraid, in a medical setting.</p> <p>19 Q. At paragraph 126 of your witness statement, you say that</p> <p>20 in relation to the oversight of healthcare at</p> <p>21 Brook House by HMIP:</p> <p>22 "All healthcare actions from the HMIP inspections</p> <p>23 from 2016 and 2019 were completed."</p> <p>24 Is that right?</p> <p>25 A. I believe that is what I stated.</p> <p style="text-align: center;">Page 150</p>	<p>1 centre wellbeing strategy, but health promotion</p> <p>2 information was displayed in the health centre, largely</p> <p>3 in English:</p> <p>4 "We were told that some information could be</p> <p>5 provided in other languages. There was no self-care and</p> <p>6 wellbeing guidance in the library in any language."</p> <p>7 And a recommendation was made:</p> <p>8 "Detainees who do not speak or read English well</p> <p>9 should have reasonable access to translated information</p> <p>10 about health services and health and wellbeing."</p> <p>11 Were you aware of that?</p> <p>12 A. Yes, I believe that we submitted a number of documents</p> <p>13 that were in a variety of languages.</p> <p>14 Q. And as a result, some leaflets were published in other</p> <p>15 languages; is that right?</p> <p>16 A. I believe so.</p> <p>17 Q. Why had G4S Health Services not identified that as</p> <p>18 a need previously?</p> <p>19 A. I don't know.</p> <p>20 Q. It seems like a relatively obvious proposition that</p> <p>21 detainees should have access to information in a form</p> <p>22 they can understand, doesn't it?</p> <p>23 A. I would accept that. I do believe that the main</p> <p>24 reliance was on translation services, in order to engage</p> <p>25 with detainees in their language, and I believe we used</p> <p style="text-align: center;">Page 152</p>

<p>1 two different translation services and that that was the</p> <p>2 primary way in which we ensured communication in</p> <p>3 an appropriate language.</p> <p>4 Q. In relation to the statement that all actions from the</p> <p>5 2016 report were completed, as you say at paragraph 126,</p> <p>6 they were assessed in the 2019 HMIP report.</p> <p>7 On page 61, it was stated in relation to progress</p> <p>8 from recommendations from the previous report:</p> <p>9 "Where a detainee claims they have been tortured,</p> <p>10 the rule 35 report should include an assessment of PTSD;</p> <p>11 where there is independent evidence of torture, the</p> <p>12 Home Office should only detain in very exceptional</p> <p>13 circumstances. Reasons for maintaining detention in</p> <p>14 such cases should be comprehensive."</p> <p>15 And it was recorded, "Not achieved".</p> <p>16 Were you aware of that?</p> <p>17 A. That is in the 2019 report, I should say, yes.</p> <p>18 Q. On page 61, it also stated:</p> <p>19 "The healthcare complaints system should maintain</p> <p>20 medical confidentiality."</p> <p>21 And it stated "Partially achieved".</p> <p>22 Were you aware of that?</p> <p>23 A. Yes.</p> <p>24 Q. On page 62:</p> <p>25 "Detainees who do not speak or read English well</p> <p style="text-align: center;">Page 153</p>	<p>1 need of the detainees as much as possible.</p> <p>2 Q. On what evidence did you base the statement that they</p> <p>3 were seeking to get treatment solely to prevent or delay</p> <p>4 deportation?</p> <p>5 A. I believe that would have been an assertion made from my</p> <p>6 inquiries with Sandra.</p> <p>7 Q. In relation to complaints, serious matters for concern</p> <p>8 were raised with NHS England in terms of complaints. If</p> <p>9 a complaint was serious, it would be passed on to</p> <p>10 NHS England to investigate. Are you aware of how many</p> <p>11 there were, in 2017, passed to NHS England?</p> <p>12 A. I don't think any were in 2017.</p> <p>13 Q. Was there any policy to guide the use of the discretion</p> <p>14 about when there should be a referral of serious</p> <p>15 concerns by the head of healthcare to NHS England, what</p> <p>16 guidance was given as to the threshold.</p> <p>17 A. I don't know.</p> <p>18 Q. Was any training provided?</p> <p>19 (Technical problem)</p> <p>20 MS SIMCOCK: Chair, given we have to pause, that may be</p> <p>21 a good opportunity to have our afternoon short break.</p> <p>22 THE CHAIR: Good idea.</p> <p>23 MS SIMCOCK: Can I say 3.35, please?</p> <p>24 THE CHAIR: Thank you very much. Thank you.</p> <p>25 (3.20 pm)</p> <p style="text-align: center;">Page 155</p>
<p>1 should have reasonable access to translated information</p> <p>2 about health services and health and wellbeing."</p> <p>3 Again, "partially achieved".</p> <p>4 Again, in those circumstances, is it really correct</p> <p>5 to say, as you do at paragraph 126, that all actions</p> <p>6 from both reports have been completed?</p> <p>7 A. Well, I guess, in terms of the last one, the company</p> <p>8 clearly didn't reach the level at which the IMB expected</p> <p>9 us to have reached in completing that.</p> <p>10 However, as you have commented on, the company had</p> <p>11 completed leaflets and made sure that both translation</p> <p>12 services were available. I guess that that would be the</p> <p>13 company's interpretation at the time versus the</p> <p>14 expectation to meet the need.</p> <p>15 Q. At paragraph 122 of your first statement, you say:</p> <p>16 "Some detainees would seek to get fast tracked</p> <p>17 through the NHS to get on to a hospital waiting list for</p> <p>18 treatment, on the assumption that being on such</p> <p>19 a waiting list would prevent deportation until the</p> <p>20 treatment had been provided and/or seek to stay in the</p> <p>21 UK until the treatment had been provided."</p> <p>22 Would there also have been occasions when there was</p> <p>23 a genuine need for the assessment and treatment of</p> <p>24 detainees?</p> <p>25 A. Indeed, and I think the doctors were trying to meet the</p> <p style="text-align: center;">Page 154</p>	<p>1 (A short break)</p> <p>2 (3.35 pm)</p> <p>3 MS SIMCOCK: Thank you, Mr Dove, were you aware that when</p> <p>4 the clinical lead, Chrissie Williams, would conduct</p> <p>5 investigations into complaints in Brook House in 2017,</p> <p>6 that she wouldn't speak to the detained person that made</p> <p>7 the complaint, but would only speak to staff members?</p> <p>8 A. No, I was not aware.</p> <p>9 Q. And that she wouldn't always require any formal</p> <p>10 statement to be taken, only if it was a serious issue,</p> <p>11 were you aware of that in 2017?</p> <p>12 A. No.</p> <p>13 Q. Do you think that is an appropriate way to conduct</p> <p>14 complaints investigations?</p> <p>15 A. I think, depending on the nature of the complaint,</p> <p>16 where, if it is a complaint that just requires the</p> <p>17 review of some documentation, or an approach, then it</p> <p>18 may be appropriate, but I can imagine, in many cases,</p> <p>19 that there would be a point at which speaking to the</p> <p>20 detained individual would be very useful.</p> <p>21 But I don't know what the policy was at the time.</p> <p>22 Q. In relation to Medical Justice, G4S Health Services</p> <p>23 received a number of clinical letters and medico-legal</p> <p>24 reports in relation to their clients in the relevant</p> <p>25 period. Do you know if G4S Health Services ever</p> <p style="text-align: center;">Page 156</p>

<p>1 responded to any of those to Medical Justice?</p> <p>2 A. No, I don't know.</p> <p>3 Q. Do you know if G4S Health Services ever approached</p> <p>4 Medical Justice as an organisation to discuss any aspect</p> <p>5 of the recurring issues that arose in those letters of</p> <p>6 medico-legal reports?</p> <p>7 A. No, I don't know.</p> <p>8 Q. If they didn't, would you have any knowledge of the</p> <p>9 reasons why they didn't?</p> <p>10 A. No, I would have no knowledge at all.</p> <p>11 Q. Brook House was, and indeed is, a closed institution,</p> <p>12 so, of course, Medical Justice wouldn't have any access</p> <p>13 to documentation at Brook House, including medical</p> <p>14 documentation, beyond the individual cases that they</p> <p>15 were involved in, would they?</p> <p>16 A. I believe not.</p> <p>17 Q. I just want to ask you what you mean, at paragraph 147</p> <p>18 of your report, by saying the company would have</p> <p>19 welcomed such input, meaningful input, from external</p> <p>20 bodies, which would have improved effective oversight</p> <p>21 and governance, and it is disappointing that such</p> <p>22 bodies, in which you included Medical Justice, didn't</p> <p>23 provide any such meaningful input.</p> <p>24 What input could they have given in the</p> <p>25 circumstances that would have been more meaningful than</p> <p style="text-align: center;">Page 157</p>	<p>1 somebody else.</p> <p>2 Q. I see. I just want to ask you, lastly, a couple of</p> <p>3 questions about E wing and the use of segregation.</p> <p>4 You said in paragraph 161 of your statement that</p> <p>5 E wing and CSU were generally quieter due to having less</p> <p>6 people and they were therefore better suited for those</p> <p>7 requiring constant watch due to suicide or self-harm</p> <p>8 risk.</p> <p>9 Did you understand that E wing was used for</p> <p>10 segregating violent detainees or refractory detainees</p> <p>11 and those resisting their removal?</p> <p>12 A. That was certainly part of E wing, wasn't it?</p> <p>13 Q. The inquiry has heard a considerable amount of evidence</p> <p>14 that E wing wasn't a very quiet place. Why did you</p> <p>15 consider that it was, given you weren't there at the</p> <p>16 time?</p> <p>17 A. I understand that the wider IRC was very busy and very</p> <p>18 noisy. E wing was a much smaller facility with far less</p> <p>19 cells in it and far greater oversight from both the</p> <p>20 custodial services and the health services, and</p> <p>21 I believe that they also had better vision into the</p> <p>22 cells, such that it was a place that was better</p> <p>23 controlled, maybe not ideal, but probably the best</p> <p>24 option in the establishment as it was configured.</p> <p>25 Q. Did G4S Health Services give consideration at a policy</p> <p style="text-align: center;">Page 159</p>
<p>1 what they were already doing?</p> <p>2 A. I don't know.</p> <p>3 Q. You say, at paragraph 155 of your statement, that there</p> <p>4 was a disconnect between Medical Justice statements on</p> <p>5 fitness for detention and observed behaviour of</p> <p>6 detainees; what do you mean by that?</p> <p>7 A. I think that an opinion provided by Medical Justice</p> <p>8 wasn't consistent with the opinion provided by the</p> <p>9 doctors.</p> <p>10 Q. Do you mean that, from their behaviour, detainees seemed</p> <p>11 well, but Medical Justice were reporting that they were</p> <p>12 unwell?</p> <p>13 A. I am not sure that it is about well and unwell, is it?</p> <p>14 I think it is about fitness to detain -- somebody may</p> <p>15 not be completely well, but they could still be</p> <p>16 perfectly fit to be detained, is my understanding.</p> <p>17 Q. You are not implying any level of dishonesty on the part</p> <p>18 of Medical Justice, are you --</p> <p>19 A. No.</p> <p>20 Q. -- or on the part of detainees --</p> <p>21 A. No.</p> <p>22 Q. -- that they were seeking to misuse the system?</p> <p>23 A. No, I think it is about perception, isn't it, when</p> <p>24 something you perceive to be a bad headache or a bad</p> <p>25 problem may not be perceived to be a bad problem by</p> <p style="text-align: center;">Page 158</p>	<p>1 level to the impact of segregation on a detainee with</p> <p>2 mental illness at the time?</p> <p>3 A. I couldn't evidence whether they did or they didn't.</p> <p>4 Q. Does healthcare have a responsibility to assess the</p> <p>5 likely impact of being in CSU on a detained person, as</p> <p>6 far as you are concerned?</p> <p>7 A. I think that healthcare has got to be concerned and</p> <p>8 medical professionals are, in my experience, extremely</p> <p>9 concerned about the wellbeing of individuals.</p> <p>10 I guess it is the choices that have to be made about</p> <p>11 what the best balanced options are in the environments</p> <p>12 in which they exist and, thus, although not ideal, my</p> <p>13 understanding is that the decisions were made on the</p> <p>14 basis that E wing was a better option than leaving</p> <p>15 individuals out in the wider establishment, which could</p> <p>16 be noisy, busy, and not necessarily have the oversight</p> <p>17 you would hope for for the individual.</p> <p>18 Q. What was your understanding of the role of a GP under</p> <p>19 rules 40 and 42 in relation to removal from association</p> <p>20 and temporary confinement?</p> <p>21 A. I am not sure the GP had a role in rule 40 and 42.</p> <p>22 Q. Well, rule 47 says:</p> <p>23 "The manager may arrange, at his discretion, for</p> <p>24 such a detained person as aforesaid to resume</p> <p>25 association with other detained persons and shall do so</p> <p style="text-align: center;">Page 160</p>

40 (Pages 157 to 160)

<p>1 if, in any case, the medical practitioner so advises on 2 medical grounds."</p> <p>3 That was a role of a GP, wasn't it?</p> <p>4 A. Yes.</p> <p>5 Q. And under subsection 9:</p> <p>6 "The manager, the medical practitioner and, at 7 a contracted-out detention centre, an officer of the 8 Secretary of State, shall visit all detained persons who 9 have been removed from association at least once each 10 day for as long as they remain so removed."</p> <p>11 So a medical practitioner had to visit every day if 12 a person was on rule 40. Again, that is a rule 13 particular to a GP in an IRC, isn't it?</p> <p>14 A. Yes.</p> <p>15 Q. The purpose of those visits and there is a similar 16 provision under rule 42 was to ensure the detained 17 person's welfare, so a safeguarding role, would you 18 agree?</p> <p>19 A. Yes.</p> <p>20 Q. How was G4S Health Services senior management monitoring 21 whether the GPs in Brook House were fulfilling that 22 safeguarding of the detainees' welfare under those rules 23 in 2017?</p> <p>24 A. I don't know. However, I do know there were daily 25 meetings between healthcare and the doctors. I would</p> <p style="text-align: center;">Page 161</p>	<p>1 First of all, what is your role at PPG?</p> <p>2 A. So I am the service director for our health industry 3 service line.</p> <p>4 Q. What does that role entail?</p> <p>5 A. Ultimately, responsible for the operations of the 6 services that we have got across England, so we run 7 healthcare in 50 prisons and immigration removal centres 8 or places of secure -- secure environments.</p> <p>9 Q. Who do you report to?</p> <p>10 A. I report to the managing director for our primary care 11 business.</p> <p>12 Q. And he reports, I think, to the chief executive?</p> <p>13 A. That's correct.</p> <p>14 Q. In the context of the IRCs at Gatwick, you line manage, 15 I think, the regional director for the south region of 16 which that service forms a part; is that right?</p> <p>17 A. That's correct.</p> <p>18 Q. You say that you have worked in the Health in 19 Justice sector since 2007, and have held a number of 20 management and leadership roles during this time. Just 21 very briefly, what type of roles have you had over that 22 period of time?</p> <p>23 A. So all operational roles, so heading up services, 24 regional management roles, regional director roles and, 25 more latterly, my current role as service director.</p> <p style="text-align: center;">Page 163</p>
<p>1 have assumed it was covered in that.</p> <p>2 MS SIMCOCK: Thank you. Chair, I have no further questions 3 for this witness. Do you have any questions?</p> <p>4 THE CHAIR: Thank you very much, Ms Simcock.</p> <p>5 I have no questions for you, Mr Dove. Thank you for 6 coming to give your evidence today. I appreciate it.</p> <p>7 A. Thank you very much.</p> <p>8 MS SIMCOCK: Chair, we are going to do a quick change over, 9 given the time and that we have already had our 10 afternoon break, so if Mr Dove can step down and we will 11 proceed with the next witness, who is Luke Wells.</p> <p>12 THE CHAIR: Thank you.</p> <p>13 MR LUKE ANDREW WELLS (affirmed)</p> <p>14 Examination by MS SIMCOCK</p> <p>15 THE CHAIR: Please take a seat, Mr Wells, thank you.</p> <p>16 MS SIMCOCK: Thank you. Can you give your full name to the 17 inquiry, please?</p> <p>18 A. Yes, it is Luke Andrew Wells.</p> <p>19 Q. Mr Wells, you have made a statement for the purposes of 20 the inquiry, which is at <PPG000169>, and I am going to 21 ask that that statement is adduced in full. What that 22 means is that I do not have to take you to every line of 23 your statement or everything in it, but I am going to 24 ask you some questions about particular topics for your 25 evidence on them.</p> <p style="text-align: center;">Page 162</p>	<p>1 Q. You say you joined PPG in June 2016, and you commenced 2 in your current role in January 2021; is that right?</p> <p>3 A. That's correct.</p> <p>4 Q. Can you just briefly explain what PPG, as a company, 5 experience is of working in IRCs as opposed to prisons?</p> <p>6 A. We have had some previous experience of working within 7 immigration removal centres. They're not particularly 8 services that I have personally been involved in before, 9 but I believe the Verne was previously an immigration 10 removal centre before it became a prison and 11 Campsfield House, I think, was another.</p> <p>12 Q. Thank you. As you say, you have, as a company, greater 13 experience previously in relation to healthcare in 14 prisons; is that right?</p> <p>15 A. That's correct.</p> <p>16 Q. Would you accept that an IRC operates a different 17 detention environment to a prison because detainees in 18 an IRC are not there by order of a court, but, rather, 19 because of an administrative power being exercised by 20 the Home Office?</p> <p>21 A. Yes, that's correct. There are obviously some 22 similarities between the two environments. But they 23 are -- they do serve a different purpose, yes.</p> <p>24 Q. And of course, there is no time limit to immigration 25 detention in contrast to that in prisons; is that right?</p> <p style="text-align: center;">Page 164</p>

<p>1 A. In most instances, yes.</p> <p>2 Q. So the role of healthcare in an IRC is, therefore, not</p> <p>3 just to provide primary healthcare to detainees, but</p> <p>4 also to provide important clinical safeguards which</p> <p>5 identify who is vulnerable to harm in detention and to</p> <p>6 notify the Home Office of those people, so that their</p> <p>7 continued detention can be promptly reviewed and that</p> <p>8 they might be removed from detention; is that right?</p> <p>9 A. That's correct.</p> <p>10 Q. You, in terms of the company, were reliant upon the</p> <p>11 existing healthcare staff transferring over from</p> <p>12 G4S Health Services to PPG when you took over the</p> <p>13 contract in relation to Brook House; is that right?</p> <p>14 A. So, for staff that are specifically delivering service</p> <p>15 on the ground, yes, largely that is the case, supported</p> <p>16 by a team of bank and agency staff as well.</p> <p>17 Q. At paragraph 9 of your witness statement, you say:</p> <p>18 "The most senior individual employed by PPG based at</p> <p>19 the IRC in Gatwick is the head of healthcare ... who is</p> <p>20 also the CQC registered manager responsible for the</p> <p>21 service. This individual holds primary responsibility</p> <p>22 for the running of the service and partnership working</p> <p>23 with the operator and the Home Office, taking the lead</p> <p>24 on local meetings and daily briefings."</p> <p>25 Is that right?</p> <p style="text-align: center;">Page 165</p>	<p>1 employed GPs.</p> <p>2 Q. But, at the moment, they are still the subcontracted GP</p> <p>3 service; is that right?</p> <p>4 A. That's correct.</p> <p>5 Q. And, as you say, you will take a phased approach to,</p> <p>6 first of all, employing some GPs but also subcontracting</p> <p>7 to them?</p> <p>8 A. Yes, that's correct.</p> <p>9 Q. Just pausing there, for a moment, what are the reasons</p> <p>10 for moving towards employing GPs directly rather than</p> <p>11 subcontracting that service, what are the benefits to</p> <p>12 doing that?</p> <p>13 A. I think, organisationally, that is always our</p> <p>14 preference. I think we tend to find that GPs that we</p> <p>15 employ directly can, at times, be more engaged with</p> <p>16 services, they certainly feel more embedded at times</p> <p>17 with the team. I also think it helps us in terms of</p> <p>18 supporting their professional development, we invest</p> <p>19 heavily in our GP workforce, so, when it comes to things</p> <p>20 like training, it offers us a greater flexibility to</p> <p>21 support them with that.</p> <p>22 Q. I see. But, currently, at any rate, and for the</p> <p>23 immediate foreseeable future, the current arrangements</p> <p>24 for healthcare provision by PPG have been informed by</p> <p>25 both Sandra Calver, as head of healthcare, and by</p> <p style="text-align: center;">Page 167</p>
<p>1 A. Correct.</p> <p>2 Q. That was -- as it was in 2017, that is now</p> <p>3 Sandra Calver; is that right?</p> <p>4 A. Yes.</p> <p>5 Q. And so she holds primary responsibility for making sure</p> <p>6 that PPG complies with the safeguards required to be</p> <p>7 operated in Brook House; is that right?</p> <p>8 A. Yes, not in isolation, so there is obviously a team that</p> <p>9 support her with that, but, yes, primarily speaking, on</p> <p>10 a day-to-day basis, that would be Sandra.</p> <p>11 Q. In relation to the GPs, DoctorPA Limited, who PPG</p> <p>12 subcontracts to provide primary care services, those are</p> <p>13 the same now as they were in 2017, Dr Oozeerally and</p> <p>14 Dr Chaudhary; is that right?</p> <p>15 A. That's correct. They don't -- they only provide the GP</p> <p>16 part of the primary care service, though. The rest of</p> <p>17 it would be provided directly by our employed nurses.</p> <p>18 Q. You say in your statements that you are transitioning</p> <p>19 away from subcontracting to DoctorPA Limited to</p> <p>20 a mixture of both subcontracted and employed doctors; is</p> <p>21 that right?</p> <p>22 A. Yes, so I think the intention is to take a phased</p> <p>23 approach to this, whereby, over time, we would reduce</p> <p>24 the involvement of DoctorPA within these services, with</p> <p>25 an aim to eventually run the services with full-time,</p> <p style="text-align: center;">Page 166</p>	<p>1 Drs Oozeerally and Chaudhary as DoctorPA Limited; is</p> <p>2 that right?</p> <p>3 A. That's correct.</p> <p>4 Q. The inquiry has heard evidence from the three of them.</p> <p>5 Did you hear their evidence?</p> <p>6 A. I have heard Sandra Calver's evidence, but I didn't hear</p> <p>7 either of the GP evidence.</p> <p>8 Q. Why not?</p> <p>9 A. Largely because, when we originally were invited to give</p> <p>10 evidence, we decided to split down our evidence, so I am</p> <p>11 here for more of an operational perspective and my</p> <p>12 colleague Dr Sarah Bromley(?) is here from more of</p> <p>13 a medical perspective, so it felt more suitable that we</p> <p>14 divvy out the evidence -- observing the evidence --</p> <p>15 Q. So if there are --</p> <p>16 A. -- on this (overspeaking).</p> <p>17 Q. -- points that come directly out of their evidence that</p> <p>18 you cannot answer, then she will be able to answer those</p> <p>19 for us?</p> <p>20 A. Hopefully so, yes.</p> <p>21 Q. Does -- given you have heard the evidence of</p> <p>22 Sandra Calver, does her evidence cause you any concern</p> <p>23 on the part of PPG about her continuation as head of</p> <p>24 healthcare at all?</p> <p>25 A. No, I think it is clear from Sandra Calver's evidence</p> <p style="text-align: center;">Page 168</p>

<p>1 that there is some work that needs to be done, certainly</p> <p>2 around things such as rule 35. However, as</p> <p>3 an individual, I believe Sandra Calver is a registered</p> <p>4 clinician. We have had no concerns in terms of her</p> <p>5 professional practice. She appears, from what we have</p> <p>6 known of her for a very short period of time, to be</p> <p>7 quite caring and compassionate and seeks to do the right</p> <p>8 thing in the interests of our patient group.</p> <p>9 Q. You have confidence in her to fulfil her obligations and</p> <p>10 responsibilities in relation to her role in Brook House?</p> <p>11 A. Yes, I think, obviously, with training and support --</p> <p>12 for additional training and support from the wider PPG</p> <p>13 organisation.</p> <p>14 Q. You -- yes, so let's look at, please, then, rules 34</p> <p>15 and 35 of the Detention Centre Rules. Are you aware of</p> <p>16 the content of those rules?</p> <p>17 A. Yes.</p> <p>18 Q. Rule 34 requires a physical and mental examination, used</p> <p>19 to identify vulnerabilities in detainees and it could,</p> <p>20 and should, result in a rule 35 report, where</p> <p>21 appropriate, so that the Home Office is notified</p> <p>22 promptly, at the outset of detention, of those</p> <p>23 vulnerabilities and that detained person's detention</p> <p>24 reviewed. Is that your understanding of the rule?</p> <p>25 A. Correct.</p> <p style="text-align: center;">Page 169</p>	<p>1 I think the notion that to carry out an assessment on</p> <p>2 somebody within their first 24 hours when they are</p> <p>3 likely to be very vulnerable, very emotional and have</p> <p>4 a lack of -- a lack of trust, really, in people of</p> <p>5 authority, I would suggest that is quite a difficult</p> <p>6 assessment to do in such an early point in which</p> <p>7 somebody has been detained, but, yes, I understand that</p> <p>8 is the purpose and that was the thinking behind the rule</p> <p>9 being written.</p> <p>10 Q. Yes. You will be aware from listening to</p> <p>11 Sandra Calver's evidence but we heard from her that the</p> <p>12 GP appointments carried out within the first 24 hours</p> <p>13 were, at the time, five minutes long and are now</p> <p>14 ten minutes long, and that that really is not enough</p> <p>15 time to do a fully-compliant rule 34 medical</p> <p>16 examination, which requires a full physical and mental</p> <p>17 examination. Would you agree with that?</p> <p>18 A. I think it is a very difficult question to fully answer.</p> <p>19 I think the wording of the rule is not very specific</p> <p>20 around the extent to which an assessment is required.</p> <p>21 So, for example, for a mental health assessment, that</p> <p>22 could involve a whole hour's appointment with</p> <p>23 the psychiatrist, for example, that is one extreme, so</p> <p>24 I think it is unclear and I think it is fair to have</p> <p>25 heard evidence over the last few days that there is</p> <p style="text-align: center;">Page 171</p>
<p>1 Q. That is particularly important as a rule because the</p> <p>2 Home Office doesn't have any pre-detention medical</p> <p>3 screening tool to identify vulnerabilities before</p> <p>4 detaining a detained person; would you agree with that?</p> <p>5 A. Largely speaking, the Home Office may not. We may</p> <p>6 sometimes have prior information based on -- depending</p> <p>7 on where the detainees come from. So, for example, if</p> <p>8 they are transferred from prison, their prison</p> <p>9 healthcare records will transfer with them, so we may</p> <p>10 have more background information than the Home Office</p> <p>11 would.</p> <p>12 Q. That information would help to inform you in the rule 34</p> <p>13 process of vulnerabilities as being the first</p> <p>14 opportunity for assessing those vulnerabilities in</p> <p>15 immigration detention; is that right?</p> <p>16 A. Yes, that information would be readily available to the</p> <p>17 GPs undertaking those assessments and the nurses who do</p> <p>18 the initial screening.</p> <p>19 Q. So as a rule, it is, therefore, vital in functioning</p> <p>20 effectively so that people particularly at risk of being</p> <p>21 harmed in detention can be identified and removed from</p> <p>22 detention, where appropriate, at the outset, at that</p> <p>23 first arrival into detention. Is that your</p> <p>24 understanding?</p> <p>25 A. That is, I think, the intention. What I would say is</p> <p style="text-align: center;">Page 170</p>	<p>1 a bit of a lack of understanding around the purpose of</p> <p>2 rule 34.</p> <p>3 Q. Dr Oozeerally also said in his evidence that it was not</p> <p>4 possible to do the sort of physical and mental state</p> <p>5 examination required at that initial GP appointment and</p> <p>6 he described it as being really only triage. Would you</p> <p>7 agree with that?</p> <p>8 A. Yes, I would, yes.</p> <p>9 Q. And he gave evidence that if there had been</p> <p>10 a disclosure, for example, of torture in that initial</p> <p>11 appointment, or something else raised, which meant there</p> <p>12 should be consideration of a rule 35 report, instead of</p> <p>13 completing a report immediately, which he wasn't doing,</p> <p>14 and indeed isn't doing, a further, longer appointment</p> <p>15 was made, sometimes some time later, and that that built</p> <p>16 in some delay. Would you agree that that is the</p> <p>17 practice even now in Brook House in relation to that</p> <p>18 initial rule 34 and then further rule 35 assessment?</p> <p>19 A. Yes, that's correct.</p> <p>20 Q. So given the importance that you have agreed of the</p> <p>21 rule 34 examination in leading to a rule 35 report,</p> <p>22 where appropriate, in that it is to screen people out of</p> <p>23 detention by notifying them to the Home Office of their</p> <p>24 vulnerability, why is it that there is insufficient</p> <p>25 provision made to ensure that rule 34 can be properly</p> <p style="text-align: center;">Page 172</p>

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<p>1 complied with, so that a rule 34 -- rule 35 report can</p> <p>2 be done immediately as a result of that appointment?</p> <p>3 A. So I think our understanding previously would have been</p> <p>4 that the spirit of rule 34 was around identifying</p> <p>5 immediate risk and then ensuring that there is follow-up</p> <p>6 action to be taken.</p> <p>7 I think, when you consider the evidence of Dr Hard,</p> <p>8 whereby he stated that these would need to be</p> <p>9 significantly longer appointments, at the moment, within</p> <p>10 the service, we would not have the capacity to do that</p> <p>11 to any great extent, so I think, operationally, we are</p> <p>12 trying to make the best we can of the safeguards we have</p> <p>13 got within the resources available to us.</p> <p>14 Q. Those initial appointments, as Dr Oozeerally confirmed</p> <p>15 in his evidence, are clearly not leading to rule 35</p> <p>16 reports directly as a result of those first</p> <p>17 appointments. Do you accept that at least one reason</p> <p>18 for that is that they are so short? It is simply not</p> <p>19 possible to complete the examination and a report within</p> <p>20 a ten-minute appointment?</p> <p>21 A. I am not sure I completely agree with that. I think,</p> <p>22 for me, there is clearly learning to be done around</p> <p>23 rule 35, and I think, with better education and</p> <p>24 understanding around rule 35, whilst the current process</p> <p>25 may not be ideal, it would still serve a purpose, given,</p> <p style="text-align: center;">Page 173</p>	<p>1 within the constraints of the service.</p> <p>2 Q. So it is still a case of trying to manage those people</p> <p>3 in detention, as opposed to using the statutory</p> <p>4 mechanism to have their detention reviewed by the</p> <p>5 Home Office; is that right?</p> <p>6 A. Yes, I think it is around the delivery of healthcare</p> <p>7 rather than just the Home Office process, that's</p> <p>8 correct.</p> <p>9 Q. Is the Home Office aware from PPG that only ten minutes</p> <p>10 are allocated to those rule 34 appointments?</p> <p>11 A. I could neither confirm nor deny what they are or are</p> <p>12 not aware of. My understanding is they are very closely</p> <p>13 involved with the service, so I would be very surprised</p> <p>14 if they didn't, but that would probably need to be</p> <p>15 a question for the Home Office.</p> <p>16 Q. Have you raised with them that those appointments are</p> <p>17 only ten minutes and, therefore, cannot comply with the</p> <p>18 rule 34 full mental and physical examination,</p> <p>19 potentially leading to a rule 35 report?</p> <p>20 A. No, I personally haven't, no.</p> <p>21 Q. Have they ever raised any concerns with you or PPG, to</p> <p>22 your knowledge, about the length or the provision</p> <p>23 generally of those appointments?</p> <p>24 A. I don't believe so, no.</p> <p>25 Q. Are you taking any steps to allow for more time to be</p> <p style="text-align: center;">Page 175</p>
<p>1 as I have already said, the context of the resources</p> <p>2 available to us and the volume of patients that we would</p> <p>3 be required to see.</p> <p>4 Q. But it does build in delay, doesn't it? The Home Office</p> <p>5 are certainly not being informed, at the outset of</p> <p>6 detention, about these people; they are continuing to be</p> <p>7 detained because their detention is not being reviewed,</p> <p>8 there are effectively delays built in to those</p> <p>9 arrangements, aren't there?</p> <p>10 A. Yes, so a follow-up rule 35 appointment would be roughly</p> <p>11 two days, so I accept that creates an element of delay.</p> <p>12 But, as I mentioned before, I think, to some degree,</p> <p>13 there is also some benefit in having a slight time lag</p> <p>14 between people arriving and that assessment taking</p> <p>15 place, if needs be, because it allows you to try and</p> <p>16 build up a greater level of trust with the individual so</p> <p>17 you get a more open and honest and transparent</p> <p>18 consultation.</p> <p>19 Q. That might occur in some cases, but there is at least</p> <p>20 also the possibility, isn't there, as the rules are</p> <p>21 designed to prevent, that someone remains in detention</p> <p>22 and deteriorates during that time, isn't there?</p> <p>23 A. Yeah, that is absolutely possible and there are other</p> <p>24 safeguards in place to try and identify those</p> <p>25 individuals and make sure we manage them as best we can</p> <p style="text-align: center;">Page 174</p>	<p>1 afforded to those initial appointments?</p> <p>2 A. So we are currently in the process of undertaking</p> <p>3 a review of our pathway for rule 35. So that is a piece</p> <p>4 of work that will take place in April.</p> <p>5 Obviously, from that, we will make decisions around</p> <p>6 what we need to do if we need to extend those</p> <p>7 appointments, and that may need to be a conversation</p> <p>8 that we have with NHS England as our commissioning body.</p> <p>9 Q. Yes, because PPG subcontracts the GP services to</p> <p>10 DoctorPA Limited, so it would be within PPG's power to</p> <p>11 obtain more resources from them, in terms of either the</p> <p>12 time the GPs who are there are using to undertake those</p> <p>13 appointments or to require more GPs to carry out the</p> <p>14 service?</p> <p>15 A. So I believe there is scope within the contract for us</p> <p>16 to negotiate around the amount of time that the doctors</p> <p>17 would spend on site, yes.</p> <p>18 Q. Has there been any review of the contract in order to</p> <p>19 make compliance with rule 35 and 34 something that is</p> <p>20 front and centre in the contract in terms of being a KPI</p> <p>21 or having penalties applied if those rules are not</p> <p>22 complied with?</p> <p>23 A. So, at this stage, no. We are seeking to engage with</p> <p>24 DoctorPA, so, as I said, there is a workshop that</p> <p>25 Dr Bromley will be chairing in April. DoctorPA have</p> <p style="text-align: center;">Page 176</p>

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<p>1 been invited to attend that, so we would like to use</p> <p>2 some of their knowledge as well, in terms of informing</p> <p>3 our pathway and our processes, in order to develop</p> <p>4 a PPG, I suppose, operating procedure, really, around</p> <p>5 rule 34 and rule 35. Once that piece of work has been</p> <p>6 conducted, then, if needs be, we can review the contract</p> <p>7 with DoctorPA, yes, but I think we would seek to work in</p> <p>8 the spirit of partnership with them and try to work and</p> <p>9 educate them rather than impose financial penalties.</p> <p>10 Q. Has there been, or is there intended to be, any review</p> <p>11 as to whether DoctorPA Limited, in the form of</p> <p>12 Drs Oozeerally and Chaudhary should retain the contract</p> <p>13 and should continue to be working at Brook House at all?</p> <p>14 A. At this stage, no. As I said, we would seek to work</p> <p>15 with the doctors involved. I think it is fair to say --</p> <p>16 as I said, there has been quite widespread</p> <p>17 misunderstandings, shall we say, around the application</p> <p>18 of those particular rules and, therefore, I think we</p> <p>19 need to seek and clarify a PPG position first, and then,</p> <p>20 you know, have very clear expectations with the doctors</p> <p>21 that work in the service that they would be expected to</p> <p>22 follow up those processes.</p> <p>23 Q. You mentioned that there is going to be a phasing out of</p> <p>24 the subcontracting services. In relation to the</p> <p>25 individuals, though, Dr Oozeerally and Dr Chaudhary, is</p> <p style="text-align: center;">Page 177</p>	<p>1 Were you aware of that?</p> <p>2 A. Well, I was, at the point at which that evidence was</p> <p>3 given. I wasn't aware of that previously.</p> <p>4 Q. That is a concern, isn't it, if it is still a continuing</p> <p>5 situation?</p> <p>6 A. Yes, and, as I said, that is why we have put in place</p> <p>7 plans to mitigate that risk. So, organisationally, we</p> <p>8 want to take an organisational position rather than this</p> <p>9 be based on the experience of one or two individuals.</p> <p>10 I think, as I said, it does appear, from having</p> <p>11 conversations with Sandra and other IRC heads of</p> <p>12 healthcare, that there is a broad lack of understanding</p> <p>13 around this, so I think we would also be seeking to work</p> <p>14 with the Home Office to understand what their</p> <p>15 expectations are.</p> <p>16 Q. In circumstances where rule 35(2) reports were not being</p> <p>17 completed in Brook House, she drafted the G4S pathway</p> <p>18 for rule 35(2) that didn't meet the technical</p> <p>19 requirements of rule 35(2) because it built in an extra</p> <p>20 step of a nurse and a delay.</p> <p>21 That pathway, we understand, from PPG's witness</p> <p>22 statement evidence is still in place in Brook House.</p> <p>23 Does that concern you?</p> <p>24 A. Yes, it is of concern, but I think it is also important</p> <p>25 to set the context for this service. So, as you know,</p> <p style="text-align: center;">Page 179</p>
<p>1 there consideration being given to employing them</p> <p>2 directly in PPG, in the future, in Brook House?</p> <p>3 A. So my understanding is that we would have explored that</p> <p>4 option with both GPs prior to the service going live.</p> <p>5 I don't believe that that was something that they were</p> <p>6 keen to explore further with us.</p> <p>7 Q. I see. In relation to rule 35, Sandra Calver accepted</p> <p>8 in her evidence that, in 2017, she had</p> <p>9 a misunderstanding of the thresholds to be applied under</p> <p>10 rule 35(1) and rule 35(2) and that she was applying too</p> <p>11 high a threshold. She gave some evidence that she had</p> <p>12 thought that a rule 35(2) report was a report stating</p> <p>13 a detainee was severely suicidal and not suitable for</p> <p>14 detention. She accepted that that threshold could be</p> <p>15 risky and potentially dangerous and wasn't in accordance</p> <p>16 with the rule. Were you aware of that?</p> <p>17 A. Of her evidence, yes.</p> <p>18 Q. She also thought that a rule 35(1) report was a report</p> <p>19 stating a detainee had a severe or unstable medical</p> <p>20 condition, which meant they were not suitable for</p> <p>21 detention.</p> <p>22 She gave evidence that she, and indeed her staff,</p> <p>23 didn't have a good understanding of rule 35(1) and (2)</p> <p>24 and that that was a significant gap in knowledge, both</p> <p>25 then, in 2017, and now.</p> <p style="text-align: center;">Page 178</p>	<p>1 this service went live with PPG on 1 September. The</p> <p>2 service has been declared an outbreak by the UK HSA</p> <p>3 throughout that period of time, which means our ability</p> <p>4 to access the site has been somewhat limited, and it</p> <p>5 also means that, unfortunately, staff have had to take</p> <p>6 up some extra responsibilities caring for those patients</p> <p>7 who are -- could be positive, and the extra monitoring</p> <p>8 involved, and plus the mass testing events.</p> <p>9 So I think this is not, probably, our standard</p> <p>10 approach to mobilisation, I would suggest. So</p> <p>11 I would've really expected us to have been working</p> <p>12 through some of these issues earlier than we are at the</p> <p>13 moment, but, I think, nonetheless, as I said, we do have</p> <p>14 plans in place to work to address this.</p> <p>15 I also think the priority was also around ensuring</p> <p>16 that we enhanced the service offering as well, so</p> <p>17 Dr Hard gave some evidence, didn't he, around the</p> <p>18 conflict around delivering healthcare and managing some</p> <p>19 of those processes and I think, organisationally,</p> <p>20 probably, our focus was on looking at the healthcare</p> <p>21 side and improving the offering in terms of things like</p> <p>22 mental health and additional ancillary services.</p> <p>23 Q. Do you accept that the clinical safeguards that operate</p> <p>24 under the rules are as, if not more, important than the</p> <p>25 provision of primary healthcare in an IRC because of</p> <p style="text-align: center;">Page 180</p>

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<p>1 their role in safeguarding vulnerable detainees by</p> <p>2 rooting them out of detention where they are likely to</p> <p>3 be harmed by detention?</p> <p>4 A. I wouldn't say they are more important, because I think,</p> <p>5 if you are running a service that purely only manages</p> <p>6 risk and isn't effectively treating people, then it is</p> <p>7 reasonable to assume that people will deteriorate;</p> <p>8 therefore, that is not good for their health either. So</p> <p>9 I think both need to be taken in equal measure.</p> <p>10 Q. What action does PPG intend to take, in particular in</p> <p>11 relation to the rule 35(2) pathway drafted by</p> <p>12 Sandra Calver?</p> <p>13 A. The purpose of the workshop is to agree what our</p> <p>14 pathways will be going forward. So a new policy will be</p> <p>15 written around that. That will be a national policy and</p> <p>16 we will expect the service (inaudible) at Gatwick to be</p> <p>17 compliant with that policy.</p> <p>18 Q. Is there a need for a pathway when the rules are clear</p> <p>19 themselves, the rules require notification under the</p> <p>20 three different limbs when the threshold is met?</p> <p>21 A. So yes, I think there is a need for a pathway, and the</p> <p>22 reason for that is that rule 35 -- you know, the</p> <p>23 process, itself, is probably more simple, but actually,</p> <p>24 as we have heard in evidence, it requires staff</p> <p>25 identifying patients and making the GPs aware of them,</p> <p style="text-align: center;">Page 181</p>	<p>1 Q. You have talked about developing the pathways in</p> <p>2 order -- and liaising with the Home Office in order to</p> <p>3 address this issue. Is there anything else that PPG is</p> <p>4 doing to ensure that reports are being completed when</p> <p>5 they should be under the rules, in circumstances where,</p> <p>6 even up to January of this year, they are not being?</p> <p>7 A. So I think, once the pathway is agreed and is</p> <p>8 formalised -- and we are not a particularly bureaucratic</p> <p>9 organisation, so that shouldn't take a significant</p> <p>10 amount of time -- we are quite confident, after the</p> <p>11 workshops are held, that can be written up. The</p> <p>12 expectation would be that that would be audited so that</p> <p>13 we can ensure compliance.</p> <p>14 Q. And audited how and by whom?</p> <p>15 A. Primarily, audits would be undertaken by the site. But</p> <p>16 I think, given the significance of the rule 35 and the</p> <p>17 level of scrutiny it has come under, then it may well be</p> <p>18 that we decide to audit that at a regional level with</p> <p>19 the regional medical lead who is a GP responsible for GP</p> <p>20 services within that region.</p> <p>21 Q. In paragraph 15 of your first witness statement, you say</p> <p>22 that provision is made for two rule 35 appointments per</p> <p>23 day, then that is over and above the provision that PPG</p> <p>24 has made for primary care services.</p> <p>25 Do you consider that to be sufficient provision?</p> <p style="text-align: center;">Page 183</p>
<p>1 so this is not just about a simple process with the</p> <p>2 Home Office, it is about trying to change a culture and</p> <p>3 change the attitude and beliefs of the people that work</p> <p>4 in the wider service.</p> <p>5 Q. Sandra Calver accepted that there was a failing in</p> <p>6 relation to the safeguards in two different respects:</p> <p>7 firstly, that nurses clearly were applying the too high</p> <p>8 a threshold that she accepted, so that they were not</p> <p>9 referring detainees to the GPs when -- for consideration</p> <p>10 of rule 35(1) and (2) reports; and she also said that,</p> <p>11 even when referred, or when GPs were seeing patients and</p> <p>12 the threshold was met, the GPs simply were not</p> <p>13 completing rule 35(1) reports, or only on very rare</p> <p>14 occasions, or rule 35(2) reports, we know, at all, in</p> <p>15 2017, and indeed since.</p> <p>16 She had tried to ensure with the GPs that they were</p> <p>17 completing rule 35(2) reports, partly through the</p> <p>18 pathway and -- but they simply weren't.</p> <p>19 We know from your colleague Sarah Bromley's</p> <p>20 statement that rule 35(2)s are still not being done and</p> <p>21 there are very few rule 35(1)s. Only one</p> <p>22 in September -- from September 2021 to January 2022.</p> <p>23 So this failure in the safeguards remains</p> <p>24 a significant concern at present, doesn't it?</p> <p>25 A. I would agree, yes.</p> <p style="text-align: center;">Page 182</p>	<p>1 A. I think that decision has been based on the previous</p> <p>2 ways of working and interpreting those rules. It may</p> <p>3 well be that we do need to review that following the</p> <p>4 outcome of the workshop and understand what provision</p> <p>5 needs to be ring-fenced for rule 35.</p> <p>6 Q. Yes, because it doesn't take account, does it, that</p> <p>7 every detainee should have a rule 34 appointment for</p> <p>8 a physical and mental examination within 24 hours of</p> <p>9 arrival, which could, and should, if appropriate, lead</p> <p>10 to a rule 35 report?</p> <p>11 A. Yes, the rule 34 appointments will be separate to that,</p> <p>12 so that is not included within those appointments.</p> <p>13 Q. What provision is there going to be for rule 34</p> <p>14 appointments that could, and should, lead to a rule 35</p> <p>15 report, if appropriate?</p> <p>16 A. So rule 34s are seen currently within the 24 hours.</p> <p>17 Q. But, again, is the intention still only to afford every</p> <p>18 detainee a ten-minute appointment going forward?</p> <p>19 A. I think we need to seek further clarity from the</p> <p>20 Home Office before making a commitment around what level</p> <p>21 of resource that would require.</p> <p>22 Q. Because that is not enough time, is it, to complete</p> <p>23 a rule 35 report, if appropriate, it still would build</p> <p>24 in the delay for a further longer appointment to be</p> <p>25 booked at a later date within those two appointments per</p> <p style="text-align: center;">Page 184</p>

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<p>1 day?</p> <p>2 A. Yes, I think the challenge is what is practical as well,</p> <p>3 so, obviously, not every patient that is reviewed under</p> <p>4 rule 34 will need a rule 35. Therefore, it is</p> <p>5 an ineffective use of a GP's time for a rule -- or</p> <p>6 an appointment length that would facilitate a rule 35</p> <p>7 appointment to be offered to every single individual and</p> <p>8 that, I think, is the balance that we are trying to</p> <p>9 understand and work through.</p> <p>10 Q. Would you agree that a high proportion of detainees in</p> <p>11 immigration detention have clinically significant levels</p> <p>12 of depression, PTSD and anxiety as Dr Bingham gave</p> <p>13 evidence about?</p> <p>14 A. Yes.</p> <p>15 Q. And are you aware that PTSD is frequently linked with</p> <p>16 a history of torture or other forms of serious</p> <p>17 ill-treatment?</p> <p>18 A. Yes, I am.</p> <p>19 Q. Would you agree that detention is likely to precipitate</p> <p>20 significant deterioration of mental health in the</p> <p>21 majority of cases?</p> <p>22 A. I would have to be led by experts in that area but it</p> <p>23 seems reasonable to me that detention could pose as</p> <p>24 a trigger for patients who have a diagnosis of PTSD,</p> <p>25 yes.</p> <p style="text-align: center;">Page 185</p>	<p>1 further and report back to the inquiry.</p> <p>2 Q. Thank you. Would you accept, though, that whether it is</p> <p>3 one or two appointments a day, given the prevalence of</p> <p>4 the conditions we have just talked about and their link</p> <p>5 with vulnerabilities and, therefore, the necessity for</p> <p>6 the safeguards to apply, that that is likely to be</p> <p>7 inadequate provision going forwards, in terms of rule 35</p> <p>8 appointments?</p> <p>9 A. Yes, as we discussed, there are certain elements of the</p> <p>10 rule 35 that appear to be non-compliant at this moment</p> <p>11 in time. Therefore, that may increase demand for that</p> <p>12 particular part of the service.</p> <p>13 Q. Yes. Were you aware of the IMB report of 2021 that</p> <p>14 reported on the year from January 2020 to December 2020?</p> <p>15 A. I have seen that report, yes.</p> <p>16 Q. Appreciating that that was before PPG took over the</p> <p>17 contract because you started, as you said,</p> <p>18 in September 2021, it would have been important for PPG</p> <p>19 to understand what the situation had been in the period</p> <p>20 prior to taking over, wouldn't it?</p> <p>21 A. Yes.</p> <p>22 Q. That report described the lack of any rule 35(2) reports</p> <p>23 to be puzzling in the light of the scale of self-harm</p> <p>24 and suicide threats made during the latter part of 2020,</p> <p>25 when there were compressed charter flights and the IMB</p> <p style="text-align: center;">Page 187</p>
<p>1 Q. And detention can also, for example, increase self-harm</p> <p>2 and suicidal ideation?</p> <p>3 A. Yes.</p> <p>4 Q. Given the high prevalence of people with PTSD and of</p> <p>5 people who are likely to have a history of torture, and</p> <p>6 who are therefore likely to be harmed in detention,</p> <p>7 their prompt identification to the Home Office is</p> <p>8 essential?</p> <p>9 A. Yes. I would agree.</p> <p>10 Q. Because prompt identification can lead to rule 35, which</p> <p>11 might -- may lead to their release from detention?</p> <p>12 A. Yes.</p> <p>13 Q. Dr Oozeerally gave some evidence that there are</p> <p>14 currently delays in getting through the number of</p> <p>15 rule 35 reports that need to be done and there is</p> <p>16 a waiting list.</p> <p>17 He said there was only one rule 35 appointment</p> <p>18 a day. Can you account for the discrepancy between that</p> <p>19 evidence and the two appointments you say are available</p> <p>20 a day?</p> <p>21 A. So in preparing my evidence, I consulted Sandra Calver,</p> <p>22 who is the head of healthcare and responsible for that</p> <p>23 service, and the regional manager, and they were very</p> <p>24 clear with me that it was two appointments a day.</p> <p>25 However, I am very happy to go back and investigate that</p> <p style="text-align: center;">Page 186</p>	<p>1 said, "We cannot reconcile the evidence of frequent</p> <p>2 suicidal ideation with there being absolutely no</p> <p>3 rule 35(2) reports". You would agree that is of</p> <p>4 significant concern?</p> <p>5 A. I would agree that is of significant concern, yes.</p> <p>6 I don't believe that IMB report was made available to us</p> <p>7 as part of the tendering process, though, so normally</p> <p>8 you would receive a health needs analysis that is</p> <p>9 commissioned by NHS England that would indicate the</p> <p>10 current level of provision and gaps in service</p> <p>11 provision. I can't absolutely categorically state, but,</p> <p>12 from memory, I don't recall any documentation to suggest</p> <p>13 that that provision was inadequate at the point at which</p> <p>14 we were tendering for the service.</p> <p>15 Q. PPG statistics on ACDTs indicate that 73 were opened</p> <p>16 with 45 on a constant watch for the period</p> <p>17 of September 2021 to December 2021.</p> <p>18 So that is since PPG took over, were you aware of</p> <p>19 that?</p> <p>20 A. I wasn't aware of that, no.</p> <p>21 Q. Would you accept, as Sandra Calver did, that someone</p> <p>22 being on a constant watch indicates that there is a high</p> <p>23 risk of suicide?</p> <p>24 A. Absolutely, yes.</p> <p>25 Q. And clearly, there were still no rule 35(2) reports in</p> <p style="text-align: center;">Page 188</p>

<p>1 that period -- so in the period from September 2021</p> <p>2 to December 2021 -- despite the 45 constant watch ACDTs.</p> <p>3 Dr Oozeerally, as I have mentioned, gave evidence</p> <p>4 that he is still not completing rule 35(2) reports, and</p> <p>5 he gave evidence now over two weeks ago. Has PPG taken</p> <p>6 any steps immediately to address that discrepancy?</p> <p>7 A. No, I think we took a conscious decision that we wanted</p> <p>8 to ensure that we had a full and robust process and</p> <p>9 policy in place rather than just making an immediate</p> <p>10 snap decision to put something right. As I said,</p> <p>11 I think this is about a whole system approach review</p> <p>12 rather than just putting in place, for want of a better</p> <p>13 phrase, a sticking plaster over an issue.</p> <p>14 Q. Isn't the risk of that, though, Mr Wells, that detainees</p> <p>15 are remaining in detention with suicidal ideation,</p> <p>16 meaning the threshold for a rule 35(2) report has been</p> <p>17 reached but hasn't been completed, exposing them to</p> <p>18 a risk of further harm in detention because their case</p> <p>19 has not been notified and, therefore, reviewed by the</p> <p>20 Home Office?</p> <p>21 A. I accept that, and I think, as I said, the lack of</p> <p>22 rule 35 doesn't necessarily mean that they are not</p> <p>23 receiving any healthcare provision or any treatment, but</p> <p>24 in terms of their detention or their potential release</p> <p>25 from detention, that is currently a gap that we are</p> <p style="text-align: center;">Page 189</p>	<p>1 would be provision for extra mental health resource,</p> <p>2 which could allow focus on preventative measures to</p> <p>3 alleviate stress and anxiety. The response, in other</p> <p>4 words, from the Home Office, was that healthcare staff</p> <p>5 had not requested any additional resource. Does your</p> <p>6 existing contract allow you to ask for more resources if</p> <p>7 you need them?</p> <p>8 A. So we can ask for more resources if we need them, yes.</p> <p>9 That would be via NHS England rather than the</p> <p>10 Home Office because they are responsible for</p> <p>11 commissioning and funding the provision of healthcare,</p> <p>12 but what I would say is I think our model is different</p> <p>13 from the model that was previously on offer under the</p> <p>14 previous provider and I think we have already built into</p> <p>15 that an element of delivering proactive healthcare, so</p> <p>16 things, for example, such as talking therapies, our</p> <p>17 Making Sense Programme, which is a trauma-informed</p> <p>18 programme aiming to support people with low-level</p> <p>19 anxiety, managing low-level mental health conditions.</p> <p>20 So I think we have already made provision for that</p> <p>21 within our existing contract, but if we felt that that</p> <p>22 was not sufficient, then we would engage in</p> <p>23 a conversation with NHS England to explore that further.</p> <p>24 Q. What about exploring further resource for the rule 34</p> <p>25 and 35 appointments in circumstances where reports still</p> <p style="text-align: center;">Page 191</p>
<p>1 seeking to address.</p> <p>2 Q. At paragraph 32 of your witness statement, you say:</p> <p>3 "Due to the nature of how IRCs operate, high volumes</p> <p>4 of patients arriving at once, especially during the</p> <p>5 night, can place a strain on staffing levels, however we</p> <p>6 have in place appropriate mechanisms to support our</p> <p>7 staff during such peak periods of demand by utilising</p> <p>8 a shortened version of the initial reception screen."</p> <p>9 Again, in relation to that, isn't there a greater</p> <p>10 risk that that will contribute to further delays in</p> <p>11 identifying vulnerabilities.</p> <p>12 A. No, I don't believe so. I think there are a couple of</p> <p>13 observations on that particular point. Firstly, since</p> <p>14 we took over the service, we have actually increased the</p> <p>15 staffing on a night from that of the previous profile so</p> <p>16 we have an additional nurse that works over at</p> <p>17 Tinsley House.</p> <p>18 So I think, largely speaking, the rule 34 nurse</p> <p>19 assessment would be done still within a couple of hours,</p> <p>20 but it may not meet the initial two-hour threshold,</p> <p>21 which is why we would want to do an immediate safety</p> <p>22 risk to ensure that patients are as safe as they can be</p> <p>23 in the interim.</p> <p>24 Q. The IMB, in their 2021 report, also said that,</p> <p>25 in September, the board asked the Home Office if there</p> <p style="text-align: center;">Page 190</p>	<p>1 are not being completed under two limbs of the rule in</p> <p>2 circumstances where there are high-levels of self-harm</p> <p>3 and suicidal ideation?</p> <p>4 A. So that may well be a route that we need to take.</p> <p>5 I think, obviously, we are conscious of use of the</p> <p>6 public purse and we would look to seek to understand</p> <p>7 what else we could do to redesign our services to</p> <p>8 accommodate that. So, for example, I do believe that</p> <p>9 there is more that the nursing team could do to take</p> <p>10 some of the workload away from the GPs. We also have</p> <p>11 a nurse that is undergoing advanced clinical practice,</p> <p>12 so we will be able to deliver a significant chunk of</p> <p>13 what currently sits with the GP. So it may be that we</p> <p>14 can reconfigure some of our existing services, but if we</p> <p>15 have reached the point whereby the service is no longer</p> <p>16 tenable in that regard, then we would be having</p> <p>17 conversations with NHS England about that.</p> <p>18 Q. I appreciate freeing up GP time by transferring some</p> <p>19 duties to nurses may assist in GPs doing rule 34 and</p> <p>20 rule 35 appointments, but nurses certainly cannot take</p> <p>21 that responsibility under the rules, can they?</p> <p>22 A. No, not currently, so that would still have to be done</p> <p>23 by the GPs. It is more around the delivery of what we</p> <p>24 would call routine healthcare or primary healthcare.</p> <p>25 Q. The period that the IMB was reporting on in their 2021</p> <p style="text-align: center;">Page 192</p>

<p>1 report was at a time when there were substantially fewer 2 detained people at Brook House. In quarter 3 in 2020, 3 there were 339 detained persons, and in quarter 4, 254; 4 whereas, in 2021, in the same period, there were 574 and 5 464 detainees respectively.</p> <p>6 Again, the problems are likely to be compounded, are 7 they, with greater numbers of detained people in 8 Brook House?</p> <p>9 A. Yes, absolutely. That is common sense really. I think 10 what we would say is our experience of the service thus 11 far has been on a significantly lower operational -- not 12 capacity, I can't think of the word I am looking for, 13 but the role, in essence, has been lower. Therefore, 14 that has been our experience thus far, but we are very 15 adapt to changing services when the need arises. So, 16 for example, if a -- a change of purpose in two of our 17 prisons, for example, where courts have been closed and 18 we have had to take significantly more new arrivals, we 19 have the ability to amend our services at relatively 20 short notice.</p> <p>21 Q. Is that also a consideration that PPG are planning to 22 review the allocation of resources to the rule 35 23 process, given an uptake in the number of detainees?</p> <p>24 A. Yes, so as part of our modelling, as I have said, 25 I think we need to understand the process that we are</p> <p style="text-align: center;">Page 193</p>	<p>1 incidence of use of force being used to deal with 2 incidents of self-harm. Were you aware of that?</p> <p>3 A. Yes.</p> <p>4 Q. And they also noted proportionately large numbers of the 5 use of rule 40 and constant watch to manage vulnerable 6 detainees; were you aware of that?</p> <p>7 A. Yes.</p> <p>8 Q. Sandra Calver confirmed in her evidence that use of 9 force is still used for relocation of detainees to 10 E wing and segregation is still used for managing mental 11 health issues, suicide risk and for detainees on 12 a constant watch, and there is no clinical risk 13 assessment for those not going to the CSU but going to 14 segregation on E wing.</p> <p>15 Are those matters for concern for PPG?</p> <p>16 A. They are, yes. I think warrant further exploration, 17 yes.</p> <p>18 Q. Use of force risks exacerbating and damaging further the 19 mental health of a vulnerable detainee; do you agree 20 that use of force shouldn't be occurring in relation to 21 vulnerable detainees unless it is immediately to prevent 22 a risk to life?</p> <p>23 A. I think if it is a planned use of force, then there 24 should be a discussion that is held in conjunction with 25 healthcare so that the centre management can make</p> <p style="text-align: center;">Page 195</p>
<p>1 endorsing, first of all, in conjunction with the 2 Home Office, and then we would need to look at what 3 level of resource would be needed to meet the service 4 demand in that area, both now and as the service 5 continues to grow.</p> <p>6 Q. The IMB also noted that there were examples, in 2020, of 7 removals whilst detainees were in a state of distress or 8 injury following self-harm, which the IMB called 9 inhumane and put detainees at further risk, and they 10 also criticised the absence of any arrangements for 11 briefings from healthcare to the Home Office about those 12 most vulnerable detainees.</p> <p>13 Were you aware of that in that report?</p> <p>14 A. I had seen it in that report. I wasn't aware of it 15 being an issue prior.</p> <p>16 Q. Are there now arrangements for such briefings from 17 healthcare to the Home Office about those types of 18 vulnerable detainees?</p> <p>19 A. I can't answer that, unfortunately, I am not sure. 20 Again, I would be happy to report back to the inquiry on 21 that particular matter. I only received the IMB report 22 quite recently, so I have not had a chance to explore 23 that further.</p> <p>24 Q. We would be very grateful. In relation to use of force, 25 the IMB report also expressed concerns about the high</p> <p style="text-align: center;">Page 194</p>	<p>1 a decision as to the appropriate way forward with our 2 advice. I don't think it could ever be categorically 3 ruled out but I think certainly, generally, our advice 4 would be that it should be avoided wherever possible.</p> <p>5 Q. It is certainly a last resort?</p> <p>6 A. Yes, I would agree it's a last resort.</p> <p>7 Q. It is a concern if it's still being used as a custodial 8 risk management tool to respond to incidents of 9 self-harm, isn't it?</p> <p>10 A. It is of concern. I can see to some extent why there is 11 a challenge to the officers that are responding to these 12 incidents, in that often they may be with good intent 13 trying to preserve life, but I accept that there has got 14 to be a balance between that and weighing up the impact 15 on a detainee's mental health.</p> <p>16 Q. Because the risk, of course, is that deficiencies in the 17 safeguards, meaning vulnerable people are not rooted out 18 of detention but remain in detention, being managed, and 19 the use of force and segregation in this way as a risk 20 management tool risks another situation like there was 21 in late 2020, where the whole detainee population, the 22 IMB found, were subject to inhumane treatment; would you 23 agree?</p> <p>24 A. Sorry, can you just repeat that question for me again?</p> <p>25 Q. So the danger is the risk is that, where there are</p> <p style="text-align: center;">Page 196</p>

<p>1 deficiencies in the safeguards, so people are being</p> <p>2 manage indeed detention and not rooted out of detention</p> <p>3 because of delays in the rule 34 and 35 process, and</p> <p>4 where there is use of force and segregation to manage</p> <p>5 incidents of self-harm, there risks a situation like</p> <p>6 there was in late 2020 which the IMB described as</p> <p>7 subjecting the whole detainee population to inhumane</p> <p>8 treatment?</p> <p>9 A. So I think I would go back to my earlier comment really</p> <p>10 around rule 35, so accepting that there is an element of</p> <p>11 non-compliance with rule 35, and that does present</p> <p>12 a risk, I still think that there are safeguards in</p> <p>13 place, ie we understand these patients, we understand</p> <p>14 their needs and therefore we should still be in position</p> <p>15 to advise detention officers on the appropriate use of</p> <p>16 force.</p> <p>17 Q. That situation that the IMB found, that Brook House</p> <p>18 wasn't a safe place for vulnerable detainees and that</p> <p>19 the circumstances there amounted to inhumane treatment</p> <p>20 of the whole detainee population, happened under the</p> <p>21 watch of Sandra Calver as head of healthcare and of the</p> <p>22 doctors that you subcontract to currently. Isn't that</p> <p>23 of concern to you?</p> <p>24 A. So, yes, I think it is.</p> <p>25 I think what I would say is inhumane is subjective.</p> <p style="text-align: center;">Page 197</p>	<p>1 believe is happening is that that is triggering</p> <p>2 a further rule 35 review in most cases at least.</p> <p>3 Q. So does PPG plan to address that gap?</p> <p>4 A. Yes. So as part of the rule 35 pathway review, that</p> <p>5 will also consider what work needs to be done to</p> <p>6 understand there are regular follow ups or reviews.</p> <p>7 I think there are already processes in place to flag</p> <p>8 whereby we have concerns around an individual, we run</p> <p>9 a multi-professional complex case conferences on a</p> <p>10 weekly basis. Those kinds of things could be discussed</p> <p>11 there, but also we have things like a duty mental health</p> <p>12 worker who could flag any immediate concerns and bring</p> <p>13 those to the attention of the head of healthcare and, if</p> <p>14 necessary, the GPs.</p> <p>15 Q. Yes.</p> <p>16 Did you watch the Panorama programme?</p> <p>17 A. I did watch it, yes.</p> <p>18 Q. You are aware then of the involvement of some healthcare</p> <p>19 staff in making derogatory and mocking comments about</p> <p>20 detainees. You would presumably agree that those types</p> <p>21 of comments have no place from healthcare staff in</p> <p>22 an IRC?</p> <p>23 A. I agree with that question.</p> <p>24 Q. And with Sandra Calver that they are completely</p> <p>25 inappropriate and would be of concern if you were aware</p> <p style="text-align: center;">Page 199</p>
<p>1 I do believe that vulnerable -- you know, an Immigration</p> <p>2 Removal Centre is probably not the right location for</p> <p>3 certain vulnerable individuals in general. So I don't</p> <p>4 believe these people should be there to start with.</p> <p>5 I am not sure quite how much of that realistically is</p> <p>6 within our gift to manage.</p> <p>7 I accept that there is more work we can do in that</p> <p>8 regard.</p> <p>9 Q. In particular in relation to rule 34 and 35?</p> <p>10 A. Correct.</p> <p>11 Q. The IMB recommended a systematic and ongoing review of</p> <p>12 vulnerable detainees to monitor the effect of continued</p> <p>13 detention on their wellbeing. Dr Hard gave some</p> <p>14 evidence that it was his opinion that there was a need</p> <p>15 for such a system of ongoing review of vulnerable</p> <p>16 detainees in detention.</p> <p>17 Has there been the introduction of a systematic and</p> <p>18 ongoing review of vulnerable detainees in detention?</p> <p>19 A. So vulnerable individuals would be reviewed as part of</p> <p>20 the delivery of healthcare services. So, for example,</p> <p>21 those with severe mental health would be assigned</p> <p>22 a caseworker within the mental health team that would</p> <p>23 meet with the individual regularly and, obviously, as</p> <p>24 part of their assessment would understand if people were</p> <p>25 deteriorating. I accept the fact that -- what I don't</p> <p style="text-align: center;">Page 198</p>	<p>1 of them?</p> <p>2 A. That's correct.</p> <p>3 Q. Does it concern you that at the time, as head of</p> <p>4 healthcare, she was unaware of them?</p> <p>5 A. So I think it is -- it is a difficult question to answer</p> <p>6 in some ways. Can we hold an individual, even though</p> <p>7 they are the head of healthcare, responsible for the</p> <p>8 actions of individuals? Some would argue yes; some</p> <p>9 perhaps no.</p> <p>10 I think the reality is that -- I think in evidence</p> <p>11 Sandra Calver said she was very surprised about that.</p> <p>12 It is a very small team who work in a very small and</p> <p>13 confined environment and by virtue of the fact it is</p> <p>14 a secure environment that means that people are pretty</p> <p>15 much on top of each other, if I am honest. So I would</p> <p>16 have been very surprised, having got to know Sandra</p> <p>17 a little bit since she has joined the organisation, if</p> <p>18 she had any concerns or suspicions that the behaviour of</p> <p>19 staff was not in line with what she would expect, that</p> <p>20 she wouldn't have addressed that.</p> <p>21 Q. What steps have or are PPG taking with regard to</p> <p>22 ensuring a culture of dehumanising and degrading</p> <p>23 detainees doesn't persist in Brook House?</p> <p>24 A. There are a couple of things really.</p> <p>25 I think, firstly, we are very keen on ensuring that</p> <p style="text-align: center;">Page 200</p>

<p>1 clinical supervision is embedded with our clinical team.</p> <p>2 That is not just to review incidents, it is about</p> <p>3 talking around reflective practice, having discussions</p> <p>4 around things like compassion fatigue and, really,</p> <p>5 having a safe space for people to be honest about some</p> <p>6 of the things that they are struggling with and the</p> <p>7 challenges that they have.</p> <p>8 I think on a broader scale we are currently working</p> <p>9 with an external organisation to look at how we better</p> <p>10 embed trauma informed care within that service and there</p> <p>11 are four themes to that really: one is around a general</p> <p>12 level of training that you would expect anybody to have,</p> <p>13 if I am honest even the detention custody officers -- we</p> <p>14 are very happy to open up that training to them. That</p> <p>15 is around basic awareness of trauma informed, looking at</p> <p>16 things like adverse childhood experiences, those kinds</p> <p>17 of things.</p> <p>18 The second is around a more detailed training that</p> <p>19 is given to healthcare professionals so they can</p> <p>20 understand or better identify signs of trauma but also,</p> <p>21 working within the course of their general duties, be</p> <p>22 able to assess for trauma. So that is another point.</p> <p>23 I think there are some bigger ambitions that we have</p> <p>24 but that will require further work with Serco, as the</p> <p>25 operator, for us to implement. So that will be around</p> <p style="text-align: center;">Page 201</p>	<p>1 of force and that has been ruled out across our whole</p> <p>2 organisation. I think it is about to commence in a site</p> <p>3 and will be on a phased roll out.</p> <p>4 Q. Yes, because it is clear they didn't understand that in</p> <p>5 2017; would you agree?</p> <p>6 A. Either they didn't understand it or chose not to enforce</p> <p>7 their role, yes.</p> <p>8 Q. And appreciating that force is of course used sometimes</p> <p>9 in prisons, the difference in the population is that you</p> <p>10 have a particularly vulnerable population in IRCs in</p> <p>11 terms of underlying mental ill-health or experiences of</p> <p>12 trauma, particularly in relation to being victims of</p> <p>13 torture, would you agree?</p> <p>14 A. I don't think it is always unique. So, for example,</p> <p>15 HMP Huntercombe, which is a prison, is used to house</p> <p>16 foreign nationals. So I think there are definitely some</p> <p>17 transferable skills within the prison estate that we can</p> <p>18 bring to the Immigration Removal Centre setting.</p> <p>19 Q. But those aspects of the population certainly need to be</p> <p>20 particularly considered in relation to training in</p> <p>21 relation to use of force, would you agree?</p> <p>22 A. So every prison is unique, or every Immigration Removal</p> <p>23 Centre is unique, and it needs to cater for the needs of</p> <p>24 the people that are detained there.</p> <p>25 Q. Would you agree with Dr Hard that there needs to be</p> <p style="text-align: center;">Page 203</p>
<p>1 the leadership team unitedly challenging things like</p> <p>2 language and behaviours, and then the fourth element,</p> <p>3 which is quite aspirational but nonetheless is one that</p> <p>4 we want to pursue, is around understanding what elements</p> <p>5 of detention can re-trigger people around their trauma</p> <p>6 and trying to avoid those.</p> <p>7 So it is a four-pronged approach that we are looking</p> <p>8 to develop to try and prevent the exact scenario that</p> <p>9 you would have seen on the Panorama documentary.</p> <p>10 Q. I just want to finally then ask you about some of</p> <p>11 Dr Hard's recommendations, particularly in relation to</p> <p>12 training and various aspects.</p> <p>13 Would you agree with him that better training is</p> <p>14 needed for both detention and healthcare staff in the</p> <p>15 use of force?</p> <p>16 A. Yes, absolutely. In fact we have also taken steps to</p> <p>17 address that ourselves.</p> <p>18 So for the last year -- because use of force is</p> <p>19 equally used within our prison establishments, so the</p> <p>20 principles are exactly the same. So we have been</p> <p>21 working with -- there is no off-the-shelf training, it</p> <p>22 is very clear. So we have been working with our</p> <p>23 director of nursing, consulting with colleagues who</p> <p>24 offer things like C&R training, for example, so nurses</p> <p>25 are absolutely clear what their role is within any use</p> <p style="text-align: center;">Page 202</p>	<p>1 better training in relation to healthcare's role in the</p> <p>2 ACDT process, and in particular that there needs to be</p> <p>3 some understanding of the link between those who are on</p> <p>4 ACDTs and the safeguards under rule 35 applying?</p> <p>5 A. So I don't necessarily agree that there needs to be</p> <p>6 further ACDT training. My understanding is that is</p> <p>7 an annual training programme that is delivered by Serco,</p> <p>8 who are the operator, and the feedback is that that</p> <p>9 generally appears to be very good and comprehensive. I</p> <p>10 think the issue is around the link to rule 35 and it is</p> <p>11 really training around rule 35 that we need to resolve.</p> <p>12 Q. That would address that link?</p> <p>13 A. Yes.</p> <p>14 Q. Including in relation to food and fluid refusal and the</p> <p>15 link between those who refuse food and fluids and,</p> <p>16 potentially, the applying of the safeguards under</p> <p>17 rule 35?</p> <p>18 A. Yes.</p> <p>19 Q. Would you agree with him that training ought to be</p> <p>20 provided aimed at addressing compassion fatigue and</p> <p>21 desensitisation of staff as to what they encounter at</p> <p>22 Brook House?</p> <p>23 A. Yes, as I have already said, I think that will be</p> <p>24 included in the trauma informed training that we are</p> <p>25 looking to roll out.</p> <p style="text-align: center;">Page 204</p>

<p>1 Q. You have already addressed that there should be better 2 training in relation to rule 35, as Dr Hard also agrees. 3 Do you consider it is PPG who should be supplying 4 that training or some other organisation? 5 A. I think it is a joint responsibility. I think it is 6 really evident that there is a lack of clarity around 7 rule 35. Therefore my view is that there should be some 8 training that is delivered by the Home Office, as it is 9 a Home Office policy or ruling; but that equally should 10 then be followed up -- as I said, it is not just around 11 the process for rule 35, it is a whole system approach 12 around the identification of people and the pathway then 13 that those people need to go through in order to get 14 their appropriate assessment. 15 So I think it is a joint responsibility and it has 16 two elements to it. 17 MS SIMCOCK: Thank you. 18 Chair, those are all the questions that I have for 19 this witness. Do you have any questions? 20 THE CHAIR: Thank you, Ms Simcock. 21 I do have a couple of questions for you, Mr Wells, 22 thank you. 23 Questions from THE CHAIR 24 THE CHAIR: I wonder if you could tell me a little about the 25 timeframes for the review of the pathway, the rule 35</p> <p style="text-align: center;">Page 205</p>	<p>1 currently being offered, you said that you would need to 2 seek further clarity from the Home Office before making 3 a commitment around the level of resource that might be 4 required to offer more than a ten-minute appointment. 5 Do you intend to have that conversation with the 6 Home Office? 7 A. Absolutely. My understanding is the Home Office have 8 already suggested locally to Brook House that there 9 needs to be some form of either further training or 10 review of that, so I would expect that is a good forum 11 in which we could explore further discussion around what 12 exactly is involved -- or what is their understanding of 13 what exactly is involved by the term "assessment" within 14 that ruling. 15 THE CHAIR: Okay, thank you. 16 Then finally, again, Ms Simcock asked you some 17 questions around this, the discrepancy in the numbers of 18 people on constant watches towards the end of 2021, in 19 contrast to the lack of rule 35(2) reports and, 20 obviously, I understand, from what you have told us 21 about some of the reviews, that you are going to be 22 commencing and looking at that as an issue, and your 23 answer to Ms Simcock was you didn't want to make any 24 immediate snap decisions around that. 25 Have you given any consideration to the potential</p> <p style="text-align: center;">Page 207</p>
<p>1 pathway that you are undertaking? 2 A. When you say -- 3 THE CHAIR: The timeframe, so when did you start it, when 4 will it be concluded? 5 A. It is commencing on 20 April. 6 THE CHAIR: The 20th? 7 A. Yes. 8 THE CHAIR: When is it due to conclude? 9 A. We haven't got -- obviously, it depends what falls out 10 of that event. As I said, we are not particularly 11 bureaucratic, so I would hope that we'd have 12 a better-informed policy, at least, within a few weeks 13 of that taking place. Obviously, depending on what the 14 findings are from that particular piece of work, if that 15 does involve, you know, service redesign or 16 conversations with our Commissioners, then that could 17 extend that period. 18 So it is a little difficult to give you 19 a definitive, but I would expect, at least, that we 20 would have a policy on it by the end of the month. 21 THE CHAIR: End of ...? 22 A. End of April, sorry. 23 THE CHAIR: End of April. Okay, thank you. 24 In response to one of the questions that Ms Simcock 25 asked you around the ten-minute appointment that is</p> <p style="text-align: center;">Page 206</p>	<p>1 issue that there are people now in detention currently, 2 who are not going to be going to be referred for 3 rule 35(2) appointments where there has been suicidal 4 ideation expressed? 5 A. Yes, I think so. I have discussed that with Dr Bromley, 6 and I think our view is clear, whilst we accept that 7 there is an element of risk within that, I think there 8 is also an element of risk, in terms of bringing in 9 a series of changes to working practice which can be 10 confusing to staff and, given that this is 11 a long-standing issue, it is not a new issue that has 12 been operating for some time, I personally am in favour 13 of an approach whereby we take a very clear approach. 14 Whilst that will involve, you know, roughly a three- or 15 four-week wait, I think it is a much better way forward 16 than us to go out with a number of different directives 17 to the team that are trying to deliver these services. 18 THE CHAIR: Thank you. I have no other questions, I am 19 grateful for your evidence and I am sorry we have kept 20 you a little late, but it has been important to hear 21 from you, so thank you. 22 A. Thank you. 23 MS SIMCOCK: Chair, in the evidence of Mr Dove, I neglected 24 to ask for his second witness statement to be adduced, 25 so I just do that now, it is at <CJS0074042>.</p> <p style="text-align: center;">Page 208</p>

1 THE CHAIR: Thank you.
2 MS SIMCOCK: Thank you. 10.00 am tomorrow.
3 THE CHAIR: 10.00 am tomorrow. Thank you.
4 (4.45 pm)
5 (The inquiry adjourned until 10.00 am the following day)
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