BROOK HOUSE INQUIRY

First Witness Statement of Reverend Nathan Ward

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1. I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 25 August 2021. I, Reverend Nathan Ward, will say as follows:

Introduction

2. I am a former G4S employee and senior manager. I worked for the company from 2001 to 2014. I was employed by G4S to work at the Gatwick Immigration Removal Centres from 2011. My last job title between July 2012 and 31 May 2014 was Head of Tinsley House. I appeared in the Brook House Panorama programme, as a former employee of G4S and a whistle blower.

3. I make this statement to assist the Inquiry with its terms of reference. In this statement, I set out my experience of the operations of G4S and the Home Office in relation to Brook House Immigration Removal Centre ('IRC'). From that experience, I set out how the systems, management, culture and practice of G4S and the Home Office and their inter-relationship with each other is likely to, or may have contributed to, the mistreatment and abuse of detained persons, and further how it may have contributed to the failure by staff and managers in both organisations to take appropriate action in relation to mistreatment and abuse. A number of concerns were raised by me (and others) during my employment for G4S and as a senior manager of Gatwick IRCs. From my experience, I am also able to offer an assessment of why mistreatment and abuse occurred, what steps could or should have been taken to prevent it, and what may assist to ensure it does not repeat in the future.

4. This statement will be structured as follows:

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        ii. Personal Views and Context
    b. Medway Secure Training Centre (STC)
    c. Gatwick IRC
        i. Background and Layout
        ii. Brook House Design and Contract
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Background

Employment History and Education

5. I can confirm my employment history as follows.

6. I was first employed by G4S (known at the time as Group 4) in 2001 as a part time Chaplain at Medway STC. I stayed in this role until 2007 and was awarded a National Youth Justice Award by the Attorney General for my work. From 2007 to 2011, I worked as an Enrichment Manager at the same STC which included being a Duty Director.

7. I left Medway STC in 2011 to complete a secondment at Gatwick IRC, where I was based primarily at Brook House. For the first few months, I did not have an official role but helped to develop the family and safeguarding policies at Tinsley House. After this, I was seconded back to work with Paul Cook, the Managing Director of Children's Services, to carry out business development in Children's Services for G4S. Around 8 months later, Derek Milliken, then the Gatwick IRC's Director, offered me a role involving the redevelopment of the Family Suite at Tinsley House, following the deputy Prime Minister's announcement to end 'child detention' at the end of 2010. The Family Suite was a section of Tinsley House which held families with children prior to their removal from the UK.

8. In January 2011, I became Head of Children's Services at Gatwick IRCs; a role I worked in until 2012, when I became Head of Tinsley House. These roles were part of the senior management team for Gatwick IRCs, which operated both Brook House and Tinsley House. I did not have a job interview or put in any form of application for these roles.

9. Within my role as Head of Children's Services, I was asked to support setting up the Cedar Pre-Departure Facility ('Cedars'); a coalition between Barnardo's, G4S and the Home Office. Contractually, Cedars was an extension to the existing Tinsley House contract which meant that the Home Office did not need to undertake a tendering exercise.

10. Around this time, G4S had lost the Immigration Overseas Escorting Contract and some of the escorting staff were transferred into Gatwick IRC's and Pre-Departure accommodation. Sarah Newland, the G4S Operations Manager (responsible for overseeing G4S' overseas escorts team for removing foreign nationals) at the time of the death of Jimmy Mubenga on 12 October 2010, was promoted in May 2011 to be Head of Cedars. As far as I was aware, there was no real formal appointment and interview process. I was asked by Managing Director Andy Clark to have an informal conversation with her, so I took the opportunity to ask her about the death of Mr Mubenga and whether she had any idea as to what had gone wrong. She told me that she was aware of a bad culture, but managers like her were sat in an office and could not control what happened on the ground. I was taken a back at the lack of responsibility as an operations manager but it presented as a typical attitude. Sarah Newland was promoted to Head of Tinsley House in 2017 and has been a Deputy Director at Gatwick IRCs since November 2019. She has continued in this role since Serco took over running the centres in May 2020.

11. I became Head of Tinsley House in July 2012. According to the HMCIP report prior to my arrival in 2009, the following concerns were raised about the centre: "*Overall, this is a deeply depressing report. Provision across a number of areas at Tinsley House had deteriorated since our last visit. In particular, the arrangements for children and single women were now wholly unacceptable and required urgent action by G4S and UKBA. It is also disappointing that the opening of the neighbouring Brook House had not led to a more thoughtful and rational approach to the use of Tinsley House. Instead, Tinsley House has become almost an afterthought, housing some poorly cared for children and a small number of scared and isolated single women. This is more than a missed opportunity; it is a wholly unacceptable state of affairs.*"[1]

[1] HMCIP, Report on an unannounced short follow-up inspect of Tinsley House Immigration Removal Centre – 13-15 July 2009', https://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/Tinsley_House_2009_rps.pdf

12. In the HMCIP's first inspection report following my appointment as Head of Tinsley House, it was found that circumstances had improved. The report summarised the findings as: "*Overall this is a very good report. Tinsley House is one of the best centres we have inspected, with good outcomes in three of our four tests of a healthy establishment. We identify a number of improvements that should be made, particularly in relation to health care, but also on the management of separation and in diversity and welfare. Those aside, the personnel associated with the work at Tinsley House should be congratulated for the continued progress of the centre.*"[2]

13. In the senior manager positions at Tinsley House, I also fulfilled the role of Duty Director, which covered both Gatwick IRCs. Whilst I was based in Tinsley House, I spent on average two days per week at Brook House. As Duty Director, I had operational control over both sites and my role profile was identical to a Deputy Director, apart from 'deputising on behalf of the Director', which in practice I did on a number of occasions when both the Director and Deputy Director were unavailable. As Duty Director, I would need to be on-site during the operational unlock, and oversee the operations that day. This would include ensuring that roll checks were complete, reviewing constant watches, checking ACDT booklets, checking daily movements, visiting areas and wings, visiting and reviewing detainees on Rule 40, reviewing anti-bullying booklets and all incident reports that came in, and checking daily staffing levels. I would act as silver commander if any major incidents arose.

14. I resigned from G4S on Monday 14 April 2014. Until this point, I had stuck it out because I felt that I could still make a difference to peoples' lives and help reform from within G4S. It was work that was something of a vocation for me and rooted in my Christian faith of service to disadvantaged marginalised people. Ultimately however, after many years of trying to make a change, I felt I just could not cope with continuing to work for G4S. I realised that by remaining in the system, I was perpetuating an unjust, inhumane system which I would now describe as barbaric.

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[2] Report of an announced full follow-up inspection of Tinsley House Immigration Removal Centre, 8-11 October 2012 - https://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/tinsley-house-2012.pdf

15. I currently work DPA which is a DPA. As well as undertaking the normal duties of a Vicar, I am also an active member of two Academy Trusts holding the roles of Trustee and Governor.

16. My relevant education and qualifications are as follows:

a. BA Community and Youth Work Studies (University of Durham) (2001)
b. First Aid Instructor and Assessors Course (2006)
c. NEBOSH National General Certificate (L3) in Occupational Health and Safety (2007)
d. City and Guilds L3 Certificate for Delivers of Conflict Management (2007)
e. City and Guilds L3 Certificate for Delivering Learning (2007)
f. First Responder (Advanced First Aid) (2007)
g. Fire Marshal Instructor (2007)
h. Mobile Team Challenge Conflict Resolution Training (2007)
i. Mobile Team Challenge Appreciative Facilitator Training (2007)
j. Physical Control in Care and Breakaway Techniques Instructor (2007)
k. MAYBO Programme in SAFER Children Conflict Management (2008)
l. NEBOSH Certificate in Fire Safety and Risk Management (2009)
m. City and Guilds Level 3 Certificate in Assessing Candidates Using a Range of Methods (A1) (2009)
n. Prison Service Silver Commander (2011/2)
o. Crisis Communications Course (2012)
p. MSc in Security and Risk Management (University of Leicester) (2012)
q. Foundation Degree in Theology for Christian Ministry (Canterbury Christ Church University) (2014)
r. BA in Theology, Ministry and Mission (University of Durham) (2018)

Personal Views and Context

17. The following sets out my personal views on the historical landscape in which Brook House IRC was established. I believe the context is important to understanding the abuse that was exposed in the Panorama documentary in 2017. My understanding of the wider context and the conclusions I have drawn, as well as the rest of my observations in this statement, which I hope will assist the Inquiry in its investigation, are based on my knowledge and experience of working in practice day-to-day within the detention estate. I have years of experience of the immigration system, working on the ground in IRCs and with the benefit of the many hours of reflection on the system and its impact on people since.

18. I have always believed that the British Government has a democratic right to 'protect its borders' and within the rule of law, to deport people who do not have the legal right to stay within the country. My view is that this is an important function - indeed sovereign right - of any State, as without this, notions of citizenship and the associated rights become limited. Therefore, I am not an 'abolitionist' when it comes to Immigration Detention.

19. Accordingly, my criticism of the system of immigration detention is not based on an underlying opposition to it, but having worked within the system for a number of years, a deep desire to see fundamental reform. Based on that experience, it is clear that its use should be closely regulated by law, strictly limited in time, only used when the Home Office can show that removal is imminent, and not used for those who are vulnerable and who will be harmed. I do not believe that indefinite detention should be permitted. I have witnessed first-hand the deep distress and despair this causes, due to the uncertainty it instils on detainees' future, safety and length of incarceration.

20. Indefinite detention is the equivalent of an indeterminate sentence or 'internment', which is normally encountered during wartime to manage threats posed by enemy aliens to national security. I have seen how in practice this is a reflection of the increasingly militaristic approach by UK governments to immigration, along with the adoption of wartime language, including naming the agency 'the Border Force' and

dressing them in militaristic uniforms. The use of indefinite detention, unwarranted in peacetime in my opinion, undermines the safeguards such as the ancient writ of habeas corpus which is supposed to protect an individual against detention without trial. I have seen how this undermines the individual; conceptualising immigrants not as fellow human beings who share our legal protections, but as alien others to be ejected from our territory.

21. Successive governments have created a climate of disrespect and dehumanisation towards migrants and asylum seekers. When opening Brook House in March 2009, the then Home Secretary Jacqui Smith emphasised, *"I am committed to removing more foreign lawbreakers faster than ever before, that's why the opening of this Immigration Removal Centre is so important… The message is clear – whether you're a visa overstayer, a foreign criminal or failed asylum seeker, the UK Border Agency is determined to track you down and remove you from Britain."*[3] This aggressive tone has only intensified. On 25 May 2012, the then Home Secretary Theresa May declared in an interview with the Telegraph that "*The aim is to create here in Britain a really hostile environment for illegal migration*."[4]

22. The comments and tone do not sit well with the Detention Centre Rules 2001, where Rule 3 states that "*the purpose of a detention centre is to provide for the secure but humane accommodation of detained persons in a relaxed regime with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environment, and to encourage and assist detained persons to make the most productive use of their time, whilst respecting in particular their dignity and the right to individual expression*". There is a clear dissonance between the political hostility and respect for human dignity with the policy and rules, demonstrated in grotesque manifestations seen in the Panorama documentary.

23. The deliberate creation of a 'hostile environment' which intensified after 2012, during which I was working at its epicentre, included in 2013 the hiring of billboard vans

[3] https://www.wired-gov.net/wg/wg-news-1.nsf/0/FB6FE92BDEE224128025757D00444829?OpenDocument **DL0000180**
[4] https://www.telegraph.co.uk/news/0/theresa-may-interview-going-give-illegal-migrants-really-hostile/ **DL0000181**

advertising 'Go home or face arrest', which whilst heavily criticised, set a context in which migrants were further ostracised from British Society. The 'hostile environment' was then codified in law through the Immigration Acts of 2014 and 2016, to restrict access to and introduce more stringent checks on the abilities of migrants to access work, healthcare, housing and bank accounts. A key part of the 'hostile environment' was more aggressive policies in respect of the use of detention and a drive to increase removals, with an increased use of Charter Flights[5] and policies in which individuals would be given 'removal windows' (where detained persons would be given 72 hours' notice that they could be removed without further warning over the next three months) instead of the exact date of their removal.[6] The hostile environment policy was also a critical factor in the Windrush scandal[7] with British Citizens even being caught up in it, facing detention and removal.

24. Whilst I understand the Inquiry's terms of reference is to focus on the events at Brook House in 2017, I believe that to answer the questions posed, it is important to analyse the wider context of the environment in which G4S and Home Office operated Brook House. This political environment and social tapestry defined the context in which jobs were created, priorities were set, work was carried out, and shaped the perceptions of staff towards those who were detained. Brook House staff were generally recruited from Gatwick Airport; often whose only experience was handling bags, not people, and whose understanding of immigration was the dominant culture of 'hostility'.

25. In the context of the 'hostile environment' and its intensification, Brook House IRC in particular, became a focal point in effecting removals as the Home Office's main centre for the use of Charter Flights.[8] Brook House was also reflective of the 'hostile environment', where the contract was geared to ensure removals were not hampered

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[5] The IMB Annual Report (May 2021) focus's heavily on the adverse and inhumane impacts of the intensification of the use of Charter flights on detainees held at Brook House in 2020 **(Annex 10).** DL0000140

[6] FB (Afghanistan) & Anor, R (On the Application Of) v SSHD [2020] EWCA Civ 1338 in which this policy was found to be unlawful. DL0000182

[7] See 'Windrush Lessons Learned Review: independent review by Wendy Williams' dated March 2020 DL0000183

[8] See e.g. comments by Ben Saunders in G4S' '360 Degree Contract Review' dated 24 June 2014 at page 2 (CJS000768) and is ongoing see IMB Annual Report for 2020 **(Annex 10).** DL0000140

by contract failures and where penalties were placed on anything that prevented deportation, such as not producing a detainee for an immigration interview on time or not presenting them when required for escort.

26. When this hostile political rhetoric becomes the driving motive for an institution which is extremely close to what the sociologist Goffman called a 'total institution', there is a strong likelihood that the institution will itself become 'hostile' and abuse will occur. Within the IRC context, I have seen how 'detainees' are mainly perceived to pose a physical and moral 'risk' to the fabric of British society and the Home Office are the authority who employ G4S to enforce the rules and these political priorities.

27. I believe it is the mix of the Home Office led hostile policies, coupled with the commercial priorities of a company like G4S[9], which embedded an institutional culture of dehumanisation and impunity which ultimately led to the abuse of detainees uncovered in the Panorama programme. I firmly believe it is the system which drives behaviours of individuals and not a few 'bad apples' that have slipped through the net.

Medway Secure Training Centre (STC)

28. I address in some detail my employment at Medway STC because it is an important part of my employment history but also because over the course of my employment for G4S at Medway STC and Gatwick IRCs, I have observed a number of very close parallels with what went wrong.

29. I first joined G4S as a Chaplain at Medway STC in 2001. On leaving Durham University, I worked for a local Church as a youth and community worker, where it was suggested that I should work for the local STC who had been seeking a Chaplain for some time. This role was a natural progression for me as my degree had covered youth and community work including education, sociology and juvenile justice, and one of my university practice placements was at HMP YOI Castington.

[9] Which is discussed further below

30. It was at Medway STC where I first trained in Physical Control and Care (PCC) and was certificated as a Custody Officer in 2001. This allowed me to legally carry out the functions of a Custody officer, whilst maintaining my role as a Chaplain. I took the decision to train because if something happened, I would be able to help rather than be passive.

31. When I first joined Medway, I had preconceived ideas that the STC would be a mecca of professionalism and that I would gain experience working with experts in the care and custody of children. However, I had concerns the moment that I arrived. The atmosphere of the STC was unsafe and unstable. Some staff used derogatory language towards the children and there was frequent physical abuse. This abuse was later documented in another undercover Panorama programme in 2016 which exposed similarly harrowing evidence with close parallels with what would be exposed a year later at Brook House, including:

    a. Officers deliberately escalating incidents so they could (in their minds) justify restraining/assaulting children;
    b. A child being restrained through pain and excessive force, and being unable to breathe;
    c. A child being held down on the ground, inflicted with painful restraint holds and taunted;
    d. Officers using restraint techniques which involved the infliction of severe pain and have been authorised only for extremely grave situations;
    e. An officer throwing a hard punch to a wall/window and then jumping in front of a child to frighten him;
    f. An officer recalling a restraint incident when a child complained he was suffocating. The officer laughed and mocked the child whilst sharing his story with colleagues, including "He was sitting there nearly in tears";
    g. An officer boasting he had assaulted a child with a fork (thrusting it into the boy's leg);

h. A child subserviently acquiescing to an officer who forced him to repeat, then shout out, "Arsenal are shit", even though this was the boy's football team;
i. Officers using foul and insulting language to describe children, for example "fat little prick" and "fat little shit";
j. Officers discussing how to hit a child, and how they had hit children, including "I was straight in, slam", "kicked in", "I'm just going to hit him. Fact." and "[I] properly tried to break his skull";
k. Officers recounting how G4S misrepresented incidents to government, in order to avoid fines; and
l. G4S officers discussing how to fabricate restraint records, and then fabricating a report on camera.

32. The unsafe nature of Medway STC at the time I was working, is reflected in the high number of Physical Control in Care (PCC) incidents that would regularly occur. Data from 2003, shows that there were 1,614 incidents of PCC and 333 incidents of assaults (total for child on child and child on staff), when the centre only had capacity to accommodate 76 children[10]. There were a number of high-level child protection allegations coming from the children and it was an unsafe place for all. I recall staff being sick on the way to work because of stress and instability of the centre. I believe both the children and staff acted violently in this environment because no-one felt safe, the environment itself was brutalising and there was a culture of fear.

33. In my opinion, the levels of abuse at Medway STC and the lack of safety in the centre stemmed in part from issues with staffing that G4S failed to properly address. There was an issue with low levels of staffing and a high turnover of staff because they did not feel safe. This issue was picked up by the Commission for Social Care Inspection's (CSCI) October 2004 at (6.1) [11] but it remained a constant problem.

[10] See page 7 of https://files.ofsted.gov.uk/v1/file/50000063 DL0000184
[11] https://files.ofsted.gov.uk/v1/file/50000064 DL0000185

34. To counter low levels of staff, extra staff were brought in from Rainsbrook STC or prisons run by G4S, and who were often aggressive and intimidating. Rainsbrook STC was run by Director John Parker, who instilled order through threats and heavy restraints. The staff that came from Rainsbrook STC were known as John Parker's 'Rufty Tufty Club', which mainly consisted of male rugby players who were abusive towards the children.

35. I witnessed examples of the abuse set out above, during my employment at Medway STC and raised complaints from the outset. In my first week, I met with Mr Howard Grassow, a psychotherapist in the centre, to raise concerns about a staff member telling a child to "fuck off". It was explained to me by Mr Grassow that I had entered into an environment where the staff had been for a long time and these practices were entrenched. Investigations sometimes happened at Medway STC when staff or children raised concerns but there were never significant outcomes.

36. In 2003, I used G4S' whistleblowing phoneline to raise my concerns but was told by a man with a Scottish accent that he had not received the training on taking whistleblowing complaints. He asked for my name and phone number and said he would call me back the next day. I politely declined as the phoneline was meant to be confidential and it did not give me any faith in the whistleblowing system.

37. As none of my complaints were being dealt with effectively internally, between 2001 to 2004 I made contact with (1) the contract monitor for Medway Youth Justice Board; (2) the local MP for Chatham; (3) the Bishop of Rochester; (4) Linda Christie of Ofsted[12]; (5) John Duff, Medway's Local Authority Designated Officer (LADO); and (6) the Prison Liaison Officer from Kent Police, to raise concerns specifically about the running of the STC and the abuse of children by the staff members.

[12] Note the Inspectorate was known as the Social Services Inspectorate, then the Commission for Social Care Inspection, before later becoming part of Ofsted

38. In 2003, I approached Professor J.M.Pitts with Aqualma Murray, a qualified social worker, who was a senior manager of Medway STC at the time. Professor Pitts was and remains one of the leading academics in the UK on Youth Justice.[13] Following a meeting with him in the summer of 2003, Professor Pitts took our concerns about Medway STC and wrote a three-page letter dated 10 September 2003 to the Head of Secure Training Centres on The Youth Justice Board, copying in others including the Director of Social Services Inspectorate and the Minister for Correctional Provision at the Home Office. **I enclose a copy of this letter as Annex 1 to my statement,** which DL0000140 includes concerns of (a) bullying and intimidation of the Director of Children's Services, and his staff; (b) encouragement to falsify statistics and not report concerns to Home Office monitors; and (c) examples of use of force not in accordance with methods approved by the Youth Justice Board, which led to a number of injuries, including severe carpet burns to children's face and chest. Please note that I only have two of three pages of the letter (having lost the second page) but the Youth Justice Board should have the whole letter on record.

39. Following the letter, Professor Pitts was approached by Kent Police who asked to speak to the whistleblower (myself) to which I agreed and was interviewed at Rochester Police Station. I cannot remember the date of this and I am unsure who else was spoken to in relation to the investigation. When I presented the Police with factual evidence, I was told that the information I held, including the use of force manual, would constitute stolen property (despite the public interest) and therefore they were unable to investigate.

40. I continued raising concerns over the next three years but to no avail. Throughout my employment at Medway STC, I raised concerns with senior managers including the Deputy Director, Angie Simpson, Directors, Jim Rose and Chris Wood, Paul Cook and various Home Office monitors about this kind of abusive practices and culture but to no avail.

[13] https://www.beds.ac.uk/iasr/about/staff/john-pitts/ DL0000186

41. In 2007, there was an investigation into an incident I reported, in which a child was grabbed by the neck by a Duty Manager, Name Irrelevant, who simultaneously said *"you will fucking respect me"*. He denied it and despite me being informed that the management team were monitoring his behaviour, there was no further action taken. That same year, I raised my general concerns with Linda Christie during her Ofsted inspection, and was told by her that it was an 'inspection' and not an 'investigation'.

42. At this point, I contacted Eric Allison, a journalist at the Guardian to raise my concerns as it was clear that none of my efforts to report the abuse had resulted in change. This eventually then led to the Panorama investigation into Medway STC.

43. By 2011, I felt that I could not go on working at Medway STC. I did not leave until then despite the misconduct and abuse I witnessed because I did not want to abandon the children. I felt that I could still make a difference to the children's lives, and I did not want to give up on them. My faith was also an important factor in driving my belief that I was duty bound to try to help these vulnerable children and not to walk away. In early 2011, I spoke to Paul Cook and explained that I could no longer work at Medway STC and he seconded me immediately to Tinsley House.

44. At Medway STC, I was always in fear that a child would die. My fears were sadly confirmed on 19 April 2014, when Gareth Myatt died in Rainsbrook STC after being held down by three adult members of staff because he refused to clean a toaster. In the police investigation into his death, officers gave themselves nicknames such as 'Clubber Clay', 'Crusher', 'Mucker', 'Mauler', 'Rowdy' and 'Breaker'.[14]

45. The Medway STC Panorama programme was finally aired in 2016 after Guy Grandjean and Eric Allison decided to take the story to Panorama. Following the Panorama programme, Kent Police launched 'Operation Woodley' and I fully co-operated with their investigation. I made a number of witness statements regarding my time at Medway STC as well as Brook House IRC, during interviews which took place

[14] https://www.communitycare.co.uk/2007/02/22/macho-culture-at-secure-training-centre-where-teenager-died-inquest-hears/ DL0000162

on 16 June 2016, 29 June 2016, 11 July 2016, 21 July 2016 and 31 August 2016. **I enclose these police interviews as Annex 2 to my statement.** DL0000140

46. The statements I gave to Kent Police set out my concerns with the treatment of young people at Medway STC. These statement included allegations of poor institutional culture, bullying, misrepresenting incidents in reports, difficulties faced when attempting to whistleblow, performance measures, two incidents during Ben Saunders' time as Director of Medway STC involving the inappropriate use of force and destruction of CCTV evidence, failure of reporting incidents to the YJB, failures to discipline staff, the unlawful use of force, staff provoking trainees to justify force, inaccurate recording during use of force and health and safety, staff being afraid to raise concerns, dishonest culture and verbal abuse.

47. Operation Woodley led to a number of staff being charged with misconduct in a public office, however only one individual was convicted, and this was for having a mobile phone in Medway STC. No one was convicted for the abuse seen in the Panorama footage and as far as I am aware, no-one was prevented from working with children and/or in social work.

48. Following the Panorama programme on Medway STC, an investigation was also raised by the Professional Standards Unit of Kent Police in relation to the allegations I had made in 2003.The investigation found that the police officer concerned should have been investigated, but he had left the force and therefore no further action would be taken.

49. After the Medway STC Panorama programme aired in 2016 and whilst I was making statements to Kent Police, I had my tyres slashed four times. I also received two anonymous threatening letters and twelve anonymous phone calls. I reported this to Kent Police and was advised to secure my home but there was no other action taken.

50. I enclose a letter from Dr Bell dated 11 August 2016 at **Annex 3**, which confirms that I was *"going through a particularly stressful period giving weekly statements to the* DL0000140

police in relation to charges of neglect and abuse that have been brought against his former employers following him whistle blowing on them. He has been living with the situation for a very long time and since January has been experiencing nightmares as well as other anxiety related symptoms... Part of his anxiety relates to fears about his own health and safety and what certain individuals might do".

51. In the interviews with Kent Police in 2016 I also described some of my specific concerns about Ben Saunders, who had been Director at Medway STC from 2007-2012 and then Brook House from 2012-2017.

52. From 2007, Medway STC had been run by Ben Saunders, who I felt was incompetent and turned a blind eye to the longstanding abuse. Ben Saunders had a lack of operational experience, having only worked at a Local Authority Children's Home with limited numbers of beds previously. His leadership and management style did not safeguard children or reflect good practices such as actively managing the centre by being present on the floor and observing the actions, inactions and interactions of members of staff. I recall one incident where a member of staff stormed out of the centre threatening to kill himself after he had hit a child. Ben Saunders refused to call the police, and the member of staff was later picked up by the police walking down the middle of a dual carriageway.

53. I reported to Kent Police, one particular incident on the green of Medway STC at some point between 2009/11, in which a child was refusing to move, in full view of Ben Saunders' office. At the time there was a law prohibiting staff from using force to move the child, but I witnessed Ben contact control and direct them to move the cameras away from the incident, and then instructed Jay Brittan to use force to move the child off the green. I also reported an incident where Ben Saunders had ordered me to crop CCTV, which the Youth Justice Board had asked to review, showing staff being negligent in the run up to a preventable assault, so as to hide the negligence from the YJB Monitor. It was common practice for staff to provoke a child in order to obtain a response, so that there would be a legal justification for the use of force. Staff were

aware that CCTV did not pick up sound and it was hard, if not impossible to prove that staff had provoked the child.

54. I understand that Jerry Petherick transferred Ben Saunders from Brook House back to Medway, as Interim Director in February 2016 which I find astonishing.

55. Ben Saunders ceased working as Director of Gatwick IRCs following the Panorama documentary into Brook House in 2017, however continues to work for Mitie [15]as a Director of Business Development in the Care and Custody department. According to Mitie's website, "*Ben has 30 years' experience delivering high quality services in the public and private sectors.*" I believe this is indicative of the lack of accountability in G4S and the wider government security contractors for the appalling abuse that have taken place at both Medway and Brook House and how failures of management of this magnitude have little consequence for those responsible both for delivering services under privatised custodial contracts and for those within the government who oversee them.

56. At Medway STC, all strategic decisions were made by Paul Cook, the Managing Director of Children's Services and John Parker, the Director of Children's Services. They too had responsibility for these failings but as far as I am aware no action was taken. I am not aware of any civil servant who has been held accountable for the grave abuses exposed at either Medway or Brook House.

57. As I have stated, I think the Inquiry can draw a number of important parallels from what happened at Medway STC with the running of Brook House, including the incidence of physical and verbal abuse, issues with staffing levels, training and profit-driven contracts, and a failure of leadership and oversight by the most senior staff and civil servants.

[15] Mitie are contracted to run Harmondsworth and Colnbrook IRCs.

58. The executive summary of the Medway Improvement Board's (an independent panel set up after the Panorama) Final Report of the Board's Advice to Secretary of State for Justice[16] (INQ000010) includes the following findings, which stand in stark similarity to Brook House:

a. There was a lack of clarity on the purpose of an STC;
b. Leadership within the STC has driven a culture that appeared to be based on control and contract compliance rather than rehabilitation and safeguarding vulnerable young people;
c. Significant concerns this culture and emphasis on contract compliance may be leading to reports of falsification of records as seen on Panorama;
d. There are blurred lines of accountability and an ambiguous management structure;
e. Current safeguarding measures are insufficient and outdated;
f. There is too much emphasis on control and contract compliance and not enough on the best interests and mental wellbeing of the trainees;
g. The Board is not convinced that the various organisations involved in scrutinising and responding to safeguarding at Medway STC are coordinated in their approach, increasing the risk of safeguarding issues falling through a gap;
h. There is a history of similar concerns being raised repeatedly in letters from whistle-blowers and former staff;
i. Policies forming part of the STC contract need to be reviewed to ensure that they support the overall safety of young people rather than focus on contractual penalties;
j. Whistle-blowers and children inside of the STC need to have an effective support framework in which they feel safe to raise concerns and complaints;

[16] See Medway Improvement Board, 'Final Report of the Board's Advice to Secretary of State for Justice', dated 30 March 2016 – INQ000010
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/523167/medway-report.pdf

k. There is a lack of understanding of the causes and drivers of behaviour problems and too much focus on controlling behaviour rather than dealing with underlying vulnerabilities;
l. The Board has concerns about how YJB manages their contract and monitors safeguarding at the STC;
m. There is a need for formal separation of the often conflicting YJB monitoring functions of ensuring contractual compliance and monitoring safeguarding;
n. Regardless of who manages Medway STC, changes in culture, leadership and staff approaches are needed; for these reasons the Improvement Plan needs to incorporate effective mechanism for continuity of improvement, assessment of impact of improvements, and a timetable for handover.

59. Specifically in relation to whistleblowing, the Board heard evidence from former G4S staff whose attempts to use the whistleblowing hotline had been thwarted, and that those who had tried to speak out were moved to different parts of the organisation or lost their jobs. Claims were also made that 'gagging restrictions' were placed on former employees, which made them too scared to speak out, even years later.[17]

60. These findings, and the report as a whole, present stark similarities to the abuse and corruption exposed in the Panorama documentary on Brook House. It is notable that at Paragraph 2.23 of the Report, Interim Director Ben Saunders (who was seconded as Director from Brook House and later returned in 2016) *'felt the key to the problems lie in organisational culture'.* At Paragraph 2.16, Peter Neden, President of G4S UK and Ireland, who later gave evidence to the Home Affairs Select Committee on Brook House, also commented that "*there was a need to encourage a change of culture, and for people to be able to openly raise their concerns".* There does not, however, seem to be to be any reflection on their own responsibility for the organisational culture.

61. One of the Recommendations of the report is "*The Improvement Plan should include G4S' analysis of what went wrong with organisational culture at Medway to enable*

[17] See paragraphs 3.64 – 3.69 of the Medway Improvement Board report – (INQ000010)

staff to feel they could act as they did towards children and how they propose to address this". That recommendation was published in 2016. I am unaware of whether G4S did any such analysis or undertook any comparison of the culture at Brook House with that seen in Medway STC. This would have been particularly important where the Board felt *'their concerns about the leadership values goes higher into G4S leadership'* (paragraph 2.33). In my view this should be the starting point for this Inquiry if lessons are really to be leant and real change brought about.

Gatwick IRCs

Background and Layout

62. Gatwick IRCs cover Tinsley House IRC and Brook House IRC, albeit they are separate contracts for the running of each.

63. Opening in 1996, Tinsley House was the first purpose-built IRC, replacing the use of the 'Beehive' in Gatwick for the accommodation of detainees in the airport terminal of Gatwick Airport. It was built to provide 150 additional detention places which allowed the Government to reduce the use of more expensive, less suitable, alternative accommodation including prisons. It was built to a high specification providing accommodation for male and female detainees and five families within zoned and separate residential accommodation.

64. The design of Tinsley House had not changed by the time I arrived from its inception, with the building being a hollow square on two levels with an open space in the middle for recreation and also to the rear a sports hall and hard surfaced recreation ground. Accommodation was in dormitory style rooms. The corridors were separated but allowed detainees to associate on each side of the square and have access to toilets and bathrooms which were separate to the bedrooms. Detainees were not locked in their rooms and there were only two rooms in the entire centre which had cell doors on, all the rest being standard wooden doors.

65. Following a significant expansion of the immigration detention estate from 250 places in 1993 to 2,644 in 2005; Brook House IRC opened in 2009 adding another 426 spaces to the estate bringing the total to 3,070[18]. Brook House was a new style IRC[19] based on prison designs developed in the 1980s and 90s built to category B security specifications. The wings were connected by corridors and were set over three floors with balcony-style landings overlooking suicide netting. The cells had internal, seat-less toilets and thick prison doors which did not have handles on the inside so, once shut (even during association hours), they could not be opened from the inside. Detainees would be locked in their cells for 11 hours overnight with poor ventilation attributable largely to sealed and barred windows which only added to the prison-like feel.

66. The 1990 Woolf Inquiry, which followed a series of prison riots, made clear the importance of the nature and fabric of prison facilities. The Report that followed found that "*[t]he physical state of a prison can significantly affect the atmosphere for both prisoners and staff*"[20] His set of principles for improving the physical buildings and prison estate included: (a) only holding prisoners in units of 50-70 with the prison itself holding no more than 400 prisoners; (b) the need to balance security with the 'avoidance of an over-oppressive atmosphere'; (c) a prisoner being entitled, if they wished, to a single cell; (d) adequate provisions for the requirements of staff; and (e) access to sanitation with standards of hygiene matching those in the community. Lord Woolf also commented that "*[o]vercrowding is the single factor that has dominated prisoners' lives, placed intolerable pressures on staff, and diverted attention away from improving the system*"[21]

Brook House Design and Contract

[18] https://righttoremain.org.uk/wp-content/uploads/2018/09/DetentionHistory.pdf **DL0000164**
[19] See for example Colnbrook IRC, built in 2004, and the concerns of the HMCIP at pages 5-6 of their 2019 report on the prison-like design - https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/04/Colnbrook-web-2018.pdf **DL0000165**
[20] http://www.prisonreformtrust.org.uk/portals/0/documents/woolf%20report.pdf – pg.17 **DL0000166**
[21] *Ibid* pg.17 and 18

67. It is my view that part of the foundation that made Brook House such a toxic and dysfunctional centre, and which ultimately allowed the human rights abuses exposed by the Panorama documentary to occur, can be found in its physical design and the terms of the contract agreed for how the regime was to be run. I will focus on three main flaws that are traced to Brook House's conception: (1) a centre designed to hold detainees for 72 hours; (2) a centre designed as a category B prison; and; (3) a contract driven by profit and cost-savings over detainee and staff welfare.

72 Hour Centre

68. When the Brook House IRC contract came out to tender, Tinsley House IRC, along with Dungavel IRC in Scotland, was already run by GSL, formerly part of G4S. G4S was sold in 2004, but was re-acquired in May 2008 after GSL successfully submitted a bid to run Brook House in 2007. Therefore, whilst GSL won the bid for Brook House, G4S ran the centre when it opened.

69. The bid submitted to run Brook House by GSL, and the proposals for how it would be operated, was prepared on the basis that it would only hold detainees for 72 hours.[22]

70. The contract also reflects the intention to use Brook House as a short term detention facility at 3.1 of Schedule D, which states that the throughput would be at least 2,500 HOM000798 detainees per month. The operating capacity for the centre at the beginning was 426 bed spaces. It is simply impossible to be able to accept and process 2,500 detainees a month with 426 bed spaces without only holding each detainee for a few days.

71. A '360 Degree Contract Review' produced by Ben Saunders in 24 June 2014 (CJS000768), as an internal G4S review of the contract, acknowledged when assessing the risks of the contract that there was a contractual requirement of a 2,500 detainee

[22] The HMCIP report of Brook House IRC, dated 15-19 March 2010, states on page 7, *"Brook House opened in March 2009 and is a purpose built immigration removal centre with a prison design. The centre was designed to hold detainees for no more than 72 hours".* DL0000167

throughput but that "*this has never been required and would be particularly onerous.*" He then noted that "*The current throughput is typically 1200-1400 per month and been at this rate for over a year, before which time it was lower*". As such he was able to confidently say: *"There is no particular residual risk from the bid. There is no material risk due to onerous contact clauses".*

72. This low throughput was far cheaper for G4S than having a high turnover of detainees. The cost for providing clothing, bedding, phones etc. was lower because there were fewer detainees in total, and less staff resources were needed to process people arriving at and leaving the centre. There was little incentive from G4S' perspective to hold them to the intended 72 hours turn around.

73. The IRC was, therefore, clearly not designed for those facing longer periods of detention as it developed into in practice. In my view, this played a significant role in the regime, activities and welfare provision proposed by G4S which would inevitably be stricter and more basic when an individual was expected to only by there for 72 hours before departing the UK. It clearly also played a role in the specification and design of the building which in my experience is not conducive to humanely detaining individuals for any significant period.[23] From my perspective, it was the failure of the Home Office to deliver their end of the deal, i.e. by only using Brook House as a 72-hour centre (for which they designed it) – or by at least updating the procurement proposals when it became clear the centre would be used beyond 72 hours, that contributed to the issues that developed.

74. Lee Hanford – who was interim Director between February 2016 and July 2016 (whilst Ben Saunders was seconded back to Medway) and then again after Ben left post-Panorama in September 2017 – confirmed to Kate Lampard and Ed Marsden in his interview for the Verita report into Brook House [VER000266] the 72 hour intention behind the design of the centre and the impact that it ultimately had upon the regime

[23] This was a point also raised by Kate Lampard in her 2018 review for G4S in which she found *"the environment was unsuitable for holding detainees for more than a few weeks"* [1.50] – a quite generous finding in reality CJS005923

and the experience for detainees at Brook House: *"[Lee Hanford – 44] I've raised this myself with the Home Office, they will get a better regime in a prison, because a prisoner will have the activity, the workshops, much fuller education facilities, a much better curriculum, really, because this is aimed at short detention. The design of the building was all about short detention. [Ed Marsden – 45] Yes, three days. [Lee Hanford – 46] Yes... The design doesn't allow for the length of stay that people are staying here for, I think that's the summary – if they were short term, it wouldn't create an issue. [Ed Marsden -47] Which is what its original purpose was. [Lee Hanford]. What the original design was for, yes."*

75. A key question for the Home Office, is: 'What was the plan for getting a 72 hour turnaround for removals on point of entry at Brook House, when history tells us that it often takes far longer than 72 hours to enforce removal from detention?' One can only assume that the plan was to develop Brook House IRC as the final part of an immigration removal journey, where people would only be detained when all obstacles had been resolved and removal was already arranged to take place and/or for detainees to spend longer periods in other centres, and only be transferred to Brook House for the final few days before the arranged removal would take place. If either had been operated effectively, there would have been a steady flow through of people. Instead, the flaws in the system led to people being detained or transferred when they could not be removed within 72 hours and people spending much longer periods of time in accommodation that was unsuitable. I believe the responsibility for this therefore lies squarely with the Home Office.

76. On a basic level, the failure to meet the policy objective of only detaining as a last resort, at the end of the process and to ensure that removal actions was taken appropriately and efficiently, led to many people being detained in Brook House for prolonged periods of time in unsuitable accommodation, with mental health suffering as a result. I was aware of many being detained when they are 'non-removable' for legal or practical reasons, many for weeks, some for many months and even for over

two years.[24] Throughout my time working in IRCs, I witnessed patterns of desperation and frustration from detainees held for these longer periods which led to pressure being placed on the IRC and tensions arising among staff. The desperation was visible in the deterioration of mental health among detainees and incidents of self-harm, staff assaults, fights between detainees and attempted suicides that I witnessed.

Category B Prison Design

77. Brook House IRC was designed to the specification of a category B prison[25].

78. The Ministry of Justice's *Security Categorisation Policy Framework* for prisons, states at paragraph 1.2, that security categorisation is *"a risk management process, the purpose of which is to ensure that those sentenced to custody are assigned the* ***lowest security category*** *appropriate to managing their risk"* [emphasis added].[26]

79. The policy goes onto state that Category B includes, *'offenders whose assessed risks require that they are held in the closed estate and who need security measures additional to those in a standard closed prison."*

80. In my opinion, the development of Brook House to the specification of a category B prison, led in practice to an experience for detainees and staff that is inconsistent with Rule 3 and Rule 39 of the Detention Centre Rules 2001 and the need for a relaxed and humane regime. It was nothing like that in reality. Whilst the policy was clearly that

[24] For example when I was working for the year 2013, according the Home Office's detention statistics, of the 30,036 people who left the detention estate only 16,926 were removed from the UK. The rest were granted leave to enter/remain, or granted temporary admission or bail or other form of release. The same statistics show that for quarter 4 of 2013, there 13 individuals held in the detention estate for 2-3 years and 3 held for 3-4 years - https://www.gov.uk/government/statistics/immigration-statistics-october-to-december-2013/immigration-statistics-october-to-december-2013#detention-1 **DL0000168**

[25] Page 5 of the HMCIP report of Brook House IRC, dated 15-19 March 2010 confirms, *"Brook House had been built to typical category B prison standards and was noisy and austere"*. Page 23, at paragraph 2.2 also states that, *"there were four residential wings A, B, C and D, each consisting of three landings designed to category B prison specifications"*. **DL0000167**

[26] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1011502/security-categorisation-pf.pdf **DL0000169**

you should have the least security to meet the risk, I witnessed many individuals being detained who were not offenders or a 'risk' at all, and many of those who were, had in fact come from lower category prisons.

81. The effect of this was twofold. Firstly, people were detained under conditions designed for a higher security than required for the majority of people. Secondly, it creates a heightened perception of 'risk' or threat. This drives the behaviour of: (a) detainees, who are frustrated and distressed by the 'security' environment in which they find themselves and (b) staff, perceiving detainees to be a higher threat than they are. Both the detainees and the staff tended to experience this as denigrating and dehumanising.

82. My experience reflects the consistent concerns of Her Majesty Chief Inspector of Prisons (HMCIP) about the prison-like environment and regime with its disproportionate restrictions on freedom and association[27]. I also agree with Stephen Shaw's assessment in his 2018 review of the immigration detention estate of the more secure prison-like IRCs of Brook House, Colnbrook and Harmondsworth that *"overcrowded, cell-like rooms with prison doors had the unacceptable feature of in-room toilets separated only by a curtain"* which he found "*troubling that such an arrangement was deemed acceptable when these institutions were designed and commissioned just a decade or so ago."* Stephen Shaw found overcrowded cell at Brook House with the introduction of three-man cell noting "*I did not find conditions in those rooms remotely acceptable or decent"*[28]something I agree with and raised concerns about, as discussed below.

Profit and Cost-Savings Driven

The Tendering process and the G4S BID

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[27] See **Annex 4** for a summary of findings from the various HCMIP reports on Brook House **DL0000140**

[28] Stephen Shaw, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons', dated July 2018 at 2.75-2.77 - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728376/Shaw_report_2018_Final_web_accessible.pdf . See also A7.4-A7.12 **HOM032600**

83. I have seen the documents **(Annex 5 and 6)** relating to the bid process for Brook House DL0000140 which confirms my experience of how it was set up to put costs saving for the Home Office and profit for G4S above the rights, welfare and dignity of those detained. It appears that GSL won the bid because they offered the cheapest bid. I have direct knowledge of the consequences of these contractual arrangements, cost savings and profit first approach.

84. The documents show that the Home Office selected GSL (later acquired by G4S) as they offered a bid that came in 35% below what the Home Office had budgeted for[29]. The Home Office's evaluation of the bids was weighted and split so that 50% would be based on the commercial proposals and 50% based on the quality of the bid (split into operational delivery at 25%, staff at 15% and maintenance at 10%). This weighting of the bid was how GSL won the contract. It seems having significantly the cheapest bid made up for the poor quality of their proposals to run the centre.

85. The Home Office was therefore proceeding from the outset knowing that GSL would be providing a service at 35% under what they had budgeted for. Although it is of course sound and prudent for a government body to seek value for money in procuring contracts when spending public funds, this is still a dramatic cost saving on their budget and led to what I experienced first and foremost that Brook House was under-resourced, under-staffed and with limited provision for detainees. This is confirmed in the evaluation of the bid by the Home Office itself, as I go on to explain.

86. The Home Office went into the Brook House contract with their eyes wide open about the poor quality of GSL provisions and the potential effects this could have on detainees including for their safety and welfare. I have had sight of the Home Office's internal evaluation of contractor proposals for Schedule D of Brook House, which my solicitors have provided to the Inquiry[30]. The regime proposed by GSL with a lengthy

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[29] See Annex 5 - Home Office's presentation of 7 December 2007, 'Brook House operating Contract Commercial Evaluation'. DL0000140

[30] See Annex 6 DL0000140

lockdown time was recognised by senior Home Office civil servants John Thomson[31], Phil Schoenenberger[32] and Marina Enwright[33] as a "*desperate attempt to reduce costs at the expense of welfare*"; as *"excessive and not in keeping with the ethos of the rest of the estate: 21 hrs -08hrs…the proposals give no justification for such a lengthy period of non-association"* and were "*rather harsh*". GSL proposals for activities during association were also described as *"extremely poor, there was no programme, the incentive scheme lacked imagination…"*

87. The Home Office had significant concerns about staffing levels, noting that *"We are seriously concerned at the GSL proposal to reduce DCO levels at 2100hrs through to 0800hrs which has clearly been done in order to accommodate the lock down hours which are at the same time. The Centre, after 2100hrs, will be staffed by [redacted] DCO trained officers and this includes [redacted] duty managers. We do not consider this to be an adequate number of staff as the Centre is still likely to be receiving detainees into the early hours of the morning and discharging a good number of detainees throughout the night. Their ability to address standard operational functions such as constant watches and RFA/TC has not been addressed during the night hours."* GSL's staffing levels overnight were deemed to "*border on the unsafe*". The Home Office described the proposals by GSL (and others that had provided similar bids) as follows: *"An ethos of cutting corners and meeting basic standards was evident from much of what we read and we are especially disappointed at the extended lock down hours proposed by these four of bidders. This appears to be a desperate attempt to reduce cost at the expense of welfare."*

88. The Home Office's concerns about GSL's bid are self-evidently stark but were not enough to dissuade them from agreeing the contract given the extremely low cost of the bid and it is clear the bid was won on the basis of 50% of the evaluation being based on commercial interests. It is all the more concerning that the Home Office's

[31] Mr Thompson went on to be Operational Head of Migration Policy in 2015.
[32] At the time of the BID Mr Shoenenberger was Head of DEPMU and the author of the documents. He later became Assistant Director of Detention Services until approximately 2018.
[33] Ms Enwright continues to work in Detention Operations

concerns about the bid all came to pass with the HMCIP from 2010 repeatedly criticising the unsafe, harsh regime and poor conditions[34]. These same basic problems were evident when I was working there in 2011-2014 to a greater or lessor extent, and were the same concerns repeated by HMCIP in 2016[35], Stephen Shaw in his reports in 2016[36] and 2018[37] and by Kate Lampard in 2018[38]. Lampard documented significant concerns about the dangerously low staffing levels and inadequate activity provision in breach of Rule 17 DCR 2001[39]. This led her [40]to conclude that the physical constraints, lack of facilities and environment made it *"unsuitable to hold the number of detainees is does"* and *"unsuitable to hold any detainee for more than a few weeks"*[41].

89. In my opinion, the Home Office should be held to its design specification of 72 hours, and any period beyond that would require fundamental changes to the layout, regime and staffing levels to ameliorate the impact of the harsh environment. In reality, where detainees ended up being held for much longer at Brook House, concerns over the regime, conditions, activities and staffing levels become much more profound. These factors laid the groundwork for the serious problems that developed and became endemic to Brook House.

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[34] *Full Announced Inspection of Brook House IRC by Her Majesty's Chief Inspector of Prisons ('HMCIP') (15-19 March 2010) (Published 12 July 2010) following a 5-day inspection* – see e.g. paras 2.7, 2.20, 2.27, 2.30, 6.5 and 6.29 **DL0000167**
Unannounced Inspection of Brook House IRC by HMCIP (12-23 September 2011) (Published 31 January 2012) – see e.g. paras HE.25, 6.3 **DL0000171**
Unannounced Inspection of Brook House IRC by HMCIP (28 May – 7 June 2013) (Published 1 October 2013) – see e.g. paras 1.55, 2.3, 3.9 **DL0000173**
The Unannounced Inspection of Brook House IRC by Her Majesty's Chief Inspector of Prisons ('HMCIP') (31 October–11 November 2016) (Published 10 March 2017) – see e.g. paras 1.40, 1.41, 1.46, 2.1-2.2, 2.65, 5.2, 5.22-5.23 **CJS000761**

[35] Ibid *The Unannounced Inspection of Brook House IRC by Her Majesty's Chief Inspector of Prisons ('HMCIP') (31 October–11 November 2016) (Published 10 March 2017)* **CJS000761**

[36] Stephen Shaw, 'Review into the Welfare in Detention of Vulnerable Persons', January 2016 – see para 2.7 where Brook House is described as being 'constructed to category B prison standards', 'somewhat claustrophobic' and 'feel and look of contemporary gaols'. See also pars 3.3, 3.5 and 3.16 **INQ000060**

[37] Stephen Shaw, 'Assessment of government progress in implementing the report on the welfare in detention of vulnerable persons', dated July 2018 at 2.75-2.77 . See also A7.4-A7.12 **HOM032600**

[38] Prepared by consultancy firm Verita, entitled: *Independent investigation into concerns about Brook House immigration removal centre* (4 December 2018) – see para 1.26 on staffing, and 1.56 on activity provisions **CJS005923**

[39] Ibid – see para 1.56

[40] Ibid 1.26, 1.32, 1.34, 8.3-8.4., 8.29, 8.44. and 8.71 above

[41] Ibid at paras 1.57 and 15.3

Cost-Cutting/Profit Making

90. The contract was also set up to encourage GSL and later G4S to cost-cut further and to share any savings with the Home Office. Schedule S of the contract explicitly compels the contractor to look for cost savings and report them immediately to the Home Office. Therefore, if profit went above the original contracted price, G4S should declare that not as extra profit, but as a cost saving to the authority.

91. This initiative engendered cost-savings that was at the expense of detainees. For example, I remember attending a Senior Management Team meeting on 11 March 2013 where Ben Saunders confirmed plans to try to differentiate between those who would be residing in Brook House on a more long-term basis and those who were arriving at the IRC to be removed on a charter flight. They wanted to propose issuing bed and cutlery packs etc. only to the former and not the latter group to produce cost savings. This is one simple example of how these cost savings measures could be implemented at the cost of basic human decency and providing basic provisions such as bedding.

92. G4S became very efficient at saving costs on a contract they had already won on the basis they were significantly under budget. In the '360 Degree Contract Review', produced by Ben Saunders in 24 June 2014, and disclosed to core participants (CJS000768), Ben Saunders noted how G4S were able to secure a contract extension to May 2017 based on "*offering clustering and efficiency savings to the customer (Brook House Efficiency Savings £246k p,a, Clustering Savings £61k p.a), (Overall £800k pa savings from Brook House, Tinsley House and Cedars) This amounts to £1.5m savings at Brook House and £4m across Gatwick over 5 years.*" What this means in practice was that G4S were able to offer clustering savings by re-structuring staffing across Brook House, Tinsley and Cedars which reduced the total number of staffing roles (such as family suite officers, a facilities officer and security) and

changed responsibilities of certain staff and their roles. It was part of this re-structuring that changed my role from Head of Children's' Services to Head of Tinsley House.

93. In addition, they introduced a key vend, an automated fingerprint system to release keys, meaning staff members were no longer required to perform the role of handing out keys. This led to a reduction in staff and the number of Assistant Custody Officers by four. It was clear that the Home Office valued G4S' ability to save costs for both the Home Office and themselves and it led to them extending the contract on this basis, despite many criticisms from the HMIP (and elsewhere) on regime and conditions. These cost savings ultimately allowed G4S to gain margins and profit beyond that allowed in the contract, which I discuss further below. Any such proposals or changes that were made to the contract would have to be approved by Jerry Petherick and possibly others above him.

94. I also witnessed improper recording of information in relation to cost savings. For example, in around 2011-2012 I received an email, which I do not have access to now, from a G4S accountant with the asset list for Cedars' pre-departure list, asking me to highlight items that were charged to the Home Office but that we would never actually buy in the end. I ignored the request.

Expansion of Capacity

95. One of the main efficiency savings and profit-increasing measures that was agreed during my employment was the expansion of the capacity of Brook House. First, this was the introduction of an additional 22 bed spaces whilst I was still there in March 2013, taking the detention capacity up to 448 spaces. The G4S 360 contract review confirms at page 24 that this led to an increase in revenue of £482,000 per annum and £28,000 profit per annum. This was made despite the obvious pressures and demands on the staff from the existing population and the inadequate staff ratios.

96. Whilst I was still there, plans also started to be made to increase bed space by an additional 60 beds by introducing a third bed in 60 of the cells. As I set out below, I

had already raised serious concerns about the cell sizes, the impact on detainees' mental health and whether they met international standards. Stephen Shaw equally raised concerns about the introduction of three-man cells in his 2016 report after visiting Brook House in May 2015,[42] and set out his disappointment in his 2018 report that it went ahead, stating *"I did not find the conditions in those rooms remotely acceptable or decent"*.[43] The introduction of these additional 60 bed spaces via three-man cells, at the clear expense of detainee welfare, ultimately went ahead in 2015/16 because it was a cost-effective way for the Home Office to advance their overriding aims of increasing the detention estate and removals which also allowed G4S to increase their profit. Ben Saunders confirms at page 24 of the 360 Degree Review that it was estimated that the introduction of these additional 60 bed would overall increase revenue by £1.5million per year with a profit margin of £91,000 per year. **CJS000798**

97. In addition, Lee Hanford confirmed to Kate Lampard in his interview for her report [VER000266] that the 60 new beds were a cost saving exercise by the Home Office to the detention estate: *"[Lee Hanford -24]: It was around that same time where government were trying to get more for less. It's all post the 2012 drive from where we've seen a lot of prison closures, and increased population across prisons. I think as another government agency they explored similar solutions. [Kate Lampard – 25]: Austerity. [Lee Hanford- 26] Austerity."*

98. I find it difficult to understand how Jerry Petherick (and anyone else responsible for the decision in G4S and the Home Office) could have given approval for the addition of the 60 beds at Brook House. In my view it was negligent and reckless to do so. It was done without regard for the impact on detainees and I understand no equality impact assessment was undertaken.[44]

Profit Margin

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[42] See para 3.5 **INQ000060**
[43] Para 2.75 **INQ000060**
[44] *R (Hussein and Rahman) v SSHD and G4S* [2018] EWHC 213. **DL0000174**

99. The profit margin under the contract was meant to be 6.38%. In the 360 Degree Review of 2014, Ben Saunders confirmed the contract margin to be 6.38% but boasted that the 'actual' contract margin was 18%, achieved having *"restructured our staffing, introduced clustering and efficiency savings such as key vend, introduced over 100 Notices of Changes since bidding the contract and added a further 22 beds to change from 426 to 448 beds at this current time"*. CJS000798

Contractual Penalties and Priorities

100. Penalty points and fines were contained in the contract. I was always very struck by the system devised for penalising breaches of the contract, and the perversity of the priorities it set. A single penalty point at Brook House equated to £1.36 compared to £0.65p at Tinsley House. Schedule G set out the performance evaluation and the HOM000921 circumstances that measures would be applied within the contract. At Brook House, a failure to admit or release a detainee resulted in 500 penalty points (£680), a substantiated serious complaint 300 points (£408) and not submitting an incident report was 100 points (£136). There were no penalty points for abuse of detainees, something the National Audit Office pointed out in their 2019 report when they deemed the contract "not fit for purpose"[45]. There were, however, points for self-harm resulting in injury and requiring healthcare intervention but only where there was a failure to follow laid down procedures for the safety of detainees as set out in Schedule D. This carried a penalty of 400 points (£544) although I am unaware of points ever being awarded under this section of the contract even though self-harm requiring healthcare intervention was a frequent occurrence at Brook House.

101. My solicitors have provided me with Home Office Freedom of Information responses (ref: 39339 and 55266) **which I enclose as Annex 7.** This confirms the DL0000140 number of self-harm incidents at Brook House requiring medical treatment for each

[45] See National Audit Office, *The Home Office's management of its contract with G4S to run Brook House Immigration Removal Centre,* July 2019 at paragraph 27: https://www.nao.org.uk/wp-content/uploads/2019/07/The-Home-Offices-management-of-its-contract-with-G4S-to-run-Brook-House-immigration-removal-centre.pdf DL0000175

year from 2010-2017 and also accords with my understanding of the incidence of self-harm, although the figures may be under reported. Figures range from 39 in 2010 to 84 in 2014 and 54 in 2017. At least for the time I worked at Gatwick IRCs, I was unaware of G4S being fined for any such self-harm incident.

102. Another point that I think is significant, is that the penalty points in Schedule G fixed a fine of £30,000 for an escape, versus £10,000 if a detainee died. This just shows the relative worth of welfare over security and how little the lives of the detainees were valued, against the imperatives of removal and how the incentives/profit costs were weighted against protecting life and welfare. HOM000921

103. This raises clear questions about the priorities and suitability of these contractual arrangements and the ability of the laid down procedures to ensure safety and welfare of detainees. The contract as a whole makes clear the Home Office's own priorities, the message it sends to the IRCs about those priorities, as well as the limited consequences for serious failings and conduct for failures to protect detainees.

104. It is notable that this similar issue was picked up in the Medway Improvement Board's Report in relation to Medway STC, run by G4S, which states at paragraph 5.9 (INQ000010), *'that penalties imposed by the YJB for not complying with all terms of the contract can be quite severe and, quite similarly, do not necessarily support a vision of a nurturing and rehabilitative environment'* At 5.10, *'the Board feels that the terms of the contract mean the contractor is penalised for incidents that do not necessarily improve safeguarding or rehabilitation and that avoiding contractual penalties has become more important than considering what purpose the provisions behind the penalty serves for the young people'.*

Conditions and Regime

105. From my experience, the conditions and regime of Brook House presents an important context to which the abuse exposed in Panorama occurred. As I have said, Brook House was from the outset, designed to Category B prison specifications and to

hold people for up to 72 hours; meaning the facilities and design was not conducive to ensuring the welfare of detainees for extended periods of detention.

106. At Brook House, there were three hard courtyards, a few snooker tables, a small gym, a library and a computer room. The facilities were not sufficient for the population, which often led to tensions e.g. over who was using the snooker table. As a result of the limited activities, detainees did not have many options to busy themselves and avoid thinking about their trauma and distress. I agree with the finding of para 1.56 of the 2018 Lampard Report[46], which states *"activities available to detainees at Brook House do not meet the standard prescribed by rule 17(1) of the Detention Centre Rule 2001. The lack of activities and opportunities for exercise present a risk to detainees' welfare and wellbeing and to the general safety and security of the centre"*. This was my own experience.

107. The only other option for detainees to keep busy was paid work for £1 an hour, described by the HMIP as being mundane and not very worthwhile. The jobs offered were limited and very repetitive, and it is my view that paying detainees £1 for a job that could be paid minimum wage, reinforces the position that detainees are not equal to the staff or other human beings. It also allows the contractor to reduce its staffing costs if they do not need to employ as many permanent staff on contracts if detainees are doing the work.

108. When the detainees were not free to associate, they were locked in their cells from 9pm until 8am. There were also two roll-calls during the day. It was a system designed so that G4S could save costs by running a more skeleton staffing roster in the evening and morning hours and had little to do with welfare of detainees.

109. It was clear to me that locking detainees down into their cells for excessive and prolonged periods of time enforced the prison like environment and was damaging to

[46] Independent investigation into concerns about Brook House immigration removal centre, November 2018 by Kate Lampard and Ed Marsden CJS005923

mental health. The evening lock-in was always a pinch point of the operational day and from my experience people were generally distressed at the fact they had to face another night behind a locked door. On many occasions, we were not able to get detainees into their cells by 9pm. People understandably did not want to go behind the doors so early and for a prolonged period of time. I witnessed use of force and physical restraint during the locking-down of detainees to force them back into their cells, as if staff were herding animals. Negotiation strategies should have been employed and not physical force and restraint.

110. I raised concerns around the cell size, cleanliness and ventilation not meeting the required standards. The cramped cells with lack of adequate ventilation and detainees being locked in throughout the night with the smell of the toilet and potentially the TV being played all night, created tension and had a real effect on detainees' mental health. I recall a number of complaints from detainees where their cellmate would watch pornography throughout the night and they would be subjected to viewing this despite their objection. Detainees would present as distressed and disturbed by being locked in these conditions. I can also recall many staff members complaining about morning unlock, when they entered detainee cells, because of the smell that resulted from locking detainees in all night, where they would be permitted to smoke, where there was an open toilet and where the cell lacked adequate ventilation.

111. I raised the issue of ventilation and cell size with Ben Saunders and Mike Bird, the Head of Facilities, in a meeting around the end of 2013 / start of 2014, around the time they were considering three-man cells. My view was that to put three men in these cells would breach the international standard. I thought that the cells were already too stuffy and to add in a third person would only make the situation intolerable. I emailed Ben Saunders the international standards on cell size. Ultimately a decision was taken to implement the three-man cells after I resigned. The decision was clearly driven by the Home Office's enforcement imperatives and profit at the expense of welfare.

112. These concerns are supported by Lee Hanford's interview with Kate Lampard. When asked if ventilation was a problem by introducing an additional 60 spaces via three-man rooms, he commented that: "[32] *I think the ventilation has always been quite an issue here anyway, because if you compare the windows here to a prison window, there is no triple vent, it's just forced air, but that's the design of the building... [34] Here they are completely sealed because we're so near the airport, whereas in the prison window you have that triple ventilation, so even though you can't open the window, you can actually create the ventilation window... [38] we didn't design this, it was a Home Office design, but once you check back to understand why these windows are different, it was all about the sound"* [VER000266_0004-0005].

113. Where I had more operational control at Tinsley House, I made a number of changes to the environment and conditions, as I felt it was important to managing culture and behaviour. These included painting the corridors softer colours, providing stations that served unlimited tea and coffee, changing bedding from blankets to duvets, putting new carpets in the bedrooms, adding books in the corridors, putting leather chairs in the reception and throughout the IRC instead of plastic, re-designing the brochure, introducing signage and directions, providing a notice board for each commonly spoken language, increasing textbooks on immigration law, having spare fax machines, and providing flip flops. Whilst seemingly small, these were environmental changes that I believe had some impact upon the emotional environment. I focused on ensuring that trigger points could be 'softened' – e.g. where an individual would come into reception, I tried to lessen the emotional response by providing a soft chair and a drink. I believe this ultimately led to less distress. I tried to encourage these sort of changes at Brook House and did some limited work regarding improving the environment but it was not sustained. I put signage around the centre to make it easier detainees to navigate their way around and I also put vinyl transfer on to the walls of the CSU to try soften the environment, but it remained fundamentally a harsh prison like environment.

<u>Staffing Levels</u>

114. There was a major issue of under-staffing at Brook House; an issue which I believe directly links to the culture and abuse of detainees. It is more likely that the ethos and operation of Brook House would have been more resilient if the contract was being run properly and there were adequate staff. People would not be so tired, stressed and overworked from doing overtime[47]. There would also be a better quality of environment that would lead to increased safety for both staff and detainees. On a daily basis I would see staff would become shorter and less tolerant towards detainees as the day went on and tiredness levels increased.

115. It is clear from the bidding documents that understaffing was hardwired into the contract. It is important to note that under the contract, G4S would receive a fixed fee for staff salaries, however despite under-staffing, would still be paid the full amount each month for what should be the full staffing complement. The penalty points for not having staff in place did not equate to and was in fact, much less than the amount G4S were being paid under the contract for that staff. Over-time was paid at a flat rate by G4S, i.e. the rate for the given role. Given that paying people overtime would be cheaper than employing extra staff (e.g. recruitment and on-duty costs – uniform, holiday pay, benefits, pension contribution, training costs etc), this reduced the cost risk for understaffing, and increased profit. There was less commercial incentive to comply with the contractually required staffing levels. I recall staffing levels dropping specifically under Ben Saunders.

116. The Home Office monitored staffing levels by total hours completed by staff collectively over a 24 hour period. However in contrast Schedule D of the contract had HOM000798 a table which stipulated that staffing levels should have been measured by the number of staff members required to be on shift for each hour of the day. Abiding by the Schedule D table would have been much more preferable in ensuring sufficient staffing levels at all times of the day. For example it would have avoided allowing G4S to get away with being overstaffed during the day and understaffed overnight.

[47] This has parallels to the Woolf report, referenced at paragraph 66 DL0000166

Misrepresentation of Staffing levels

117. In my time working for G4S, I observed a number of practices that are indicative of the culture in G4S and the manipulation of information particularly in respect of staffing levels. This included reporting that people were operational when in fact they were not available to be operational, to avoid penalty points. So for example, officers who were on training days, and were therefore not operational, were commonly recorded as being operational within the IRCs, particularly towards the end of my time at Gatwick IRCs. I became aware of this because I shared an office with Michelle Brown who was responsible for ensuring staffing levels met the contractual levels.

118. I also recall people being recorded as working full time at Brook House when they were in fact at Tinsley House, which gave a false picture of who was working and avoided penalty points. For example, the Activities Manager, Ramon Giraldo-Albelaez, would regularly be recorded as being operational as an officer at Brook House when he was actually working at Tinsley House. I was aware of this because each morning I was at Brook House I would speak to Oscar 1 about the situation for the day and they would produce a staffing rota that was frequently and deliberately wrong. Debbie Weston was concerned about the staffing levels at Tinsley House so she asked if the system, 'Tracker', used for officers to access each centre and obtain keys and radio, recorded the numbers of staff at the centre at any given time – but was told wrongly that it did not.

Staff/Detainee Ratios

119. The adequacy of the staffing levels must also be considered in the context of the numbers of detainees and conditions of overcrowding. As above, the throughput was significantly lower than had been envisaged, detainees were staying longer, fewer removals were taking place, and the centre was overcrowded. Capacity was increased

from the design intent of 426 to 448 in 2013 and then in 2016 to 508 detainees and at the time of Panorama.

120. There was a particular issue with staffing levels at night, which was a critical time to have sufficient staff in place. I was aware of some evenings where there would only be six staff in total on a shift, which led to Tinsley House having to send staff to Brook House, leaving Tinsley House short as it was deemed 'lower risk', or where a member of staff had to be responsible for two wings. There needs to be sufficient staff on the night shift to deal with operational demands which could be anticipated. For example, there must be sufficient staff to cover all wings, for multiple constant watches, for ambulances to be called and sufficient escorts/bed watch staff in place, and for an influx of detainee arrivals.

121. The low numbers on night shift were particularly concerning given the number of Charter flights that took place outside of normal working hours and which put huge pressure on the IRC, as well as the amount of throughput Brook House would get overnight. Brook House was described by Ben Saunders in his 2014 '360 Contract Review' as "*the main centre used to manage the discharge of charters, which is a high profile and high cost operation for the Authority [the Home Office].*" CJS000798

122. G4S agreed a 'night state' regime from the outset with the Home Office that would allow them to have a low number of staff overnight because detainees would be locked in their cells. As I set out above, the Home Office had significant concerns during the procurement process that G4S' overnight staffing proposals "*border on the unsafe*" and this assessment proved to be correct. DL0000140

G4S Staff and Management Culture

123. I believe addressing the culture of Brook House staff and management is critical and intrinsic to the other topics I cover below, including the use of force, segregation and treatment of vulnerable detainees.

124. It is my opinion that most staff working in G4S while I was there were good people and there were examples of good practice amongst staff. However, even good staff were in a system and culture where it was difficult to hold and maintain professionalism, integrity, and humanity. We must not under-estimate the link between detainee well-being and staff well-being.

Impact of Trauma, Mental Distress and Self-Harm

125. I myself have been diagnosed with PTSD, anxiety disorder and insomnia from the trauma I witnessed and experienced working for G4S at Medway STC and then at Brook House. Following my resignation, I visited a psychiatrist Dr Gary Bell at Cognacity, who referred me to psychologist Dr Sarah Jane Khalid, who I then saw weekly for counselling. I exhibit a letter from Dr Bell to my GP dated 11 August 2016[48] confirming he would refer me to Dr Khalid, who subsequently diagnosed me with PTSD. I had not previously seen a psychiatrist until after I had left G4S. I have also since been prescribed Sensitive/Irrelevant.

126. I am an intelligent person with high level qualifications, and I can understand the dynamics and the wider social issues of secure training centres and immigration removal centres, but the impact of working in a centre like Brook House has a profound impact on all staff. The work was tiring, hard and stressful with long shifts and a challenging environment. There was no trauma training for staff and no ability to emotionally release. I observed a pattern of high levels of alcohol use among staff, evident from their conversation and social media posts. I also got the sense that certain staff members used drugs and I reported to Kent Police that even the Director Ben Saunders had suggested on one social occasion that they "go to London and do some lines" when he was Director of Gatwick IRCs[49]. The Deputy Director Duncan Partridge also failed a routine drug test at work, as mentioned in my exit interview, detailed below.

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[48] See Annex 3 DL0000140
[49] See Annex 2 DL0000140

127. Working at Brook or Tinsley House was emotionally very challenging as it required working with a group of individuals who have been separated from their families and homes in a traumatic way. Personal histories of torture, ill-treatment were common place and often exacerbated by detention. This, coupled with the administrative whirlwind of the Home Office and the fear of being returned to their country of origin, created further distress and anxiety. Staff faced this level of trauma from multiple individuals each day.

128. Witnessing acute anguish, self-harm and attempts of suicide is traumatic. Some of the memories I have from Gatwick IRCs will never leave me; such as seeing a man in protest having sewn his lips together, or another trying to suffocate himself by tying a bag around his neck. I saw multiple others cutting themselves or using ligatures. The countless times detainees would be crying and showing me the scars from torture whilst holding letters from the Home Office denying their torture claims is just as traumatic, particularly when you are largely powerless to help. Foreign National Offenders also presented with particular stressors where they may have felt they could be released having served their sentence; and/or may have found themselves in a harsher regime for a longer period of time than where they served their criminal sentence, and perhaps further from their families. This led to particular frustrations and anger amongst a potentially more challenging population and which exacerbated mental health problems which were also present in this group as any other, and sometime at the more severe end.

129. In Brook House, staff were dealing with extreme trauma every day in a stressful and combat-like environment, without the training, skills or capacity to deal with it. In my opinion, neither G4S nor the Home Office put anything effective in place for staff to understand or handle such trauma. There was insufficient resources and no clinical supervision or support for staff. Staff were doing their jobs in a centre not designed to hold as many individuals including many that were totally unsuitable for the environment, for long periods, with insufficient staffing numbers and a lack of care or support from their superiors.

Hostile Environment

130. On top of this, staff at Brook House also worked in the prison-like environment where ventilation, light and acoustics are poor, where there are few windows and with a brutal physical setting which was often excessively noisy and chaotic leading to alienation and stress. Against the backdrop of cultural and political hostility, this makes for an extremely pressurised working environment.

131. In my opinion, working for G4S in Brook House had parallels with working in a military environment. The language used is similar to that of a battlefield: including the 'us' vs 'them' mentality, and the environment had similar stressors. These included foreign culture and language, distance from family and friends, unreliable communication tools, unclear mission or changing mission (whether acting as a 'safeguarder' such as preventing a person from harming themselves or as an 'enforcer' to effect their removal – or sometimes doing these roles simultaneously), unclear norms or standards of behaviour, long periods of repetitive work, overall mission or purpose not understood as worthwhile or important, real risk of harm and long working hours.[50]

Long Hours

132. The traumatic environment and lack of support was further exacerbated by the long working hours. It was expected of staff to opt out of the 48 hour maximum weekly limit for Working Time Regulations (WTR) 1998 and in fact the rota was drafted in a way that it meant people needed to opt out if they worked there. Even those who did not opt out, I suspect many worked more hours than the WTR allowed.

133. Many staff became mentally unwell and periods of staff sickness was common. I remember there being a particular spike in sickness levels in late 2012 to early 2013.

[50] Whilst I was working at G4S, I compared the working environment to that set out in the book *Performance Under Stress* edited by Peter A. Hancock and James L. Szalma, and note that there are many similarities

This coincided with the arrival of Ben Saunders as Director. I remember attending a Senior Management Team meeting on 11 February 2013 where Ben Saunders asked managers to monitor the levels of sickness across the Gatwick IRCs as there were concerns about how high the numbers were. At the same meeting we discussed the results of a staff survey where the overall staff satisfaction for Brook House was 51% and Tinsley House was 52% reflecting the seriously low morale of staff and the stresses of the job exacerbated by under-staffing.

Low Staff Morale

134. In 2013, I was asked by Ben Saunders to instigate the investors in diversity scheme at Gatwick IRCs. This involved an internal stakeholder survey which was DL0000142 completed in or around April 2013, which represented a snapshot of the incidence of low staff morale, inflexibility of working hours and favouritism in Brook House. Some of the answers included:

a. In answer to the question "**I can give examples of new things[…]my organisation has introduced because of the diverse experience of people who work for them or with them"** someone wrote: *[Strongly disagree] Even if you have a skill and feel you could help the company on a whole it still wouldn't benefit you, you would just get used without even gratitude or praise*"

b. In answer to the question **"Do you currently have or have you previously had a longstanding physical or mental health condition or disability? If yes, please describe how this has been or is being dealt with and any support you have received or are receiving from your employer"** someone wrote: *DEPRESSION- NO SUPPORT AND IGNORED"*

c. In response to the question, '**In the last 12 months, do you feel that you have been treated differently compared to those you work with because of',** answers included: *"FOR THE PAST 2 YEARS AT BROOK HOUSE THERE HAS BEEN MORE MALE PROMOTED THAN FEMALE. {FACT} . FOR THE*

PAST 4 YEARS AT BROOK HOUSE THERE HAS ONLY BEEN 1 PERSON OF COLOUR PROMOTED {FACT} RECENTLY" and *"Favouritism"*

d. In response to the question **If you, or anyone you know within the organisation, have requested flexible working conditions, please describe the response received and what changes were made,** answers included: *"An officer who returned from maternity leave wanted to work hours that were more suited to her home life, this was refused"; "yes was told g4s do not do fexible* [sic]*time"; "isnt facilitated due to contract"; "NONE, THEY WERE ASKED TO DEMOTE OR LEAVE",;* and *"Very negative attitude to staff requests, including time for compassionate reasons"*

Institutional Culture

Culture of Dehumanisation and Othering

135. As I have stated above, I believe there were examples of good practice by staff. There were events where people put themselves at risk of harm to protect life and to prevent harm to others, whilst having to struggle with the traumatic and harsh working environment they found themselves at Brook house. But at the same time, none of this provides an excuse for mistreatment and I believe this was a context and environment in which abuse was always likely to and indeed enabled to occur. In my opinion, the Home Office and G4S are just as culpable for the abuse that took place and the environment that presented itself at Brook House as the individuals who perpetrated specific acts of abuse.

136. So why was it that this environment created people who I originally believed were intrinsically good people to do bad things? I believe that the working environment I explained above and vicarious trauma led to staff dehumanising and detaching from detainees in order to cope with their jobs. A common way that I observed staff dealing with this, was through attitudes and behaviours, which reflected detainees being seen

as having less intrinsic value. I saw this myself first hand and it is clearly evident in Panorama, where needs of detainees were not seen as significant particularly when they were in pain or distress.

137. The dehumanisation of detainees was perpetuated by language of 'othering' which was fed down through Home Office hostile policies to the IRC. Individuals were referred to as 'detainees' rather than 'residents'; and the 'rooms' looked like and were called 'cells' by staff. This dehumanised prison-style language could also be seen in the phrases used for the night state ("bang up" and "lock down") and removal from association (being sent to "the block"). During Charter Flights, staff would refer to individuals as being 'loaded' onto flights, as if they were cargo. This dehumanisation of detainees which was present when I was employed there is seen so often and repeatedly in the Panorama footage (both in the documentary, the wider unused footage and the transcripts) and in such graphic terms that there can be no other conclusion that the language used by staff and the disgraceful treatment of detainees can be nothing other than standard and accepted practice.

138. I have seen a summary (see **Annex 8**) of the violent, threating and abusive DL0000140 language as well as the taunting and callous indifference to the suffering of detainees which was apparently routinely used by staff in 2017 and which went unchallenged by other officers present, who treat it as an acceptable and mundane occurrence. Whilst I myself did not witness the frequency and extremes of abusive language directed personally at detainees now documented, swearing was not uncommon and was part of the hostile '*us and them*' attitude to detainees. I was well aware of the poor culture as were all other senior managers. I raised it myself during numerous discussions with other senior managers and during my resignation meeting, and I am not surprised by it. I see it as a product of the environment and institutional culture within which Brook House operated.

Us and Them

139. The *'us and them'* mentality and language was an aspect of this culture which contributes to the abusive treatment. It created a rigid divide and separation and it desensitised staff to the suffering of those on the other side.

140. The dehumanisation was also evident in the physical separation of staff and detainees, and contributed to the *'us and them'* mentality. Informally there were staff and detainee spaces, which were delineated either physically or psychologically. Staff areas included the wing office, behind counters or cell doors, and by doors to the wing. The rest of the wings, especially the landings, would be 'detainee areas' where staff would rarely walk. This kind of separation is seen in the Panorama documentary, where staff engage with detainees through a flap on their door, or through a screen, which seems more like voyeurism than clinical observations or care.

141. I believe the design of the centre and the processing of detainees in a functional way also contributed to their dehumanisation. The physical layout of Brook House is plain and designed around the task of processing individuals. When placed in this setting from the outset, detainees are depersonalised; they are provided an identity number, have their personal belongings removed and given generic, institutional clothing (if they do not have their own) and bedding. Staff interact with detainees often using their identity cards to get information required, which dissuades human interaction. Care is formalised and staff only see detainees during 'wing office opening hours'. This subtly reinforced the idea that staff did not care as people, and only as a function. Only in that context can you understand how the staff could treat detainees, not only in such a manner that was seen at its most extreme in the Panorama documentary, but also in the more repeated mundane day-to-day regime - disrespect was hard wired in.

142. This dehumanisation of detainees was exacerbated by the power dynamic with staff having control over the minutia of detainee life and in poor conditions, with detainees having limited to no agency. Requests had to be made for basic items such as toilet roll and detainees were subjected to three lock downs per day; in dirty and

poorly ventilated cells that detainees were expected to clean themselves, often without having adequate materials to do so.

143. From my experiences at Brook House, I also witnessed a culture of perceiving non-compliant detainee behaviours as disobedience rather than a manifestation of trauma or distress. Disturbed behaviour was also seen as non-complaint, deliberately disruptive or attention seeking rather than symptoms of mental illness. This attitude is seen in the footage of D1527 in Panorama, where there is no attempt by staff to understand his behaviour in the framework of trauma, instead the reason is because *'he is an arse'*. Even the medical staff appeared indifferent to his condition. When I delivered training around conflict management, I encouraged staff to look at the reasons behind behaviour, encouraging explanation and inquiry. However, in Brook House, this approach was resisted and did not get entrenched. The levels of trauma, and the traumatic environment individuals found themselves in, meant staff often found it easier to default to perceiving behaviour as disobedience, rather than the harder method of engaging with the reasons behind the behaviour.

144. This can also quite clearly be seen in the extended footage of the incident between DCM Steve Webb and DCO Charlie Francis with detainee D728 (KENCOV1044) – **see (z) of Annex 8,** who is clearly distressed, has a history of mental health issues, and has been placed on CSU after protesting on the suicide netting. He is 'acting out' not only as a manifestation of this but because he wants a shower (so he can be clean to pray as a Muslim) and his psychiatric medication. D728 has clear needs that the officers should have dealt with but instead they resort to hostile confrontation, highly inappropriate language and even threatening to assault him. It should be noted that the shower room was directly opposite his CSU cell. I cannot comment on DCM Webb and DCO Francis' state of mind or the difficulties they were having with the job at the time but it is notable that DCM Webb repeatedly says things along the lines of "I'm not in the mood for you, today". DL0000140

145. This approach is representative of the much easier method of relating to the complex trauma within the detained environment, for which you have no proper training or skills and which you powerless to alleviate, and which is demoralising and hopeless. I often saw this tension in reviews of Rule 40 and Rule 42 DCR 2001, which I undertook as Duty Director, where Oscar 1s would frequently disengage with detainees, would not ask questions or be concerned to understand how they were feeling. I frequently experienced tensions between myself and the Oscar 1 on this practice because I would always attempt to engage with the detainee.

146. The approach set out above could also be seen in the frequent ignorance towards detainees who were not able to speak English. Where a person whose first language is not English, and who automatically defaulted to their mother tongue, staff would often interpret this as disobedience and disrespect, rather than a natural response. I would witness staff frequently raise their voices and say, 'speak English, I know you can speak English'. On this very basic level the failure to have a conceptual understanding of these issues, means that detainees (who are predominantly non-white / non-British) are dehumanised and demonised. I recall as one example an incident on 24 January 2013, where an officer justified a use of force because the detainee was 'non-compliant' and one of the reasons he was perceived to be aggressive was because he was shouting and speaking in Spanish. When reviewing the incident, I drew the officer's attention to the fact that he had failed to properly consider the movement order which noted that the individual had mental health issues.

Institutional Racism

147. As I have set out above, I believe there was a dehumanisation of detainees based on the environment itself at Brook House and the effect this had on staff/ detainee relationships and interactions. Given the make-up of Brook House and the diversity levels of staff and detainees, I would also say that this dehumanisation contributed to the institutionalised racism that was present in Brook House.

148. The Macpherson report (6.34) which arose from the public inquiry into the death of Stephen Lawrence, defines institutional racism as "*The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people*." DL0000176

149. As I have explained in detail, I do not believe that even the contractual arrangements provided the resources and regime to ensure an appropriate and professional service to people, who by their very nature are 'non-white British', but also who are vilified and demonised as a group and hidden away from society and the general population.

150. I myself did not witness any verbal abuse that was overtly racist, whether by detainees or other staff members. If I had, I would have challenged it immediately and reported it through the appropriate mechanisms. Other staff would have known I would take this approach.

151. I have seen the Panorama footage of DCM John Connelly advising Callum Tulley prior to a planned C&R as follows:

> *"Say, 'Listen here, nigger. Listen to me' ... If he fucks about, we need to get him in here. Fuck him up around the corner. If he refuses, shove him in here... These stairs. That's our justification for fucking throwing him in that corner. And fucking dealing with him in that corner here... Can't be fighting on top of the stairs".*

152. DCM John Connelly is an experienced DCM who has a leadership position over the DCOs, and is also an Instructor in the use of force. His background was in the Army and he was known to be aggressive in his approach to Control and Restraint (C & R). The reactions of others present is also significant to me. The use of this overt

racist and violent language is not challenged by those present; he is only warned that it may be on camera. John Connelly's response is that he would *"scrub the [cunt]. No fucking problem. Can't fuck about with him. Had his fucking chance."* (28:40mins). I was shocked by this as I am to other records of overtly racist and violent conversations which I have seen at **Annex 8.** DL0000140

153. Despite not having witnessed any verbal abuse that was overtly racist while I was at Gatwick IRCs, I did witness treatment of detainees which I considered was part of a wider culture of racism or xenophobia. This included the use of cultural stereotypes, such as Romanians being violent or Jamaicans having drugs. Staff would understand the workings of the centre and deal with different groups within these cultural generalisations, which would clearly fall under the definition of racism. I believe this demonstrated a lack of understanding for the context in which they worked, which I would say was institutionally racist. I believe the insensitivity and incompetence was representative of racism through ignorance, rather than malicious intent although that may also have been present but not revealed to me when I was there.

154. It is also important to state the detention centres are by their very nature, racially diverse environments and it is important that there is adequate training on race awareness, diversity and equality. I do not believe that there was any adequate training on these issues, which meant staff generally did not understand or care that much about cultural nuances in relation to issues such as food or prayer, but instead, used stereotypes as a form of population management. This was also an important feature of the *'us and them'* mentality.

155. The internal survey I refer to at paragraph 134 above, shows an overwhelming majority of staff describing their ethnicity as 'white', with 35.7% of the respondents reporting that they were 'white English', 34.4% 'white British', 0.6% 'white Scottish, 0.6% 'white Irish', and 3.2% as 'white other'. 0.6% stated that they were White Gypsy or Irish Traveller, 1.9% 'mixed / multiple ethnic groups White and Asian', 1.9% 'Asian / Asian British Indian', 0.6% 'Asian / Asian British Pakistani', 0.6% 'Black / Black DL0000142

British African', 0.6% 'Black / Black British – Caribbean' and 1.3% 'Black / African / Caribbean – Any other background'. 17.5% of respondents stated 'prefer not to say'. These figures are obviously disproportionate to the race, colour and ethnicity of detainees, who are predominantly non-white. When the *'us'* and *'them'* is reflective of disproportionately 'white' and 'non-white' populations, I would say that this contributes to institutional racism, particularly in the context of 'border control'.

156. On a specific level, I remember attending a Senior Management Team meeting on 8 November 2013 where I raised a complaint about Union Flags being placed in the offices, and specifically one stating 'R.I.P. Lee Rigby'. I raised these concerns as I felt it was insensitive towards detainees, who would see it when they entered the wing office, which was dominated by staff. During the discussion, I recall Juls Williams, Residential Manager at Brook House, could not really see any issue with it, but he was instructed to take them down by the Director. The senior managers generally understood my concerns, but some of the middle managers did not, and certainly the staff on the wings did not. I am aware that a number of staff members have Facebook pages with England flags and military photos as part of their profiles.

157. I was also aware that there were some individuals where specific allegations of racism were made. For example, I recall being told by a member of the senior management team that Stephen Pearson, a DCM, had been demoted for making racially inappropriate comments when he was on hold to the Home Office. He was not sacked for this however, and his demotion actually meant he had more contact with detainees. I also recall accusations about Graham Purnell, a good friend of Juls Williams, using racist language, but I cannot recall the precise details of that and what if any action was taken.

158. The internal stakeholder survey I refer to at paragraph 134, also highlights the presence of racism, discrimination and a racially charged environment at Brook House: DL0000142

a. Answers to the question "**If you do feel that you have been treated differently compared to those you work with, please give examples"** included:

i. *ETHNIC MINORITY STAFF AT BROOK HOUSE ALWAYS DISADVANTAGED, COLOUR DEFINES YOUR ABILITY AT BROOK HOUSE.*
ii. *Unfortunately we work in a face fits society. if your not in the face fits bracket then you get left behind*
iii. *by colleagues possibly by colour/age, not part of the circle. because not one of the boys abusive, disresprectful and do not believe their attitude/ behavious is right for this career*
iv. *my manager was racially victimised and received a pay out from g4s*
v. *IF ANYTHING WITH RELIGION IS MENTIONED WITH ANYONE PEOPLE DON'T WANT TO KNOW*
vi. *INDIRECT INSTITUTIONALISED RACIST REMARKS, EXAMPLES ARE VARY TO INDIRECT AND COMPLEX TO EVEN MENTION. ONE MEMBER OF UKBA TALK NICELY TO WHITE MEMBER, BUT NOT ETHNICS.?*
vii. *In my opinion older people are not valued in this workforce, the majority of managers are under 35years of age* (p.39)

b. Answers to the question: "**I feel confident that I could describe things that my organisation has done to improve understanding between the different groups of people it works with**", included:
   i. *The company is RACIST point blank.*
   ii. *PEOPLE STILL MOCK ETHNIC WORKERS WHEN I SAY PEOPLE I MEAN STAFF DON'T KNOW THE MEANING BEHIND RESPECTING OTHER PEOPLES BELIEFS. THEY MOCK ACCENTS OF FELLOW WORKERS AND EVEN DETAINEES, I DON'T FEEL LIKE I WORK IN A PROFESSIONAL ENVIRONMENT". (p.25)*

Institutionally Corrupt and Toxic Culture

159. The assaults and abuse we witness in the Panorama are a gross manifestation of the institutional corrupt and toxic culture that I have tried to describe above. Whilst the footage inevitably focuses on a core group of staff, in my experience, it is likely the behaviour of staff was perpetuated by the system in which they were working in. It represents a system in which members of staff felt confident enough to take this action and even cover up outrageous abuse without repercussion. I see this core group as the people who exercised the 'physical' sense of power, who would be relied on to attend incidents and to take the lead on using force but, I do not believe from my knowledge that they could have conducted themselves in this way without the wider institutional culture of dehumanization and othering that was at play, which made this conduct accepted by many more staff.

160. I think it is important to recognise that individuals behaving like this are likely to become the dominant group in part at least in response to fear and the threat from the unsafe environment that was also a prominent feature of the experience of Brook House; with insufficient staff numbers, training and skills to properly and safely manage the population. This was evident when I was working there between 2012 and 2014 but other factors such as prevalence of illegal drugs and additional numbers of detainees would only have exacerbated the levels of fear and threat and general chaos experienced by staff in later years. In this context, the mentality of *'us and them'* I have described above, intensifies further and contributes to more conflict and tension, and a reliance on those with physical power and dominance among the staff group whose behaviour then becomes normalised and accepted. I experienced a very similar pattern at Medway STC.

161. When I was employed by G4S, I had limited direct interaction with the people in this group at Brook House and it would be fair to say that I was very much seen as an 'outsider'. For example, I exhibit a Facebook message from DCM Adam Clayton dated 11 May 2018 at **Annex 9,** which states, *"I wanted to write as I watched the panorama documentary. I will be honest I never really understood you or what you was about. Having watched the documentary, I kinda do now."* DL0000140

162. In my role as Head of Tinsley House, I was not embroiled in the Brook House culture on a daily basis. The time that I spent physically present on the wings in the centre was relatively limited. I would say that the general culture and ethos was known but largely unmonitored and unchallenged in Brook House. Management meetings were performance related, and included figures for sickness, complaints, removals etc. There was no effective method or time for the culture and practice to be reviewed and challenged. It was not a priority or on the agenda at Brook House. The focus was much more on finances and meeting the Home Office's objectives around removal and responding to that pressure. When I raised issues around poor culture, including staff being asleep on shift, not complying with good practice on CSU and phones not working in the command suite (all of which are indicative of a culture of complacency and negligence), it was generally ignored.

163. At Tinsley House, where the physical environment was less harsh and I had more direct control, I was able to take some steps to create a more hospitable, positive and professional service but this was not replicated at Brook House. For example, I produced booklets with key information for staff and a phrase booklet, for staff to carry with them at all times. The key information for staff included an outline of the Human Rights Act 1998 and the Detention Centre Rules 2001. I wanted this to be the centre of how people operated in Tinsley House, to ty to affect the culture in a positive way. The phrase book was designed to encourage engagement between staff and detainees, to ensure more meaningful assessments. Although I then developed these booklets for use at Brook House (tailored to the different regime), they weren't embedded in the same way and were met with greater resistance from the staff in Brook House who did not want to actively use them.

164. Generally in Brook House, there was a toxic-masculine and bullish culture. From the perspective of the staff themselves, the toxic and corrupt institutional culture, mired by bullying and dominance, is exemplified in the internal stakeholder survey I completed in around April 2013: DL0000142

a. Answers to the question "**Have you witnessed inappropriate behaviour, discrimination, or bullying / harassment within your organisation in the last 12 months?"** included:

i. *NUMEROUS COMPLAINTS MADE BY BOTH DETAINEE AND STAFF AND IT GOT BRUSH UNDER THE CARPET. AT ONE POINT EVEN MANAGERS {DCM} WHERE BULLYING AND STILL IS DETAINEE AND STAFF*

ii. *2 TWO STAFF LEFT BECAUSE OF BULLYING DESPITE COMPLAINING NOTHING WAS DONE TO PROTECT THE STAFF MEMBER*

iii. *DCM BULLYING DCO's*

iv. *Inappropriate comments made in relation to Control and Restraint use in the work place. Challenge at the time*

v. *some acts of bullying is swept under the carpet by senior managers*

vi. *managers aware of staff being bullied but taking no action*

vii. *Singling people out/bullying single members of staff. ONE member of staff spoken to.*

viii. *Indirect bullying, handled by DCM's, bullying continued handled by senior managers.*

ix. *Officer sexually harassing member of staff, nothing done. senior manager engaging in inappropriate behaviour with a manager nothing done*

x. *INDIANS ARE THE WORST PEOPLE & BELIEVING IN THE DIFFERENT TYPES OF GODS & COMMENTING ON THEM*

xi. *Hard to say because the process is not open due to privacy*

xii. *Staff from minorities have been excluded and at times felt bullied by other staff, often goes unchallenged by line managers" (pp.42-43)*

b. One answer to the question: **Do you feel that there are groups of people that your organisation need to do more to include? You may choose more than one,** also included: *IN REGARDS TO QUESTION 27. NOTHING WOULD BE*

DONE AS SOME COLLEAGUES ARE UNTOUCHABLE E.G [DCM] THEY BULLY AND DISCREMINATE ALL THE TIME. REPORTS MADE NOTHING GETS DONE. THERE IS NO POINT IN REPORTING ANYMORE (p.44)

165. This institutional culture was also reflected in staff interactions with detainees. There was an incident I can remember from October 2012 in Brook House that is demonstrative of this dehumanisation and the bullying culture that aimed to torment and belittle detainees, and which was all done under the supervision and involvement of a DCM – Adam Clayton. Michelle Brown's investigation of this incident at CJS005900 has been obtained by the Inquiry. This incident occurred on E-wing and related to a detainee, D4289, who had been located there owing to his mental health vulnerabilities. At 00:48 hours on 19 October 2012, D4289 had made a ligature in his cell in E-wing and as a result was placed on constant supervision. Michelle Brown's report confirms that during the hours that followed through the night shift D4289 was "displaying volatile behaviour", at was point he was "attempting to push his fingers into his ribs" and was reported by one officer to be "physically shaking". Despite this the CCTV shows the officers on the wings – DCO Yems, DCO Willoughby, DCO Grant, DCO Austin and DCM Clayton – at various points throwing and bounding a tennis ball, a bottle and other items outside D4289. This shows the kind of complete disrespect and disregard for D4289's vulnerabilities that I have described. Even more worryingly, the footage showed that at various points DCO Willoughby and DCO Grant were involving themselves in these games when they were on constant supervision duty for D4289, meaning they did not have their attention on a detainee who was deemed an active suicide risk.

166. The report confirms the next evening at 00:18 on 20 October 2012, CCTV captures DCO Willoughby walking through CSU wearing a 'Derek Trotter' mask (a character from the sitcom 'Only Fools and Horses') and entering E-wing, then going on to perform her constant supervision duties on D4289 whilst wearing the mask. She is seen wearing the mask by several colleagues who raise no objections and it is clear they find it funny. The mask is removed at 00:19 but left hanging on the door within view of D4289 and at one point DCO Willoughby holds it up against the glass of

D4289's cell. DCO Austin, who later takes over constant supervision duties, is also seen wearing the make in front of D4289. He is also seen at certain points to again not be within eye sight of D4289 when carrying out his constant supervision duties. D4289 later complained to the mental health nurse on 21 October 2012 that officers had woken him up with the mask and complained that they had been noisy and kept him awake. It appears that officers kept music channels on loudly overnight within the wing.

167. Michelle Brown rightly concludes that several officers - DCOs Willoughby, O'Connor, Grant, Yems, Culleton, Tyrell, Austin, and DCM Clayton - failed in their duty of care, acting inappropriately and finding that many breached DCR Rule 41, constant supervision policy and procedure and the G4S employee charter. This incident showed several staff (almost the entire complement of the night shift for each night), including the supervising DCM, all casually being involved in incidents that dehumanised and made light of D4289's clear vulnerabilities and acute suicidal crisis, whilst at the same time failing to properly carry out the constant supervision duties. Although various recommendations were made by Michelle Brown, I cannot recall what the outcome of the investigation was. I am also not aware of this being escalated by senior management or any further follow up being undertaken to address how widespread this culture as and what should be done to address it. I do not believe that this was a one off incident given how many staff were involved. It is also clearly an aspect of the institutional culture that continued for years as the Panorama recordings show.

168. While I was at Gatwick IRCs, I had a particular issue with Residential Manager Juls Williams, who was in charge of all the residential staff and therefore responsible for setting the tone and attitude of the staff / detainee relationships. Juls didn't embody the values of respect and dignity; he would simply get the job done and was dedicated to making things happen, regardless of the human cost. He was surrounded by a number of staff for which I felt he was inappropriately close, such as Graham Purnell, Alan James, Anthony Morgan, David Aldis, Joe Marshall, Luke Hutchinson, Nathan Ring, Simon Brobyn and Stephen Marner. This group were protected and favoured by Juls Williams, and this dynamic is representative of the hierarchies that operated in

Brook House amongst the staff, which fostered a sense of collusion and impunity. If you were in Juls Williams' inner circle, you knew that you would be protected.

169. It appears from the footage and transcripts that at least Nathan Ring, Graham Purnell, David Aldis and Joe Marshall remained working at Brook House at the time of the filming in 2017. Extracts from the transcripts of conversations between Joe Marshall, Ed Fiddy and Callum Tulley confirm my fears about the consequences of this of a totally disrespectful attitude and abusive treatment of detainees. (See TRN0000002 (KENCOV1007 Tuesday 25 April) and TRN0000030) KENCOV1023 Friday 13 August 2017 (and **Annex 8**)). DL0000140

170. I was not surprised by the abusive behaviour and language I witnessed of Nathan Ring in the Panorama, and it appears from the footage and transcripts that in 2016-17 it was endemic in the culture. Nathan Ring started life in Brook House, then transferred to Tinsley House in my time. He quickly gained a reputation for being lazy and slapdash in his approach. He was managed by Michelle Brown and was definitely someone she would have to watch. He didn't engage well with staff or detainees, but he was the person that we had and it was slim pickings. I remember being extremely surprised when he passed the DCM as I did not believe he was competent.

171. Whilst I didn't witness any specific abuse from him towards detainees at Tinsley House, I understand from what I have seen in the Panorama and with the context of the hierarchies I have described above, that he was in the core group of officers at Brook House as one who was valued for his toughness with detainees and became a dominant figure whose conduct was accepted and not challenged. I have seen summarised extensively in **Annex 8 (see (d), (e), (o), (r))** the comments he was captured making DL0000140 by Panorama and they reflect not only his fundamental disrespect and disregard for the dignity and well-being of detainees, but also his immaturity, his unsuitability to lead and total unprofessionalism. Those comments speak for them themselves as to how entirely inappropriate it was that he was allowed to be promoted to DCM.

172. There were other individuals I witnessed on the Brook House Panorama, who were there during and represented the culture I had experienced when there. For example, Steve Dix was not very capable and did not have a strong sense of professionalism or managerial authority. The use of force incident he oversaw relating to **D1527** on 4 May 2017 (CJS005530) is reflective of my concerns about his approach to his role – where I believe he made a rushed and inappropriate decision to use Rule 40, leading to an inappropriate use of force on a vulnerable person to transfer him to the CSU. He failed to follow correct procedures in respect of body-worn cameras and searches. I was also highly concerned by his flippant and uncaring comment to Callum Tulley in the build-up to the use of force, when Callum Tulley asks if he is concerned if D1527 might jump off the netting *("Oh well, its his own choice init"* [16:47mins] [V201705040002 clip 2]).

173. Dave Webb is my brother-in-law, and due to this personal relationship, I professionally distanced myself from him at work. Charlie Francis was one of the old-school generation of 'boys don't cry' and had no other emotional framework to respond in any other way to detainees. From what I witnessed while working at Gatwick IRCs, I did not perceive Charlie to have malintent but was incompetent and easily led. He was an example of someone who was caught up in the culture of Brook House – where he did not have physical power, he would act up and try fit in with the macho culture when others were around. In both the incidents in which he is featured in Panorama, it is notable that he takes inappropriate action and uses inappropriate and offensive language when in the company of more dominant staff members (Yan Paschali in the incidents with D1527 on 25 April 2017, and DCM Steve Webb in the incidents with D728 on 6 July 2017).

174. The truth is, there was a limited pool of staff that we were able to recruit from. A majority of staff had few qualifications, many came from baggage handling at Gatwick airport, and they were working in complex and institutionally corrupt environments with people with complex needs, many of whom should not have been in detention at all if the Home Office was doing its job properly. The DCOs would rise

through the ranks to become DCMs and there was an entrenched culture which did not benefit from fresh perspectives. This was worsened by the fact that G4S had a recruitment scheme whereby if you recruited someone and they remained in the job for a certain amount of time, you would receive £250. This encouraged staff to recruit their friends, which would inevitably entrench these cultures.

G4S Responsibility

175. When I stated in the Panorama, "*we need to look at the people that have put these people in place and allowed them to do what they've done*" [53:23-53:32], I was referring to how it would be very easy to narrow our focus on individual members of staff as a few 'bad apples'. As I have sought to explain, I think this would be very much the wrong approach and would not lead to a proper understanding of the key factors that create the conditions for such a culture to be established and for such abuse to take place. Scrutiny should be much wider to ask the question as to how 'bad apples' got there and remained entrenched in the system. When I said this quotation, I was thinking of issues such as the vetting and training systems; and in particular the fact that poor attitudes and dysfunctional cultures were allowed to become established and left unchallenged by those in more senior positions. The Inquiry must look at those in leadership positions in G4S and the Home Office, with overall responsibility as well as those on the ground.

176. I raised that the institutional culture at Brook House was poor and unprofessional during my employment and upon my resignation. It was frustrating because the culture was accepted and entrenched and I saw no inclination by senior managers to do anything about it. There was also no apparent incentives placed on those above them from the Home Office or G4S to change the culture. The combination of a lack of strong, principled leadership and indifference meant there was no real counter balance to all the factors that created this toxic environment and which lead to a culture of impunity and an accountability deficit which I fear is still in place today without some radical changes having taken place.

177. I think it is significant that despite the serious failings at Medway, Ben Saunders was appointed to run Brook House in 2012 and indeed remained in this post despite the Medway Panorama programme, the subsequent Police investigation in 2016 and the Medway Improvement Board of 30 March 2016 (INQ000010), which draws similar parallels to the failings of Brook House.

The Home Office

178. I also think it is important to address the Home Office's responsibility, both at individual level and systemically. I believe its role is critical to understanding the institutional culture, lack of accountability and the climate of impunity. To reiterate what I have stated at paragraphs 67 – 89, I believe the Home Office are responsible for the failures of Brook House at its inception, including the flawed design and contract, which ultimately facilitated the development and aggravation of issues that arose.

179. Systemically, the Home Office was responsible for the culture of the 'hostile environment' and the prioritising above all else, the driving up of removal statistics with increased use of detention to achieve removal which was especially intense with the use of Charter flights. [51] As above, this was seen in the contract, where penalties were placed on anything that prevented removal, such as failing to produce a detainee for removal but silent on penalties for allowing detainees to be mistreated and relaxed on G4S developing a regime that was recognised to be harsh and excessively secure. This approach by the Home Office was even noted by Lee Hanford when he came into Brook House as interim Director in 2016 – in his interview with Kate Lampard for the Verita report he notes some G4S staff were even being criticised by the Home Office for *"[288]...showing too much empathy, supporting detainees in their appeals and the*

[51]The impact is described in the 2 October 2020 the Brook House IMB and IMB Charter Flight Monitoring Team (CFMT) notice under Detention Centre Rules 61 (3) and (5), bringing a concern to the attention of the Minister and identifying practices in detention that could amount to inhuman or degrading treatment concerning the severe impacts of Charter Flights on the mental health and welfare of detainees at Brook House and the IMB Annual Report for 2020 (May 2021) **(Annex 10).** DL0000140

like" [VER000266]. The Home Office's approach created an institution that was closed and a rhetoric that only intensified year on year and which would drive a culture of abuse. The contract, being based on removal rather than welfare, allowed G4S to exploit this for profit, and success was assessed by the Home Office based on maximising removals at the expense of detainee well-being.

180. This had a direct impact on the IRCs. We were put under pressure in 2014 for immigration statistics to be improved for the general election in 2015. I recall a campaign lead by Ben Saunders to ensure that we pushed voluntary returns; putting up posters and reminding detainees of the process. A man who I believe to be the late James Brokenshire, then the Immigration Minister, also visited Brook House in 2014 and specifically referred to removal statistics, encouraging us to drive up figures. I also recall the Home Office targeting particular nationalities for detention they thought were more complaint, to push up removal figures, even if they were not otherwise seen as strategic priorities. This drive is demonstrated in the Home Office statistics that show an increase in the number of people entering immigration detention year on year between 2010 and 2015[52].

181. There were also Home Office officials who drove a disrespectful and dehumanising culture. The Home Office manager for Tinsley House, Deborah Western, who out of all the Home Office staff I met, was in fact most concerned with detainee welfare, once said to me '*it's a game of Home Office and detainee, whoever breaks first*'. Other Home Office officials such as Paul Gasson, who ended up as Centre Manager, came across as particularly emotionless and detached towards detainees when we would have our morning meetings and during CSU reviews. Paul Gasson was purely functional and clinical about the tasks he performed, and did not show any sign of compassion towards human situations. This was particularly apparent during CSU reviews, where detainees had been self-harming and can also be demonstrated by the incident I described below from 6 October 2012 at paragraph 245.

[52] Home Office data confirms that 25,904 people entered detention in 2010, rising to 27,089 in 2011, 28,905 in 2012, 30,418 in 2013, 30,364 in 2014 and 32,447 in 2015.

Too Close Relationship between Home Office and G4S

182. Generally, I believe that the relationship between G4S and the Home Office lacked any real institutional independence and became far too close. The Home Office was reliant on G4S as an operator to actually undertake what it needed to do, in a contract that was fundamentally flawed from the outset.

183. The inappropriate closeness of the two can be seen from the fact that Mark Francis (the Deputy Facilities Manager) stated in a phone call to me that G4S and Home Office managers watched the Brook House Panorama together in the Director's Office. It can also be seen from the fact that Home Office on-site managers Vanessa Smith and Heenaxi Patel are 'Facebook' friends with several G4S officers – see screenshots at **Annex 11.** DL0000140

184. The closeness can also be seen in the cross-over of employment positions. For example, Wayne Debnam historically worked for UKBA as their Senior Safety Advisor between May 2006 and September 2009. During that period, he assessed the G4S procurement bid for the Home Office[53]. Wayne Debnam went onto work for G4S as Head of Safety and Security at Brook House from September 2009. Duncan Partridge also went from being the Home Office's Head of Population Management/Area Manager to G4S' Deputy Director at Gatwick IRCs in September 2012. On LinkedIn, he describes his previous role for the Home Office as including: DL0000177 *"Led UK Government contract implementation /compliance at immigration removal centres (2012)... Led 124 staff on 2 sites; controlling detention, escorting & population management as head of DEMPU (2010-11)... Directed contract/SLA monitoring and compliance at Gatwick, HMPs IRCs as UKBA area manager (2009-10)*". As Deputy Director for G4S at Gatwick IRCs, he describes his role as including: *"Led contract delivery and care at Gatwick Immigration Removal Centres as a Deputy Director for G4S, Led on operational solutions and unique selling points for UK Government custodial bids... Successfully managed subcontractors and partners to deliver continuous contractual and standards delivery improvement."* Across these two

[53] See **Annex 6** – Wayne Debnam is listed as reviewing the health and safety sections of the Brook House bid. DL0000140

descriptions he makes clear that he used his inner-knowledge of working for the Home Office on G4S' Gatwick IRC contractual compliance and brought this knowledge directly across to working for the contractor helping to produce 'unique selling points for UK government custodial bids'. It appears the Home Office had no concerns about G4S employing him in such a role.

Home Office Knowledge and Oversight

185. At a macro level, the Home Office obviously authorise continued detention, carry out regular reviews of detention, authorise use of force, receive Rule 35s, IS91RAs, and Part C risk assessments, which identify such matters as use of force, removal from association, mental illness and suicide risk. They therefore have direct and institutional knowledge of key matters. On the ground, Home Office Managers, the Contract Monitor and Staff would be present in the IRC. In the morning, Home Office staff would do the rounds in the Care and Separation Unit (CSU) on E Wing dealing with Rule 40 and 42 cases. They were involved in the ACDT process and would attend the morning briefings.

186. Each morning there would be two meetings within Brook House. The first one would be at 8.30am, which would involve all of the Senior and Middle Management Team, Healthcare Manager and the OSCAR 1 (Duty Manager) for the day. This is where the last 24 hours would be reviewed and any concerns raised regarding individual detainees. The Duty Director and OSCAR 1 would then attend a 9.30am meeting which would consist of the Home Office Duty Manager, all OSCAR's (residential, reception, security) and safer community. Any concerns raised in the earlier meeting would also be raised here with the Home Office.

187. However, the Home Office staff on the ground were not the caseworkers on detainees' cases. Therefore, when raising requests with the Home Office in relation to detainees' detention, the Home Office staff in the IRC would simply state that they would raise it with the relevant person external to the centre. There would usually be no follow up responses or action from the relevant caseworker on the issues raised.

From the detainees' perspective, there was considerable frustration because they were unable to easily access Home Office officials for information about their cases and this could be a flash point and source of distress that the IRC staff had to manage and follow up with the Home Office.

188. The only other way for DCMs to inform the Home Office of any concerns about a detainee was to complete, or ask a Duty Director to complete an IS91RA Part C risk assessment. This was sent to DEPMU which was concerned with the overall managing the detention estate and so must have had a general oversight of what was happening on these key risk indicators. The problem was that an IS19RA Part C did not trigger a review of detention. It was not sent directly to the Home Office detention case worker and we often did not get a response even when raising acute concerns about a detainee's welfare or risk levels in the centre.

189. Most of the time, Home Office officials on site would be in their office completing paperwork or interviewing detainees and their focus was clearly on removal and purely administrative tasks. Despite this, it would have been impossible, in my view, not to be aware of the general culture and attitudes to detainees especially in light of the evidence from the Inquiry of how pervasive the verbal abuse was, and the presence of large numbers of staff when abusive conduct takes place.

190. From my experience, there was no sense of Home Office leadership and oversight of the IRC. There was no healthy culture of challenge and professional scrutiny. In terms of contractual performance, as G4S we had to complete monthly reporting and declare our own breaches. It was the Home Office's role to check this, however, I believe they should have completed their own reviews, with a proactive scrutiny of the contractor. There were UKBA audits but this only happened once a year. This was an issue highlighted in the Medway Improvement Board's report of 2016 (INQ000010), in relation to the G4S run Medway STC, which noted conclusions that *'due to the 'self-reporting' nature of the current STC contracts, there is a significant reliance on the contractor to provide data without a robust independent*

assurance mechanism. Underreporting of incidents and issues, therefore, cannot be successfully detected or challenged'.

191. To me, those employed by the Home Office did not seem to have sufficient quality training and experience on how custodial environments should or should not work, and I did not detect any real motivation to properly scrutinise and/or hold G4S to account. Furthermore, G4S have a track record of being dishonest in government contracts, which inhibits the ability to ensure scrutiny which requires openness and transparency, where it was reporting its own breaches. I saw little due diligence on the part of the Home Office. I think it was of institutional benefit to them not to proactively supervise what went on at the detention centres and they permitted the conditions for a culture of impunity to develop.

192. From my perspective, we were working in a system where the Home Office, despite being ultimately responsible for detaining people and for ensuring that their human rights were respected, gave no active leadership or direction that put the rights and welfare of detainees as a priority. To the contrary my strong sense was that it was an institution that fundamentally did not care about the safeguards and protections for detainees and its main driver was always the political imperative of removal above anything else. [54]

193. I believe the toxic culture that I have witnessed in the Brook House Panorama, occurred in a context of neglect and impunity for which the Senior Managers in G4S and Home Office officials at all levels, including the highest, were responsible.

Assessing Vulnerabilities

194. I believe that there were systemic failings in relation to the assessment of vulnerable people at the outset of detention, which resulted in many people who were

[54] The IMB letter and Annual Report for 2020 strongly indicate this remains the case (**Annex 10**) DL0000140

unsuitable for detention, being detained. The consequences of this should not be underestimated.

195. It is my view that every detainee, whether former criminal or asylum seeker, is potentially vulnerable by virtue of the fact that they are detained. The high levels of self-harm and serious mental health problems in detention are a reflection of those vulnerabilities. I do not believe the distinction between the two groups (made day-to-day by officers on the ground but also by politicians, and by the Home Office when setting policies on detention) is helpful, as those with criminal records may also have complex mental health needs, a history of trauma in their home countries and may well be asylum seekers themselves. It may be that those mental health issues contributed to their criminality, or that the fact of living on the fringes of society without immigration status or social support has made them much more likely to fall foul of the law.

196. Every detainee was supposed to be seen by healthcare on arrival and then offered a GP appointment within 24 hours. I do not believe the initial on-arrival healthcare assessments by nurses were efficient or effective. I frequently witnessed assessments being completed over a short period of time and right upon a detainee's arrival at the centre, when someone may have been brought in after a traumatising enforcement in the middle of the night and were unlikely to be in a position to disclose their history of torture, mistreatment or trauma. In my view and experience, disclosures of 'abuse' and 'trauma' are more likely to be made within relationships that are based on trust. I recall instances of trauma being disclosed to staff members in Tinsley House after building a level of trust, which had not been picked up by healthcare but then triggered a Rule 35 report. The fact that individuals are detained without any prior opportunity to make representations as to their suitability for detention, and where they are, the initial screening process by healthcare is not set up to address difficulties with disclosure, is one of the concerns I have about the rule 34/35 process, which I detail below.

197. Throughout a period of detention, the ability for detainees to communicate with the Home Office about their vulnerabilities was woefully inadequate. Detainees would not have a direct line of communication with their Home Office caseworker and so would have to rely on officers and healthcare to raise concerns, or through their lawyers if they were lucky enough to have a competent one. As a G4S member of staff, if you had a concern about a vulnerable individual, you should report to a DCM in charge and healthcare would be informed. The only real route that officers would be able to raise concerns about a detainee was through the Part C system, which as I have stated above, to my knowledge did not always generate a response from the Home Office and did not trigger a review for detaining the person.

198. On top of this, there was often very little you could practically do to alleviate mental health problems, where complaints usually stemmed from stressors of the detained environment, such as being locked up for long periods of time causing a triggering of symptoms or the prospect of being removed. I believe a large number of mental health concerns were rooted in the uncertainty of the length of detention, based on what detainees told me, and for which we had no control over.

Rule 35

199. The systems that detainees were able to alert the Home Office as to their vulnerabilities, were via Rule 34 and Rule 35 reports. These were completed by healthcare and were known not to work effectively, even where detainees were torture victims, seriously mentally ill, self- harming, a suicide risk and/or presenting with disturbed and disruptive symptoms such as psychosis.

200. Although I understand that this is wrong, Rule 35 was treated as synonymous with victims of torture, i.e. Rule 35(3) reports, and not wider physical or mental health issues even when the person was self-harming or suicidal. This was despite the distinction between the terms of Rule 35(1) (concerns health is likely to be injuriously affected by continued detention) and Rule 35(2) where there are suspicions that a detainee may have suicidal intentions).

201. The need to obtain a Rule 35(3) report from healthcare and responses from the Home Office to such reports (often maintaining detention) were a serious source of tension for detainees. Whilst at Tinsley House, on several occasions I spoke with detainees who were in distress following letters they had received from the Home Office not accepting their claim of being a victim of torture and/or not accepting that they should be released as a result. In their distress they showed me the scars on their torsos. I have no doubt whatsoever that victims of torture were being inappropriately held both in Tinsley House and Brook House. To keep survivors of torture in detention is repugnant. To deny the reality of their history is callous.

202. I have seen Freedom of Information data and Home Office immigration statistics **(enclosed as Annex 12 to my statement)** which confirms that between 2013 DL0000140 and 2021 there has never been a Rule 35(2) report – where a doctor suspects a detainee of having suicidal intentions - issued at Brook House. It is difficult to understand why this is the case given the high number of self-harm incidents requiring medical treatment each year (See **Annex 7** and at paragraph 101 above), the regularity in which DL0000140 constant watch ACDT observations were opened each week, and even by reference to the Panorama documentary where at least four different detainees are recorded as having actually attempted suicide (including core participants D1527, D687 and D1914

203. Where individuals were a self-harm or suicide risk, the standard practice was to place the detainee on ACDT (which I examine in further detail below). The G4S Operational Instruction, 'Constant Supervision – Caring for detainees at risk' (the version May 2019 has been disclosed by G4S – CJS006378) explains the use of constant supervision (ACDT):

> *"The aim of this guidance is to ensure we provide a safe and decent environment for detainees at a heightened risk of suicide or self-harm and to provide clear instructions for staff working with them. The aim of placing a detainee on constant supervision is to reduce their acute suicidal crisis or thoughts and/or*

attempts to self-harm and to support the individual in managing their heightened emotions."

204. The guidance confirms constant supervision was used for those in an acute suicidal crisis. Given the frequency with which this was required at Brook House and given the high levels of concerns of suicidality of detainees, this cannot be squared with the fact that healthcare have never issued a Rule 35(2) report at Brook House. On the custodial side, our focus was on using ACDT for those with self-harm or suicide concerns and issuing a 'Part C' to inform the Home Office that it had been opened. However, from my understanding, this did not trigger a review of the individual's detention, in the way a Rule 35 report would, and was completed by G4S officers rather than healthcare. I do not recall anyone being released from detention as a result of a Part C. I believe this is one of the reasons there was such a significant number of seriously mentally ill people in Brook House.

205. During my time in Gatwick IRCs, it was one of my concerns that the healthcare staff were not sufficiently trained and resourced to properly identify the levels of trauma of the detainee population who required Rule 34 and Rule 35 reports. This included the routine failure to record scars from torture, where I had seen those scars first hand on the detainees, or where healthcare have failed to understand the risks detention could have on torture survivors in reigniting past trauma. The complete absence of any Rule 35(2) reports at Brook House, and the very low numbers of Rule 35(1) reports (as also demonstrated by **Annex 12**) reflects how insufficiently DL0000140 healthcare were raising concerns about detainees and ultimately failing to protect the welfare of their patients, leaving so many ill people in the centre who we did not have the resources or skills to care for.

206. I was also aware that even when Rule 35 reports were issued, more often than not, it did not result in release of the vulnerable individual. I witnessed healthcare staff becoming disenfranchised and disaffected by notifying the Home Office of their concerns, and these concerns would be ignored and detention maintained. I recall a

number of E-Wing cases, where healthcare continued to raise concerns with the Home Office and seemingly nothing happened and the individual remained in detention. This was also something picked up on by the first Shaw report in 2016[55].

207. Under schedule G of the contract, there are no financial penalties for the failure HOM000921 to do Rule 35 reports, and there was no proactive internal G4S monitoring of the Rule 35 reports. Rule 35s were considered a medical report and therefore we would not see them due to patient confidentiality and it was not something that was actively discussed at management meetings. On the reverse, I was aware that G4S received penalty points and fines for self-harm in detention, which in turn dis-incentivised the reporting of incidents, as this was something that was regularly discussed at senior management meetings.

208. It was certainly not in the Home Office's interests for concerns to be effectively raised with the Rule 35 process, where it may interfere with the ability to detain and remove individuals. There was no communication from the Home Office or G4S senior managers that I can recall, that put a priority on making sure the Rule 34/35 process was working effectively during my time there between 2011-2014, although I now understand and saw from the first Shaw Report (2016) that there was a lot of concern being raised directly with the Home Office about its effectiveness, alongside a number of legal challenges. INQ000060

ACDT

209. I found the ACDT policy and procedures not fit for purpose as they were not specifically designed for the context of an Immigration Removal Centre and were based heavily on the prison service's ACCT policy which had an entirely different population with different challenges. On a practical level, I found the way in which

[55] See paragraph 4.102 of the Stephen Shaw report of 2016, which states that just 15% of rule 35 reports actually resulted in release and at 4.118 *'it is abundantly clear to me...that rule 35 does not do what it was intended to do – that is, to protect vulnerable people who find themselves in detention'. 'The Home Office does not trust the mechanisms it has created to support its own policy'.* INQ000060

constant supervision was carried out was dehumanising to detainees and an invasion of their privacy, especially when done through a clear polycarbonate door or if continued over a prolonged period of time. It was also exhausting and resource-intensive for staff who had no medical training, and it was clear that many staff members were not equipped to carry out this role and some had no wish to do so diligently. At Tinsley House, the doors were solid wood so they had to be open to allow constant watch and I encouraged officers to engage with detainees and to maintain communication whilst on constant watch where possible.

210. In my view, observations may work on a short-term basis to prevent suicide if done correctly, however they are not aimed at resolving underlying issues, meaning their use is limited. ACDT was really used as a management tool and not a health intervention. Whilst we aimed to have multidisciplinary meetings for each person on an ACDT, it was not used for assessing their suitability for detention, just managing their risk. This draws parallels to the 2016 Medway Improvement Board Report (INQ000010), which states at paragraph 3.21 in relation to Medway STC *'the practice for dealing with* [self-harm] *seems to be focussed on preventing the potential for young people to have access to the means to commit self-harm, than on alleviating the causes of vulnerability and distress'.*

211. I do not have any specific recollection of the Home Office attending ACDT reviews although they were entitled to do so. They never raised the absence of Rule 35(2) reports even though they were aware of ACDTs being opened. It seems clear to me now that it should be mandatory for Rule 35(2) reports to be issued when ACDT is required so that alongside short-term management of suicide risk by detention staff, there is a proper and informed review of that person's continued suitability for detention by healthcare and the Home Office.

212. One of the consequences of having so many unwell people who were not suitable to be detained in detention, was as I explained above, that staff detached themselves from the high levels of trauma and distress altogether, and were desensitised to suffering. In relation to self-harm, it was extremely intensive for staff

to be around high levels self-harm and attempted suicides, and the primary mechanism I witnessed staff employ, was to create a mythology that detainees were self-harming for attention. Due to such high levels of trauma and self-harm, many of the staff would find it easier to use this reasoning to understand mental health rather than employing empathy. There is evidence of this in the Brook House Panorama, where footage shows this had the consequences that staff would even mock or ridicule the mentally unwell. For example, officer (Kalvin Sanders) refers to D1527 when on ACDT as: "*you're just attention seeking aren't you, you little prick*" – **see (h) of Annex 8**. DL0000140

213. In a report commissioned by the NHS in 2012, detailed below at paragraph 220, it is found that *'All DCOs do receive mental health awareness training as part of the ACDT mandatory training but this is as part of their induction process and appears not to have influenced the work practices of the DCOs we interviewed. Even the DCOs we interviewed who routinely worked on the CSU had received no additional training on how to deal with this client group many of whom had significant mental health problems'.*

214. As I stated above, I did not fit the mould of the Brook House culture, particularly in my interactions with detainees, and this often irritated the DCOs. This was particularly clear in relation to dealing with mentally unwell detainees. For example, when someone was on a dirty protest, often staff would refuse to enter the detainee's cell. However, I would make a point of opening the door and speaking to the person. The same would happen when there was an altercation between detainees and staff. I would say to the detainee 'Do you mind if I sit down? Can you tell me what happened?' DCMs and DCOs would interrupt and take a view that I was on the side of the detainees, as opposed to this dialogue being part of an intentional process on my end to try defuse a situation. Even where the detainee was obviously mentally ill, the '*us against them'* mentality often dictated interactions.

Healthcare

215. The healthcare department (although later taken over by G4S Health Services (UK) Limited) was separate and operationally independent from G4S Care and Justice Services, and had its own functioning and complaints system.

216. I recall that there was antagonism between the Home Office officials onsite and Healthcare, against visiting Doctors for example from Medical Justice. Healthcare understood their visits as undermining their credibility as doctors, and who in their belief acted out of political motives and not medical facts. I did not understand this level of distrust of other professionals. It reflected and further fostered the *'us and them'* mentality.

217. Generally, I was concerned about the quality of healthcare provision. It did not seem to be to be adequate to meet the needs of the population. During a quarterly clinical governance healthcare meeting during either 2013 or 2014, I became aware of the concerning practice of prescribing high levels of sleeping pills within Brook House along with analgesics. It is my opinion that healthcare provided these sleeping pills because there was not the resources to provide proper trauma related therapy or such to those who were suffering from trauma related mental health problems. It is also my opinion that the environment was not suitable to enable many detainees to sleep without medication.

218. On a specific level, I witnessed Dr Geraint Thomas on at least one occasion, sedate a detainee at Brook House following an incident without informed consent. There had been an incident in E-wing, where a detainee was clearly distressed and there were concerns that it could be a psychotic episode. Dr Thomas informed me that he had given him a sedative but when he recounted the incident, it was clear that there had not been any significant conversation with the detainee or that a full explanation had been given as to what he was administering. I heard healthcare staff talk about giving sedatives in similar circumstances on other occasions. I raised this orally with the Director, Ben Saunders, however nothing was done about it. In hindsight, I wish that I had gone to the GMC about it.

219. I also recall issues with bed spaces in relation to the local hospital and psychiatric unit. There was an institutional anxiety surrounding detainees with severe mental health problems, as we were not equipped to deal with them. Healthcare were the only department who could declare a detainee 'not fit' to be detained. There were occasions where there was a tension between an individual being assessed by healthcare as not fit for detention due to their mental health problems, and the Home Office wanting them to be transferred, but the local hospital would not accept them. I would say I dealt with around ten or so people who were so ill it was accepted they needed a place on a psychiatric ward, but there was no space for them. This situation left the unacceptable choice of continuing detaining or put them out on the streets. At least two of these cases, to my knowledge, were just put out onto the streets with no arrangements made. These were often the type of cases where transfer into CSU was used, as was the use of force. I believe these cases highlight the failure of the Home Office detention decision making and screening in the IRC because the cases I refer to above, did not develop mental health issues whilst in detention – they were present upon arrival and deteriorated to the point that they needed urgent inpatient care and could not be safely released.

220. In a report commissioned by the NHS and produced by the Institute for Criminal Policy Research in July 2012, the health needs of those detained at Brook House, Tinsley House and Cedars, were assessed. The report sets out some findings in relation to the poor mental health provision in detention which would reflect my own experience, including [emphasis added]:

a. Several interviewees felt that **little was done to address the impact of detention on detainees' mental health**. The review of the literature suggests that the experience of indeterminate detention combined with the prospect of being returned against one's will has a negative impact on many detainees' mental health and that these negative effects increase the longer that a person is detained.

b. **Many interviewees expressed a similar view and felt that there was not sufficient provision aimed at supporting detainees to cope with the experience of detention** and associated depression, anxiety and other mental health concern… This information suggests that not only does an extended stay impact on detainees' mental health, but that **those who are admitted with mental health concerns are doubly vulnerable because they tend to stay in detention for longer**…

c. Interviewees noted that there were **no psychiatric interventions apart from a review of medication and some prescribing**. The lack of any individual-or group-based talking therapies was cited by most interviewees.

d. Several interviewees cited the difficulties of detainees suffering from Post-Traumatic Stress Disorder, many of whom were **unable to access an appropriate service**…

e. The **lack of any health care beds for detainees with physical or mental health problems** was widely regarded as extremely problematic. **Detainees about whom there were serious concerns of self-harm and who, therefore, could not be managed by mainstream ACDT procedures in general accommodation were effectively placed into solitary confinement in the Care and Separation Unit**. The lack of medical support combined with being locked in a cell for 23 hours a day was generally agreed to exacerbate the poor mental health of most detainees. The fact that the two observation cells (with Perspex viewing panels from the waist up) faced each other was also regarded as unhelpful.

f. There was a consensus that where detainees had serious mental health problems and needed to be assessed for possible compulsory admission to in-patient care under the provisions of section 48 of the Mental Health Act, it proved very difficult to implement these procedures.

221. Whilst this report was commissioned while I was at Brook House, I was not aware of it when I working for G4S and as far as I am aware, no action was taken to bring it to our attention and address its concerns. From my understanding, it did not

lead to any change in practice regarding the numbers of seriously mentally ill people in Brook House or address the issues raised about the poor care provided.

222. I am aware from information given to me by my solicitors, that there were two cases decided in 2012 where detainees with serious mental illness where found by the High Court to have been subject to inhuman and degrading treatment in breach of Article 3 ECHR while at Brook House. Until the first Shaw Review, I was not aware of any such cases. There was no communication whatsoever from Senior Managers in G4S or the Home Office about what had happened in these cases, and no review or follow up was conducted with the IRC staff that I was made aware of.

223. The case of HA(Nigeria)[56] is one of those cases and is important because it shows that not only that Home Office officials based in Brook House were aware of the sort of problems I have explained, but also that information was passed to senior civil servants and at the highest levels. The case was in the year before I was seconded to Brook House in 2010 and documents emails between the Simon Evans (Manager at Brook House), Duncan Partridge (the UKBA area Manager), Bob Evans (DEPMU), Phil Schoenenberger (Assistant Director in Detention services at UKBA), and Alan Kittle (Director of Detention Services). The factors taken into account in deciding that HA was subject to Article 3 ill-treatment included a failure to provide appropriate medical treatment to alleviate his mental illness, prolonged segregation, and the use of force against him was authorised on several occasions. I understand that all of these officials remained in their posts despite the decision.

224. The case of DX took place in 2011 and was decided in 2012, when I was in post. I cannot confirm that I specifically remember the detainee but he is definitely the sort of case I have referred to above. The Court found that DX was subject to Article 3 ill treatment because his mental state deteriorated to the point that he lacked capacity. The Court took into account that the medical treatment for his mental illness was negligent,

[56] R(HA Nigeria) v SSHD [2012] EWHC 979. DL0000178
[57] R(D) v SSHD [2012] EWHC 2501. DL0000179

and recourse was had to sanctions under rule 40 and 42, which was said to be unsuitable for a man with his condition.

225. As far as I am aware, there was no follow up with Brook House managers or health care staff about the finding in these two cases in 2012 or any time during my time at Gatwick IRCs. We were not informed about the serious concerns with the medical treatment these men received and that removal from association and use of force on mentally ill people might contribute to inhuman or degrading treatment in breach of Article 3 ECHR. I am not aware of any action being taken in respect of anyone responsible for the ill-treatment of these two men.

Control and Restraint (C&R) and Use of Force

226. As stated above, I have completed a City and Guilds L3 Certificate for Deliverers of Conflict Management (2007), Crisis Communications Course (2012), Prison Service Silver Commander (2011/2), First Responder (Advanced First Aid) (2007), Mobile Team Challenge Conflict Resolution Training (2007), Physical Control in Care and Breakaway Techniques Instructor (2007), MAYBO Programme in SAFER Children Conflict Management (2008). In 2012, I completed a Master's degree in Security and Risk Management at the University of Leicester. I was trained by the Ministry of Justice as a Use of Force instructor and I am widely read on the subject. I have been used twice as a consultant by the Ministry of Justice NTRG regarding conflict management which is referenced in the MMPR Manual. MMPR stands for 'minimising and managing physical restraint' and is a far more comprehensive approach to the training of conflict management which implicitly includes quality assurance within the scheme of work.

227. For my dissertation, I focused on use of force, which included examining 156 deaths that were related to the use of force in custody. The conclusion for my dissertation titled, 'Use of Physical Restraint within STCs', was that use of physical restraint, routinely as a first resort, is irrational and does not follow the legal principle

of last resort. It should be noted however, that where there is a direct and imminent threat to life, physical restraint may have to be used, although this should be the exception not the rule.

228. I used my knowledge to inform my work and the policies and practices at Tinsley House. One of the reasons Tinsley House was different, was because we had the family suite with women and children. At Brook House, there was a culture of control and restraint; it was believed that there was no other way of managing the detainee population. My opinion is and was that force should rarely be used due to the risk it carries of serious injury or death, for the person being restrained. Furthermore, restraint also presents a risk to the person carrying out the restraint, for example, I recall a significant proportion of the injuries recorded within Tinsley House and Brook House, were related to the use of force which therefore makes it irrational even from the perspective of the staff.

229. From my experience, the notion of 'risk' in the use of force is constructed by the individual carrying out the use of force, who is heavily influenced by emotions aroused from the fear and threat of violence. This inhibits the ability to process information which is a key element in making rational choices, and coupled with the rise of emotions, is more than likely to increase the perception of the 'risk.' This leads to an increased likelihood to resort to the use of force, where the perceived 'risk' is greater than the objective danger.

Control and Restraint (C&R)

Training and Attitudes

230. Control and restraint (C&R) techniques for custodial environments have been taught nationally as early as the late 1960s in an attempt to bring a standardised approach to managing incidents in prisons. The National Tactical Response Group (NTRG) who deal with the most violent and dangerous incidents nationally, are the

team who now develop and deliver the C&R methods and training. The NTRG were born out of a hostage incident in Peterhead Prison in October 1987 where a 56 year old officer was taken hostage. The Government did not have a suitable operational response within the Prison Service and so had to deploy members of the UK Special Forces to resolve the incident. Following this, the Prison Service developed NTRG. From its inception, C&R instructors were an elite team within the Prison Service who were extremely fit and able to dominate the most violent of circumstances. Intentionally or not, this is the environment in which local C&R instructors are taught at the national training centres. The local instructors then deliver the training within their own establishments and try and replicate their own 'national experience' which is expressed as a toxic masculine culture, which I witnessed filter down to G4S staff and the methods they would to carry out force and C&R in practice, and which is evident in Panorama.

231. During my own time being trained by NTRG as a Use of Force Instructor, people used to reminisce about NTRG trainers, who boasted about their method of sleeping with females on the course by 'being harsh to them at the start of the week and then be kind at the end', and ending the course with heavy drinking on the penultimate night. As a teetotal I did not partake in social events which involved heavy drinking.

232. The toxic masculine culture which filtered down to G4S was evident. I witnessed staff being trained in degrading ways such as forcing them to dress up in boiler suits and helmets to do warm-ups, with press-ups if they made mistakes. I complained about the C&R training to Wayne Debnam and Ben Saunders at the time as I felt it was inappropriate, humiliating, and set the wrong culture for the centre. They stopped the warm-up practices for a certain period of time. I complained about the C&R training more than anything, as I saw it as being central to the running of Brook House, which to my mind was wrong and perpetuated a negative, macho-aggressive culture.

233. Another issue I had with C&R, was the emotional responses I witnessed from certain officers. In 1988, the prison service undertook some research into the effectiveness of their relatively new C&R techniques. The research noted that *"...responses indicated that engaging in the use of C&R techniques is an 'emotional experience for Officers'. Their stated feelings generally tend to be at either end of an emotional scale, either 'elated' / 'great' / 'confident' or 'nervous' / 'worried' / 'anxious'"* (Brookes, M., 1988[58]). This range of emotional experiences can be seen in the Panorama documentary and which reflect my own experience of observing staff, some of whom would present themselves as 'victorious'. During my time at Brook House, I witnessed the visible adrenaline of certain staff who would regularly engage in C&R following the restraint. They seemingly enjoyed the adrenaline rush and it was reflective of the alpha male attitude. There are clear examples of it recorded in the Panorama documentary with officers boasting about the use of force. A stark example is Yan Paschali who boasts after apparently strangling D1527 that: *"We don't cringe at breaking bones…If I killed a man, I wouldn't be bothered. I'd carry on."* (52:57mins - Panorama). Whilst this may be shocking, from my experience, it is a reflection of the methods and ethos of C&R.

234. Another issue with C&R was the nature of the training and the lack of education about the benefits and drawbacks of the use of force for any given scenario. Just because you have the right to use some force in certain circumstances, it does not make all force legal or the best or safest option in a given scenario; however this was never instilled through the training.

235. Many trainers at Brook House taught C&R in the final week as block training sessions, without a break. Having the training at the end of the course gave an impression that this was the skill that would be used to save your life and was the most crucial aspect of the role. There was not a strong emphasis on alternatives based on de-escalation; something I took issue with as I saw it as dangerous to encourage use of

[58] Brookes, M (1988) *Control and Restraints Techniques A Study Into Its Effectiveness at MHP Gartree,* London: Directorate of Psychological Services, Home Office, Prisons Department

force as a first resort. In my opinion, it's important to have training in the classroom, mixed with training on the floor, and then reflective practices. I believe there should be but there wasn't, clear supervision and mentoring. There was a probationary period for new staff, however I am unaware of anyone failing this probationary period. The only structured system of supervision was the Employee Development Review (EDR) which was ineffective and focused on 'objectives' opposed to developing a reflective practitioner that had supervision, as seen with care professions.

236. The training should also be contextualised in the environment and to the population in which they take place but insufficient attention was given to information and understanding of the complex profile, needs and vulnerabilities of those in immigration detention. There was no distinct training on use of C&R techniques on victims of torture or other trauma and on those with serious mental illness. The training on C&R should be held in context with the other topics such as mental health, law, and human rights.

Method Unsuitable for IRCs

237. I do not believe that C&R as a training package designed for prisons is suitable for IRCs (it can also be questioned in prisons). Instead, investment needs to be made in developing a system which is able to deal with conflict and violence within residential settings, which has a stronger focus on prevention, de-escalation and the ethical use of force. Staff should also receive as much training in crisis communications as they do any physical restraint methods. I fully acknowledge that at times, there is a need for restraint techniques, but they should be considered a part of the wider system, not the focus. Models such as MMPR should be developed for use within IRCs and other adult contexts.

238. There is also a need to address whether these C&R methods are appropriate when used on victims of torture or trauma and those with a serious mental illness including trauma related mental illness. It does not appear that any lessons about this

were learnt from what was said in the cases of DX and DX From my experience C&R was often used as a response to and a form of management of the symptoms of mental illness, which as I have explained were often treated as non-compliance and disruptive. In my view, this was beyond the expertise and training of IRC staff. From my experience, if the person has symptoms of mental illness that require C&R to manage them, that is clear evidence that they are unsuitable to be detained and can't be safely and humanely manged in the detention environment. This is all the more the case if the behaviour being manged is self- harm and suicide risk.

239. In Tinsley House, I did try and train every DCM in crisis communications and negotiation strategies and it did have an impact on the number of use of force incidents which were significantly lower than at Brook House[59].This approach was not embraced and it led to be being treated as an outsider by those such as Juls Williams and the majority of DCMs, particularly those working at Brook House. I felt as though I was not trusted by the staff or managers in Brook House who believed I prioritised detainee needs at the expense of staff, and there was a level of tension and conflict with the DCM's about this. It ran counter to the dominant '*us against them'* mentality and I was sidelined as soft and weak.

Use of Force

240. For planned use of force, the C&R manual states that *"Planned C&R incidents are supervised by an officer who is accountable for the management of the incident until the prisoner is re-located ("the supervising officer"). Normally, this officer will be the Orderly Officer or Duty Governor (at least senior officer rank, although competence and experience are as important as rank)."* In the IRC context this was normally undertaken by DCMs (Oscar 1s) and rarely by the Duty Director. If onsite, John Connelly would supervise (referred to above at paragraph 151, and seen extensively in the Panorama documentary giving totally inappropriate instruction and

[59] A December 2012 Gatwick SMT Presentation shows that there were a total of 107 uses of control and restraint at Brook House and only 16 at Tinsley House.

making highly alarming comments about intending to assault a detainee during a planned C+R which thankfully did not proceed). When John Connelly was not onsite, Mick Glennard or Wayne Debnam would take on this role as the C&R instructors.

241. After an incident of use of force, members of the C&R team would usually de-brief and explain what had happened. Often, this would not be very detailed as there was neither the time nor the space to write up detailed notes. The process of the de-brief was often immediately followed by writing up the reports at the same time. This was not conducive to effective scrutiny and in my experience did not facilitate poor practice being addressed or challenged. That was not the culture.

242. As Head of Tinsley House, I was involved in reviewing all incident reports. I went out of my way to ensure that if there was a use of force incident, I would review the CCTV and read the reports. I would often bring staff into the office to discuss the use of force and what could have been done differently so that officers felt accountable for their actions and lessons could be learned. This was not done as far as I am aware at Brook House.

243. I witnessed or was aware of a number of inappropriate uses of force at Brook House. One particular driver was that the contract penalised G4S for not presenting a detainee for removal or otherwise. This created a commercial and widespread pressure for presenting a detainee for removal by whatever means were necessary. I recall the most common use of force I witnessed was either to effect removal or to prevent self-harm, including when removing the person from association.

244. I recall reviewing one particular incident which took place on 24 January 2013, and which was not untypical, which involved a male detainee who had known mental health problems, however inappropriate use of force was applied within 5 minutes of his arrival in detention. The situation had escalated due to a failure in communication between the detainee and the staff, which the staff misinterpreted as non-compliant behaviour. The staff members did not adapt their behaviour towards the detainee

despite knowing about his claimed mental health issues. CCTV showed that the detainee was not aggressive and the incident report of a DCO did not mention aggression. The detainee was non-compliant in relation to a search, so staff took hold of his head and restrained him. If rational thought had been applied and there had been a detailed analysis of his available paperwork, then other methods could have been employed to de-escalate the situation. I recall finding that use of force not reasonable or proportionate as no immediate threat was presented by the detainee to anyone else. For the above incident, I reached the conclusion that there were a number of things that could have been done prior to using force, and therefore force was not used as last resort. I sent the use of force report to the Director at the time, however I didn't hear anything back.

245. Another incident was on the 6 October 2012, where at approximately 1815hrs, a detainee on C wing of Brook House, was on the third landing with a ligature around his neck that was attached to the banister. He was on the phone to his 9 year old son and at times was balancing on the ledge on the wrong side of the barrier. The command suite was opened and the wing locked down (except for three cells directly behind where the detainee was). In the three unlocked cells where a total of four detainees, one of which had been diagnosed with mental health issues and had not taken his anti-psychotic medication for two weeks. Paul Gasson who was the Duty Manager from the Home Office had in my view wrongly refused national assistance, however I protested in the strongest of terms to Jerry Petherick (G4S Gold), who was supportive and escalated my concerns within the Home Office. National resources (NTRG and NTDSG) eventually were deployed and supported Brook House. At 2320hrs the detainee surrendered and was then removed to the Care and Separation Unit on a constant watch. No force was used during the incident however many of the staff were unhappy that we did not restrain him and were keen to use force at the earliest opportunity despite the clear risks of doing so. I believe this would have happened if I was not present.

246. I did attend a number of meetings with Gatwick IRC senior management on use of force that covered both Brook and Tinsley House, but not until 2013. The first was on 1 July 2013, which was the first meeting of its kind. I can remember a number of concerns arising in this meeting on 1 July 2013, including Michelle Brown, Security Manager, raising concerns that not all DCMs in the centres knew how to supervise a planned C&R intervention, a concerning revelation given it was often a required aspect of their role. I can also remember her raising worries that we were using a great deal of use of force on preventing self-harm which meant that something was clearly going wrong with our Safer Community assessments that it would lead to this. It was confirmed that most uses of force tended to happen in E-wing and that they were primarily linked to removal of detainees from the centre or self-harm. [60]

247. I can also remember Wayne Debnam, the Head of Safety and Security, confirming at the meeting that most uses of force were spontaneous. This led me to also raise the point as to whether some of these so-called 'spontaneous' uses of force were actually supposed to be planned uses of force – i.e. ones where we were planning a removal or transfer and should have gone away and made a plan (which should include negotiation and de-escalation before using force) but instead officers were just going ahead and using force without prior authorisation. This practice of not properly planning these situations was a concern to me both because these more 'spontaneous' instances of use of force and are much less likely to be fully recorded than if it was planned, and because it was less likely to involve to use alternatives and to seek to de-escalate the situation.

248. I recall that the Deputy Director, Duncan Partridge sent out a message at the 1 July 2013 meeting, that both he and Ben Saunders would support anyone who had used force so long as it was applied correctly; and that there was no appetite for challenging judgments about whether force was appropriate at all and whether alternatives should have been used. I think that was again an aspect of the *'us and them'* mentality – senior

[60] This is confirmed by the IMB Annual report for 2020 to reflect more current practice (**Annex 10**). DL0000140

managers would back the action of the staff on the ground, rather than scrutinise and hold them to account for resorting to the use of force.

249. The meetings on use of force were meant to take place quarterly but this did not happen and the next use of force meeting was on 14 January 2014. At that meeting, I raised issues about the powers being used including whether we were actually able to use force to enforce removal. I was trying to challenge the culture in the centre of resorting to the use of force and trying to stress that it needed to be reasonable and proportionate and always a measure of last resort, not the default. However, my point was not taken on board by the rest of management and my concerns were therefore ignored.

Instances of Use of Force at Brook House during 'Relevant Period' in 2017

250. I have looked at some of the use of force reports disclosed by G4S to the Inquiry during the Relevant Period and can confirm that it reflects the kind of concerns I had. I have looked at the reports of a Use of Force incident 86/17 (CJS005529) which happened at Brook House IRC on 5 April 2017 against detainee D2159. The use of force reports state that the detainee in question had not eaten for over six weeks and had at some point urinated on the floor. A multidisciplinary meeting was held, at which it was discussed that healthcare had expressed serious concerns about his food and fluid refusal and his hygiene. It was decided that a planned intervention would take place and as part of the plan, it was suggested that there would be an attempt to speak to him first and if he 'did not respond or engage or become refractory', the team would use force. It had already been noted that the detainee did not engage in English, although it was suggested that he could understand and speak English. There is no record of staff considering to use interpreting services.

251. I do not have the C&R manual that was in use in 2017, however from my knowledge of C&R, I would have thought that nine members of staff would be in

excess of the requirements of the manual and on the facts as stated in the reports, I do not see why nine members of staff were required.

252. The report then sets out a number of contingencies in which force will be used: *"get him into seated position on the bed, in figure of four arm locks, he will be spoken to again to see if he will comply with walking to Eden wing the team will stand up to see that Mr D2159 will support his own wait* [sic] *and walk compliantly. For Mr D2159's safety and the officers safety handcuffs will be applied behind his back to assist him walking down the stairs."*

253. From the descriptions given in the reports, he was simply lying in his bed, which suggests he was not posing any threat and no officer stated that they felt threatened by the circumstances that they met.

254. The account given by the number 1, who was the officer with the shield, says that he went in first and immediately placed the shield on the detainee's chest prior to any negotiation taking place. This is clearly a use of force before conversation. The other reports, however, suggests that DCM Steve Dix went in and had a conversation and only then, force was used. Healthcare's reports state that no force was ever used. It appears from the reports that force was used to sit the detainee upon his bed, force was used to apply handcuffs from his arms to his rear, and force was used to walk him downstairs, all because he failed to respond (which may be consistent with him not speaking English at all, or not being able to speak English in stressful circumstances, of which the officers were already aware).

255. At the conclusion of the incident, by which time he had been moved to E-wing, the reports suggest he is 'unresponsive' but there is nothing to indicate that anybody checked his vital signs.

256. This is an example of a wider pattern of force being used irrationally due to the illegitimate perception of risk that is contradictory to the facts that all staff were made

aware of. This was a detainee who had not eaten for six weeks, who may not have had any English language or may not have been able to speak English in stressful circumstances. The incongruence is highlighted in the phrase 'handcuffed to help him walk down the stairs'. Because of the political rhetoric in the background, there was often this perception that detainees were violent. The example also demonstrates the detachment and dehumanisation shown by staff.

257. I have also reviewed the incident concerning D1527 on 4 May 2017 (CJS005530). On the incident reports, it is stated that the use of force was unplanned and there were three reasons: non-compliance, to prevent self-harm, and injury to third party. There were four members of staff present, including Oscar 1, plus healthcare, which is surprising if the use of force was really unplanned. In these circumstances, body-worn cameras should be on, and it is also questionable that DCM Steve Dix is able to participate in the use of force whilst being a 'Supervising Officer' as he is unable to gain distance from the situation to properly supervise.

258. On reviewing the incident documents, there are several observations that I would make. Firstly, the rationale for force is unclear and seems to be directly correlated to placing someone who is calm onto Rule 40. I do not believe that D1527 would have met the criteria for Rule 40, as the issue of him being on the netting is historic (i.e. he no longer posed a risk to himself or the centre), and there was no urgency for G4S to self-authorise his segregation when he had calmed down – authority was required from the Home Office. DCM Steve Dix writes in his incident report that restraint is used as MA has his hands in his pockets, that he might therefore have something in his pocket he might use, and there is a risk of him hurting himself or others. It is clear from reading the incident reports that DCM Steve Dix initiates the use of force. I do not believe that use of force is reasonable, proportionate or necessary in these circumstances.

259. From reading his incident report, I am concerned about the issue with DCO Michael Yates, and I am also concerned why a full search was required, when a rub

down or metal detector would have been sufficient. The authorisation of a full search in these instances is unjustified and humiliating.

260. When comparing DCM Steve Dix incident reports to DCO Mohammad Shaukat, Ryan Bromley and Yates, there are clear inconsistencies, in particular relation to the reasons for the use of force. Where DCM Steve Dix states that use of force was applied when D1527 had his hands in his pockets and that his initiated the force; Shaukat states that use of force was due to D1527 becoming aggressive and trying to swallow his phone and that he initiated force first; Bromley agrees with Shaukat and says forced was used after he reached for his phone a second time and that Shaukat initiated the force; and Yates states that at point force was used, D1527 had removed his hands from his pockets and had his fists clenched shouting and that Dix initiated force before Bromley and Shaukat had even entered the cell. In the incident report, Shaukat confirms that he is on a 13 hour shift and has been working for only 4 months. Yates also describes D1527s behaviour as 'not acceptable', which reinforces the idea that segregation is used as a punishment.

261. It appears this is an example where staff believe there are circumstances that justify the use of force, but the test of reasonable, proportionate and necessary are not met. D1527 has informed the staff that he is not going anywhere, and has been calmed by going to a friend's cell, however staff use swarming and pain inflection tactics such as the 'thumb lexion/lock'. It is clear from the incident reports that the other detainees are able to calm D1527 and actually get him off the netting; which demonstrates the failure by officers to employ alternative negotiation tactics and rely on unnecessary force to achieve their aims.

262. When reviewing use of force reports, I am very concerned about the pattern of force being used for apparent non-compliance with no regard for the mental state of the detainee. In my view, there is no justification for this use of force but it reflects how force was generally used as the default at Brook House.

263. I have also witnessed the BBC footage in relation to the use of force used against D1527 on 25 April 2017.

264. If I were investigating this use of force, a line of inquiry would be to ascertain where Nathan Ring was at the time of the incident - as the DCM on duty and who had been in D1527 's cell just moments before the strangulation incident - given the lack of managerial oversight. To do this I would review CCTV, look at the log books which are kept on the wing but also in the main control room. I would also look at the radio system which automatically logs all radio communications, this would help me understand if any staff had pressed their emergency buttons. As part of the investigation I would also seek confirmation from Jo Buss that she had a pulse oximeter (SATS Probe) that measures oxygen levels in the blood as well as pulse rate. I would want to know why she felt the need to use it and subsequently what the reading was. A low oxygen level would indicate possible positional asphyxia which should then be treated as a medical emergency.

265. Jo Buss, who is a nurse and not trained in C&R appears at some stages to be leading the staff members. I am therefore confused as to whether it is a behavioural incident or a medical emergency, and the involvement of Jo Buss creates a default on her as a nurse that it is a medical emergency. It should have been understood by the staff involved, especially a qualified nurse, that D1527 would not have been able to kill himself by self-strangulation using his hands.

266. Given that there was no senior manager available, the person who led was DCO Yan Pascali, as the dominant member of the group. I observed DCO Yan Pascali (a G4S staff member who I did not have prior knowledge of) use his fingers to push down on D1527 's throat. From my knowledge of First-Aid, use of force and restraint related deaths, his actions were extremely dangerous. The movement into a recovery position was particularly frightening as the situation then became a medical emergency.

267. Any suggestion that DCO Yan Pascali's actions is that of a first aider trying to prevent choking is perverse. If this was the case why was the qualified nurse not dealing with the choking? That aside, I presume DCO Yan Pascali was a qualified first aider and as such would have known that: (1) you cannot treat choking until the person is actually choking and not where there is just an item in someone's mouth; and (2) the first aid response is in three stages – attempt to remove the object using a finger sweep in the mouth, perform back slaps and finally if unsuccessful use abdominal thrusts none of these were done. Although you can administer supine abdominal thrusts, it is impossible to give back slaps with him lying on his back.

268. Observing the situation in the round, it is clear that it developed into a classic 'us' and 'him' situation. This begins at the outset where the door is closed and acts as a physical and psychological barrier between D1527 and the staff. I have no doubt that D1527 would have been able to hear the nurse and staff talking about him from behind the door. If I were there, I would have removed the spectators and engaged with D1527 in the cell through conversation. I would attempt to normalise the situation and ask D1527 what happened, with the overarching importance of making sure D1527 understood that I was there to help. There is nothing in the footage that I can see to show any form of negotiation or engagement, and for this reason, it is difficult to understand the 'trigger point'.

269. Based on my experience of working in custodial institutions over a long period of time, it is clear that this behaviour does not appear to be an isolated incident. From viewing the behaviour of staff in the footage, it is clear that they were conditioned to such displays of violence from other staff as little shock or opposition was shown apart from that of Callum Tulley. The fact that none of the behaviour had been reported prior to Panorama airing also shows the degree of institutional compliance with such actions.

270. I understand that Sussex Police and the CPS have failed to secure a prosecution of DCO Yan Pascali or any other members of staff in relation to the Brook House Panorama documentary. I believe this is an abject and abhorrent failure, and exemplifies the impunity of those who abuse detainees.

Collusion

271. I did not have any direct experience of staff colluding and recording incidents incorrectly, mainly because it was clear I would not have colluded and if it had occurred it would be difficult to identify it on review. However, there were often times where Rule 40 reviews were distinctly different from the narratives of detainees. This centred on the antecedence of incidents not being included by staff in Rule 40 paperwork which would normally begin with how the detainee was behaving. When I spoke to detainees on many occasions it was clear that 'the incident' had begun by a member of staff being abrupt or rude to them, or with the detainee having a legitimate complaint which they perceived was not being dealt with properly, which then escalated through frustration into aggression. On one occasion I recall undertaking a Rule 40 review with DCM Adam Clayton with a detainee who had allegedly assaulted a member of staff. When I entered the cell, I asked to sit down on the end of the bed which the detainee allowed me to do. I then asked them to talk through what had happened the day before from their perspective. Immediately DCM Adam Clayton interrupted me and said 'we're not here to talk about that'. I reminded him that I was the Duty Director, and we would talk about anything I wanted to talk about. I do not remember the exact detail of what the detainee said but remember that as described above, it was an incident that could have been prevented by staff, however I also remember that he admitted assaulting the member of staff.

Use of Segregation / E-Wing

272. E wing is made up of two parts: thirteen cells of 'normal association' (that are formally known as 'E-wing') and six cells with a separate shower separated by a gate and door (the 'Care and Separation Unit' (CSU)). Historically, the whole area was the CSU, however this was reduced to the six cells behind the gate and door, which became used for Rule 40 and Rule 42. The two cells in the larger section were made into constant supervision cells, which had fitted furniture that reduces ligature points and

doors which have removable solid panels that reveal the clear polycarbonate to allow viewing into the cell even when the door is closed. Staff were able to separate off these cells using a hospital-type screen. When the CSU was converted under 'NOC 84', no equality impact assessment took place to assess the impact on those with particular religious beliefs or disability such as mental health problems.

273. The use of E-wing to place detainees deemed as unsuitable to mix with the general population, led to a concerning mix of mentally unwell and vulnerable detainees, age dispute cases and those including foreign national offenders that were deemed to be unsafe to be in general association. It was also used in order to transfer people prior to removal, to keep disruption low during Charter flights. In the minutes from a DEAT meeting on 23 April 2013, I recall a DCM confirming that FNOs and those unsuitable for detention were kept on E-wing, some expecting to be there a few days but many ending up there for several weeks.

274. The six cells in the CSU were triple certificated under Rule 40, Rule 42 and Rule 15. In my opinion, this allowed for the mixing of the most vulnerable and the most disruptive or violent. It allowed for those on constant watch being in the same area as those who were not deemed unsuitable to mix with the general population. E-wing was not a calm, tranquil place suitable for those with mental health issues. Instead, it was a place of conflict and had an atmosphere of hostility.

275. The mixed population prevented a clear focus for the staff on what their roles and tasks were. Staff on E-wing would be pulled between caring for those on constant watch, and dealing with the most experienced challenging prisoners. Conflating the two groups as the 'difficult' populations in Brook House allowed for an unhelpful conflation of mental health needs, re-enforcing the notion that mental illness was just another form of disobedience or disruptive behaviour. It leads, as I think the Panorama footage shows, to staff acting in similar ways towards the two populations, where the mental health needs were seen as behavioural issues, to the absence of empathy and the dehumanisation in which abuse occurred.

276. I do not recall any real training or education on the impact of isolation on detainees and detainees with mental health issues for those on Rule 40/42 or constant supervision at Brook House. Training was focused on the functions and legal aspects of the rules, as opposed to the impact on the detainees.

277. For those on constant watch, there was very limited interaction by the staff observing them in Brook House. There were some occasions where I would see staff reading books whilst on a constant supervision which I would challenge. I am aware from the BBC Panorama transcripts that there is footage of an officer, DCO Sean Sayers, admitting to falling asleep during a constant supervision (KENCOV1037 - V2017061900010) which is highly concerning. I also specifically recall an incident on or around 19 April 2012 where I complained about an officer failing to maintain a constant watch. The officer left the detainee unsupervised while he went to make a coffee. The approach to constant watch at Brook House was that it was considered a purely a mundane observational task that did not require an officer's undivided attention– the clip regarding DCO Sean Sayers confirms that was still the case in 2017. I disagreed with this approach and therefore encouraged interaction and engagement for those at Tinsley House. There was only one cells with operational use for Rule 40 /42 in Tinsley House, which we used very infrequently. The lack of cells for Rule 40/42, meant that staff were encouraged to prioritise negotiation and de-escalate situations. Constant supervision was carried out within the normal centre, and the staff engaged with those on constant watch. It was not resented in the same way as it was at Brook House as an inconvenient and annoying task.

278. In order to release the person from constant supervision, a multidisciplinary meeting would take place between the Duty Director, healthcare, Safer Community and the chaplaincy. However, it was often difficult to get people together and this meant that reviews were sometimes carried out without the full multidisciplinary attendance.

Impact on Mental Health

279. From my observations, the lack of engagement and stimulation for those on constant watch at Brook House, particularly where there was nothing in the cell, perpetuated mental health problems. Those in segregation had an extremely restricted regime. They were prevented from all association and were only allowed out for fresh air for a certain period of time. Being held in sparse cells in such conditions without any personal artefacts did not support positive mental health and I saw that it caused distress.

Misuse of Rule 40/42

280. I believe there was an issue with the administration of Rule 40/42. Whilst the guidance states that they should be used for the least possible amount of time, in practice, staff would only review them once a day and therefore people could be left in there for 24 hours until they were reviewed. I recall some people being in Rule 40/42 for significant periods, for days and sometimes up to 2 weeks. This compared to my experience at Medway, where according to policy, children could only be kept in isolation for a maximum of 2 hours in any 24 hour period. Despite this, it is important to note that at Medway, it was found that there was *'evident confusion between policies which are supposed to protect vulnerable young people and those which are supposed to maintain good order and discipline'*[61].

281. Furthermore, there were also serious problems in seeking the Home Office's authorisation before initiating Rule 40/42 and instead claims were made that the decision was urgent (Rule 40(2)/ 42(2) allow G4S managers to authorise use in cases of urgency) when they clearly were not. I have already highlighted the 4 May 2017 decision to segregate D1527 above, which I believe was not urgent and so unlawfully authorised by G4S.

[61] See the Medway Improvement Board's Final Report of the Board's Advice to Secretary of State for Justice, 2016 – para 3.17 (INQ000010)

282. I also believe that staff used Rule 40/42 as they had no other ways of dealing with poor behaviour or mental health issues. The centre did not have a sanctions and rewards system and therefore the only 'sanction' they had to punish poor behaviour was Rule 40 – this was clear from my reviews of Rule 40 as described previously. Furthermore, due to the lack of resources to support detainees with mental health issues, detainees would be placed on Rule 40 due to their presenting behaviour as staff would believe there was no other way (but in reality no other '*convenient*' way) to manage their behaviour within general association. In fact, the underlying mental health issue was what needed to be addressed.

283. I raised concerns about the use of E-wing, in particular around staff engagement with those on constant watch, and our inability to adequately care for some detainees, particularly those with substance misuse issues. I was aware from raising my concerns with him that Deputy Director Duncan Partridge shared these concerns, and Tony Bond who was the Safer Community officer, was also particularly frustrated by the situation. I do not know if they raised these concerns with the Home Office but no effective action was taken whilst I was there.

Safeguarding Policy

284. The Inquiry has requested that I comment on the safeguarding policy which I originally drafted in 2010. At the time, it was solely drafted in respect of children. I was very clear that policies external to the centre were not being followed by staff. I understand the safeguarding policy I completed in relation to children was developed into a safeguarding policy for vulnerable adults too. It is clear from the Panorama documentary on Brook House that policies set in place to protect vulnerable people were not followed. Furthermore, it should be understood that no policies or procedures can ultimately protect vulnerable people who find themselves in an institution in which they should not be held, and which is operated as a hostile environment. CJS000499

Children

285. If a child who clearly looked under the age of 18 was detained, this would be a failure of the enforcement teams, police, escorts and reception – all of these stakeholders should have acted to safeguard the child before they were detained. If I had a suspicion of someone being under the age of 18, as a Deputy Director, I needed to make an assessment to ensure the person was safe. Then, I would inform the Home Office who would advise whether there had been a *Merton* compliant age assessment by a local authority.

286. However, there was a moral dilemma once the child was in detention if the *Merton* compliant age assessment was not immediate as it could take days if not in excess of a week. Therefore, in the meantime, you would be faced with limited options which included either to place them in the Family Suite, where they may be the only individual there and suffer isolation, or Rule 40 for their own safety, which would be barbaric, or in the main population, where they may be surrounded by potentially dangerous adults or where they may find comfort and solace with people from their own nationality. Ideally, when a person is suspected of being a child they should immediately be taken into the care of the local authority who until proven otherwise should be treated as an unaccompanied asylum seeking child. This however, rarely happened in practice and young people including those later assessed to be children were kept within the centre until age assessments were undertaken. I was also aware of cases where the *Merton* assessment did not accord with our experience for those who we believed them to be under 18, but who were assessed to be adults. This was very difficult as children are obviously highly vulnerable to a whole range of abusive behaviour.

Training

287. The Inquiry have asked me to comment on the quality of training G4S staff provide to the staff and in particular whether it was adequate for them to perform the

role. In my opinion, the training provided was not at all adequate for staff to perform their role effectively, and within the principles set out in Rule 3 of the Detention Centre Rules. There was a serious lack of understanding and awareness of the importance of protecting the welfare of detainees and their human rights. There was no directive in the training to treat this as one of the key responsibilities for which we would be held accountable. I have also addressed this in some detail above, where I explain:

(i) the lack of training on equality and diversity [154];
(ii) the inappropriate methods of C&R that were used from the prison context, which was in any event limited and of very poor quality and from my experience fostered the toxic culture [230 – 233, 237- 239];
(iii) the lack of training on alternatives to C&R as the default response meant no effective methods for managing conflict or crisis situations [234 – 236];
(iv) the lack of training in respect of torture, trauma and mental illness and how that should be factored into C&R [213, 236];
(v) the lack of training and support to staff on dealing with the high incidence of trauma, self-harm, suicide risk and distress [126, 209, 276].

288. In order to obtain a DCO Certification, you must 'complete' training on a number of elements. In practice, however, the training was very basic and to 'complete' in reality meant sitting through PowerPoint presentations on each of the topics. Refresher trainer was not a priority and was very poor. In the internal stakeholder DL0000142 survey I completed in April 2014, in response to one of the questions, someone answered: *"In DCO refresher but not fully as no one trained was there only leaflets."*

289. There are only two elements of the training to become a DCO that are tested (First Aid and C&R). You also did not have to complete a test or further training to become DCM. I believe this issue comes back to the fact that the running of Brook House is a commercial contract, and there is little incentive for G4S to do more than the minimum required in the contract.

290. In my opinion, to be a good DCO, you must have good working knowledge of the law, rules and policy under which the Home Office and G4S are supposed to operate, as well as the legal and human rights obligations and how they are enforced in the courts. There should also be good understanding of equality and diversity, and trauma and torture. When I did training at Tinsley House, I would play documentary films on immigration to ensure the staff understood the historical and political context they were working in, whereas at Brook House this did not occur. I believe better training would encourage staff to humanise detainees and understand how to deal sensitively with certain behaviours, with the understanding that it may be rooted in trauma.

291. There was no trauma or torture training in the Initial Training Course. I do recall a psychologist coming in on one occasion to deliver training but I cannot remember if this was just for the family suite. I also contacted Medical Justice in I believe 2013, to ask if we could source some training regarding torture, however this did not transpire. I believe this was because Medical Justice were concerned about being associated with the operation of Brook House, and were not in a position to deliver training at the time. I organised conflict management training for Oscars and held it at Tinsley House for all those working in both Centres, when I was Head of Tinsley House, but it was not taken up and embedded within the wider culture at Brook House. It was not a priority and the will and energy to influence the culture was not there.

292. Overall, I think DCOs should understand the principles and protections of law and be tested on this, to be able to be working with vulnerable individuals in the immigration context. I feel that it is important to understand your own powers and duties, and to understand the dynamic that comes with the power of being an officer. If officers had a better understanding of what powers they had and didn't have, perhaps this would prevent abuse of that power.

293. Training is also needed to instil a culture of challenge and accountability which was fundamentally lacking at all levels. Improved training needs to apply to all senior managers and civil servants in the Home Office and, like staff members, should be

performance managed on their compliance with the standards and obligations set. It should be understood that failures would be treated as misconduct and action taken.

Security and Drugs

294. Whilst spice was not an issue in Brook House IRC when I resigned in 2014, I was not altogether surprised by the footage on Panorama in relation to what appears to be widespread drug use and I would see this as part of the lawlessness and chaos of the place that this could happen. There were incidents of other drug use when I was working there but not on the scale exposed by Panorama.

295. From the knowledge I have, Brook House has drug netting and drone lifts would not be possible as Gatwick airport is nearby. Therefore, this leaves three main routes for supply: visits, postal system and staff.

296. In an email dated 5 January 2017 **(Annex 13)**, former Head of Tinsley House Stacie Dean states, *'In the case of the DCOs we discussed, they are also known to be supplying spice to detainees yet there has not been a single staff search since this information has been known.'* It was also reported by the former Head of Security that Duncan Partridge also failed a drugs test, as noted in my exit interview records **(Annex 14)**. Both of these examples demonstrate an inappropriate attitude towards drugs and a possibility that staff were involved in bringing in and supplying drugs to detainees. DL0000140 DL0000140

297. Staff searches were not routine, nor were security and intelligence reports about staff. There were contractual requirements to search staff, however in practice it was lackadaisical. There was not a proactive culture for promoting professional standards. I was searched at Brook House around once in about four years. There was also a bomb-blast room to search mail, however it was rarely used. There was one occasion when I was on duty, and I saw a massive hole under the perimeter fence at Brook House. It had not been picked up by the perimeter check on the day, which showed the carelessness applied to security checks.

298. At Tinsley House, I would ensure there were routine staff searches to make clear the deterrent to staff of bringing inappropriate items into the centre. I believe strict searches are important to re-enforce the idea that staff are not outside the law.

Complaints and Whistleblowing

299. I have been asked to comment on complaints and whistle-blowing procedures. In my sections on my history at Medway and Gatwick IRCs, I believe I have addressed the complaints that I have made and the inadequacy of the response to those complaints in detail and I summarise the position here.

300. From my experience at Medway STC, I had absolutely no confidence in any of the methods open to raise concerns both internally and externally and that any action would be taken. I tried for years to raise complaints internally and externally as follows:

a. Ofsted inspection;
b. The contract monitor for Medway Youth Justice Board;
c. The local MP for Chatham;
d. The Bishop of Rochester;
e. Medway's Local Authority Designated Officer (LADO);
f. The Prison Liaison Officer from Kent Police;
g. Kent police.

301. None of these methods resulted in any effective action until the Panorama broadcast in 2016. Even after that, the criminal prosecutions largely failed. Moreover no action was taken to hold to account Senior Managers in G4S and the Ministry of Justice.

302. This informed my decision-making when at Brook House, and my faith in the mechanisms available to raise concerns. The steps I did take to raise my concerns were largely ignored and I was side-lined, but included:

a. Raising concerns with the Deputy Director, Duncan Partridge;
b. Raising concerns with the Director, Ben Saunders;
c. Raising concerns with the Home Office Monitor at Tinsley House, Deborah Western;
d. Raising concerns with the regional HR Manager, Steph Philips;
e. Raising concerns with the Managing Director, Jerry Petherick;
f. Raising concerns with Kent Police which I was told were shared with Sussex Police and the Serious Fraud Office;
g. Raising concerns with the Home Affairs Select Committee.

303. I believe that staff on the ground are dissuaded to complain or use the whistleblowing strategy, due to a culture of fear that is instilled. Staff are worried about their safety and/or have a fear of being isolated and left alone on the wing. In the internal survey I completed in April 2013, someone stated, *'I feel that those who challenge management are excluded from progression'.* This makes people feel as though they are unable to speak out against the dominant culture. I have witnessed staff who have spoken out being marginalised, in particular DCOs on the ground. The staff at Tinsley House as a whole were side-lined by not wanting to work at Brook House for fear of their safety. DL0000142

304. I also refer you to my police statements at **Annex 2,** where I state on page 19, DL0000140 *"If staff were seen to act on concerns outside of the control of the centre's management this was dealt with by excluding them from the centre itself either through raising spurious Security issues or by raising other significant concerns. An occasion noted was when a Health Care Manager was suspended from site after they raised safeguarding concerns outside of the centre... Other examples were where independent advocates were also side-lined after they raised concerns. This all led staff within this centre to tow the line or fear for not only their job but also criminal*

prosecution'. Whilst this is in relation to Medway STC, I believe it is representative of the wider culture of G4S. It is also evident in the account given by Stacie Dean in her emails at **Annex 13.** DL0000140

305. The fear comes from the dominant institutional culture within G4S and the fact that those whom you may complain about are also the people who you will need the support of if anything goes wrong. When you observe a system which allows wrong things to continually happen without challenge, when you see people continually get away with bad things, then you soon understand that you aren't challenging the individual but the system itself. You understand that if you do challenge it, then you are putting yourself against the system itself, which is enough to put fear into the bravest of souls.

306. In my view, it is the culture of impunity at all levels of the system that is a significant factor in why toxic institutional cultures are established and abuse occurs. The Inquiry must investigate who has actually been held accountable, why accountability is so limited and why those at the highest levels within G4S and the Home Office have not faced any disciplinary action and why there is no political accountability for the misconduct, appalling treatment and repeated failures.

307. I am not aware of whistleblowing allegations at Brook House resulting in the sanction or removal of staff.

308. The fact that there has been no criminal prosecutions arising from the events at Brook House is also a major accountability deficit that impacts on people's trust and confidence in the system. The fact that no one at all has been prosecuted despite so much misconduct being captured on film inevitably destroys any faith in the system.

309. The lack of accountability and sanctions to date - is my primary reason for participating in the Inquiry and why I consider it so important. However, I strongly believe that things will not fundamentally change unless people are held to account at

all levels of the system and serious consequences occur for the individuals and the corporate bodies. I do not understand how G4S could continue being the contract provided for almost 3 years after the Panorama broadcast which included a two year extension; and equally why any contract could continue to be run with G4S after the Medway and Brook House reporting. I also do not understand how managers within G4S with oversight for these centres or on site, like Ben Saunders, Steve Skitt, Juls Williams or Steve Dix were not dismissed but were able to continue in their roles or take up posts elsewhere. I also do not understand how senior civil servants responsible for these contracts such as Paul Gasson or Mr Schoenberger and for detention services generally have not been disciplined but remained in post.

310. Until concerted action is taken and is seen to be taken, complaints made will be ignored or more likely won't be made at all because people will have no confidence in the system.

Complaints Procedure for Detainees

311. The complaints system for detainees involved filling out a complaint form, which would be placed in a post box, picked up by the Home Office and passed to the relevant team. From my experience, whilst the complaints from detainees went directly to the Home Office, the vast majority of them were passed to G4S to investigate internally and report their findings back to the Professional Standards Unit. Very rarely did a complaint go to the Professional Standards Unit unless it was extremely serious, i.e. a complaint of assault.

312. Detainees were aware of the complaints system but many would openly tell me they were suspicious and fearful of it as they felt it would affect their immigration status. I tried to encourage and re-assure them that it would not affect their immigration case but it is understandable why this occurred. Detainees didn't feel as though there was much independence and did not have confidence their complaints would be

investigated by the people who were detaining them. There was a general mistrust of the system and a perceived lack of independence.

313. There were also many obstacles to complaints including language barriers, illiteracy, and many come from cultures where they are deferent or fearful of authority. As I have explained, a large number of detainees were experiencing trauma and distress, and many had significant mental illness. There was no system such as mental health advocates to assist them in making complaints or to make them on their behalf. I did some training on the Mental Capacity Act but there was no follow up and no practical steps to help people with serious mental illness and who had capacity issues access complaints or legal advice. For many, detainees would simply not be aware of their rights and what you could and could not object to.

314. Even where complaints were made by detainees, if it was in relation to something that there was no contractual obligation for G4S to provide, G4S were entitled to reject the complaints. Detainees did not understand why their complaints were not upheld, leading to a lot of frustration and which reinforced the sense that there was no point to complaining. I have seen the complaint (CJS001493) disclosed in the Inquiry, where a detainee complains about not being provided with a phone to contact his wife who has recently undergone heart surgery. The complaint is not upheld and one of the reasons provided is that G4S are only contracted to provide phones for one in ten detainees. This is an example of the approach taken by G4S.

Oversight Mechanisms

IMB

315. In my experience, the Independent Monitoring Board (IMB) was ineffective and unable to accurately and effectively scrutinise the system. I believe IMB staff/volunteers were not adequately trained and skilled to have a critical presence in custodial environments or to establish a positive ethos and culture. Instead it was very

surface level; they were more interested in optics than the granular operation of the centres.

316. Whilst IMB did have a presence in the centre, they would only obtain a snapshot of the situation when they visited. On the days that I was at Brook House, I would be there from 8am until 9pm; and I would attend the morning meetings each day to ensure I had an overview of what was happening across both centres. IMB however, never attended the morning meetings in all the time that I was at Gatwick IRC. The IMB would do weekly visits and turn up to major incidents, for which they would write reports. I would attend monthly meetings and address any issues or concerns they raised. There was an illusion of oversight from them but I do not feel their scrutiny of the centre was robust or sufficient.

317. I believe the relationship between senior management and the IMB was also too close and their independence was comprised. I was aware that the Director Ben Saunders used to take them out for lunch regularly, which I felt was inappropriate. Generally however, there was a feeling not to worry about the IMB as they did not have as much clout.

318. I have seen a notice issued under the Detention Centre Rules 61 (3) and (5), by the Brook House IMB and IMB Charter Flight Monitoring Team (CFMT) bringing a concern to the attention of the Minister on the 2 of October 2020 and identifying practices in detention that could amount to inhuman or degrading treatment[62]. I have no recollection of these mechanisms being used when I was at Brook House although many of these factors were present as long standing issues, as I have described above.

319. The notice states that the IMB have evidence that the concentred programme of Charter flights in 2020 "*indicates a series of issues ... collectively and cumulatively having an unnecessary, severe and continuing impact on detainees, particularly those facing removal on charter flights, as well as across the detainee population as a whole. We believe that the cumulative effect of these concerns amounts to inhumane*

[62] See Annex 10 **DL0000140**

treatment". It documents an increase in the number of vulnerable detainees, high incidence of self-harm requiring use of ACDT and generally causing high levels of stress and anxiety. It also documents the breakdown in the Rule 35 process and people being removed when on ACDT and at risk of self-harm/suicide.

320. It was clear to me that the Charter Flight removals when I worked there had adverse impacts on detainees. I would, however, also add, as I have sought to indicate above, that the pressures relating to Charter Flight and removals had a wider impact on the system and staff within the IRC because they are so politically charged and central to meeting the targets of importance to the government. Removals were often the occasions where use of force of the kind I have described above, was likely to be routinely used as the default including on vulnerable detainees with significant mental health issues, as it was in 2017 both in transfers to the CSU and for flights. I am, therefore, surprised that the concerns don't go wider than the impact on mental health, although that is obviously serious in itself. In light of what was exposed by Panorama, this is a concern to me. Either way, it does seem to indicate that some of the same toxic mix of factors I raised concerns about and in play in 2017 are still operating and significantly have been assessed to risk treatment in breach of Article 3 ECHR by the IMB. I have not seen any response from the Home Office to know if it is any different from the past, whether it continues to ignore the evidence of harm of its practices in detention and instead continues to put political imperatives above fundamental rights and the welfare of individuals.

Her Majesty's Inspectorate (HMI)

321. HMI was a far better professional inspectorate, however they were only able to assess and inspect what they viewed on those days, and the time-frames allowed senior managers to organise the centre. Inspections took place in two parts; there would be a brief tour and survey on the unannounced inspection, then they would come back for triangulation. This offered a lot of time for senior managers to make changes including: redecorating, sorting out files and addressing any outstanding issues, reviewing the kitchen menus, replacing items for better quality etc. The approach was taken from

Paul Cook's ethos of 'if the Queen is coming round for tea, you get the best china out' and was instilled by Ben Saunders at Brook House.

322. I was also aware that such practices could include managing which staff were present through the staff rotas or holidays, taking superficial steps to improve physical appearance and completing the paperwork. I was aware from Medway STC that this period could allow for "ghosting" which was a practice of transferring problematic cases to other centres. I did not directly witness that at my time at Brook House but transfers particularly of mentally ill detainees between centres was not uncommon. I have seen that there was some evidence to suggest this in the HA case although the Court made no finding on it. Generally, detainees could also be released to avoid scrutiny and adverse consequences. I witnessed this with food and fluid refusers, where if there was a risk of a detainee dying, they would release them to prevent a death in custody.

323. I think it would also be fair to say that a number of the recommendations repeatedly made by the HMI relating to the prison-like environment, the lock down regime, and the conditions of the cells, were not acted upon or even if addressed, the changes were superficial and transient. If the HMI is really to act as a robust safeguard, the Home Office should be required to act on its recommendations. Otherwise, the Inspection process has no real teeth and its concerns can be simply ignored.

324. In my view, the Home Office staff who were on site should have been responsible on a day-by-day basis for looking at what was happening on the ground. However, in my view, the institutional culture at Brook House itself, but also within the G4S and Home Office staff including at a senior level coupled with the links between them, are such that they are unlikely to identify failings on the ground and act upon them.

325. As I have mentioned above, there was also an issue whereby the Home Office staff were burdened with the administrative demands of Brook House, and therefore

may not have the capacity to assess the IRC sufficiently. There did not seem to be much of a will from on-site Home Office staff to identify failures. The only time I heard anything negative from Home Office staff at Brook House was when a 'failure' had impacted on their own work, e.g. failures to produce detainees on the visits corridors or for charter flights.

326. I think it is necessary for there to be some form of independent professional inspectorate who should closely monitor the operation of the IRC that takes over the role of the IMB, expands it to cover contract monitoring and which can provide frequent, robust and regulated oversight.

327. This would better supplement the more snapshot HMI inspections whose recommendation should be mandatory and followed by the Home Office to give it teeth.

Resignation

328. In 2013, Derek Milliken and Ian Danskin, who were the Director and Deputy Director respectively, left to work for Surinder Arora, who owned the land Tinsley House was built on and who had plans to prepare a bid to the Home Office to run his own IRC with an airstrip just for deportation and removals [see Lee Hanford interview with Kate Lampard at paragraph 216]. Jerry Petherick then recruited Deputy Director VER000266 Duncan Partridge and Director Ben Saunders as senior management at Brook House. Steve Skitt was also brought in from HMP Birmingham. In my view the management of Brook House went further downhill very quickly under their leadership, particularly in respect of staffing and sickness levels, and poor staff morale.

329. I made my resignation from G4S on Monday 14 April 2014 to Duncan Partridge. The reasons for my resignation was the collection of the many of complaints and concerns that I have explained above with the running of Gatwick IRCs and which were not addressed. I was finding it difficult to come into work because I was so

exhausted and overwhelmed by trying to make a difference in a system that was so entrenched. I met with Jerry Petherick and Alison Ashcroft from Human Resources to have an exit interview in Southside, London on the 23 April 2014. During this meeting, I read out a list of grievances (**see Annex 14**) I had with G4S Management which DL0000140 included:

i) *"2 whistleblowing allegations, have only had an informal meeting with Duncan* [Partidge] *regarding one of them"*

[This allegation was to demonstrate that the whistleblowing system clearly did not work. I was made aware of one complaint against me for making a female officer cry (which I denied), but I was not aware of the other two allegations.][63]

ii) *"More critical of any issues that happen at Tinsley House and seemingly gloss over issues at Brook House"*

iii) *"Inconsistency in disciplinary outcome and process in relation to staff at Tinsley and Brook (ACDTs for example – Andy Jennings compared to similar cases at Tinsley)"*

[These allegations were in relation to the disproportionate criticism and disciplinary action taken against staff at Tinsley House over Brook House. I believed this was a clear bias against Tinsley House and used as a tool to undermine me]

iv) *"No formal de-briefs following being Silver in incidents"*

[63] The officer I believe was Cheryl Nugent who came into my office and left crying. The reason for her crying was that she was upset by other members of staff at how they were treating her. I had a positive relationship with her and at no point was the reason for her crying. It was not Cheryl who made the complaint but other members of staff.

[This allegation referred to me not being included in formal meetings and de-briefs. I believe this was part of the strategy to isolate me as an 'outsider']

v) *"No action taken for months regarding concerns raised following incident (phones not working in command suite, out of date contingencies, no MOE equipment available etc)"*

[This allegation is reflective of the complaints I would make regarding the poor facilities in the Gatwick IRC's; and the failure to take action by management]

vi) *"At first away day when discussing Juls Williams birthday he joked about going up to London and doing some lines"*

vii) *DCMs state that during a Home Office search Duncan Partridge was stopped and had a positive drug test*

viii) *"When two members of staff were suspended pending police investigation regarding drugs, it was extremely hard to contact one of them however Juls Williams (who had brought one of them into the company) was always able to make contact with him"*

[These allegations are based on my concerns that senior members of staff were using drugs and another was protecting staff bringing drugs into the centre]

ix) *Poor culture amongst Brook House residential staff and it is as though some are protected by Juls Williams and this goes unchallenged*

[These allegations of poor culture operating at Brook House related to what I have explained in detail and representative of the close knit group that Juls

Williams controlled and protected; which in turn is representative of the collusion between staff at Brook House to continue the poor culture]

x) *Incident on 11th April 2014, telling staff not to contact Gold and attended scene himself*

[This allegation is regarding either Ben Saunders or Duncan Partridge. I cannot recall the incident I was referring to]

xi) *Asking me what to do regarding ARF forecasted overspend*

[This allegation is regarding Ben Saunders and his direction to complete jobs that were not my job role. I was left to my own devices at Tinsley House, even though he was the Director at both IRCs and should have had more of a presence. He was extremely rarely at Tinsley House]

xii) *Staffing figures I believe have been manipulated and falsely represented to the authority*

xiii) *Have been promised support on numerous occasions with no result*

xiv) *Have raised concerns regarding facilities and was essentially told I needed to manage them and be on top of them*

[This allegation relates to the fact that I did not have support and was required to take on more than my job role. Mike Bird was the Head of Facilities and was line-managed by Ben Saunders; however he would imply that I was responsible for these issues. I felt this was also part of me being side-lined by senior management]

xv) It is in the minutes that vetting concerns were raised by the Home Office at Tinsley house in March 2013 in a meeting where assurances were given by Duncan Partridge that there would not be an issue

xvi)Following a meeting on Tuesday 15th April regarding vetting concerns, a member of the ITC who did not have CTC clearance was allowed onto site at Tinsley House in a detainee area and then was tasked in the afternoon with archiving detainee paperwork which is confidential

[These allegations concerns staff members having the right training and checks. Duncan Partridge assured me that this did not matter probably due to staffing issues, however this standard of professionalism concerned me. ITC refers to 'initial training course' and it was particularly concerning that individuals had access to detainees and/or their information without getting clearance]

330. After I had gone through my list of grievances, I used an example diagram for domestic violence and applied it to the behaviour of Ben Saunders. I explained that he operated with intimidation and isolation, followed by being kind to win you back. I know that Wayne Debnam made allegations about Ben Saunders' management style in 2012 (see Lee Hanford's interview with Kate Lampard at 2013 – VER000266_0015), and was suspended as a result. Both the former head of Tinsley House Stacie Dean and Deputy Director Duncan Partridge also raised concerns about Ben Saunders' management before they left. Duncan's grievance against Ben is confirmed by Lee Hanford in his interview with Kate Lampard as he completed the grievance investigations. He describes the relationships between senior managers as *'like Emmerdale'* [198] and *'quite toxic'* [238] and this was certainly my experience at the time.

331. Alison Ashcroft of HR in a letter dated 7 May 2014, stated *"it is recognised that you didn't wish for the information disclosed to Jerry and myself on 23rd April 2014 to*

be treated as a formal grievance but it is important to understand that matters raised will be taken seriously and treated as deemed appropriate". I did not want it to be treated as a formal grievance as I did not want the situation to drag on. I did not have the emotional energy to attend further meetings and I had no faith in the process to achieve anything. Furthermore G4S did not require a formal grievance to be raised in order for them to take action against these complaints.

332. I am now aware that Jerry Petherick visited Brook House on the 28 October 2014 following a grievance made by Michelle Brown. She made a number of similar complaints I had raised about Ben Saunders' poor leadership and incompetence before I left in 2014 and which were known. It appears that Jerry Petherick was very critical of Ben Saunders but it is unclear what if any steps were taken and why Ben Saunders remained in post until 2017.

333. I believe the Inquiry should seek statements if they have not already done so regarding the management of Brook House from:

a. Stacie Dean – former Head of Security Gatwick IRCs
b. Wayne Debnam - former Head of Security Gatwick IRCs
c. Stephanie Philips – former HR business partner for Gatwick IRCs
d. Katie Rix – Former Head of HR for Gatwick IRCs

Stacie Dean

334. On 5 and 14 September 2017, I received a series of emails from the former Head of Tinsley House Stacie Dean, which contained a number of emails to senior members of G4S annexed to this statement **(as Annex 13).** DL0000140

335. In an email dated 2 January 2017, which appears to be addressed to Peter Neden, G4S regional president for the UK and Ireland, Stacie Dean raised the following matters of relevance to the Inquiry (emphasis added) :

a. She had submitted an earlier grievance in 2014 to Jerry Petherick and after a grievance hearing heard by Lee Hanford, who took over the running of Brook House when Ben Saunders was temporarily seconded to Medway STC in 2016 she was persuaded to withdraw her grievance on the understanding that the Director Ben Saunders (her Line Manager) would be "dealt" with, made to be more organised and not always give a heavy workload to a select few. She also requested an answer to her policy queries regarding the temporary promotion process that she was made to complete twice when others hadn't;

b. She did not receive a satisfactory response to her concerns but was asked to used her complaints to form part of the evidence for a "Duncan Partridge grievance";

c. Following the failure to address the issues with Ben Saunders she went of sick suffering from anxiety/stress and sciatica. On return there was no follow up from Lee Hanford or Jerry Petherick although they were aware of the issues with her line manager and had met with other employees for similar issues prior to them leaving the business;

d. She continued to be ignored on issues such as ongoing bullying that she had formally raised with Ben Saunders and Steve Skitt and other issues at Brook which were never dealt with;

e. Ben Saunders was sent to Medway in early 2016 to resolve the issues there in relation to bullying and false reporting, all of which were also occurring at Gatwick;

f. Lee Hanford made improvements in reporting issues and dealing with problems whilst Ben Saunders was at Medway and shortly before he left, she was asked to investigate the same staff she had previously raised concerns about. She was pleased to have the opportunity to thoroughly investigate this issue, but shortly after this Ben returned and told her not to complete the investigation as he thought she should instead investigate a grievance brought by one of these staff. She felt that the fact that she would have highlighted the previous issue which Ben Saunders and Steve Skitt had not dealt with, was the reason she was taken off the investigation;

g. Bullying of staff at Brook House has also been highlighted by her and others and nothing has been done. This has been an ongoing issue and prior to his leaving, Nathan Ward completed an investigation in which he said bullying was rife on one wing at Brook and that this should be subject of a further investigation, yet again nothing was done.

h. The environment at Gatwick is toxic because there is no faith by the majority of the SMT or DCMs that any issues are dealt with or that any decisions are made.

i. She referred to staff shortages at Tinsley House for a prolonged period and, lots of staff were leaving due to issues with having to work at Brook House, changes to contracts which were managed appallingly by Ben and the POA and repeatedly late pay talks and decisions on annual leave.

j. Ben Saunders and Steve Skitt would interfere by making decisions re staff who would work at Brook and she was not be able to operate a core group of staff, this suited them at Brook, they had no regard for staff and when this was raised as an issue that meant people may leave, Ben Saunders responded with "look at my face, is it bothered".

k. She stated that she had no trust in the company at all. She had previously worked in HMP for 17 years and have never felt so excluded, undervalued and depressed. The SMT at Gatwick does not and has never operated as an SMT as no one trusts anyone and the company treat people as a faceless commodity.

l. She believed that there is no truth in the company values, there is no transparency, under-reporting of incidents and a feeling that G4S promote people when they feel like it with no process.

336. According to the email of 5 January 2017, Stacie Dean met with Jerry Petherick on the 3 January 2017 and following this meeting, forwarded an email she had sent to Ben Saunders and Stephen Skitt on 25 October 2015, which raised issues including:

a. A detainee complaint about two staff members (DCOs Fagbo[64] and Instone-Brewer[65]) goading him for a week and provoking him that she had raised with Ben Saunders and Stephen Skitt on 25 October 2015. She reported how every time there is an issue on D Wing she always receive complaints about these two in particular. It appears they may have fabricated SIRs. Other staff confirmed her concerns and said they need to be split up. She said it needs to be looked into as much as she would love to trust the staff and their account she simply didn't. It appears no action was taken;
b. The conduct of other DCOs but it is not clear who.

337. This email had been forwarded to Lee Hanford on 16 June 2016, with the message, *'As discussed earlier, this is just one of a few!'*. In the email which appears to be addressed to Jerry Petherick, she forwarded this chain and added the following also of relevance to the Inquiry:

a. The 2015 EDRs [Employee Development Reviews] were not completed at Brook House and the figures submitted were false so that the bonus scheme would still apply.
b. The Action Plan (AP) provided to him after the Brook escape claimed to have been completed after the escape at Colnbrook, this was a lie.
c. The AP he was given was cobbled together the morning after the Brook escape. Nothing had been done by either Neil or Steve (Skitt) and Ben (Saunders) was fully aware nothing had been done
d. In the case of the DCOs discussed, they are also known to be supplying spice to detainees yet there has not been a single staff search since this information has been known, Steve (Skitt) constantly fobs off decisions.

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[64] DCO Fagbo (also referred to as 'Babs') was dismissed in October 2017 for inappropriate conduct with detainees – see CJS000473. See also comments from DCO Instone-Brewer to Callum Tulley about why 'Babs' was suspended (TRN0000076 / KENCOV1012)

[65] Panorama transcripts show that DCO Instone-Brewer (also referred to as 'Ginge') was potentially an officer who was bringing drugs into the centre – see TRN0000023 (KENCOV1013) pg.12
See also CJS003348 0001-0027 – a complaint is made by D1538 that on 3 June 2017, he was pushed, slapped and removed to Rule 40 and denied the use of the computer room. DCO Instone-Brewer is one of the officers identified in the complaint.

338. I am not aware of the circumstances that followed these emails. I have seen Lee Hanford's interview with Kate Lampard in which he accepts that: *"[176]...I don't it [how she was treated and her role diminished] was well managed how that happened, but I think Stacey as a consequence put a grievance in about that, and has since departed from the company."* [VER000266_0014] In her emails, it is clear that Stacie Dean felt side-lined, excluded and ultimately pushed out of the company. This reflects my experience at G4S.

339. This is a clear example of whistleblowing allegations at Brook House not resulting in the sanction or removal of staff. The experience of Michelle Brown who issued a grievance and Duncan Partridge are possible other examples but I do not have any material relating to that.

Panorama

340. My first involvement with Panorama was during my time at Medway. I was the person who had approached Eric Allison (Prison Correspondent) at the Guardian newspaper in 2007, who was connected to Panorama, who ultimately produced the documentary in 2016. I was integral to providing information of the abuse at Medway to Panorama. At this point, I was too scared to be associated with the documentary and therefore I did not consent to have my face or identity visible in the film. I had senior people such as Paul Cook, who had said that he could end peoples' careers so I was terrified. I was in touch with Eric from around 2007, however the film was not aired until 2016.

341. I understand that Callum Tulley approached Panorama about Brook House, after having watched the Medway Panorama. I was initially approached by Joe Plomin from Panorama, to meet up at the Langham Hotel next to the BBC, where I was informed that a programme was going to be made about immigration detention.

342. The first time I met Callum Tulley and saw any Panorama footage was when he attended my church service (the footage of which is in the Panorama). During that meeting, I was quite guarded as I felt slightly side-lined and had no idea they had been filming. However, when the Panorama team came to my house for the second interview, I felt free to share my views. I had left G4S and did not feel any fear that my career could be ended.

343. At the time of the Brook House Panorama, I was Head of Care and Justice for Diagrama, a UK arm of a Spanish Charity which runs children's homes and focuses on youth custody, and an apprentice for a vicar in the DPA DPA.

344. I would like to confirm that whilst I did not witness the appalling levels of abuse at Brook House exposed by Panorama during my time as senior manager at Gatwick IRCs, I believe that the regime, conditions and institutional cultures, I have described, created the environment in which this abuse occurred. I was, therefore, shocked but not surprised by the level of abuse exposed by the Panorama reporting. The footage reflects attitudes and conduct which are a manifestation of the toxic institutional cultures and systemic failure from the top down, I experienced while working at Gatwick IRCs, and have sought to explain.

Post Panorama

345. After the Panorama documentary was aired, the only bodies to approach me were the HMIP, the Home Affairs Select Committee and G4S. I was contacted by Phil Jones, Second Clerk to the Home Affairs Select Committee around 9 September 2017 which in turn led me to giving oral evidence on 14 September 2017. At no stage have the Home Office contacted me.

346. Following Panorama, I was contacted by Peter Small, Director of G4S, however I politely declined to be interviewed for the internal investigation as I did not see it as

independent. I shared the document that was seen on the television in relation to the notes I took to the meeting with Jerry Petherick. However, I raised concerns that he was in effect, investigating his own line manager as part of the internal investigation.

347. On the 5 October 2017 I was contacted by Stephen Cotter who was the Risk and Assurance Manager for G4S UK and Ireland Region asking me to provide any further information about the concerns I had raised at the time and since about G4S operations. Again there did not seem to be any level of independence to the investigation and therefore I did not respond to Stephen Cotter.

348. I was approached on the 8 March 2018 by Nicola Salmon who was a consultant to Verita, to be interviewed by Kate Lampard and Ed Marsden. On examining the company's website I believed that the report, commissioned and paid for by G4S was unlikely to be a robust investigation which would be placed in the public domain. The terms of reference set were almost entirely focussed on low level staff and procedures where I believed the problems stem primarily from the institutional pressures and cultures for which the senior management and the Home Office should be held accountable. It was not truly independent and the limited extracts that Veritas had placed on their website focus on their success in protecting the image of their customer, which is the fundamental flaw in all commissioned audits. I therefore declined to take part.

Conclusions, Recommendations and Lessons Learned

349. From these experiences, I have come to the view that only fundamental change to the legal regime can realistically address the risk of repeated abuse scandals at Brook House and in IRCs more generally. Tackling the institutional toxic cultures of dehumanisation, racism and impunity requires very robust measures to strictly limit the use of these powers.

350. In my view, immigration detention should be limited for all detainees for a maximum period of 28 days and this should be urgently implemented. I also believe

that for those with vulnerability, the maximum period should be 72 hours, with a short further possible 72 hour extension authorised by a Judge if absolutely necessary. This framework would follow a model where all necessary processes and procedures for removal have been completed (the flight is booked, notice of removal has been issued, travel documents are in place, all medical issues have been considered and the individual's legal and appeal rights have been exhausted). The IRC is therefore only used to facilitate the actual removal. An independent panel (ideally Judge-led) would be in place to fully assess all these removability issues prior to detention being authorised for 72 hours. The removal preparation process should otherwise be managed within the community. This system would reflect the Home Office's 'Family returns process' which in my opinion and from my experience at Tinsley House, is both a more effective and more humane way of managing removals. This process followed years of criticism about the barbaric and damaging impact of detention on children and their parents. It is also similar to the strict limits on detention of pregnant women in the Immigration Act 2016, introduced after similar long standing criticism of the detention of pregnant women. For Foreign National Offenders (FNOs) facing deportation, the Home Office should start the deportation process much earlier so that legal challenges can be brought before the individual has finished their sentence and so that removal can be facilitated at the point of their sentence ending. If the Home Office has been unable to do this by the end of sentence, then the FNO's removal should go on to be managed within the community.

351. Brook House was specifically designed for a 72 hour limit and if that model is to be used, then there should be enforceable limits so that detainees do not find themselves in that environment for longer periods.

352. In summary, I believe that 'humane' and 'hostile' are simply two words that don't go together. They are incongruent, opposites and incompatible. A system designed to be hostile is a system that cannot be humane. It's that simple.

353. I think the Inquiry therefore consider recommending the following:

Strict Limits

a. The design of IRCs should be urgently reviewed, particularly those designed to a category B prison standards. If Brook House is to continue as an IRC, it must be strictly limited to the 72 hour maximum limit for which it was intended.
b. A 28 day time limit should be imposed on all detentions.
c. The equivalent of the family returns policy should be implemented for all removals and an independent returns panel should be established similar to the 'Family Returns Panel' for all detainees.
d. Detention for those with vulnerabilities should be limited to 72 hours and only extended for a further 72 hours by a Judge.
e. This scheme should be scoped for implementation for all those detained.

Contract

f. All future contracts should be tendered on a fixed price basis. Therefore the awarding of the contract will be based on the quality of provision alone and not 'the cheapest bid'.
g. There should be external independent involvement and scrutiny of the contractual arrangements when made.
h. The monitoring of the contract from both the perspective of compliance by the Home Office and the Contractor should be independent and undertaken by an independent professional inspectorate replacing or in addition to the IMB.
i. The contractual arrangements should be published and made transparent.
j. Schedule G of contracts should be far wider in scope and application. The penalty points must be weighted to give priority to the welfare of detainees and to heavily penalise misconduct, failures to protect their welfare and for breaches of the safeguards like Rule 34 and 35.
k. The contracts should be re-evaluated in a way that should completely outweigh any benefit of not meeting that part of the contract.
l. Periodic break clauses should be included so that they can be promptly brought to an end.

Accountability

m. The law should be reviewed to ensure adequate protection for those detained against abuse from staff. The fact that no official or staff has been prosecuted following the Panorama documentary reflects the legal vacuum in which detainees reside.
n. More robust vetting procedures should be introduced for staff akin to 'Positive Vetting'.
o. There should be increased legal provision for all detainees, with consideration given to legal representation being required prior to detention being determined.

Use of Force

p. The current approach to C&R should be fundamentally changed and the manual re-written specifically for the context of IRCs:
    i. Removing all references to Prisons and Prisoners;
    ii. Highlighting and accounting for the specific vulnerabilities that immigration detainees have;
    iii. Account for the specific contexts in which C&R takes place in IRCs and to prioritise negotiation and de-escalation;
    iv. C&R always to be used as a measure of last resort.
q. Equal time should be given to crisis communications and conflict management as is given to the teaching of physical restraint techniques.
r. Use of force to prevent self-harm/suicide and in cases of mental illness must follow NICE guidelines and be added as an indicator for a Rule 35 report. In all cases where an ACDT is opened, a Rule 35 report should automatically follow.
s. There should be a national centre for physical restraint that continually researches and develops appropriate techniques for the various settings in which it is used throughout the UK.

t. All managers should have a working knowledge of key reports that relate to custody such as the Woolf Report and Medway Report. There is no systematic passing on of lessons learnt through the generations.

u. All restraint techniques should be medically tested (see the work of John Parkes, Coventry University).

v. The Safeguarding Principles outlined by Fordham, Stefaneli and Eser in their book 'Immigration Detention and the Rule of Law Safeguarding Principles should be adopted by Government with immediate effect.

w. There should be a nationally recognised suite of training courses for all those working in custodial settings, including and with specific tailored training for IRCs which is rights-based, progressive in nature and robustly assessed.

x. Operational staff should undertake a validated certificate course on a yearly basis, supervisors should have a Diploma, Senior Managers a Degree and Directors a master degree in a relevant course. These courses should cover not only operational practicalities but also underpinning theories of sociology, psychology, criminology, human rights, security and risk management.

y. The content, delivery and compline training courses should form of contract monitoring and be a part of HMI inspections.

Self-Harm

z. The management of suicide and self-harm should be treatment led and implemented by healthcare and apply NICE guidelines and not the Prison Service guidelines.

aa. Self-harm and/or a credible risk of suicide should be sufficient to mean that the person is not suitable for detention in an IRC. Rule 35(2) reports must be issued and result in review and release.

bb. Imposition of Rule 40 and 42 removal on association should not be applied to those with a mental illness and if it is judged necessary should be an indicator for a Rule 35 report and release from detention.

Statement of Truth	
I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth. I am content for this witness statement to form part of the evidence before the Brook House Inquiry and to be published on the Inquiry's website.	
Name	Reverend Nathan Ward
Signature	**Signature**
Date	10/11/2021 | 12:00:07 GMT