BROOK HOUSE INQUIRY

Second Witness Statement of James Begg

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 13 October 2021, and a further written request dated 17 January 2022.

My address is known to the Inquiry, and I will say as follows

Background

1. I left employment with G4S on 8 February 2019 to develop my career. I joined the Home Office on 11 February 2019 as a Border Force Officer. In February 2021 I moved to Immigration Enforcement under the Foreign National Offender Removals Command within Her Majesty's Prison Maidstone, Immigration Prison Team, as the Chief Immigration Officer.

2. In 2016 I was appointed Safer Community Detention Custody Manager ("DCM"). A summary of the duties and responsibilities of the role (taken from the job description at the time I applied for the role), is as follows:

    a. To manage and develop the anti-bullying strategy so that a safe environment is maintained.
    b. To manage and develop the Assessment, Care in Detention and Teamwork (ACDT) policy and its implementation to ensure it is managed effectively within the Centre.

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Exhibits:	None

c. To advise, support and guide the management team on the implementation of company policy on Self-Harm, Race Relations, Food and Fluid Refusal and Diversity in order to meet legislative and contractual requirements.
d. To provide statistical and written reports covering all aspects of safer detention to the management team in order to meet contractual and audit requirements.
e. To coach and support staff to maximise their performance and ensure values, ethical standards, equality and diversity, policies and procedures and contractual requirements are met.
f. To undertake the operational management role when required, ensuring the effective daily operation of the Centre, including efficient staff deployment and monitoring an effective ACDT system to minimise suicides, self-harm and bullying within the centre.
g. To assist in the promotion of creating a positive Health & Safety culture to achieve and maintain recognition.
h. To manage childcare services in the Centre and ensure compliance with childcare policies and procedures (at Tinsley House only).

Culture

3. At paragraph 11 of my first statement, I refer to receiving good feedback from an HMIP inspection. This was a reference to a Notice to Staff (issued by the Senior Management Team of G4S) that was provided following the inspection. I cannot remember precisely what the Notice stated but it praised the Safer Community Department and recommended that DCMs from other Departments needed to use Safer Community policies better. There is also positive feedback about the Safer Community Department within the HMIP report, VER000117, at paragraph 5.47, which refers to "Excellent monitoring and analysis of a wide range of data at the monthly safer community meetings…".

4. I have been referred by the Inquiry to the report of the Home Office Professional Standards Unit into the circumstances surrounding the detention of D1527

(CJS001107) and to some of the ACDT records of D1527: CJS001030; CJS001085; HOM000769; HOM000414; and HOM003042, and asked to comment on an audit that I carried out on the ACDT records of detained person D1527 (referred to at paragraph 9.22, page 42 of CJS001107). The ACDT records provided by the Inquiry are incomplete, and the records that I audited in 2017/18 were also incomplete. Without a complete set of ACDT records it is difficult to comment on them, for example, I am unable to see if Emergency Case Reviews were completed when required. Further, without sight of my audit report it is difficult to comment on any observations for improvement that I made, because I cannot recall the content of my report. I have reviewed the ACDT records that have been provided, and I make the following observations:

a. Some staff have not printed their name by their entries.
b. On 23/04/2017 at 22:30 the observation states that D1527 is headbanging. There is then an observation that Oscar 1 Detainee Custody Manager A Lyden speaks to D1527. However, I cannot ascertain whether this was while D1527 was on a constant supervision. If he was not, then this would have required an Emergency Case Review and potentially a new Assessment by an ACDT Assessor if the head banging is different to the previous methods of self-harm. I note that later that night D1527 then self-harms by cutting.
c. The pages are not in date time order, which is challenged by DCM Michele Eggleton on 18/05/2017 at 09:45.
d. The dates missing from some entries.
e. Some of the handwriting is not legible. In training I advised that when making an entry it should be in block capitals or at least sufficiently clear to be able to read their entries.
f. There are good records of staff offering meals to D1527 and providing reasons for why he was not eating. For example on 18/05/2017 at 13:05, "Did not come to servery to collect food", and then later on 18/05/2017 at 14:35, "Came back to the Wing with food from the shop and told me the shop isn't far and when he is hungry he will get food".

g. Black ink is used throughout by Detainee Custody Officers, and document checks are completed by Safer Community and Duty Directors in red ink. This was best practice at the time as it differentiated between an observation and a document check.

h. Handover stamps have been used consistently between shifts in accordance with correct procedure.

i. Post-it notes appear to be blocking pages throughout (see examples within HOM000414 at page 5, and page 112). This was poor practice adopted by staff at the time as a means of reminding themselves of the level of care and observations required. I would warn against this practice during training, and I would usually remove post-it notes when I came across them in ACDT document as they were not part of the formal record.

j. There are some good records of interactions with D1527 throughout.

k. Corrections should be made with 1 line through the incorrect entry and an initial either side of the error. The correction on 25/05/2017 at 23:19 does not follow the correct procedure as it contains 3 lines through watching and no initial.

l. The terminology "constant watch" is incorrect. The training provided on the Initial Training Course was that those who were at high risk may be placed on "constant supervision" to emphasise that an Officer should be interacting and supporting the individual at risk rather than just watching them.

m. Some of the documents provided appear to be from D1527's time at HMP Belmarsh when he was subject to an ACCT document. See pages 21 to 81 of HOM000414.

n. Document checks from myself, DCM Eggleton, and DCM Conway Edwards recognise the need for the care map to be updated (see example at HOM000414 page 116 18 April 2017 9:41). The care map is one of the most important aspects of the ACDT record because it evidences the care being provided to the detained person rather than simply the observations being carried out. Compliance with updating the care plan did improve over time, and its importance was emphasised at ITC and refresher training.

o. DCM Eggleton also picked up on an occasion when an incorrect document was used to record observations - see page 139 of HOM000414 which is a Supported Living Plan Observation Sheet rather than an ACDT Observation Sheet. This is not a particularly serious issue, and it would appear to be simply a case of human error in selecting the wrong form.

5. I can say that while I was Safer Community DCM, I carried out an audit on all ACDT records and any failures to record information to the required standard were identified and shared with DCM colleagues for learning. Issues such as missed observations, would result in an investigation, and if the investigation confirmed that there had been a failure to comply with proper procedure, then this would usually result in the member of staff concerned being required to attend the Safer Community part of the Initial Training Course ("ITC").

6. Regarding occasions when I have challenged the behaviour of colleagues towards detained persons, the only specific incident that I can recall is when I was a Residential DCM around 2014-2015. A Detention Custody Officer ("DCO"), whose name I cannot remember, was beginning their night shift on Delta Wing and was being given a handover from a member of staff who had worked the day shift. I was observing the handover when I heard the DCO say, "When you're gone, I will be pulling the wing sofa into the Office to have a nap". I challenged this as it was unacceptable, particularly as there were detained persons who were subject to ACDT on the Wing who needed to be checked during the night. I also raised this with the DCO's line manager (a DCM) who again, I cannot remember the name of. My practice was to challenge inappropriate behaviour verbally in the first instance and I found that early intervention usually avoided repeat behaviour and the need for further, more formal action.

Violence

7. As mentioned in my first statement, I became Violence Reduction Manager in December 2017. However, prior to this and as part of my role as Safer Community

DCM, I produced the Safer Community Reports and Violence Reduction Reports. I have been asked to review Violence Reduction Reports CJS000476 (July 2017), CJS000496 (April 2017), CJS000545 (August 2017), CJS000614 (May 2017) and CJS000615 (June 2017). I can confirm that these reports were collated by me in my role as Safer Community DCM. The information collated within the reports would usually be provided to me in spreadsheet format by one of the Security Collators in the Security Department. I tried to obtain the information on a fortnightly basis, even though the reports were monthly, in order to identify trends at an early stage. In October 2017 I was seconded to the Senior Management Team as Safeguarding Manager, and while in this role I continued with the responsibilities of Safer Community DCM as no one was brought in to cover this role while I was seconded. In and around December 2017, Mark Demian was appointed as permanent Head of Safeguarding and I continued on secondment with the Senior Management Team as Violence Reduction Manager, and in this role I continued to produce the Violence Reduction Reports.

8. Violence Reduction Reports were distributed to all Departments, Managers/ Heads of Function, visiting Samaritans, and the IMB, and they were also displayed in the Gatehouse for DCOs to view. The Reports were discussed at the monthly Safer Community Meetings to discuss trends and formulate action plans in response. The data collected included age groups, faith, nationality, location of incident, and if increased activity and/or specific issues were identified then we would develop actions in response. For example, if a particular demographic were identified as responsible for a high percentage of violent incidents, then action would be tailored to those groups, such as seeking to engage through faith leaders.

9. The physical violence graph within the Violence Reduction Report for August 2017 (CJS000545) shows that assaults on detainees and staff peaked in June 2017. I am asked to provide my opinion as to why violence peaked at this time. I have reviewed a schedule of violent incidents in June 2017 (CJS000896) and have the following observations:

a. 7 detainees were involved in 3 or more different incidents and these 7 detainees accounted for 25% of all incident reports.
b. 10% of incidents involved detainees being denied access to residential units that they were not allowed to access.
c. The biggest single cause for the spike in violence that I can identify from the Security Information Reports is that 21% related to drugs and alcohol (44 out of 208).

10. The reports were very useful for identifying and recording violent incidents. However due to the ever-changing population of Brook House it was difficult to pinpoint trends on a month-to-month basis, as the average time a detained person was resident at Brook House was only approximately one month.

Bullying

11. The Anti-Bullying Policy was good. However, getting residential staff to use the policy to its full potential was an issue. When collating the monthly Violence Reduction Report, I would identify a number of violent incidents that should have been referred for consideration of bullying. When I took up the role of Violence Reduction Manager, I made changes to the policy so that every incident of harm to a person resulted in a Monitor-Challenge-Support document being opened. I left G4S a few months later so I am not aware of the impact of this change. The Anti-Bullying Policy in place over the relevant period (2017) required that the Monitor-Challenge-Support process (which was recorded within a booklet) remained open for a minimum of two months. If issues around bullying persisted, then the process and booklet would remain open and reviewed on a weekly basis.

12. There was a three-stage programme for detained persons found to be responsible for bullying behaviour and they were offered lessons in the education room with teacher Sebastien Ganga-Valle. If the bullying behaviour continued, then the

booklet could be used as evidence for the Home Office to transfer the detained person responsible for the bullying behaviour to another centre for a fresh start. However, while I was with the Safer Community Department this never happened. Allegations of bullying by members of staff were dealt with through the grievance and disciplinary process.

13. Other measures to protect detained persons from bullying behaviour were: relocation to Eden Wing, particularly for those who would not identify the person or persons responsible for the bullying; training staff on issues of bullying and the relevant processes and procedures (at the ITC and refresher courses); weekly reviews of the Monitor-Challenge-Support document by the relevant wing DCM, or in their absence by me; transfer of the person bullied to another centre (Tinsley House would often be used for this purpose, particularly as it was also run by G4S); staff were required to engage with a detained person who had experienced bullying, three times per day which was recorded within the Monitor-Challenge-Support document; ensuring that the detained person who was subject to bullying behaviour and the detained person responsible for the bullying behaviour were located on different residential Wings; and to buddy detained persons who were subject to bullying behaviour with people of the same nationality and to seek assistance from Safer Community/ Diversity Orderlies to provide assistance.

14. I have been referred to two Security Information Reports (CJS004975 and CJS005017) which both raise issues of bullying. CJS004975 is a report that was initiated by me on 20 April 2017 in response to an allegation of bullying behaviour towards a detained person. The issue was addressed by DCO Ward who spoke with the detained persons responsible and in the absence of any further incidents it was not deemed necessary to open a Monitor-Challenge-Support booklet. However, I did provide the detained person with contact details on which he could contact me directly should there be any further incidents.

15. CJS005017 is a report initiated by H Attwater on 7 April 2017 as a result of an altercation between two detained persons about a failed plan to sell a bracelet to purchase cannabis. The incident was referred to me on 8 April 2017 to investigate whether any bullying behaviour was involved. I cannot recall this incident. However, I feel sure that I would have asked the relevant Wing Manager to conduct an anti-bullying investigation. The Investigation Log and the Anti-Bullying Log for 2017 should contain a record of the investigation. If the investigation had found that there was a risk of bullying, then the Monitor-Challenge-Support process should have been initiated.

Drug Issues

16. At paragraph 24 of my first statement, I stated that a detained person from Dove Wing provided me with information about drugs entering Brook House. I believe that this occurred in 2014. However, I cannot remember the name of the detained person who provided the information, or any specific details of the information provided. I recorded the information provided to me within a Security Information Report at the time and Security took over all action in response.

17. At paragraph 25 of my first statement, I refer to an investigation of a female member of staff who was suspected of bringing drugs into Brook House and passing them to a detained person on Arun Wing. I believe that this incident was towards the end of 2017 and that the officer I investigated was DCO Clarissa Hepburn. However, the Inquiry will be able to confirm this from G4S/Brook House records, particularly as the member of staff was dismissed following the investigation.

18. Unannounced staff searches were carried out by the Security Department and a select group of staff would assist with the searches.

19. If a detained person was found to be under the influence of drugs, then Healthcare and The Forward Trust would be informed.

20. The drug rehabilitation support available within Brook House consisted of education sessions (in a classroom setting delivered by Sebastien Ganga-Valle), and sessions provided by The Forward Trust at Brook House. I have known several detained persons come off drugs while detained at Brook House. However, it is hard to know how effective the rehabilitation was because of the high turnover of detained persons and relatively short average duration of their stay at Brook House (approximately one month).

21. The measures taken to prevent the entry of drugs to Brook House were staff and visitor searches, targeted searches as a result of intelligence from Security Information Reports, and the photocopying of all post for detained persons because the original documents could contain drugs that had been sprayed onto the paper. I can only recall the use of sniffer dogs on one occasion over the ten years I was employed at Brook House.

Disciplinaries and Grievances

22. At paragraph 26 of my first statement, I refer to a grievance raised by DCO Nathan Harris. I believe this occurred between December 2017 and January 2018. In my first statement I state that DCO Harris' grievance was against DCO Singh. However, I believe the grievance was in fact against DCO Nabir Sandhar, and not DCO Singh. Again, a written record of the investigation will exist within G4S/Brook House archives.

23. At paragraph 28 of my first statement, I state that a large number of disciplinary investigations, approximately two each week, were in respect of doors being unlocked. The Head of Security, Michelle Brown, would have overall

responsibility, and she would refer each incident to the Department Head for the area in question, and the Department Head would either carry out an investigation themselves, or delegate responsibility to a member of their team. The issue of an unlocked door was taken seriously by staff, hence why it was reported so frequently. I don't believe that doors were ever left unlocked deliberately, it was more human error. The sanction for leaving a door unlocked, was to be banned from carrying keys until further training was completed.

Training

24. I have been referred to my email of 12 February 2018 to Helen Wilkinson (HOM002512) in which I make reference to increased levels of self-harm and suicides within custodial environments. This was not a specific reference to Brook House, and I do not know the underlying reasons for the increase of self-harm and suicides within custodial settings generally. However, as a result of the National Offender Management Service ("NOMS")/the Prison and Probation Service ("HMPPS") making changes to the way that they delivered their training (their new package was called Suicide and Self Harm Prevention – SASH) I made changes to the way ACDT training was delivered within Brook House (as set out in my email). Most of the ACDT training sessions in 2017 were delivered by me. On occasion the sessions were also delivered by DCM Michele Eggleton and DCO Santi Rodrigues.

25. The changes to the ACDT training mentioned in paragraph 24 were introduced sometime in 2017. An issue that I had with the ACDT training prior to this was that Brook House was still using version 1, whereas NOMS/HMPPS were using version 5 (prior to the introduction of SASH). I raised this concern by email to the Home Office and verbally to Lee Hanford at G4S, and the issue was included within the annual report for the three reporting years 2014-2016. As to whether changes to the ACDT training in 2017 resulted in lower levels of self-harm and suicide, I cannot

say without access to the data and the statistical information held by Brook House/G4S.

26. Regarding training on mental health issues, I received the same training as other officers during the ITC. In 2016 I was trained to deliver the introductory mental health training (provided in the ITC), and also the advanced mental health training provided to ACDT assessors. I also attended a Suicide and Self-Harm (SASH) Introduction to Mental Health course, which I also refer to below at paragraph 45.

27. The mental health training delivered to staff was part of the NOMS/ HMPPS package which addressed issues of anxiety, depression, bi-polar, psychosis & schizophrenia and personality disorder. The mental health training also covered issues of stigma, the differences between physical (visible) and mental (not visible) health problems, the difference between mental health (which everyone has) and mental illness, and a mental health continuum (an assessment tool), and the help available in the centre. ACDT assessors would attend a further advanced course in mental health.

28. I attended a meeting with the local Safeguarding Board on one occasion as part of a review of the Safeguarding Policy for Brook House. I attended in my capacity as Violence Reduction Manager to assist the new Safeguarding Manager.

29. In terms of my suitability for the role of Safeguarding Manager, this was a role that I performed on a temporary basis between October 2017 and December 2017, at which point a permanent appointment to the role was made, as I mention above at paragraph 7. I believe that I was the most appropriate person to cover this role while a permanent appointment could be made, because of my experience as Safer Community DCM. At the time of covering the role of Safeguarding Manager I had completed my Silver Commander training and was waiting to complete a level 5 course in management.

Staffing Levels

30. Staffing shortages were an issue at Brook House from day one. On completion of the ITC in January 2009 a female DCO was asked to show the Home Secretary around Brook House on a visit. They were advised to tell the Home Secretary that five DCOs would be working on each residential Wing, even though it was known that the intended number was three DCOs per Wing.

31. Having gone live in 2009, I remember days when I would be on the Wing with only one other DCO and did not have a break all shift. The concerning thing about this was that if you needed to leave the Wing, for example to collect toiletries, escort a detained person to attend the kitchen to carry out activities, or to speak to someone in another department, you had to leave a member of staff on their own with 100+ detained persons to manage.

32. In the early days there were many occasions when I worked on a Wing on my own, including unlocking a Wing on my own. You had to rely on your rapport with detained persons to ensure that order was maintained. I reported these occasions to the relevant DCM at the time, but nothing happened immediately, and it took time to resolve staffing issues. On one occasion we received support from HMP colleagues, which was helpful as we were able to learn from their experience.

33. Around 2011 there was an improved and more consistent approach to staffing (more staff and greater continuity of staff on each Wing so that they were known to the detained persons). During this period, I mainly worked on a Wing with at least two other DCOs.

34. However, escort duties could still take staff away from the Wing, despite there being a Control and Security Team of DCOs that should have been performing these tasks. Staff who worked in the control room assigned duties to other staff, and they looked

after themselves. When the Control and Security Team were disbanded and merged into the residential units/ reception/ visits, I can remember hearing a former member of the Control and Security Team comment that, "it was really good as we looked after each other".

35. On my return to Brook House, in approximately 2013, having been a DCM at Tinsley House, I noticed a change in the approach of staff towards detained persons. Before I left in 2011 staff were visible on the Wings and would play pool, table tennis, and games consoles with detained persons, in between other duties. When I returned there were very few staff doing this. I tried to re-introduce this as a DCM by telling staff to get out of the office more. But it seemed that the workload had increased and staffing levels were no longer at a consistent level of 3 DCOs per Wing.

36. In 2017 I do not believe that shortages of DCOs affected my ability to carry out my role, because over this period, while Tinsley House was being refurbished, there were more DCOs than there had ever been at Brook House.

37. I have been asked to comment on my response (within CJS001425) to the complaint of a detained person of a shortage of staff in Welfare. I can confirm that the recruitment of a further two Welfare Orderlies (paid work for detained persons) was carried out. The additional Welfare Orderlies were very useful and assisted with managing the waiting queue, answering ad hoc questions, and signposting other information available to detained persons. An additional Welfare Officer was also recruited (in late 2017/early 2018), which made a total of five Welfare Officers. The shortage of Welfare staff must have caused frustration among detained persons.

Use of Force

38. I have been asked to expand on the reference at paragraph 30 of my first witness statement to my involvement in incident management. It was a requirement of the

role of DCM to supervise use of force incidents (which required completion of a report). DCOs received the same training and could also undertake the role of supervisor if a DCM was not present during a spontaneous use of force incident.

39. At paragraph 33 of my first witness statement, I refer to my role as a negotiator for the purpose of de-escalating incidents without the need for use of force. My training for this role was attendance at a pre-selection course, followed by a three-day intensive course, run by HMPPS at New Bold Revel on 14 July 2016. Subsequently, I attended refresher courses (of two day's duration) on 11 January 2017 and 24 April 2018. Other negotiators that I can remember are, Dean Brackenridge, Andy Jennings, Ian Middleton, and Ray Pemberton. I consider that the negotiations that I conducted were successful because the incidents I was involved in did not result in anyone coming to harm.

40. There were contingency plans for concerted indiscipline, passive protest, and hostage situations, and simulations were carried out for training purposes.

41. The command suite would be opened to deal with a critical incident. The command suite could be run by a Silver Commander (see my reference to having completed Silver Commander training at paragraph 29 above) until the Director or a Deputy Director took over. I can recall a protest on C Wing, with numerous detained persons on the netting, in response to which the command suite was opened.

Individual Welfare

42. I have been referred to a number of Suicide Prevention and Self-Harm Prevention Reports: CJS000458 (June 2017); CJS000465 (July 2017); CJS000521 (April 2017); CJS000528 (May 2017); CJS000544 (August 2017). I collated these reports in my capacity as Safer Community DCM. I used the incident reports of self-harm to carry out investigations into these cases and to develop ongoing improvement.

Actions in response to issues and themes raised within the reports were agreed at Safer Community Meetings, and could include targeting a particular demographic, such as younger detained persons who were complained of boredom and a lack of activities.

43. Detained persons who self-harmed would be subject to ACDT and a care map plan. I am unable to comment on the aftercare provided by Healthcare. However, I can recall that Healthcare provided me with a form F213, which contained a body map and an account of the injuries sustained by detained persons who had self-harmed.

44. The process for opening an ACDT was that any member of staff could (and should) do so, if they had concerns for the welfare of a detained person. An ACDT assessment would then be carried out by a trained ACDT assessor, and a member of staff trained to case manager level (usually a DCM) would then decide what action, if any, should be taken in response to the assessment, which could include observations at regular intervals, and transfer to Eden Wing for constant supervision. Constant supervisions would be reviewed by the Duty Director.

45. Decisions to close an ACDT were taken at case reviews, which were multi-disciplinary and attended by the detained person, Wing Officers, Case Manager, Home Office staff, and members of the Healthcare Team. I chaired case reviews which were for the purpose of formulating a plan through the care map to support detained persons and to ensure staff awareness. If all the care map objectives had been completed and there were no further concerns for the welfare of the detained person, then the ACDT would be closed, by the agreement of the case review team, which included the detained person. I received training in how to communicate with people experiencing mental health issues through a Suicide and Self-Harm Prevention (SASH) Introduction to Mental Health training course. Any reasons given by detained persons for their feelings or actions of self-harm would be included within the case review summaries.

46. The process followed when a detained person refused to eat was that a food and fluid refusal was recorded on the first day that a detained person failed to collect their food from the DCO responsible for distributing meals on their Wing. If this persisted, then on day three an ACDT would be opened, in accordance with Detention Services Order (DSO) 03/2017. If a DCO had a strong rapport with a detained person they could often encourage a detained person to eat, even if it was just food from the shop or sometimes food from the cultural kitchen. Meals would always be taken to a person who was refusing to eat.

47. I am asked to comment on the outcome of the case reviews for D1766 (CJS002696) and D1077 (CJS003567), both of whom refused to eat in protest at the Home Office. I am not aware whether either protest influenced their immigration status. However, some cases of refusal of food and fluid did result in a transfer of a detained person to hospital and could also result in release from detention.

48. I explained in my interview with Verita at page 14 of VER000279, that the process for setting appointments for case reviews did not work very well because DCMs who were acting as case managers might set case review appointments for dates on which they were not available, which meant that another DCM, who did not necessarily know the circumstances of the case would have to perform the case review. I raised my concerns about this practice with management and I continually challenged colleagues both in person (one to one), and in refresher courses, to ensure consistency of personnel with case reviews. A consequence of a lack of continuity was that the detained person may have to repeat personal and sensitive information to a DCM with no previous knowledge or experience of their issue. However, if the quality of the case review notes were of the required standard, then a new DCM should be able to understand the issues sufficiently well to perform the review. The introduction of more DCM staff (around the time I left G4S) should have improved this issue.

49. I am asked to summarise the case manager refresher training that I provided and to confirm that I provided it in 2017. Although I am confident that refresher training was delivered over this period (which be confirmed with reference to G4S/Brook House records) I do not recall any particular case manager refresher training session over this period. The refresher training was a day long. However, training sessions were frequently cancelled for operational reasons (usually staff shortages).

Complaints

50. I have reviewed document HOM005048, an email from Karen Goulder dated 14 February 2018, which details the complaint process, and I can confirm that this is my understanding of the process. My suggestion for improvement of the complaints process is for all complaints to be reviewed by someone who is independent.

51. I have been referred to the following complaints by detained persons: D725 (CJS001381 at pages 1-2 and HOM005242), investigated by me; D381 (CJS001425 at pages 5-7) investigated by me; D606 (CJS001527) in which I provided a statement; D803 (CJS001548) investigated by me; D2294 (CJS001555 and CJS005512) investigated by me. I am asked to comment on my involvement, my experience of the process, and my opinion of the outcome. I am not able to comment on my involvement and experience beyond the information that is contained within the documents referred to. In those investigations that I conducted I believe that the outcome was correct and fair.

52. I am asked to explain why I advised D606 not to make a complaint (recorded at page four of CJS001527). As set out in my statement at page four of CJS001527, detained person D606 accused DCO Crepin of racism (on the basis that DCO Crepin only helped black detainees) following DCO Crepin's refusal to allow D606 access to the Welfare Office in order that D606 could telephone the NRC (National Removal Command). DCO Crepin explained to me that the reason for refusing

D606 access to the Welfare Office to speak to the NRC, was because D606 had been repeatedly rude and abusive on the phone to the NRC. I resolved the issue by agreeing with D606 that another DCO, DCO Sharma, would assist D606 with the phone call. Having already resolved the issue to D606's satisfaction, and it being clear that DCO Crepin had refused D606 access to the Welfare Office because of a legitimate reason, namely his rude and abusive behaviour, I advised D606 against making a complaint.

53. With regard to the complaint by D2294 (CJS001555 and CJS005512) I am asked whether there were any criteria for a transfer between detention centres, and how the transfer of D2294 compared to the usual amount of time taken to transfer a detained person. The transfer of D2294 to Tinsley House occurred on 22 July 2017 in response to incidents on 14 and 21 July. D2294 was given an opportunity to transfer to Tinsley House on 17 July but declined on that occasion. He subsequently changed his mind and submitted a transfer request to the Home Office on 20 July, and agreed to move to Eden Wing, prior to transfer to Tinsley House, on 21 July. Transfer decisions are determined by the Home Office. However, in my experience the transfer of D2294 was quicker than average. Capacity issues have a bearing on whether transfers can be accommodated and the time that they take. Transfers to Tinsley House take account of a detainee's background and risk factors such as a history of violent behaviour, which would usually prevent a transfer to Tinsley House.

54. At paragraph 38 of my first statement, I refer to the fact that I was subject to investigations by the Professional Standards Unit ("PSU") and G4S. The PSU investigation occurred around 2010 following an allegation by a detained person that I had sexually assaulted him. The PSU investigation cleared me.

55. In 2011 I was investigated in connection with an incident involving the use of force while facilitating the transfer of a detained person from Tinsley House to another Immigration Removal Centre. I was placed on a final written warning for 12 months in connection with this incident.

Post Panorama

56. I was shaken by the Panorama programme because it portrayed my workplace negatively and lacked balance. I was also shocked because I was shown in the programme having been covertly recorded, without my consent. I saw a visiting G4S counsellor because I wanted to access the support that was available to me. The meeting lasted no more than 30 minutes and we spoke about my experiences.

57. Following the Panorama programme an internal review was carried out and a report was produced, the PRISM report (CJS000516), in November 2017. I was one of the staff interviewed for the report and I owned the action plan in response to the report as part of my responsibilities as the Violence Reduction Manager. As a result of the action plan, there was an approximately 70% reduction in violence.

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	James Begg
Signature	Signature
Date	21.02.2022