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1	Wednesday, 16 March 2022	1	Q. Just to give more of an overview, you also say in your
2	(10.00 am)	2	first witness statement, paragraph 2, that you worked at
3	MR JULIAN PAUL WILLIAMS (affirmed)	3	Brook House until July 2018, when you said it was time
4	Examination by MS TOWNSHEND	4	to move on?
5	MS TOWNSHEND: Good morning, chair. We will be hearing from	5	A. Yes.
6	Mr Julian Williams this morning.	6	Q. You now work for Mitie in Gatwick as a DCO overseas
7	Mr Williams, please could you give your full name to	7	officer?
8	the inquiry?	8	A. It's MIT, not Mitie, but, yes, that's correct, yes.
9	A. Julian Paul Williams.	9	Q. You started that in February 2019?
10	Q. Can I just ask you to make sure that I see you're	10	A. Yes.
11	leaning into the microphone. That's helpful. But if	11	Q. Please could you tell us more about what that role
12	you can keep your voice raised so that everybody can	12	involves?
13	hear you, that would be great. Ah, that's why we can't	13	A. Basically, it means going to detention centres, or IRCs,
14	hear. The microphone isn't on. Thank you.	14	and collecting detainees and putting them on planes to
15	Mr Williams, is it correct that you have provided	15	remove them back to their own countries.
16	two witness statements to this inquiry the first	16	Q. In terms of the level that that is on, that was a DCO
17	dated 7 March and the second dated 15 March?	17	level and, prior to that, you were at a manager level?
18	A. Correct.	18	A. Yes.
19	Q. Chair, may these two witness statements be adduced.	19	Q. So is that a demotion, then? Is that further down the
20	Their reference numbers are <inq000166> and <inq000170>?</inq000170></inq000166>	20	tree than residential manager?
21	THE CHAIR: Thank you, indeed.	21	A. Compared to the IRCs, yes.
22	MS TOWNSHEND: Mr Williams, I want to first ask you about	22	Q. I want to ask you now about your role as a residential
23	your background. Is it correct that you prior to	23	manager. You say in your witness statement first
24	working as a DCO, you were in the RAF for 13 and a half	24	witness statement, paragraphs 3 and 4, that it meant
25	years?	25	looking after the needs and welfare of detainee across
	D 4		D 2
	Page 1		Page 3
1	A. Yes.	1	four wings?
2	Q. You then joined Group 4, which was the predecessor,	2	A. Yes.
3	I assume, to G4S?	3	Q. You say that other areas of responsibility were paid
4	A. Yes.	4	work by detainees, activities, arts and education?
5	Q. In September 1993, as a DCO?	5	A. Yes.
6	A. Yes.	6	Q. And day to day, this would mean attending meetings,
7	Q. Then, over the next 24 and a half years, you progressed	7	holding disciplinaries, investigations, dealing with
8	from being a DCO to a supervisor to deputy shift manager	8	complaints, walking around the wings and activities
9	to shift manager and then to residential manager?	9	corridor, talking to staff and detainees and inspecting
10	A. Yes.	10	the cleanliness of the wing?
11	Q. You worked at Campsfield IRC, then Oakington and then at	11	A. Yes, that's part of it, yes.
12	Brook House?	12	Q. Is there any other part of it that I've missed?
13	A. Yes.	13	A. No. Doing everything, I think, was also, you'd have
14	Q. You became residential manager at Brook House in 2009,	14	duty director as well on once a week.
15	which was six months after Brook House had, in fact,	15	Q. So you would hold the role as a duty director, you say,
16	opened?	16	once a week?
17	A. Yes.	17	A. Yes.
18	Q. When the appointments when you were appointed as	18	Q. I assume then there were other duty directors who would
19	residential manager, you say in your second witness	19	hold that position on the other days?
20	statement, paragraph 3 no need to refer to it unless	20	A. Yes.
21	you need to that the role was advertised and you	21	Q. Can you remember, in 2017, who those other duty
	were then passed a selection process. Do you	22	directors were?
22	1 (0.1 / 1 / 1 / 1 / 1	23	A. Michelle Brown, Dan Haughton I can't I think
22 23	remember if that was advertised externally as well as	2	
	internally?	24	Sara Edwards, I believe Steve Skitt may have picked up
23	,	24 25	Sara Edwards, I believe Steve Skitt may have picked up a few of the duties.
23 24	internally?		

1 (Pages 1 to 4)

1	Q. Yes.	1	Thirdly, you would have the detainee consultative
2	A. Yeah.	2	meetings. And, fourthly, use of force meetings. Is
3	Q. You have said in your witness statement, the first	3	that right?
4	witness statement, paragraph 23, in terms of training	4	A. Yes.
5	for the role, you say:	5	Q. I want to ask you specifically about a meeting that you
6	"I was given any specific training for this role.	6	were said to have attended in 2016. Michelle Brown, in
7	I did shadow various managers for a short period of	7	her witness statement no need to bring it up on
8	time."	8	screen says at paragraph 119, <inq000164>. She says</inq000164>
9	Can I just clarify with you, did you mean that you	9	you were in attendance during a meeting in January 2016
10	were not given specific training for your role as	10	where she raised concerns that G4S would have a similar
11	residential manager?	11	issue to Medway, and, in particular, that because, of
12	A. No.	12	course, at Medway, there was abuse that was uncovered by
13	Q. You were not?	13	an undercover journalist in a BBC Panorama programme.
14	A. No. I shadowed the outgoing residential manager for	14	She says she raised that with Ben Saunders and
15	a month.	15	Steve Skitt and that you were also present at the
16	Q. Would you have found training to be a residential	16	meeting as well as Stacie Dean. Do you recall that
17	manager useful?	17	meeting?
18	A. As a residential manager, I don't know what training	18	A. No. No. Not the contents of the meeting, no.
19	there was available. As a manager, then there should	19	Q. So you don't recall Michelle Brown raising the issue of
20	have been some training available.	20	Medway?
21	Q. Can we assume by the fact that you didn't get any	21	A. No.
22	training that there was no training available?	22	Q. I want to ask you about use of force review meetings.
23	A. I believe so, yes.	23	You say in your first witness statement at paragraph 46
24	Q. That there wasn't any?	24	that use of force was first reviewed by a C&R instructor
25	A. There wasn't.	25	and any learning issues were then reported. You said
	Page 5		Page 7
1	Q. You were in the role of residential manager for ten	1	that you don't know how often these meetings took place,
2	years, right up until and the relevant period was	2	but, firstly, a C&R instructor would look at the
3	right at the end of that period. So the relevant period	3	incident and any learning issues would be reported at
4	being in 2017. What did you consider the challenges to	4	these meetings. Senior management would then review
5	have been for your role during that time?	5	these issues within the use of force paperwork, and then
6	A. The needs of the detainees was a lot. Their demands was	6	issues would be reported back to the C&R instructor to
7	heavy. And even their attitudes was boisterous at	7	see if refresher training was needed.
8	times. So a lot of them didn't want to be there. So it	8	That use of force instructor, can you remember if,
9	was a case of trying to look after them the best we	9	during the relevant period, that was Steve Webb?
10	could, and provide the needs for them the best we could.	10	A. No, it weren't Steve Webb, no.
11	The role in itself was very challenging. You had staff	11	Q. Who do you think it was?
12	who were trying to deal with 120 detainees on a wing,	12	A. I believe John Connolly was one of them.
13	going on and off the wing throughout the day. The	13	Q. Yes.
14	cleanliness of the centre detainees to keep their	14	A. And Dave Killick. But over what period, I'm not sure.
15	rooms clean and tidy, where some would just graffiti	15	Q. Could Steve Webb have also been doing those reviews, do
16	their rooms. Just stuff like that, really.	16	you know?
17	Q. I want to ask you now about the meetings that you were	17	A. Maybe, yes.
18	involved in. Firstly about meetings in general that you	18	Q. When you say they were first reviewed by use of force
19	attended. You have said in your first witness statement	19	instructor, do you know if - we heard evidence from
20	at paragraphs 44 to 49 that you attended essentially	20	Steve Webb that those reviews took place just on his
21	four types of meeting. So the first were the morning	21	own, and he was looking through the footage and,
22	meetings, which lasted which were the last 24 hours,	22	essentially, it was a tick-box exercise to review that
23	rather, were discussed with senior management, DCMs, the	23	footage and review the paperwork. Are those the
24	Home Office facilities, healthcare, catering and IMB.	24	meetings you're talking about, in terms of the use of
25	Second, you would have the monthly security meetings.	25	force review meetings, or are you talking about an extra
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2 (Pages 5 to 8)

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1	layer of accountability above that?	1	as soft and weak."
2	A. I believe that it when the reviews took place, they	2	You have commented in your second witness statement
3	would sign them off to say that they've done the review,	3	that you saw things differently to Nathan Ward. Can you
4	and then any issues or learning issues would then be	4	explain what you mean by that?
5	sent up to a second meeting, which is attended by	5	A. Can I just
6	management, to review these issues and such paperwork	6	Q. It is page 4, paragraph 14 of your second witness
7	and to see if there's any learning issues there, to make	7	statement.
8	sure — even if there weren't learning issues, to make	8	A. Yes. Basically, Nathan Ward came from a young
9	sure everything was done correctly.	9	offenders' institute, so he wanted to make sure that the
10	Q. Did you attend those meetings?	10	way we were looking after families and young offenders,
11	A. Yes.	11	or children, was done correctly, and I think, up until
12	Q. You said you can't remember how often. Were they ad hoc	12	then, we didn't have the experienced people, qualified
13	meetings or were they standing meetings?	13	people, to look after them. So he was making
14	A. I believe they were standing meetings.	14	arrangements for these people to go on various courses
15	Q. You said you can't remember how often. Was it weekly,	15	to gain the qualification needed to look after young
16	monthly, quarterly?	16	children and their families, which is what I meant by
17	A. I believe they were monthly.	17	"seeing things differently" because I hadn't come from
18	Q. Can you remember specifically attending any during the	18	that background, so I could only go off of what he was
19	relevant period in 2017?	19	telling us.
20	A. No.	20	Q. So from what I understand, Nathan Ward, in his statement
21	Q. I want to	21	here, is suggesting that every DCM should be trained in
22	A. Sorry, do you mean can I refer to any times	22	crisis communications and negotiations at Brook House as
23	I referred or did I attend?	23	well?
24	Q. Did you attend any meetings during that relevant period?	24	A. Yes.
25	A. Oh, if there was meetings, yes, I would have attended.	25	Q. What did you think of that?
	Page 9		Page 11
1	Q. You said "if there were meetings".		
		1	A. I didn't have a problem with it, because it helped
2		1 2	A. I didn't have a problem with it, because it helped assist with the DCMs learning more, getting more
2	A. Yes.	2	assist with the DCMs learning more, getting more
2 3 4	A. Yes. Q. Could you be sure that there were meetings that were		assist with the DCMs learning more, getting more training behind them. He'd obviously had some previous
3 4	A. Yes.Q. Could you be sure that there were meetings that were held between April and August 2017?	2	assist with the DCMs learning more, getting more training behind them. He'd obviously had some previous training from this area and knew to value valuable
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3 (Pages 9 to 12)

1	looking out of a window, seeing barbed wire, was not	1	management. You've got E1s, which was my grade, and
2	correct, so he wanted to soften the environment for them	2	then you had D grades, which is next level up, which is
3	to make it easier and more comfortable for them.	3	heads of department. So that's why I asked him, when he
4	Q. What about at Brook House, where there wasn't any	4	asked for a meeting with senior management, did it
5	children?	5	include me, and he said, yes, if I'm a duty director,
6	A. I don't think he prioritised there. I think Nathan felt	6	then, as far as he's concerned, yes, I'm part of that
7	that he was restricted in what he could do at	7	team.
8	Brook House because he was in charge of Tinsley and	8	Q. So Lee Hanford describes in his second Verita interview
9	not Brook House so apart from training, I can't	9	that there was, and I quote, "a huge missing link" which
10	recall anything else he tried to do at Brook House at	10	resulted in you representing res on the SMT. He says
11	the expense of staff.	11	that you were representing res since you were the most
12	Q. He says that he was sidelined as soft and weak. Did you	12	senior residential manager, but there wasn't, in fact,
13	see him as soft and weak?	13	a head of res position in place at the time at
14	A. No. No. A lot of people seen Nathan Ward as different	14	Brook House, and you weren't paid, and I quote, anywhere
15	because of his personal life. He was looking to join	15	near the grade of head of residence because you were an
16	the church and stuff like that. So people seen him	16	E1 grade, as you have just said, DCMs were E2, and there
17	different in that respect. But I found him to be	17	wasn't a D grade manager that was above that. Is that
18	a pretty good manager. When he done duty director, he	18	an accurate description?
19	was spot on. I even done a couple of investigations on	19	A. Yes. I actually took it that the deputy director was
20	his behalf for him. So I would have never classed him	20	the head of residence, because he represented me if
21	as soft and weak.	21	there was ever meetings with the Home Office and IMB and
22	Q. What do you mean by "his personal life"?	22	stuff like that.
23	A. Outside – if I remember rightly, he didn't own a TV or	23	Q. Pause there. Who was that at the time?
24	anything like that at home. So his life was different	24	A. At that particular time, that would be Steve Skitt.
25	to how most people see it when they have got a TV at	25	Q. He was your line manager?
	Page 13		Page 15
1	home and all that. Also, he was joining the church to	1	A. Yes, at that particular in the relevant period.
2	become a church member, so, yeah, it was different from	2	Q. So he was right then, wasn't he, that there was
3	the environment we was in.	3	a missing link
4	Q. I want to ask you now about your role specifically as	4	A. Yes.
5	a residential regimes manager. You said in your first	5	Q between you and the duty director?
6	witness statement, paragraph 5, that you were part of	6	A. Yes well, not the duty director
7	the senior management team from the outset of taking up	7	Q. Sorry, not the duty director, the deputy director,
8	that position?	8	Steve Skitt?
9	A. Yes.	9	A. Yes.
10	Q. You describe Lee Hanford arriving. When you say	10	Q. There should have been somebody in between the two of
11	Lee Hanford arrived in your witness statement, are you	11	you?
12	talking about 2016, before the relevant period?	12	A. Yes.
13	A. Yes, I believe so, yes.	13	Q. Was that the case for the whole of the time you were at
14	Q. So he asked for an SMT meeting. When you asked him if	14	Brook House or just during the relevant period?
15	this included you, he asked if you performed the	15	A. Right up until I believe it was January 2018, when
16	director duty the daily duty role, and when you	16	Mark Demian was appointed as head of residence.
17	replied yes, he said, "Then you're a part of the SMT"?	17	Q. In your second witness statement, as we have just
18	A. Yes.	18	discussed, you said that there should have been
19	Q. Why did you think it was necessary to ask Lee Hanford if	19	a manager between you and the deputy director, but you
20	you were part of the SMT?	20	said, "At the time, I believe it was appropriate for me
21	A. When Lee Hanford come in, I knew that his position from	21	to be on the SMT". Would you have benefited from the
22	outside of the company was sufficiently higher in what	22	support of having another manager between you and the
23	he'd done; looking after projects and stuff like that.	23	deputy director?
24			
	So when he come in and asked for a meeting with the	24	A. Yes, I believe so.
25	So when he come in and asked for a meeting with the senior management team, there is two groups of senior	24 25	Q. How would you have benefited, do you think?

4 (Pages 13 to 16)

1	A. Because I would have someone with more direct contact	1	the food and weather, it could have been more it
2	with — the deputy director was not always available.	2	could have been more use than what it was. I think,
3	He obviously had other things he needed to deal with.	3	when the weather was bad, then the courtyards were
4	So where I had an in-between link, then I had someone	4	closed, so games were not played then, so that had an
5	I could go to more directly and speak with and sort	5	impact of more detainees walking around the centre with
6	things out, rather than hassling the duty director	6	nothing to do.
7	deputy director sorry, deputy centre manager all the	7	Q. Were activities something that you were responsible for?
8	time.	8	A. Yes.
9	Q. You say "with issues". Were there any particular issues	9	Q. Were there any other issues with activities, apart from
10	that it would have been helpful to have been able to	10	the vagaries of the weather?
11	have spoken directly to a manager?	11	A. The computer room used to cause problems at time. We
12	A. I can't think of any particular issues. I know that	12	had no control over the IT system externally. So that
13	coming back down, it would have been sufficient because	13	could cause problems at times. So that would go down
14	information would have come back that way rather than	14	and detainees would be unhappy about that, but we needed
15	wanting to see the deputy centre director all the time	15	to make arrangements through welfare for them to use the
16	to find out information. I would have someone I could	16	computer if it was an urgent need. So that also could
17	have just gone and seen, and vice versa.	17	be a problem at times.
18	Q. Lee Hanford also said in his interview to Verita that	18	The cultural kitchen was also an issue at times,
19	you were not competent in a managerial role. He says	19	when we didn't always have the staff to put someone in
20	that at <ver000239> page 4, paragraph 19. He also said:</ver000239>	20	there to look after it for the detainees to go and cook.
21	" we were expecting [Julian Williams] to punch	21	Q. I'll come on to staffings later on in your evidence.
22	above his weight in an area that I don't think he has	22	I'm also going to now put to you another statement, or,
23	the confidence to do that, to be perfectly honest.	23	rather, interview, by Verita, and this time this
24	···	24	interview was with Ian Castle. Did you know Ian Castle?
25	" we have the skill set at other grades within	25	A. Yes.
	Page 17		Page 19
	1 050 1		2.456.17
1	the safeguarding, to support that area, but [areas that	1	Q. He said of you, you appeared to sorry:
2	are] still failing, particularly October, November,	2	"In order to be a good manager, it is handy to have
3	December and moving into the early part of January, the	3	a bit of charisma, a bit of personality. That is not
4	area that was failing was residence."	4	something that he is endowed with at all. I would also
5	Your answer to this is in your second witness	5	expect a manager to be able to communicate with his
6	statement, where you say there were some areas, such as	6	staff, to communicate with detainees, but I am pretty
7	cleanliness, which are audited by an external auditor.	7	certain that he doesn't have the respect of the staff
8	Other than that, are there any other areas in which you	8	nor of the majority of the rest of SMT."
9	consider that he was right that there were areas in	9	That's at <ver000268> page 7. Did you feel that you</ver000268>
10	which you were failing?	10	were able to communicate with those you managed, the
11	A. Apart from cleanliness, I can't think of any. There may	11	staff?
12	have been issues which needed resolving on the wings,	12	A. Yes.
13	like the cleanliness of the wings, the rooms, searching,	13	Q. What about detainees?
14	but I can't think of anything directly.	14	A. Yes, I didn't have a problem communicating with
15	Q. Ed Marsden, who was questioning Lee Hanford, in the	15	detainees.
16	Verita interview, seemed to suggest that there may have	16	Q. Did you feel that those you managed and the rest of
17	been an issue with lack of regular activities. Do you	17	the SMT respected you?
18	think there was an issue with lack of regular	18	A. I can't answer for how the SMT felt about me. I worked
19	activities?	19	with them. We attended meetings. So I can't answer how
20	A. That depended on the weather. I think, given the way	20	they felt about me.
21	Brook House was laid out, we made best use of the rooms	21	Q. I'm going to take you now to something Michelle Brown
22	what was available throughout the centre. We also tried	22	said in relation to Steve Skitt's management of you. If
23	to put activities, sort of card games, and stuff like	23	we can please turn to <ver000221>, page 117 [sic]. It's</ver000221>
24	that, on the wings for detainees to have as well. So	24	paragraph 250. So this is a second interview
25	I think we made best use of what was available. I think	25	in February 2018 with Michelle Brown by Verita. It is
	D 46		D 20
L	Page 18	<u></u>	Page 20

5 (Pages 17 to 20)

1	250. I will start with the second sentence:	1	A. I believe so, yes.
2	"If you go through SMT minutes, there is stuff that	2	Q. What do you say about the allegation that you don't like
3	we talked about - changing, informing the committee	3	being challenged by females?
4	about [employment] of the month. That never happened.	4	A. I didn't have a problem with that. I did not have
5	Things in meetings, just are talked about, if that makes	5	a problem with that at all.
6	sense. The 28th is a perfect example: we raised it. We	6	Q. And what about grunting at Stacie Dean and
7	raised it the month before and Jules didn't bother	7	Michelle Brown? Did you do that?
8	coming to the security meeting and so I complained.	8	A. I don't believe so.
9	When Jules did come to the security meeting, Jules came	9	Q. You don't believe so or you didn't?
10	in and fell asleep. It's on there it is an ongoing	10	A. I don't believe I grunted at either of them.
11	action. I don't think Jules likes challenges from	11	Q. In terms of performance management, Michelle Brown is
12	females. There was a member of staff before	12	suggesting there that Steve ought to have been
13	Stacie Dean - who was security senior manager, and he	13	performance managing you. Were you, in fact, ever on
14	would [just] kind of grunt at her. He grunts at me.	14	a performance management programme?
15	I don't know what conversations Steve has with Jules,	15	A. No.
16	because Steve says to me 'I'm managing him' and I am	16	Q. Was it ever discussed with you by Steve Skitt or any
17	thinking 'performance managing him or managing him?"	17	other manager?
18	There is a difference. I genuinely don't know whether	18	A. No.
19	we are into that process at all but I suspect that we	19	Q. In your second witness statement, paragraph 13, you
20	are not and it is just a conversation in the morning to	20	describe Steve Skitt as an honest and effective line
21	say 'You need to look at that'."	21	manager, and that if there was a problem, he would tell
22	Did you regularly attend security meetings?	22	you and his expectations of you. Can you remember
23	A. Not as regularly as I should have done.	23	Steve Skitt raising any particular issues in 2017?
24	Q. Were you required to go to every security meeting?	24	A. Again, one of them would be cleanliness of the centre,
25	A. I was. However, I was also under the impression that if	25	following the Home Office doing an inspection or an
	•		
	Page 21		Page 23
		1	
1	I couldn't attend, then I could send one of the DCMs	1	external auditor coming in doing an inspection. Steve
1 2		1 2	external auditor coming in doing an inspection. Steve would tell me then. Other things would be to see DCMs
	I couldn't attend, then I could send one of the DCMs from the wings to represent me, which is what I done at times.		
2	from the wings to represent me, which is what I done at	2	would tell me then. Other things would be to see DCMs
2 3	from the wings to represent me, which is what I done at times.	2	would tell me then. Other things would be to see DCMs on the wing on a more regular basis during meal times,
2 3 4	from the wings to represent me, which is what I done at times. Q. When you say "under the impression", does that mean —	2 3 4	would tell me then. Other things would be to see DCMs on the wing on a more regular basis during meal times, he'd pull me up for that, if someone wasn't there at
2 3 4 5	from the wings to represent me, which is what I done at times. Q. When you say "under the impression", does that mean — were you under the right impression, was that the right	2 3 4 5	would tell me then. Other things would be to see DCMs on the wing on a more regular basis during meal times, he'd pull me up for that, if someone wasn't there at meal times. Other areas would be, like, completing investigations on time.
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6 (Pages 21 to 24)

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1	get copies of the emails as well. Investigations would	1	Brook House, I attended various courses to learn. Once
2	be if I had an investigation I may not have had an	2	I become a senior manager, I didn't find many courses
3	investigation for a couple of months, but timescale	3	available which to assist me to go forward. So the
4	might have fallen behind, so they would pull me up for	4	desire to and the desire to develop myself, I believe
5	it. DCMs on the wings, again, that wouldn't be all the	5	that may be referring to the Corndell course, which we
6	time. That would be, like, at meal times if someone	6	were put on, which I was struggling with. As to others
7	wasn't there, so, again, he would only pull me up if he	7	around me on their EDRs, I used to give targets, I used
8	was aware of the situation.	8	to ask them to go and look at various courses, which
9	Q. You've mentioned cleanliness quite a few times?	9	they liked to do, so in order to help them develop.
10	A. Yeah.	10	Q. You have mentioned Corndell. That was something that
11	Q. Was that a particular issue at Brook House?	11	was brought in by Lee Hanford after the relevant period,
12	A. Yes, yes.	12	wasn't it?
13	Q. In a particular wing or a particular place or?	13	A. Yes.
14	A. One of the main areas where we used to get pulled up	14	Q. You said that you struggled with Corndell?
15	a lot was the showers, and, as I used to try to explain	15	A. Yes.
16	to management, I wouldn't scrub one of those showers for	16	Q. That was a kind of training scheme, wasn't it, for
17	a pound an hour, so it's difficult to get detainees to	17	managers?
18	scrub body fat off the back of the showers for a pound	18	A. It was a level 5 management training scheme.
19	an hour, and so we'd quite often get pulled up for it.	19	Q. Why did you say you struggled with it? In what way?
20	The other areas would be the floor would be dirty,	20	A. Finding the time to do it. I didn't struggle with
21	if it needed polishing or cleaning, or bins needed	21	actually doing it. But it was finding the time to do it
22	emptying, and stuff like that, or graffiti on the walls.	22	and Lee Hanford's answer was that I should do it at home
23	Q. Where detainees didn't clean, such as in the showers,	23	if I couldn't find the time at work to do it.
24	wasn't there a cleaning contract for paid staff to come	24	Q. We will come on to training for DCMs as well, in
25	and clean it?	25	a moment, and some of the problems there. I just want
	Page 25		Page 27
1	A. For Aramark, no. From what I can gather over the years,	1	to ask you a few more questions about what
2	there's been a bit of to and froing of who was actually	2	Michelle Brown has said. How were your computer skills?
3	to do it. Certainly in the earlier years, I used to	3	A. I could use a computer. I could carry out
4	work alongside of Aramark and they used to clean the	4 5	investigations using investigation skills. My wording
5	showers, give them a scrubdown once a month, but then it	6	may have been a bit bad. I was tested for dyslexia, and
6 7	came about that they were not responsible for it, and so	7	so my wording, or the way I sentenced stuff together,
8	it then fell down to me to get paid workers to get to do	8	was might have been a bit bad, and I did have
9	it. Q. I want to now take you to Michelle Brown's witness	9	a computer programme to put on my computer to help me
10		10	with that — (inaudible) that line, to increase it. But
11	statement, <inq000164>, page 3. It is paragraph 4. This is Michelle Brown's witness statement speaking</inq000164>	11	basic computer skills, yes, I could write reports up, I could use it, I could
12	about you. I will summarise it here. Essentially, she	12	Q. Do you accept any of the criticisms that she makes
13	says that she experienced some frustrations working with	13	there?
14	you. She said that you lacked coaching skills and	14	A. No, I don't accept any of that. The only thing I would
15	a desire to develop yourself or others around you.	15	say was that was delivering or completing
16	There was a perception that there was a lack of faith in	16	investigations, (inaudible) some time. I did struggle
17	your ability to complete and deliver to the required	17	with that at times, completing investigations on time,
18	standard, that you did not have the skill set to deal	18	and would have to ask for extensions.
19	with computer work, and high-level stakeholder	19	Q. Why would you have to ask for extensions?
20	engagement was needed. Do you agree that you lacked	20	A. Some of it could be that staff weren't available at the
21	coaching skills and a desire to develop others around	21	time, so I had to wait for them to come back on shift.
22	you?	22	Other times, could be that I had other work going on at
23	A. I don't know what she means by "coaching skills" or	23	the same time or there was a duty director, so there
24	"desire to develop". In the early days, I had attended	24	could be times that the investigations wasn't completed
1		1	
25	various courses. Certainly, before I joined	25	on time and I would be chased up for it.
25	various courses. Certainly, before I joined Page 26	25	on time and I would be chased up for it. Page 28

1	Q. I want to now ask you about your visibility on wings,	1	of reasons.
2	and also cliques. You have said in your first witness	2	Q. Did you ever hear a DCO use bad language towards
3	statement that you used to get around the wings on	3	a detainee?
4	a regular basis that's paragraph 23 "and in	4	A. No, not in my presence. Not while I was on the wings.
5	general I did not see any issues with staff attitudes	5	Q. How often did you have to speak to a DCO for having an
6	towards detainees, including during the relevant	6	argument with a detainee?
7	period". Mr Williams, we have heard evidence that,	7	A. I wouldn't say it was that often. Maybe once a month
8	compared to Steve Skitt and Michelle Brown, you were	8	I'd call someone up, just because they're having an
9	much more present on the wings. So DCO Ed Fiddy said	9	argument with a detainee and voices were raised.
10	that. Did you watch Panorama?	10	Q. Was this during the relevant period as well, in 2017?
11	A. Yes.	11	A. Yes.
12	Q. Did you watch it live or did you watch it afterwards?	12	Q. You said in your witness statement, your first witness
13	A. I watched it live.	13	statement, paragraph 7, that the culture at Brook House
14	Q. Were you surprised at what you saw or not?	14	had improved from when you first started in 2009. In
15	A. I was disgusted with what I saw, and surprised. Because	15	what way had it improved?
16	I didn't think that was going on. But I was actually	16	A. The staff had become more experienced. When I first
17	disgusted with what I saw.	17	started there in September 2009, staff were very
18	Q. Is it right, as Ed Fiddy said, that you were around the	18	inexperienced. They'd never worked in a detention
19	wings a lot?	19	centre before. So they were learning their way as they
20	A. Yes.	20	were going along. And so detainees became more settled
21	Q. We have heard evidence from numerous detention centre	21	down in the centre. A lot of detainees come from
22	officers during this inquiry, including Steve Webb, who	22	prisons and areas like that when first Brook House
23	called D728 a "fucking twat", threatened to "punch the	23	first opened up, so they knew staff were inexperienced
24	cunt" in E wing. Mr Fiddy himself called a detainee "an	24	so they took advantage of it and, after the years passed
25	absolute poofter", and so on. There was a lot of	25	on, the staff become more experienced, more settled
	Page 29		Page 31
	- 1962		1 1000
1	swearing and verbal abuse of detainees that was seen on	1	down. Detainees became more settled down. So the place
2	Panorama we have heard during this inquiry. If you were	2	became a better-running place/environment.
3	on the wings a lot, how did you not hear this kind of	3	Q. What did you mean by "culture"? What culture had there
4	verbal abuse that took place?	4	been at the beginning when you came in 2009, compared to
5	A. When I was on the wings, staff would be aware of it. So	5	the end?
6	there wouldn't be — they'd know that if they were	6	A. There was when I first started there, there was
7	behaving that way towards a detainee, I would pull that	7	a very hatred/dislike for Home Office.
8	member of staff up straight away. I would take them to	8	Q. Pause there. From who?
9	the office, call them up to my office. Because staff	9	A. The detainees. That caused a lot of problems which the
10	once a senior manager walks on the wing, then staff	10	staff had to deal with, because they were the front-line
11	behave normal.	11	between them and the Home Office, so the staff had to
12	Q. You said that you would call them up into the office.	12	deal with that, and a lot of issues arose from detainees
13	How often did that happen?	13	in that respect, because they'd want to speak to them,
14	A. Not very often. Some of the times I've been I've	14	they'd want to see them all the time, like, so there was
15	come down to a wing and a member of staff would be	15	issues there.
16	having an argument with a detainee, and so I'd wait for	16	The actual running of the place, once detainees had
17	that to finish and then I'd speak to that member of	17	been in there for a little while, they seemed to settle
18	staff privately or call them up to my office and ask	18	down in the environment, they found friends, they found
19	them what all that was about. I'd go to see the	19	friends of different nationalities, friends from
20	detainees to see if there was an issue.	20	outside, so in that respect, the culture changed and
21	Q. When you say an "argument", what do you mean? What kind	21	settled more.
22	of thing were a detainee and a DCO arguing about?	22	Q. But the same detainees weren't there from 2009 until
23	A. It could be anything from the detainee demanding to see	23	2018, were they?
24	the Home Office, wanting to know why he hasn't gone	24	A. No, no. No.
25	home, why he hasn't been released; it could be a number	25	Q. So why would detainees' attitudes towards the
1			70 44
	Page 30		Page 32

8 (Pages 29 to 32)

			-
1	Home Office have changed in that period?	1	co-operate with you. My experience was most staff were
2	A. I think it was because the Home Office had moved forward	2	too scared to raise concerns."
3	in regards to giving back — feeding back information to	3	That's <inq000106> page 29. Do you have any comment</inq000106>
4	detainees. One of the areas that I can think of was	4	to make in relation to that?
5	that - I can't remember when it came out, but they	5	A. I know staff didn't trust the DCMs. They didn't trust
6	would give detainees 24 hours' notice of their impending	6	them because — exactly like you said, they wouldn't
7	removal. This allowed detainees to arrange visits, to	7	take any further action on anything.
8	arrange onward transport when they got home, to make	8	Q. Was there any particular DCMs you're thinking of?
9	phone calls, and so they were happy about this because,	9	A. No, I can't think of any particular ones at this time.
10	prior to then, they weren't getting notification of	10	But I know staff didn't trust them at times.
11	removals.	11	Q. Which staff didn't trust who?
12	Q. What about staff culture? You have spoken about the way	12	A. Various staff on the wings. They believed that – with
13	detainees felt about the Home Office. What about staff	13	some of the DCMs, there was no point talking to them
14	culture? Had that changed during your time at	14	because nothing would get done or they wouldn't act upon
15	Brook House?	15	it or they wasn't visible on the wings to deal with the
16	A. Yes, because staff started understanding that their role	16	issues.
17	in what they were doing and how to look after detainees	17	Q. Are you thinking of anyone in particular?
18	and the detainee needs. During that relevant period,	18	A. No, I'm just I'm just summarising how staff felt at
19	the staff culture or the morale went downhill big style	19	times.
20	because a lot of staff were disgusted with they saw on	20	Q. What about you? He is not just saying that DCMs can't
21	the Panorama programme, and then had to deal with the	21	be trusted, he's saying that he'd have no confidence
22	aftermath of it with detainees.	22	that members of the SMT would take anything forward.
23	Q. So the culture that we saw in Panorama of staff, that	23	A. If it was brought to me, I would have dealt with it;
24	was better than what you saw in 2009? The way that	24	it's simple as that.
25	staff that we saw in	25	Q. Were you close to abusive members of staff like
	-		
	Page 33		Page 35
1	A. No.	1	Graham Purnell?
2	Q were acting towards detainees?	2	A. I knew Graham Purnell, yes. I did socialise externally
3	A. No, that's just during disgusting the way they were	3	with Graham Purnell.
4	behaving. That's not what I saw back in the early days.	4	Q. We will come now to Nathan's evidence in relation to
5	Q. You said in your first witness statement, paragraph 36:	5	socialising and the existence of the clique. If we can
6	"I would like to think that I had an open-door	6	please turn to <dl0000141> pages 59 to 60,</dl0000141>
7	approach with staff. I would often walk around the	7	paragraph 166. This is Nathan Ward's first witness
8	wings speaking to detainees and staff."	8	statement to the inquiry. It is paragraph 166. Over
9	We heard from Callum Tulley, in his live evidence,	9	the page, please. I'm afraid that doesn't seem to be
10	this. He said:	10	the right paragraph. I'll read it out, if that's all
11	"The most egregious act of cruelty and mistreatment	11	right:
12	of a detainee that I can remember was performed by two	12	"While I was at Gatwick IRCs, I had a particular
13	DCMs, so I think when you're a DCO, if you have people	13	issue with residential manager Jules Williams, who was
14	above you that are treating people so abhorrently, then	14	in charge of all the residential staff and therefore
15	you're not going to have any confidence in raising	15	responsible for setting the tone and attitude of staff
16	complaints. The SMT were barely visible. Members of	16	and detainee relationships. Jules didn't embody the
17	the SMT, like Jules Williams, were close to abusive	17	values of respect and dignity. He would simply get the
18	members of staff, like Graham Panel, so people like	18	job done and was dedicated to making things happen,
19	myself had no confidence that going to the SMT would be	19	regardless of the human cost."
1 1/		20	Thank you, it is 168. Why do you think that
20	anything other than fruitless and whose word was it		
1	anything other than fruitless and whose word was it going to be? The word of a DCO against the word of	21	Nathan Ward would think that about you?
20	•	21 22	Nathan Ward would think that about you? A. I don't know. It's correct that I was dedicated to
20 21	going to be? The word of a DCO against the word of		· · · · · · · · · · · · · · · · · · ·
20 21 22	going to be? The word of a DCO against the word of a DCM? Much of the abuse would happen inside cells in	22	A. I don't know. It's correct that I was dedicated to
20 21 22 23	going to be? The word of a DCO against the word of a DCM? Much of the abuse would happen inside cells in which there were no cameras, so how you would	22 23	A. I don't know. It's correct that I was dedicated to making things happen and get the jobs done. I wouldn't
20 21 22 23 24	going to be? The word of a DCO against the word of a DCM? Much of the abuse would happen inside cells in which there were no cameras, so how you would substantiate any of your complaints would be very difficult unless you had other officers who would	22 23 24	A. I don't know. It's correct that I was dedicated to making things happen and get the jobs done. I wouldn't have said "regardless of human cost", there's no way — I don't know why he would have said that. And I did
20 21 22 23 24	going to be? The word of a DCO against the word of a DCM? Much of the abuse would happen inside cells in which there were no cameras, so how you would substantiate any of your complaints would be very	22 23 24	A. I don't know. It's correct that I was dedicated to making things happen and get the jobs done. I wouldn't have said "regardless of human cost", there's no way —

9 (Pages 33 to 36)

r		,	
1	respect the detainees. I used to show them a lot of	1	"Man up". He'd spoken to HR about it and he said it was
2	respect and dignity. So I don't know why Nathan Ward	2	borderline bullying. Did you bully Ed Fiddy?
3	would say these things. I have no idea.	3	A. No.
4	Q. I'm going to continue. I think it is over the page:	4	Q. Do you remember the incident that he's talking about,
5	"He was surrounded by a number of staff which	5	about pulling him up in front of staff about unlocking
6	I felt he was inappropriately close, such as	6	a door incorrectly?
7	Graham Purnell, Alan James, Anthony Morgan, David Aldis,	7	A. No.
8	Joe Marshall, Luke Hutchinson, Nathan Ring, Simon Brobyn	8	Q. Did HR speak to you about the fact that Mr Fiddy had
9	and Stephen Marner. This group were protected and	9	complained about you bullying him?
10	favoured by Jules Williams and this dynamic is	10	A. No. I know during one annual report where he had an EDR
11	representative of the hierarchies that operated in	11	appraisal, Ed Fiddy was not happy about the comments
12	Brook House amongst the staff which fostered a sense of	12	I put on it, and we spoke about it. And we if I'm
13	collusion and impunity. If you were in Jules Williams'	13	right in saying, I readjusted the comments, which he was
14	inner circle, you knew that you would be protected."	14	then happy about, but that's as far as
15	Were you friends with the people mentioned there?	15	Q. What were the comments?
16	A. Can you just go back one?	16	A. I can't remember now. I think it had something to do
17	Q. Just scroll back a page, sorry, thank you. The bottom	17	with his work. But I can't remember what they actually
18	of the page: Graham Purnell, Alan James, Anthony Morgan,	18	were. It was a few years I think it was about six,
19	David Aldis, Joe Marshall, and so on?	19	seven years ago, so I can't remember.
20	A. I disagree with that.	20	Q. You said that you agreed to change what you'd said in
21	Q. Just firstly, the question that I asked was, were you	21	this review; is that right?
22	friends with those people that are listed there?	22	A. Yes.
23	A. The majority of them, yes. Not all of them.	23	Q. Can you remember at all what it was that you changed it
24	Q. He describes them as your "inner circle". Were you	24	to, the issue?
25	close friends with those people?	25	A. I think I changed the wording. I didn't actually change
	Page 37		Page 39
1	A. With some of them, yes.	1	what it was I said in regards to the importance of it.
1 2	A. With some of them, yes. O. Did you socialise with them outside of work?	1 2	what it was I said in regards to the importance of it. I just worded it differently.
	Q. Did you socialise with them outside of work?		I just worded it differently.
2	•	2	-
2	Q. Did you socialise with them outside of work?A. With some of them, yes.	2 3	I just worded it differently. Q. Did you ever say to him, "Man up"?
2 3 4	Q. Did you socialise with them outside of work?A. With some of them, yes.Q. Do you know what he means by you would be protected if you were part of this inner circle?	2 3 4	I just worded it differently. Q. Did you ever say to him, "Man up"? A. I can't recall.
2 3 4 5	Q. Did you socialise with them outside of work?A. With some of them, yes.Q. Do you know what he means by you would be protected if	2 3 4 5	I just worded it differently. Q. Did you ever say to him, "Man up"? A. I can't recall. Q. Have you ever said to any other DCO or DCM, for that
2 3 4 5 6	 Q. Did you socialise with them outside of work? A. With some of them, yes. Q. Do you know what he means by you would be protected if you were part of this inner circle? A. No, I don't, because there's names on there where I'd 	2 3 4 5 6	I just worded it differently. Q. Did you ever say to him, "Man up"? A. I can't recall. Q. Have you ever said to any other DCO or DCM, for that matter, "Man up"?
2 3 4 5 6 7	 Q. Did you socialise with them outside of work? A. With some of them, yes. Q. Do you know what he means by you would be protected if you were part of this inner circle? A. No, I don't, because there's names on there where I'd done investigations and CID reports and some of them 	2 3 4 5 6 7	I just worded it differently. Q. Did you ever say to him, "Man up"? A. I can't recall. Q. Have you ever said to any other DCO or DCM, for that matter, "Man up"? A. Not as far as I know.
2 3 4 5 6 7 8	 Q. Did you socialise with them outside of work? A. With some of them, yes. Q. Do you know what he means by you would be protected if you were part of this inner circle? A. No, I don't, because there's names on there where I'd done investigations and CID reports and some of them I had issued disciplinaries to, so I wouldn't have 	2 3 4 5 6 7 8	I just worded it differently. Q. Did you ever say to him, "Man up"? A. I can't recall. Q. Have you ever said to any other DCO or DCM, for that matter, "Man up"? A. Not as far as I know. Q. Is that
2 3 4 5 6 7 8 9	 Q. Did you socialise with them outside of work? A. With some of them, yes. Q. Do you know what he means by you would be protected if you were part of this inner circle? A. No, I don't, because there's names on there where I'd done investigations and CID reports and some of them I had issued disciplinaries to, so I wouldn't have protected them. 	2 3 4 5 6 7 8 9	I just worded it differently. Q. Did you ever say to him, "Man up"? A. I can't recall. Q. Have you ever said to any other DCO or DCM, for that matter, "Man up"? A. Not as far as I know. Q. Is that A. Not as far as I know.
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2 3 4 5 6 7 8 9 10 11	 Q. Did you socialise with them outside of work? A. With some of them, yes. Q. Do you know what he means by you would be protected if you were part of this inner circle? A. No, I don't, because there's names on there where I'd done investigations and CID reports and some of them I had issued disciplinaries to, so I wouldn't have protected them. Q. Who are those people? A. Joe Marshall would have been one. Graham Purnell is another one. Simon Brobyn. 	2 3 4 5 6 7 8 9 10 11 12	I just worded it differently. Q. Did you ever say to him, "Man up"? A. I can't recall. Q. Have you ever said to any other DCO or DCM, for that matter, "Man up"? A. Not as far as I know. Q. Is that A. Not as far as I know. Q. I assume you would know because you were the person saying it. A. Yes, yes.
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10 (Pages 37 to 40)

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1	Q. We have heard from several witnesses that that phrase,	1	a case of not being able to bring their concerns to me,
2	"Man up", was used regularly around the centre. Did you	2	it would be a case that, if they was doing something
3	see evidence of this as a macho culture?	3	wrong at that particular time, like not checking ID
4	A. If I'd have heard of it, then I would have dealt with	4	cards on doors, I'd pull them up for it, I'd ask them
5	it, because it's not appropriate. So whether I see it	5	why they didn't do it. That's what I mean by being
6	as a culture, it's not for me to say, because I haven't	6	critical. There has been times I've given praise as
7	actually heard it myself, so	7	well. I can say I have given praise. Not often, but
8	Q. Do you think there was a macho culture at Brook House?	8	I have done it.
9	A. I believe there was some people who thought they were	9	Q. Did those that you were managing bring forward concerns
10	above what they were doing. Having watched that	10	to you?
11	Panorama programme, yes.	11	A. If they had issues on the wings, they would speak to me,
12	Q. What about, in your day to day forget Panorama for	12	yes.
13	a moment. But from what you saw, being on the wings for	13	Q. What kind of issues?
14	nine years, did you see evidence of a macho culture?	14	A. It could be anything from a detainee complaining on the
15	A. No, not directly, no.	15	wing, wanting information, refusing to leave the wing,
16	Q. So you're just saying that you saw evidence of that on	16	got on the wrong wing and wouldn't get off again. It
17	the Panorama programme, but not in reality; is that what	17	could be anything from a day-to-day running of
18	you're saying?	18	the centre.
19	A. Yes.	19	Q. I want to ask you about your management now of DCMs.
20	Q. Sorry, rather, in your experience?	20	You can take that down, thank you.
21	A. Yeah, in my experience, no.	21	In their interviews with Verita, both Ryan Harkness
22	Q. If we can go to what Ben Saunders has said about you,	22	and Stuart Povey-Meier comment on the difficulty
23	it's <ken000001>, page 31. It is paragraph 166. Right</ken000001>	23	completing DCM training, and we referred earlier to your
24	at the top of the page, the bullet point at the top:	24	difficulties in completing the Corndell training.
25	"Jules Williams as residential manager at	25	A. Yes.
23	Jules Williams as residential manager at	23	A. 103.
	Page 41		Page 43
1	Brook House, he had quite a large area of responsibility	1	Q. Harkness, in his Verita interview I won't bring it up
2	managing all issues of a residential nature. There were	2	for reasons of team <ver000238> page 5 stated that he</ver000238>
3	some things he did well. He could also become quite	3	never had any training as a DCM and that you were
4	defensive and abrupt and there was tendency for him to	4	responsible for his training as his line manager. He
5	be more critical rather than giving praise."	5	said that he didn't have couldn't do this training
6	Do you agree with that statement?	6	because he couldn't find time during the day to do the
7	A. I could, yes, become defensive and abrupt, especially in	7	micro study. Povey-Meier stated in his Verita interview
8	meetings, because I'd be defending staff on the wings at	8	<ver000280> page 9 that it was not easy to get the</ver000280>
9	meetings, so I'd always want to put have my say and	9	training due to poor staffing levels and turnover.
10			
	but my point across, so I como become defensive and	10	We also heard from other DCMs who gave live evidence
	put my point across, so I could become defensive and abrunt.	10	We also heard from other DCMs who gave live evidence to the inquiry for example. Luke Instone-Brewer and
11	abrupt.	11	to the inquiry, for example, Luke Instone-Brewer and
11 12	abrupt. As for being critical, yes, I pulled staff up.	11 12	to the inquiry, for example, Luke Instone-Brewer and Stephen Webb, that they received no training to become
11 12 13	abrupt. As for being critical, yes, I pulled staff up. I quite often would pull staff up, rather than giving	11 12 13	to the inquiry, for example, Luke Instone-Brewer and Stephen Webb, that they received no training to become a DCM. Is there supposed to be some training —
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11 (Pages 41 to 44)

1	manager to give them that training so they could then	1	that he did not have an objective setting session with
2	follow a certain path of knowing what they had to learn	2	you as his line manager and he never had targets
3	in order to become a DCM.	3	objectives, nothing, never had an EDR. Firstly, what's
4	Q. So a type of booklet which set out what they needed to	4	an EDR?
5	be trained in?	5	A. It's the annual appraisal system.
6	A. Yes.	6	Q. Is it correct that he never had an EDR with you?
7	Q. Or, rather, the training itself?	7	A. He would have had at least one with me.
8	A. Yes.	8	Q. So you've said in your second witness statement that you
9	Q. Were you aware that there were difficulties of DCMs	9	would have had one yearly. He says he would have
10	completing this training?	10	expected one a week after he went live as a DCO,
11	A. Yes.	11	in April of that year. Would you have normally had an
12	Q. When asked whether Ryan Harkness had ever had an	12	EDR when somebody first becomes a DCO?
13	opportunity to discuss with you the difficulties about	13	A. No.
14	training, he said in his Verita interview <ver000238></ver000238>	14	Q. In terms of EDRs, did you do them regularly with the
15	page 5:	15	DCMs that you line managed?
16	"Jules is a difficult person to get your point	16	A. They were annually, and also we used to do a six-monthly
17	across with. He is not very understanding."	17	review, just to see where they were with any training
18	What do you make to that?	18	courses they'd asked to attend or objectives, to see
19	A. I believe Ryan Harkness is referring to the Corndell	19	where they were with it and to see whether we needed to
20	training, because, along with myself, a lot of us was	20	review those particular objectives or training courses.
21	actually struggling to complete it.	21	Q. I want to bring on to that was what Ryan Harkness has
22	Q. But he says when he tried to raise this with you, he	22	said about your management of him. I want to turn now
23	said "Jules is a difficult person to get your point	23	to what Ramon Giraldo Arbalaez has said. Michelle Brown
24	across with. He's not very understanding". What do you	24	in her witness statement I won't bring it up, but it
25	say to that?	25	is <inq00164> page 3, paragraph 4, says that DCM Giraldo</inq00164>
	Page 45		Page 47
1	A. I believe because I understood where he was coming	1	was frustrated with you, upset by lack of support he
2	from, so there's no offer of help I could give him	2	received and how he was spoken to at times. Looking at
3	because I was in the same situation.	3	his Verita interview, he also says that. It is
4	Q. What action did you take, if any, about this fact?	4	<ver000215> page 7. He says that he moved to</ver000215>
5	A. At the time, none, I don't think.	5	Tinsley House because he couldn't work with you. Do you
6	Q. Why not?	6	know why DCM Giraldo said this?
7	A. Because, as I've said, I was in the same situation,	7	A. I don't, because, as far as I was aware, he
8	struggling to complete the training myself.	8	Steve Skitt moved him to Tinsley House. He didn't move
9	Q. Why didn't you raise the fact that you were struggling	9	himself.
10	to complete this training with someone more senior to	10	Q. I want to ask you now about staffing levels. We have
11	you?	11	touched on that in relation to training. If we can
12	A. I had.	12	bring up, please, on screen <cjs000462> page 4. This is</cjs000462>
13	Q. For example, Steve Skitt?	13	a residential update that you gave to the SMT meeting on
14	A. I had.	14	23 August 2016. It should be the top of the page there
15	Q. What was his response?	15	under the heading "BH residential (JW)". It says:
16	A. Their response was that they were going to offer me	16	"Updated on staffing issues due to covering other
17	support, or I could go and see two particular managers,	17	areas."
18	who would help me with computer training. The problem	18	What did you mean by "staffing issues"?
19	was, it wasn't actually doing the job, it was finding	19	A. One of the main issues was staffing on the wings. It
20	the time. So I never went to them to speak to them.	20	was one area which was always being ripped apart and
21	Q. So did you, in fact, finish the Corndell	21	also activities. So if staff were short on the wings,
22	A. No.	22	then staff would be pulled away from activities or
23	Q apprenticeship programme?	23	visits to cover wing staff.
24	A. No.	24	Q. How regularly did that happen?
25	Q. Ryan Harkness also said in the same interview, page 6,	25	A. Weekends was a main area. Again, this was due to
	T		Page 48
	Page 46	5	

12 (Pages 45 to 48)

1	sickness as well. And also whatever was happening	1	lines 228 to 232. Ms Lampard asks:
2	within the centre at times. Certainly, if we'd have had	2	"Question: When was that, [was that for the period
3	escorts on, then staff would be taken from the wings to	3	we are] talking about?
4	cover this; if we had constant supervision on, staff	4	"Answer: That would be 2016/17.
5	would be taken away from wings, from visits, from	5	"Question: When did you go off the wing?
6	activities, to cover constant supervisions. So - but	6	"Answer: January 2017, so yes, it would be more
7	on weekends, the staffing level was slightly lower and	7	2016. That's when I was at breaking point. For
8	so had more of an impact on the weekend.	8	instance, there was one day where it was myself and
9	Q. What effect did the lack of staff in activities have on	9	Louis Jacks on Delta and two officers on Charlie wing,
10	detained persons?	10	DCM Steve Dicks came onto Delta wing and said, one of
11	A. It meant that some of the areas couldn't be opened,	11	you needs to go to the courtyard. I said, that's not
12	simple as that, and we sort of, like, aimed to make sure	12	going to happen. He said, why? I said, there are only
13	the main areas, which was like the gym, the courtyard,	13	two of us on a wing [and the contract] minimum is two at
14	and the library and the computer room, were always open	14	a time. That was the requirement at the time, I'm not
15	for them.	15	sure it's changed, so no, I'm not going go do it,
16	Q. You have raised that in that meeting, the SMT meeting,	16	Louis's not going to do it. We've been on Delta wing
17	in August 2016. What, if anything, was done about it?	17	for a few years now, we are established. DCO Dicks
18	A. It would go back to detail. Detail would be asked to	18	said, that's fine, and walked off."
19	look at it, why there was an issue, what happened, was	19	Was that something that you were aware of, that
20	it a staffing issue, had staff phoned in sick? And so	20	there sometimes would be only two people on a wing?
21	detail would be asked to look into it and to find out	21	A. Yes.
22	the reasons why there was a shortage of staff for that	22	Q. Was that enough, in your view?
23	particular weekend or that period.	23	A. No.
24	Q. Did you get feedback after that?	24	Q. Why not?
25	A. If I went and asked for it, yes. Otherwise, I left it	25	A. The daily running of a wing for 12 hours can be very
	22 2 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		The thic unity running of a stange of 12 hours can be set;
	Page 49		Page 51
1	to conjor management because these meetings would be	1	damanding on mambans of staff. Vaniva got one on the
1	to senior management because these meetings would be	1	demanding on members of staff. You've got one on the
2	brought up, and so I left it I left it at that, for	2	door, opening and closing the door all day long, and
2 3	brought up, and so I left it I left it at that, for them to look into.	2	door, opening and closing the door all day long, and you've got the other one walking around the wing doing
2 3 4	brought up, and so I left it I left it at that, for them to look into. Q. Was this a regular issue?	2 3 4	door, opening and closing the door all day long, and you've got the other one walking around the wing doing responsibilities in the wings and all the rest of it.
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13 (Pages 49 to 52)

1	Q. He says "it kept going on". That suggests that the	1	Q. Did you feel they did something about it?
2	problem with staffing persisted. Would you agree that	2	A. I believe I think something did change. I can't
3	it persisted from 2016 to 2017?	3	remember when. I know they - they done vast recruiting
4	A. Yes. If you because it may well have started out	4	drives to increase the staffing levels to make it easier
5	with three officers that day on that wing, but then, if	5	for the staff on the wings.
6	they had an external escort, then the staff had to be	6	Q. Just pause there. Was this after Panorama? So in the
7	taken from somewhere which would then leave them to two	7	end of 2017/beginning of 2018?
8	officers on a wing. So it was an ongoing thing.	8	A. I can't remember whether it was after or before, but
9	Q. I want to take you now to minutes of an SMT meeting on	9	I know they done significant recruitment drives to get
10	9 February 2017, <cjs000555> page 1. It is item 3</cjs000555>	10	staff in.
11	"Matter arising":	11	Q. I'm going to ask you about the additional extra beds?
12	"BS [Ben Saunders] updated about staff engagement	12	A. Yes.
13	and staff retention need to organise focus groups and	13	Q. Do you remember, in early 2017, there were 60 additional
14	ways to support staff."	14	beds that were introduced over three wings. You have
15	Then later, starting with "Vision" at the bottom	15	said in your witness statement in paragraph 9 that there
16	there:	16	was no increase in staff.
17	"Vision BS [Ben Saunders] asked for feedback on	17	A. Yes.
18	the new poster. DH [Dan Haughton] said that 'a great	18	Q. Steve Skitt in his witness statement I won't bring it
19	place to work' might not resonate with staff and MB	19	up <ser000455>, page 29, says the opposite to you at</ser000455>
20	[Michelle Brown] it was [not] a vision not where we are	20	
			paragraph 84. He says:
21	at the moment."	21	"Extra staffing and some scope for greater activity
22	Do you agree that it wasn't a great place to work?	22	was built into the contract for these beds."
23	A. I agree it is not a great place to work in the length of	23	Was that your impression?
24	hours staff done. It was totally unfair for asking them	24	A. I believe at the time I don't Steve Skitt said
25	to be to work 12 hours. It could be very draining on	25	extra staff. I believe the extra staff was just
	Page 53		Page 55
		<u> </u>	
1			
1	them. So I agree with that. I also agree in respect	1	replacing staff that had already left, in that respect.
2	them. So I agree with that. I also agree in respect that there may well have been staff shortages at times,	2	replacing staff that had already left, in that respect. Q. So there wasn't net extra staff?
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	that there may well have been staff shortages at times, which also then put a lot of pressure on staff, which made their job a lot harder, so, yes, I would agree with that in that respect. Q. You said in your witness statement that it might not resonate staff because of the long hours, which you just mentioned, and because staff believed they were not listened to. Who were they not listened to by? A. That would be by senior management. Q. You were part of the senior management team, weren't you? A. Yes. Q. So do you include yourself in that? A. Yes. Q. Why did you not listen to staff? A. I would have listened to staff on what I needed to deal with. What these staff, I believe, are talking about is the hours and the shift patterns and stuff like that and the sickness, is what I believe they're talking about. Q. Why did you not listen to them in that respect about the long hours, and so on? A. Because there's nothing I could do about it. All I could do is pass it up to Ben Saunders, Steve Skitt, for them to look at. I could do nothing about it.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 Q. So there wasn't net extra staff? A. I don't believe there was net extra staff, no; I believe they were just replacing staff that had already left. Q. We heard from Lee Hanford yesterday there were not enough activities for people who were detained before the 60 beds were introduced, never mind once they were. Do you agree with that? A. Yes. Yes. The activities were, like I said earlier, minimum. We made best use of what was available, rooms and all the rest of it. We did try to do a little bit more for them, but whether that was because of the extra 60 beds, I'm not sure. Like a cinema room, and stuff like that. But I don't think that was actually because of the extra beds. I think that was just something we was trying to do anyway. Q. Did the having 60 extra detained persons, did that have an effect on any other aspects of the regime? A. It worked out that there would be 120 on a wing across the three wings, so it didn't really have that much of an impact on the wings itself or the activities other than what was already there. Q. I want to ask you now about ACDT and mental health of detainees. You say in your first witness statement at paragraph 10:
2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	that there may well have been staff shortages at times, which also then put a lot of pressure on staff, which made their job a lot harder, so, yes, I would agree with that in that respect. Q. You said in your witness statement that it might not resonate staff because of the long hours, which you just mentioned, and because staff believed they were not listened to. Who were they not listened to by? A. That would be by senior management. Q. You were part of the senior management team, weren't you? A. Yes. Q. So do you include yourself in that? A. Yes. Q. Why did you not listen to staff? A. I would have listened to staff on what I needed to deal with. What these staff, I believe, are talking about is the hours and the shift patterns and stuff like that and the sickness, is what I believe they're talking about. Q. Why did you not listen to them in that respect about the long hours, and so on? A. Because there's nothing I could do about it. All I could do is pass it up to Ben Saunders, Steve Skitt,	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 Q. So there wasn't net extra staff? A. I don't believe there was net extra staff, no; I believe they were just replacing staff that had already left. Q. We heard from Lee Hanford yesterday there were not enough activities for people who were detained before the 60 beds were introduced, never mind once they were. Do you agree with that? A. Yes. Yes. The activities were, like I said earlier, minimum. We made best use of what was available, rooms and all the rest of it. We did try to do a little bit more for them, but whether that was because of the extra 60 beds, I'm not sure. Like a cinema room, and stuff like that. But I don't think that was actually because of the extra beds. I think that was just something we was trying to do anyway. Q. Did the having 60 extra detained persons, did that have an effect on any other aspects of the regime? A. It worked out that there would be 120 on a wing across the three wings, so it didn't really have that much of an impact on the wings itself or the activities other than what was already there. Q. I want to ask you now about ACDT and mental health of detainees. You say in your first witness statement at

14 (Pages 53 to 56)

1	"Some detainees did slip through the net because	1	A. Yeah
2	they did not show outward signs of issues or did not	2	Q. You said some slipped through the net?
3	speak out about their issues to officers or healthcare	3	A I mean by demonstrating self-harm, is what I mean,
4	staff or there was language barrier problems."	4	"outward signs" or coming to us saying, "I've got mental
5	What did you see as outward signs of issues or	5	health problems. I'm hearing stuff in my head. I need
6	mental health?	6	to speak to someone".
7	A. Sorry, can you say where is that?	7	Q. Did you know what to look out for, apart from somebody
8	Q. It's your first witness statement, page 3, paragraph 10.	8	saying, "I'm going to self-harm" or, in fact,
9	A. It's not in there.	9	self-harming?
10	THE CHAIR: It's actually the beginning at the top of	10	A. Yes, there was other signs, detained people being
11	page 4, I think, of your first witness statement. If	11	withdrawn by staying in their room, not coming out of
12	you just turn the page.	12	their room, would also be a sign; being a bit of a loner
13	A. Right, sorry.	13	when they was out and about would also be something we
14	MS TOWNSHEND: Apologies. Thank you, chair.	14	would pick up on. So there's other outward signs as
15	It is right at the bottom of that paragraph, page 4.	15	well we would pick up on that somebody perhaps was
16	Can you see:	16	struggling.
17	"(c) we worked alongside in-house nursing staff."	17	Q. Did you have any training on how to look out for the
18	Can you see that paragraph?	18	outward signs of mental health?
19	A. Is that my first statement, you said?	19	A. We sorry, I say "we". I did attend a one-day
20	O. It is your first statement, page 4. It should be after	20	training course with healthcare regarding mental health
21	the first tab. Can you see at the top (a), (b), (c) and	21	issues.
22	then (a), (b), (c)?	22	Q. When was that? Was that at the beginning of your time
23	A. Yes. Right, yes, I'm with you now. Sorry.	23	at Brook House?
24	Q. That's okay. The last sentence of that paragraph says:	24	A. No, no, that was years later, but I did attend
25	"Some detainees did slip through the net because	25	a training course, yes.
23	bonic detainees and ship amough the net occurse		a craiming course, yes
	Page 57		Page 59
1	they did not show outward signs of issues or did not	1	Q. And it was just one day?
2	speak out about their issues to officers or healthcare	2	A. I believe so, yes.
3	staff or language barrier problems."	3	Q. Was that the only mental health training you had in the
4	A. Yes.	4	whole of those nine years?
5	Q. My question was, what are outward signs of mental health	5	A. Yes, I believe so. And I think that's because we were
6	issues?	6	pushing it for some kind of training because it was
7	A. Basically, detainees we had we used to do	7	a case of, we had to train so we could deal with people
8	a monthly review of detainees on the wings to make sure	8	with these issues rather than not deal with them and
9	they was okay, and all the rest of it.	9	also recognise signs and stuff like that.
10	Q. A monthly review?	10	Q. Did you feel confident that you could recognise the
11	A. A monthly review with detainees on the wings.	11	signs of somebody who was struggling from mental
12	Q. Do you mean all detainees or do you mean just detainees	12	ill-health?
13	under ACDT?	13	A. Only through experience, not through training. Only
14	A. All detainees on the wings should have had a monthly	14	through experience that I was able to pick stuff up.
15	review on them. So these questions would be asked how	15	Q. Would you have benefited from more mental health
16	they were then, how they felt. They would have the same	16	training?
17	questions when they first arrived in the centre, whether	17	A. Yes.
18	they had any mental health issues or tendencies of	18	Q. You said that you only got that one-day mental training,
19	suicidal. They would be asked a few days later, again,	19	having badgered, presumably, senior management for it?
20	the same question to making sure that they didn't have	20	A. Yeah, well, we kept asking for it. I at one stage,
21	any $-$ they didn't show anything $-$ or tell us anything.	21	I did arrange for a small group of people to attend
22	So we done everything we could to pick up whether they	22	a course at college, but that fell through, and so we
23	had any suicidal thoughts or tendency thoughts in that	23	then reverted back to our own healthcare for training,
24	respect.	24	and I think senior — the senior management then
25	Q. You have said outward	25	arranged it properly through healthcare.
	Page 58		Page 60
	U	3	Ú.

1	Q. And that was the one day you're talking about?	1	think?
2	A. Yes.	2	A. I think all the wings viewed it the same: if a detainee
3	Q. You said that there were language barrier problems. Are	3	is not eating, but was seen taking food or buying food
4	you suggesting that detained persons who did not speak	4	from the shop, because they could actually generate
5	English had less protection, had less help, from	5	a hot meal for themselves, then, yes, it was the same
6	healthcare?	6	across all the wings.
7	A. No, because they would use the LanguageLine, the same as	7	Q. You said in your Verita interview, page 23 no need to
8	we would. So it was there, available for them, or	8	go to it now that an ACDT was rarely opened for fluid
9	bigword, available for them to use the same as what we	9	or food refusal; is that right?
10	had.	10	A. Yes. In the early days, it used to be raised, it used
11	Q. Why did you say that some detainees slipped through the	11	to be opened, but then, like I said, policies changed
12	net in part due to language barrier problems?	12	and so it didn't need to be opened straight away.
13	A. Oh, yeah, sorry. Basically, because they couldn't speak	13	MS TOWNSHEND: Chair, I have probably around 15 minutes
14	English, so they couldn't get it across at the end of	14	left. I don't know whether you'd like to have a break
15	the day, I suppose that's all I'm referring to there.	15	now for 15 minutes or continue? Entirely in your hands.
16	Q. So do you think that bigword, was it, the company	16	THE CHAIR: I think we will continue for 15 minutes, if
17	that was used for interpreting?	17	that's okay.
18	A. Yes.	18	MS TOWNSHEND: Thank you. I want to ask you now about
19	Q. Do you think that wasn't effective?	19	drugs, Mr Williams. If I can take you to the document
20	A. It was effective when they got — when they were used.	20	<cjs000530>, page 3. These are minutes of an SMT</cjs000530>
21	I found them effective many a times when I used them.	21	meeting on 28 April 2016. Just go to the top. It
22	Q. So why did you say that some detainees slipped through	22	should read, and I will read it now, the second line:
23	the net?	23	"Intel to do searching at Brook House but not being
24	A. Because of not recognising signs.	24	closed off. Not enough staff to do full searches.
25	Q. Was that due to lack of training of officers, do you	25	Discussions about where the resources come from to do
	Page 61		Page 63
1	think?	1	full searches and who are doing them."
2	A. Yeah, perhaps.	2	You were present at this meeting. Were extra
3	Q. I want to ask you about food refusal. Is it correct	3	resources provided for this, to do full searches?
4	that the policy requires someone to be identified as	4	A. I don't think extra resources were provided. What we
5	refusing food if they miss two meals from the servery?	5	had to do was change the way or the timing of
6	Is that right?	6	searches, so we had additional staff around the centre
7	A. To be honest with you, I can't remember it's	7	to carry out these searches.
8	because the policy has changed so many times over what's	8	Q. So additional staff were provided to carry out the
9	reported, what's not reported, to the Home Office and	9	searches?
10	what's raised as an ACDT and not an ACDT. Someone who	10	A. I believe so, yeah. We would take staff from visits
11	hasn't is classed as someone not eating not	11	maybe to help with the searching or, depending on the
12	necessarily food refusal, but purely not eating for that	12	time, if we'd get the office closed and the staff on the
13	day.	13	wing, we'd then go off and do a certain amount of
14	Q. But there would be a food refusal log, wouldn't there,	14	searches.
15	that you were required to fill out?	15	Q. So were you confident that searches were properly taking
16	A. Yes.	16	place following this meeting?
17	Q. You said in your witness statement at paragraph 91, the	17	A. I believe yeah, I believe at times they did struggle
18	first one, that food and fluid refusal policy was not	18	but, again, what came out of meetings was that they need
19	followed if, for example, a detained person was buying	19	to be done, we have to make the effort to get them done,
20	food from the shop; is that right?	20	and so we have to do what needs to be done to get them
21	A. Yes.	21	completed.
22	Q. Even though that is not, in fact, the correct policy, is	22	Q. We can take that down, thank you.
23	it? It was about taking meals from the servery?	23	Nathan Ward makes the following allegations in his
24	A. Yes.	24	witness statement. I won't bring it up. But he says:
25	Q. Was that ignorance of the policy widespread, do you	25	"When two members of staff were suspended pending
	Page 62		Page 64
			16 (Pages 61 to 64)

16 (Pages 61 to 64)

1	police investigation regarding drugs, it was extremely	1	any involvement in myself, then that would have come
2	police investigation regarding drugs, it was extremely hard to contact one of them. However, Jules Williams,	2	· · ·
3		3	through — via security. But, otherwise, it was just
4	who had brought one of them into the company, was always able to make contact with him. Poor culture amongst	4	security-led intelligence, and they would deal with it and I wouldn't even know it was happening until these
5	Brook House residential staff and it is as though some	5	members of staff were suspended.
6	are protected by Jules Williams and this goes	6	Q. I'll bring us on now to disciplinary and grievances.
7	unchallenged."	7	You said in your first witness statement, paragraph 55,
8	Were you aware of staff bringing drugs into the	8	that your role generally was to carry out
9	centre?	9	investigations, and then that were given to you by
10	A. First of all, I never brought anyone into the company.	10	a head of department, such as security, HR, head of
11	I never have in 24 years. So I don't know where	11	residence and so on, and that included viewing CCTV,
12	Nathan Ward has got that information from.	12	reading reports, interviewing staff and so on.
13	I wasn't aware of staff bringing drugs into the	13	In terms of disciplinary grievances concerning you,
14	centre until they were suspended, and as to contacting	14	there was one disciplinary matter which you were
15	them, if I was to appointed by HR to be their contact	15	involved in, and that was a formal investigation in
16	manager, then I would do what it takes to contact them	16	which Sarah Newland appeared to have conducted the
17	by phone, leave messages for them.	17	investigation. We know this from notes of
18	Q. Was it true that you were always able to make contact	18	Jerry Petherick's visit to Gatwick in October 2014. I
19	with staff	19	won't bring them up, but they are at <ver000103> at</ver000103>
20	A. No.	20	page 2. Can you explain what this investigation was
21	Q pending police investigations	21	into and what the outcome was, please?
22	A. No.	22	A. Basically, one weekend I was in the office with other
23	Q even when it was difficult to contact them otherwise?	23	members of staff and I was mucking about with a banana.
24	A. Well, there's two things: one, there's no reason if	24	One of the members of staff was a lesbian in there and,
25	I was the contact manager, there'd be no reason for	25	for some strange reason, a couple of days later, it
20	1 was the contact manager, there a be no reason for	20	to some strange reason, a couple of anys faces, te
	Page 65		Page 67
1	anyone else trying to contact them because any	1	come it was suggested that I'd been homophobic
2	information would have gone through me, other than via	2	towards this member of staff. I was spoken to by
3	letter; secondly, I didn't contact them straight away.	3	Michelle Brown, who I apologised to, and apologised to
4	I would have to leave messages. Sometimes it would two	4	the two members of staff. A few days later, an
5	or three weeks before they would come back to me.	5	investigation was opened up on me. Sarah Newland
6	Q. Jerry Petherick says in his interview <cjs0073667></cjs0073667>	6	conducted it. I was found not guilty of
7	page 3 no need to go to it now. He says:	7	the allegations, but my behaviour was not befitting of
8	"My take on him [that's you] is that he is clumsy,	8	a senior manager and so I was issued with a first and
		0	a senior manager and so I was issued with a first and
9	no sophistication, but Lee Hanford, interim director at	9	final written warning.
10	no sophistication, but Lee Hanford, interim director at Gatwick currently, believes Jules would not tolerate		, and the second
-	*	9	final written warning.
10	Gatwick currently, believes Jules would not tolerate	9 10	final written warning. Q. So do you accept that your behaviour was not befitting of a manager? A. Yes.
10 11	Gatwick currently, believes Jules would not tolerate such behaviour." You said in your witness statement that what you believed this is in your second witness statement,	9 10 11 12 13	final written warning. Q. So do you accept that your behaviour was not befitting of a manager? A. Yes. Q. Turning briefly to a grievance meeting which took place
10 11 12 13 14	Gatwick currently, believes Jules would not tolerate such behaviour." You said in your witness statement that what you believed this is in your second witness statement, paragraph 34. You say that Lee Hanford saw you as	9 10 11 12 13 14	final written warning. Q. So do you accept that your behaviour was not befitting of a manager? A. Yes. Q. Turning briefly to a grievance meeting which took place on 4 January 2017, which included bullying by
10 11 12 13	Gatwick currently, believes Jules would not tolerate such behaviour." You said in your witness statement that what you believed this is in your second witness statement, paragraph 34. You say that Lee Hanford saw you as a straight-down-the-middle person and if you knew anyone	9 10 11 12 13 14 15	final written warning. Q. So do you accept that your behaviour was not befitting of a manager? A. Yes. Q. Turning briefly to a grievance meeting which took place
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1	members of staff had an impact on the willingness to	1	Q. Did you struggle with any other aspects of your job?
2	speak up and raise issues, but do you know any other	2	A. Not as far as I know.
3	reason why Stacie Dean would say this?	3	Q. Michelle Brown talks there about the possibility of
4	A. I believe it's because of my relationship with some	4	being demoted. Did you know that at the time?
5	members of staff, like I mean, yes, I got on with	5	A. No.
6	Babs during work, but, externally, I'd been out	6	Q. Were you spoken to about any problems, apart from what
7	socialising with Luke. So I believe that's because of	7	you have just referred to, the investigation
8	my relationship with some of the staff externally.	8	disciplinaries and
9	Q. Did you let those relationships that you had with staff	9	A. I was spoken to about the cleanliness about the centre.
10	externally affect any of your decision making within the	10	That was one of my areas. Because, obviously, like
11	centre?	11	I said previously, the Home Office would do their
12	A. No.	12	walk-around and pick up areas in the centre, so I'd be
13	Q. I want to ask you finally about your departure from	13	spoken to about that.
14	Brook House. You have said in your witness statement	14	Q. Were any actions taken to support or assist you?
15	in your second witness statement that you were	15	A. No. I just - I was just given this information and
16	struggling with the documentation side of things, and	16	then got on with it.
17	that you were constantly chasing DCMs for paperwork and	17	Q. You said in your second statement, paragraph 11, that
18	had to fill them out. Michelle Brown says in her	18	eventually there was put in place a new head of
19	witness statement that, in August 2017, there was	19	residence?
20	a conversation about you struggling in the role and that	20	A. Yes.
21	you were potentially going to be demoted. The	21	Q. So you had a direct line. So that missing link that
22	suggestion is that nothing happened due to the Panorama	22	Lee Hanford had been speaking about was then filled in?
23	broadcast.	23	A. Yes.
24	In your witness statement, what paperwork are you	24	Q. So does that mean that the head of residence then was
25	referring to that you had problems with?	25	your direct manager?
	Page 69		Page 71
1	A. I'm referring to carrying out investigations and	1	A. Yes.
2	grievances because they were all time bound. I'm also	2	Q. Who was that?
3	referring to the Corndell management programme, because	3	A. Mark Demian.
4	I believe that had a greater impact as well because	4	Q. When did that take place?
5	I was seen as not participating in it correctly or	5	A. I believe that was January 2018.
6	help or trying to complete it in any stage, and I was	6	Q. Finally, I won't bring it up, but Lee Hanford has said
7	spoken to by management, senior management, on a couple	7	this <cjs0074048> page 8, paragraph 28:</cjs0074048>
8	of times as to why I wasn't completing it on time.	8	"During my second period" which was just after
9	Q. You have already given your explanation as to why you	9	the relevant period. He came into post
10	didn't complete it on time. You said due to	10	in September 2017:
11	understaffing.	11	" it became apparent that due to increasing
12	A. Mmm.	12	demands on service delivery Jules was struggling.
13	Q. But what about the investigations?	13	Managers who were reporting to him reinforced this
14	A. Again, investigations and grievances, it could be	14	opinion. Areas of service delivery were failing and
15	delayed because of the staff not being in the centre,	15	causing frustrations amongst staff and detainees. Jules
16	off sickness, I would have to wait for them to come back	16	was not embracing the investment that G4S had made
17	on shift patterns, and sometimes I'd have five or six	17	towards his development, despite further support being
18	staff come back, they could be on holiday, so I'd have	18	offered, and he left the company in July 2018."
19	to wait, and so sometimes investigations and things got	19	Was further support offered?
20	delayed that way.	20	A. No.
21	Q. Those are just the usual types of issues?	21	Q. Why did you leave Brook House?
22	A. Yes.	22	A. I was actually made redundant. Lee Hanford had
23	Q. But was there anything above and beyond that that	23	obviously spoken to his seniors and it was decided for
24	stopped you from conducting investigations in time?	24	me that I was no longer required as I was not committed,
25	A. No.	25	and so I was made redundant.
	Daga 70		D ₂₀₀ 72
	Page 70	<u></u>	Page 72

18 (Pages 69 to 72)

			
1	Q. Was it true? Did you feel it was true that you were not	1	manager role, and is that an E1 role?
2	committed?	2	A. That's an E1 role, yes.
3	A. I didn't think it was true at all.	3	Q. We have heard that E1 is sort of in between DCM and
4	MS TOWNSHEND: Thank you, Mr Williams. I don't have any	4	senior management?
5	more questions. Chair, do you have any questions?	5	A. Yes, that's correct.
6	THE CHAIR: I don't have any questions for you, Mr Williams.	6	Q. Then you secured a permanent E1 role in July 2016, and
7	Thank you very much for coming this morning. I know it	7	this was support services?
8	is not an easy experience, but I'm grateful that you	8	A. Yes. So the role was changed to support services, but
9	have come and given evidence to the inquiry today.	9	yes.
10	Ms Townshend, shall we take 20 minutes? We are	10	Q. I hope we can have on screen <cjs0072810>. You have</cjs0072810>
11	having a change of witness.	11	already commented on this in your witness statement. If
12	MS TOWNSHEND: Yes, thank you, 12.05 pm.	12	we go to page 2. This is an organogram or a chart
13	(11.50 am)	13	A. Yes.
14	(A short break)	14	Q of G4S as it was during the relevant period. You are
15	(12.08 pm)	15	there, on the left-hand side, as head of support
16	MS MOORE: Good afternoon, chair. We have the evidence now	16	services. You say, actually, that's not the correct
17	of Mr Haughton.	17	title?
18	MR DANIEL JAMES HAUGHTON (affirmed)	18	A. It was just known as support services manager. "Head
19	Examination by MS MOORE	19	of" normally denoted you were part of the SMT;
20	MS MOORE: Good afternoon, Mr Haughton. Could you confirm	20	a D grade, they referred to them as.
21	for us your full name?	21	Q. You were, as you said, an E1?
22	A. Yes, my name is Daniel James Haughton.	22	A. Yes.
23	Q. You have there a white folder of documents, which I may	23	Q. Underneath that is the list of responsibilities, so
24	refer you to, or I might show them on the screen. At	24	contracts, auditing, complaints, training, health and
25	tab 1 is your witness statement which you made to the	25	safety. You say C&R, in fact, wasn't part of your role?
			sately. Total say could in rate, washer part of your role.
	Page 73		Page 75
1	inquiry and you signed on 2 March 2022. That statement	1	A. No, it wasn't part of my role.
2	will be adduced in full and the reference for that is		
	will be addited in full and the reference for that is	2	Q. Whose did that fall under?
3	SER000453>. What that means, Mr Haughton, is, we won't	3	Q. Whose did that fall under?A. During the relevant period, I can't quite remember.
3 4			A. During the relevant period, I can't quite remember.
	$<\!$ SER000453>. What that means, Mr Haughton, is, we won't	3	
4	<ser000453>. What that means, Mr Haughton, is, we won't go over everything in your witness statement today. We</ser000453>	3 4	A. During the relevant period, I can't quite remember. I think it sat within security at the time and it sort
4 5	<ser000453>. What that means, Mr Haughton, is, we won't go over everything in your witness statement today. We already have that as your evidence, and the chair can</ser000453>	3 4 5	A. During the relevant period, I can't quite remember. I think it sat within security at the time and it sort of remained there.
4 5 6	<ser000453>. What that means, Mr Haughton, is, we won't go over everything in your witness statement today. We already have that as your evidence, and the chair can consider all of it. We are going to focus on some of</ser000453>	3 4 5 6	A. During the relevant period, I can't quite remember.I think it sat within security at the time and it sort of remained there.Q. But the rest is correct?
4 5 6 7	<ser000453>. What that means, Mr Haughton, is, we won't go over everything in your witness statement today. We already have that as your evidence, and the chair can consider all of it. We are going to focus on some of the key issues. A. Okay.</ser000453>	3 4 5 6 7	 A. During the relevant period, I can't quite remember. I think it sat within security at the time and it sort of remained there. Q. But the rest is correct? A. Yes, stores was sort of co-managed between
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4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	<ser000453>. What that means, Mr Haughton, is, we won't go over everything in your witness statement today. We already have that as your evidence, and the chair can consider all of it. We are going to focus on some of the key issues. A. Okay. Q. So as to your background, you joined Brook House in January 2009? A. Yes. Q. That was a DCO role. And that was to be trained for when Brook House started accepting detainees in March 2009? A. Yes. Q. So you have been there since the start? A. Since the start of Brook, yes. Q. You were promoted to team leader, which is later known as DCM A. Yes. Q in September or October 2009. You say in your statement that you ended up working many of the DCM roles in Brook House? A. Correct.</ser000453>	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	 A. During the relevant period, I can't quite remember. I think it sat within security at the time and it sort of remained there. Q. But the rest is correct? A. Yes, stores was sort of co-managed between Jules Williams, who was just on — took most of the share of stores and I had an oversight for some of the ACO areas, but that moved in sort of operations as well. Q. What did the role of a support services manager in brief kind of mean for you day to day? Were you doing lots of different tasks within these, did you have an oversight? A. Yes, so it is having oversight of those different sort of satellite functions, so it was — had audits and compliance as a team, complaints, training, health and safety, central detail was also part of my remit, even though it's sort of sitting under Michelle Brown there, that was sitting in support services. So lots of — a number of small teams with a few people in those, so it was touching base with lots of those people. Q. You have told us that during the relevant period, you were — while you were in this E1 role, part of that

19 (Pages 73 to 76)

2 once a week, and then, one every seven or ejebt weeklends, we would pick up daty director. 4 Q. How did that role differ from your normal day-to-day role as support services transage? 5 Robert of the centre, so we had operational sort of running— 6 Robert of the centre, so we had operational sort of running— 7 the centre, so we had operational sort of running— 8 responsibility to run the centre day to day, so we would look after sort of staffing issues, any incidents, in a stead certain reviews and certain meetings. So it a deeper, to focus an daight wife centre of the same ground gardy director. 10 a degree, to focus an daight director, a stead of certain reviews and certain meetings. So it a deeper, to focus an daight director, a stead of the same ground and the staff from across the contract. So all the other functions would feed in to safety and the same ground gardy director of gardy directors. The same ground gardy director of gardy directors and the safety of the same ground gardy searchay from —1 wout to sak shout your and the same ground gardy - about the monthly separes. We heard a little gardy of the same ground gardy - and will try on no go over too much of the same ground gardy - and will try on no go over too much of the same ground gardy - and will try on no go over too much of the same ground gardy - and will try on no go over too much of the same ground gardy - and will try on no go over too much of the same ground gardy - and will try on no go over too much of the same ground gardy - and will try on no go over too much of the same ground gardy - and will try on no go over too much of the same ground gardy - and will try on no go ove				
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Q. How did that role differ from your normal day-to-day role as support services manager? A. So the day director role was about oversight of the centre, we we had operational sort of running — reponsibility to run the centre day to day, so we would book after sort of stuffing issues, any incidents, attend certain reviews and certain meetings. So it was — you sort of steped away from your day job, to a degree, to focus on deling they director. Q. I see. You're the sensior peason on he ground? A. Nentor person on site, yee. Q. You current role is the assistant director of safeguarding at Catwick. A. Yes, on you current role is the assistant director of safeguarding at Catwick. Q. We heard yesteduly from — I sount to ask about your and its role. We heard yesteduly from — I sount to ask about your and its role. We heard yesteduly from — I sount to ask about your and its role. We heard yesteduly from — I sount to ask about your and its role. We heard yesteduly from — I sount to ask about your and its role. We heard yesteduly from — I sount to ask about your and its role. We heard yesteduly from — I sount to ask about your and its role. We heard yesteduly from L sound to ask about your and its role. We heard yesteduly from a long to the contract of A. Yes. Q. You discuss your role in this at page 22 of your Page 77 1 statement, so pumgraphs 87 to 89. I want to ask first about the monathy reports. We heard a little yesterday— and I will try on do go over too much of the same ground again — about schedule G of the nother provide a variable services, penalties can attache to them. Went the manager, deputy of the contract A. Yes. Q. You discuss your role in his at page 22 of your Page 77 1 statement, so pumgraphs 87 to 89. I want to ask first about the monathy reports. We heard yesteduly from to a gover too mach of the time of the meeting, the weekly meeting, the well and the information and part in time for the sound we would account and the families of the definition of the definition of the contract A.	2	once a week, and then, one every seven or eight	2	A. So the compliance function that I oversaw I think the
5 role as support services manager? 6 A. As the duty director role was about oversight of the catter, so we had operational sort of running — responsibility to run the centre day to day, so we would look after sort of staffing issues, any incidents, 10 attend certain rectives and certain meetings. So it at the other guys who was in post, would have completed them. So generally, the role of that function would be to compile all the management data from across the contract. So all the other functions would feel in to as their relevant data and we would engel it and put it into this report. And this report was generated as a result of the meetings, the weekly meetings, we had with the Home Offices and that was what we reported on this. 10 Q. You current to all from Mr. Castle and Mr. Cason, some detail about contractual monitoring? 21 A. Yes. 22 Q. We heard yesterday, from Mr. Castle and Mr. Cason, some detail about contractual monitoring? 23 A. Yes. 24 A. Yes. 25 Q. You discuss your role in this at page 22 of your 26 Page 77 1 statement, so paragraphs 87 to 89. I want to oak first about the monthly reports. We heard a little yesterday means the measure isn't met, is own the fact and any penalties which altach. Al 2, there is the failure to them. When the measure isn't met, is own when there is a failure to meet that measure, this should be reported to the measure for measures, points anached to the first measurement of the measure isn't met, is own the screen. <a "st904586"="" 2017.="" 3,="" a="" ab="" ask="" at="" be="" but="" for="" from="" have="" href="#castle-reported-the-available-deline-places, the total number per the contract and the total number in fact and any penalties which altach. Al 2, there is the failure to provide available services, penalties can attach to that. Al page 3, here is a list of management of free events, coverned to the month, we see penalty points based on available DCO hours — 27 A. Yes. 28 D. In essence — do correct mei ff am wenny — schedule of the measure for the month, we see penalty points based on available points furner for the month, we see penalty poin</td><td>3</td><td>weekends, we would pick up duty director.</td><td>3</td><td>reason why I completed this report is probably because</td></tr><tr><td>A. So the duty director role was about oversight of the centre, so we had operational oversight of the centre, so we had operational oversight of the centre, so we had operational oversit of the centre day to day, so we would book after sort of staffing issues, any incidents, and it is a degree, to focus on doing duty director. Q. I see, Vortire the sealing person on the ground? A. Senior person on site, yes. Q. Your current role at Brook House, where you still work, a little contentant? A. Yes, normally Harry at the time or Vicky, or one of the thome. So generally, the role of that function would be to compile all the management data from across the contract. 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You current role at Brook House, where you sail work, it is too this report. And this report. And this report was generated as a result of the meetings, the weekly meetings, we had with the House Office, where they would accept or refuse mitigation for the issues we raised, and that was what we reported on this. Q. We chard yesterday from—I want to ask about your andits role. We heard yesterday, from Mr Caste and a but your andits role. We heard yesterday from—I want to ask about your andits role. We heard yesterday from—I want to ask about your andits role. We heard yesterday from—I want to ask about the mosthly reports. We heard a little about the mosthly reports. 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A.</td><td>5</td><td>role as support services manager?</td><td>5</td><td>Normally -</td></tr><tr><td>the other gray who was in post, would have completed from Seguerally, the role of that function would be to compile at the most certain reviews. So it of perfect on this. The safeguarding at Gatvick. A. Senior person on site, yes. A. Yes, on your current role at Brook House, where you still work, it is not a failure to meet fail the distribution of the sustess we raised, and that was what we reported on this. The safeguarding at Gatvick. The safeguarding at Gatvick isse? A. Yes, on your role in this at page 22 of your audit is role. We heard yesterday, from the Caste and when the monthly reports, we have about the monthly reports. We heard a bild yesteday — and I will try to not go over too much of the contract? A. Yes. A.</td><td>6</td><td>A. So the duty director role was about oversight of</td><td>6</td><td>Q. 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Yes. 27 Q. In essence—do correct me if I am wrong—webedule G of the contract? 28 them. When the measure ish't met, is results in a financial penalty? 29 A. Yes, that's correct. 20 Q. In we look at a accample from June 2017, you have it at about her monthly reports. We heard so departs a failure to meet that measure, this should be reported to the Home Office and unless there is an accepted militagion, a reason why that wasn't met, it results in a financial penalty? 21 Q. Can we look at as example from June 2017, you have it at about the monthly reports. We heard was first in the scheme of the monthly reports was generated as a with the full manufacture. So glove the wise is the financial penalty? 22 A. Yes. 23 Q. You discuss your role in this at page 22 of your 24 A. Yes. 25 Q. I me sence — do correct me if I am wrong—whedaile G of the contract? 26 A. Yes. 27 Q. In essence — do correct me if I am wrong—whedaile G of the contract? 28 A. Yes. 29 Q. I won't go on to these, but at page 13, we see the total punish growing and the provided was penalty</td><td>7</td><td>the centre, so we had operational sort of running</td><td>7</td><td>A. Yes, normally Barry at the time or Vicky, or one of</td></tr><tr><td>attend certain reviews and certain meetings. So it 11 was—you sort of stepped away from your day job, to 22 a degree, to fecus on doing duty director. 23 Q. I see. You're the senior person on the ground? 24 A. Senior person on site, yes. 25 Q. You current role at Book House, where you still work, 26 I understand? 27 A. Yes, so my current role is the assistant director of 28 safeguarding at Catwick. 29 Q. So for all of the Garwick size? 20 Q. We heard yesterday, from Mr Castle and 21 Mr Gasson, some detail about contractual monitoring? 22 A. Yes. 23 Q. You discuss your role in this at page 22 of your 24 Page 77 25 statement, so paragraphs 87 to 89. I want to ask first 2 shout the monthly reports. 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23 and various Home Office parties, head of care and 24 regimes, et cetera. What's your role in preparing these 25 reports? Obviously you sign it off, but what role do 28 aren't they? 29 A. Yes. 20 Then if we go back to page 3, please, some of them	21	below a list of who it is circulated to. So centre and	21	rooms available, the number of DCO hours provided.
regimes, et cetera. What's your role in preparing these 24 A. Yes. 25 reports? Obviously you sign it off, but what role do 25 Q. Then if we go back to page 3, please, some of them	22	deputy sorry, centre manager, deputy centre manager,	22	They're just things that you can tot up and count,
reports? Obviously you sign it off, but what role do 25 Q. Then if we go back to page 3, please, some of them	23	and various Home Office parties, head of care and	23	aren't they?
	24	regimes, et cetera. What's your role in preparing these	24	A. Yes.
Page 78 Page 80	25	reports? Obviously you sign it off, but what role do	25	Q. Then if we go back to page 3, please, some of them
Page 78 Page 80		D 70		D 00
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20 (Pages 77 to 80)

1	required an element of judgment. So we were speaking	1	the Home Office. It had to be with them within
2	yesterday about the self-harm resulting in injury data.	2	24 hours. So that would have detailed the sort of
3	A. Yes.	3	the officers' version or account of events that had
4	Q. You mentioned that the data is provided by functional	4	taken place. And also there's a monthly Safer Community
5	heads. Do you know who the head providing this element	5	meeting where, again, acts of self-harm are discussed
6	of data, the self-harm resulting in injury data, would	6	and the results of investigations discussed. So had
7	have been?	7	those investigations decided that that was relevant, it
8	A. So it would have been who was looking after the Safer	8	would have been reported as that to the Home Office.
9	Community Team at the time. I think it I can't quite	9	Q. Sure. You say that there is self-harm investigations
10	recall who it was. It was Michelle Brown or it might	10	after each after acts of self-harm. Is that after
11	have been yeah, I can't quite recall exactly who it	11	every act of self-harm?
12	was. It sort of changed. It was quite fluid, at that	12	A. I think that was the intention. I can't tell you it
13	time, with the senior management role, so it did move	13	wasn't my function. I can't tell you whether it did
14	around a bit. But the functional head for that was	14	happen 100 per cent of the time. But they were supposed
15	reporting.	15	to happen.
16	Q. That's somebody at SMT level?	16	Q. Would they have been done by the Safer Community Team?
17	A. Yes, the D grade would present that to us.	17	A. Yes.
18	Q. Obviously, not all incidents of self-harm resulting in	18	Q. So you rely on the information that's given to you by
19	injury need to be recorded here, and that's clear	19	the Safer Community Team
20	from - if you look at the wording in schedule G, isn't	20	A. Yes.
21	it, because it is only those where there is a failure to	21	Q in order to complete this part? You or whoever
22	follow processes?	22	completed, Mr Timms
23	A. Mmm.	23	A. Yes, that specific part would be from Safer Community.
24	Q. So, for example, and I won't ask you to look at it now	24	Other parts would come from different functions, yes.
25	on the screen, but the same month, June 2017, there's	25	Q. When reports weren't completed by you, but by Mr Timms,
	Page 81		Page 83
	rage or		1 age 63
1	a combined report which is a report that's provided to	1	for example, did you have an oversight of the data in
2	the IMB which records that there were nine acts of	2	there?
3	self-harm that month	3	A. Yes.
4	A. Yes.	4	Q. Did you check it?
5	Q and three of which required treatment on site. So at	5	A. So Barry or whoever was completing it would send it to
6	least three resulting in injury. Do you know how the	6	me first for me to check before it was then submitted.
7	person who inputs the data here knows that the nine	7	Q. Just using this as one example, the self-harm resulting
8	events of self-harm don't need to be reported?	8	in injury, the data that you're provided, do you do any
9	A. I think - I'm not entirely sure of the wording for	9	check on the adequacy or accuracy of that data?
10	that. So that part of (c) is quite cut down. I think	10	A. There would be some level of checks. I don't recall
11	it	11	what checks we did. Generally, we would accept what we
12	Q. That's right.	12	were being given by the functions and report back on
13	A. I think it mentions around "resulting in injury that	13	what - because they were the subject matter experts, so
14	requires hospital", is it, hospital treatment?	14	we'd report back on what they reported to us.
15	Q. I think it is just "healthcare treatment"?	15	Q. That would be, for self-harm, as you said, the Safer
16	A. And it is a direct result of a failure of procedure.	16	Community manager?
17	Q. That's not quite right. It is where it involves	17	A. Yes, much like, you know, if for security information
18	a failure to follow procedures set out in schedule D.	18	reports and stats on other bits and pieces that we get.
19	A. So I know that, at the time, the Safer Community Team	19	Q. We have heard, and we discussed yesterday with two of
20	would have done self-harm investigations, so following	20	the witnesses, that during the relevant period, there
21	an incident of self-harm, they would have done an	21	were never any reports that found their way into these
22	investigation into that and would have looked to try and	22	documents of self-harm resulting in injury that
23	identify whether there was a failure under that. Every	23	fulfilled the contractual requirements of schedule G.
24	act of self-harm that occurred at Brook House was	24	A. Yes.
25	reported via an incident report and that was shared with	25	Q. Was that something you were aware of at the time?
			<u>.</u>
L	Page 82	<u></u>	Page 84
			21 (Pages 81 to 84)

21 (Pages 81 to 84)

1	A. I think, from recollection, it was very, very rare that	1	resulted in a penalty. But that requires that a DCM
2	anything did result in that	2	says, "I made a mistake", potentially, or, "One of my
3	Q. Yes.	3	team made a mistake"?
4	A you know? And still, you know, outside of	4	A. Sure, yes.
5	the relevant period, it was very rare for a self-harm	5	Q. We have seen, for example, the evidence of
6	relating in injury to be a consequence of a failure of	6	Mr Chris Donnelly. I don't know if you watched his
7	procedure.	7	evidence on 23 February?
8	Q. Did you know that there was, in fact, a level of	8	A. I didn't, no, but I'm aware of it.
9	self-harm for example, 60 events during the relevant	9	Q. We have given you access, I think, to his transcript as
10	period. Did you know that there was self-harm, despite	10	well. In brief, he was asked by Mr Altman about an
11	that it isn't recorded?	11	incident with D865 who tried to hang himself in his room
12	A. Yes, that would have been reported on a different	12	on 4 July 2017. In summary, Mr Donnelly didn't realise,
13	end-of-month report.	13	on entering the room, that D865, who was unconscious,
14	Q. We see it, for example, in the combined reports that go	14	had a ligature around his neck.
15	to the IMB?	15	A. Correct.
16	A. Yes, so it was all reported in different reports.	16	Q. It meant that that ligature wasn't removed for about two
17	Q. Did you ever question the fact that, despite the fact	17	minutes. Mr Donnelly accepts he should have checked for
18	that there was such you know, there was a level of	18	a ligature immediately. He also accepted that, in the
19	self-harm, there was none fulfilling the untoward event	19	forms about the event, he wrongly failed to record that
20	requirement.	20	the two-minute delay had happened. So this is obviously
21	A. I never questioned it, no.	21	a case of self-harm involving injury?
22	Q. Looking back, do you think it's something that could	22	A. Yes.
23	have been looked into in more detail to ensure that	23	Q. The man was unconscious. Do you know it is not
24	that	24	a test, if you don't know, it is fine. Do you know if
25	A. I think	25	this would be classed as a case involving a failure to
	Page 85		Page 87
1		5	
1	O. – data was accurate?	1	follow procedures?
1 2	Q. — data was accurate? A. — there's a number of things — sorry. I spoke over	1 2	follow procedures? A. Looking at it, it could be. Yeah, it could be.
2	A there's a number of things sorry, \boldsymbol{I} spoke over	2	A. Looking at it, it could be. Yeah, it could be,
l	A. — there's a number of things — sorry, I spoke over you. I think there's a number of things in that report		A. Looking at it, it could be. Yeah, it could be, definitely. I wasn't aware of it at the time.
2	A. — there's a number of things — sorry, I spoke over you. I think there's a number of things in that report that never constituted a failure. So did I look at	2	A. Looking at it, it could be. Yeah, it could be, definitely. I wasn't aware of it at the time. Q. Sure.
2 3 4	A. — there's a number of things — sorry, I spoke over you. I think there's a number of things in that report that never constituted a failure. So did I look at self-harm differently to any of the other failures in	2 3 4	 A. Looking at it, it could be. Yeah, it could be, definitely. I wasn't aware of it at the time. Q. Sure. A. But a failure to identify a ligature is you know,
2 3 4 5	A. — there's a number of things — sorry, I spoke over you. I think there's a number of things in that report that never constituted a failure. So did I look at self-harm differently to any of the other failures in there that didn't have one? No. Obviously, that's not	2 3 4 5	 A. Looking at it, it could be. Yeah, it could be, definitely. I wasn't aware of it at the time. Q. Sure. A. But a failure to identify a ligature is — you know, is — on our part as a team is, you know, is an error,
2 3 4 5 6 7	A. — there's a number of things — sorry, I spoke over you. I think there's a number of things in that report that never constituted a failure. So did I look at self-harm differently to any of the other failures in there that didn't have one? No. Obviously, that's not to say it's not, you know, more serious than some of	2 3 4 5 6 7	 A. Looking at it, it could be. Yeah, it could be, definitely. I wasn't aware of it at the time. Q. Sure. A. But a failure to identify a ligature is — you know, is — on our part as a team is, you know, is an error, a massive error.
2 3 4 5 6 7 8	A. — there's a number of things — sorry, I spoke over you. I think there's a number of things in that report that never constituted a failure. So did I look at self-harm differently to any of the other failures in there that didn't have one? No. Obviously, that's not to say it's not, you know, more serious than some of the other things, but, no, I didn't actively go out and	2 3 4 5 6	 A. Looking at it, it could be. Yeah, it could be, definitely. I wasn't aware of it at the time. Q. Sure. A. But a failure to identify a ligature is — you know, is — on our part as a team is, you know, is an error, a massive error. Q. You say you didn't know at the time. That's the
2 3 4 5 6 7 8 9	A. — there's a number of things — sorry, I spoke over you. I think there's a number of things in that report that never constituted a failure. So did I look at self-harm differently to any of the other failures in there that didn't have one? No. Obviously, that's not to say it's not, you know, more serious than some of the other things, but, no, I didn't actively go out and think, "This is strange that it hasn't been reported".	2 3 4 5 6 7 8	 A. Looking at it, it could be. Yeah, it could be, definitely. I wasn't aware of it at the time. Q. Sure. A. But a failure to identify a ligature is — you know, is — on our part as a team is, you know, is an error, a massive error. Q. You say you didn't know at the time. That's the problem, isn't it, because unless you know at the time,
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2 3 4 5 6 7 8 9 10 11 12 13 14	 A. – there's a number of things – sorry, I spoke over you. I think there's a number of things in that report that never constituted a failure. So did I look at self-harm differently to any of the other failures in there that didn't have one? No. Obviously, that's not to say it's not, you know, more serious than some of the other things, but, no, I didn't actively go out and think, "This is strange that it hasn't been reported". Q. Do you know if anyone did? A. I'm not aware of if anyone did or not, but, like I said, you know, the Safer Community Team would have been completing the reports. Knowing the people that – you know, especially the DCMs that were involved in some of 	2 3 4 5 6 7 8 9 10 11 12 13	 A. Looking at it, it could be. Yeah, it could be, definitely. I wasn't aware of it at the time. Q. Sure. A. But a failure to identify a ligature is — you know, is — on our part as a team is, you know, is an error, a massive error. Q. You say you didn't know at the time. That's the problem, isn't it, because unless you know at the time, it can't be reported? A. Yes. Q. You discuss a general point in your statement at page 21, paragraph 86, some barriers that hindered you
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22 (Pages 85 to 88)

		T	
1	A. But in terms of managing action plans and compliance or	1	Q during the relevant period?
2	compliance as a result of action plans, it was	2	A. They would have been part of monthly meetings, yes.
3	difficult, because there was no challenge for inaction.	3	Q. Were you at those meetings?
4	Q. Had you you said there was no job description. Had	4	A. I would have been at SMT meetings. I would have been at
5	you had any training before you went into the role you	5	the monthly ops meetings with the Home Office, yes.
6	were in during the relevant period on auditing of	6	Q. You say, at paragraph 88, that you attended weekly
7	the type that we are looking at	7	meetings to talk about the contract and your compliance
8	A. No.	8	with it; is that right?
9	Q and monthly reports. We have been talking then about	9	A. Yes.
10	2017 and the G4S contract. Obviously, now there is	10	Q. Was that meetings with the Home Office or just G4S?
11	a new contract in place	11	A. No, it was Home Office.
12	A. Yes.	12	Q. You say that this would have involved this is, again,
13	Q which also contains similarly, I think, KPIs and	13	at paragraph 88 conversations about changes to the
14	penalty points. Is it still within your remit to work	14	contract?
15	on and compile these reports?	15	A. Yes.
16	A. I will compile management data for my function.	16	Q. Can you recall during the relevant period or thereabouts
17	Q. Yes. Of the same sort of nature of what we looked at	17	whether anyone at these meetings suggested that the
18	now?	18	contract should be changed to increase staffing levels?
19	A. Only relating to mine, yes.	19	A. I can't recall anyone bringing it up, no. Not as part
20	Q. Do you know and you might be able to say from your	20	of a performance issue.
21	experience within a slightly different part of	21	Q. Or at all?
22	the jigsaw are they done on the same basis? So	22	A. No. I mean, we discussed staffing issues when after
23	functional heads or individual managers report it to one	23	Panorama. We increased so there were a number of
24	person?	24	meetings about that. There were staffing meetings
25	A. Yes.	25	because we were in a bid process at the time.
	D 00		D 04
	Page 89		Page 91
1	Q. And the one person, do they come back to you to audit	1	Q. Yes.
2	and check the quality of your data?	2	A. But in those weekly meetings, I don't recall anyone
3	A. They will ask questions if they feel that it's not	3	having discussions about increasing staffing. It was
4	correct. They will cross-reference against different	4	normally myself and Barry or Barry and the Home Office.
5	sources. And we are - our functions are audited, so	5	Ultimately, it was a Home Office contract. So if they
6	contractually they're audited. Every DSO is audited and	6	wanted to increase staffing, they could have changed the
7	every operating standard that falls into our function is	7	contract and changed it.
8	audited. So	8	Q. Equally, if you thought "you" as in G4S wanted to
9	Q. Who is it now who creates the sort of reports that we	9	increase staffing
10	see now for the purposes of applying	10	A. We could have gone to them and asked to increase, yes.
11	A. It is a much larger team. So back in 2017, when we were	11	Q. You mentioned the staffing around the bid, so you cover
12	doing it, it was myself overseeing Barry. Barry was	12	this in your statement at 84 to 85. It is page 21.
13	seconded in to cover a maternity cover. Now, there's	13	Under the heading "Management decisions/the contract".
14	probably - well, now there's an assistant director of	14	You say there at 84 can we show it on screen,
15	governance that looks after the team. There's	15	<ser000453>, page 21. Paragraph 84 on that page:</ser000453>
16	a number there's a couple of DOMs, I think two DOMs,	16	"I recall a decision made by Ben Saunders to run
17	and then probably three or four officers	17	staffing levels below the typical head count. This was
18	Q. So	18	prior to an upcoming contract renewal. The upcoming
19	A in audits and compliance.	19	contract had a lower number of staff than levels at the
20	Q DOM is the new	20	time. Therefore, Ben took the decision to not recruit
	A. DOM is the new DCM, yes.	21	to our target number of staff (but wanted to keep
21		22	staffing to contractual requirements) on the basis that
21 22	Q. Fine. Thank you. The reports that we have just seen,	1	
l	Q. Fine. Thank you. The reports that we have just seen, were they discussed at a meeting, the performance	23	if G4S retained the contract, Brook House would not be
22		1	if G4S retained the contract, Brook House would not be over head count. The decision was financially
22 23	were they discussed at a meeting, the performance	23	
22 23 24	were they discussed at a meeting, the performance points A. The performance points	23 24	over head count. The decision was financially beneficial, as all savings increased the margin."
22 23 24	were they discussed at a meeting, the performance points	23 24	over head count. The decision was financially

23 (Pages 89 to 92)

1	Can you help me understand this: do you know when	1	Q. Yes.
2	approximately I know the bid process is quite long.	2	A. And that fluctuated based on head count. So if the head
3	A. Yes.	3	count in the centre was high, the number of hours that
4	Q. When was contract renewal coming up?	4	needed to be provided over a 24-hour were higher and if
5	A. So I think the renewal was in 2018.	5	it was lower, it was lower. So, in effect, you could
6	Q. Yes.	6	not have your full head count but still provide your
7	A. So I think a lot of the bid work had been done or was	7	contracted hours.
8	being done. I wasn't massively involved in it. I was	8	Q. I see. And not reach the point at which you would incur
9	made aware that the new bid that we were being asked	9	a penalty?
10	to or that we were bidding for and other people were	10	A. Yes.
11	bidding for was much - the staffing levels were lower,	11	Q. This policy of running the staffing numbers lower in the
12	the level of education and services to residents, such	12	run-up to the bid, is that an explicit policy by
13	as welfare, was lower. So that's, I think, where a lot	13	Ben Saunders or was it more of an unspoken kind of
14	of the staffing savings were. So instead of welfare	14	gradual plan?
15	being opened seven days a week, it was only open five	15	A. It was a discussion he had with me that said he wanted
16	days a week, and that was the spec that was being bid	16	me to maintain the contracted hours, but that he wasn't
17	on.	17	going to recruit to the full head count.
18	So Ben said that he didn't want to recruit to our	18	Q. Was the Home Office aware of that?
19	full sort of FTE full-time equivalent head count.	19	A. I don't know.
20	I can't recall what the number was.	20	Q. Did you ever have a conversation with him in the
21	Q. Sure.	21	presence of anyone from the Home Office about that?
22	A. But he was content to run with vacancies to minimise	22	A. I don't recall that happening with the Home Office
23	that transition, should we win the contract.	23	present.
24	Q. And to show that costs were low at the time that the bid	24	Q. You have said at 85 that this added unnecessary pressure
25	was being (overspeaking)?	25	to the staff and made the role more difficult?
	Page 93		Page 95
1	A. I don't think showing costs were low would have	1	A. Yes, of course it did. It's a minimum for a reason.
2	benefited the bid	2	Obviously, when the contract was written, the minimum
3	Q. Right, so	3	is, you know, what you should be able to run the centre
4	A because it was a completely different spec. I think	4	safely on. That's what's agreed as the minimum the
5	it just meant that we would have transitioned into the	5	MSL, I think it's referred to, minimum staffing level.
6	new contract with the right number of people as opposed	6	Q. Minimum staffing level, yes.
7	to being —	7	A. So that's agreed in the contract. But, obviously, if
8	Q. Having it?	8	you are continually running at that, there should be
9	A. -20 or 30 people over.	9	days when, you know, you haven't got training on and you
10	Q. I see and then having a kind of steep drop-off?	10	haven't got leave and you'll have over your MSL, which
11	A. Then you would have had to through people resigning,	11	makes the place, obviously, a little bit easier to run
12	you would have had to have lowered your numbers.	12	and a better place to be in.
13	Q. Can you help with the difference between the target	13	Q. You said that running on that minimum for the majority
14	number of staff and then the contractual requirement	14	of the time rather than as an exceptional, I suppose,
15	number of staff?	15	led to the feeling of staffing being tight and "had we
16	A. Yes. So the contract was difficult in terms of managing	16	recruited more staff, there would have been many more
17	staffing numbers. So there was a target number, as in	17	days where we did not feel that we were scraping by"?
18	a target number of full-time equivalent head count of	18	A. Yes, very much my opinion.
19	officers and DCMs, or DOMs. The idea with that is that	19	Q. Sure.
20	should have then provided you enough people when you	20	A. But yes.
21	build in your sickness and your leave and your	21	Q. It is not because it is not solely because it was
22	non-effective rate. It should have provided you with	22	difficult to recruit people, from what you have told us,
23	enough staff to run the centre.	23	but, in fact, because there was a decision not to
24	Q. Yes.	24	recruit people at that time?
25	A. What we were managed on is a table of contracted hours.	25	A. Yeah, it was difficult to recruit at the time, but also,
			,
	Page 94		Page 96

24 (Pages 93 to 96)

1	there was part of my remit was training and it was	1	Q. Yes.
2	a frustration between Santi and I. I had many difficult	2	A. Is two people enough to look after 120 residents on
3	conversations with Santi, who was my training officer,	3	a wing at Brook House? I don't not to provide the
4	about providing initial training plans sorry, initial	4	adequate services that we want to. However, there's
5	training courses, ITCs, where we would come up we'd	5	times when, actually, if all your support services on
6	be asked to come up with plans to provide a training	6	the outside welfare, activities, regime if all of
7	course for 30, 40, 50 people. We would spend weeks	7	that stuff is very well resourced, then actually it can
8	planning that and identifying external venues and lots	8	be, because a lot of residents spend most of their time
9	of other places to make sure resource-wise we could	9	off of the units. But, you know, even if you doubled
10	deliver, only to be told that we wouldn't be doing that	10	that to four, depending on what the ask is of
11	anymore or to be told that, actually, an ITC where we	11	the officer, is four enough people to look after 120
12	were guaranteed 20 people turned up with six. So in	12	people? So it's very subjective. So that's why I try
13	terms of resource of running a training plan for — or	13	to draw the difference between the two.
14	a training course for six people, it was quite	14	Q. And what the meaning of "adequacy" is as you set out in
15	demoralising for Santi sometimes.	15	your statement?
16	Q. Sure.	16	A. Absolutely. You have your contract compliance, which is
17	A. So, yeah, there was a frustration there.	17	one, and the minimum number there was two per wing. But
18	Q. You would be told, you say, that you weren't doing it	18	is that adequate? And that's a different question.
19	anymore so that the ITC had been cancelled and there was	19	Q. You say in your statement, well, more staff can't
20	no-one being trained at that period?	20	guarantee safety, because
21	A. No, it would just be that I would knowing that we	21	A. No.
22	were you know, knowing that we needed to recruit	22	Q something can happen and it doesn't really matter if
23	numbers, I would make the offer to say, "I can run	23	you have two or four staff. An unsafe event can happen?
24	you know, we can run you an ITC that's got 40 or 50	24	A. Yes.
25	people on it".	25	Q. But, of course, more staff can increase the level of
	Profession .		
	Page 97		Page 99
1	Q. In anticipation of it getting those (overspeaking)?	1	safety, can't they?
2	A. In anticipation, looking at the numbers and the plan you	2	A. Absolutely, yes, it would definitely help.
3	can see that's the numbers you need, so we would go out	3	Q. Moving away just from safety, would you agree that more
4	and plan for that, and to be told we wouldn't be doing	4	staffing improves the quality of life for detained
5	that anymore and you'd get 10 or 12 people through the	5	persons because of stuff like activities being able to
6	door.	6	be run, people who want someone to talk to, having
7	Q. You understood that just to make sure I have	7	somebody they can talk to?
8	understood your point to be a combination of	8	A. It most certainly can do. You know, a lot of
9	recruitment itself being difficult but also a decision	9	frustration for the residents is not getting answers
10	not to recruit to the normal staffing levels and keep it	10	quickly or not having questions answered. So if
11	at a minimum?	11	there's you know, and I've operated as an officer on
12	A. That's my understanding of it at the time, yes.	12	a wing with two how much time can you afford one
13	Q. Thank you. That can come off the screen now. You cover	13	person if you are looking after 120 people? So it's
14	staffing generally from paragraph 123, so this is	14	difficult.
15	page 29 of your statement, wherein you say:	15	Q. At 125, you say that "We talked about staffing levels
16	"Generally, staff were unhappy with staffing	16	amongst ourselves and the fact that two people on a wing
17	levels."	17	made it difficult. Ultimately, it was part of
18	You say it was in line with the contract, but you	18	the contract". Then you say, "We could manage with two
19	didn't feel that two people per wing was adequate. You	19	people, but it limited our ability to assist residents".
20	say it should have been more like three DCOs per wing	20	You say you talked about staffing levels amongst
21	and one DCM and ideally six or seven staff.	21	yourselves, do you mean amongst the SMT, amongst you and
22	A. It's a really difficult number to formalise in your	22	people on the wings?
23	head. It's so opinionated about what people think is	23	A. I think everyone, you know, staffing levels is quite
24	the right number and what people think is the wrong	24	a hot topic whenever you are discussing it. So I think
25	number.	25	I was referring to the fact we probably spoke about it
		§	- • • •
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25 (Pages 97 to 100)

1	as an SMT, we definitely did, but also we would have	1	I don't yeah, I'm not too sure what the resilience
2	spoken about it with DOMs and with officers as well.	2	was. I think there was a resilience to accept failure
3	Q. And with Home Office?	3	in your own function at times, which is what I sort of
4	A. And with the Home Office, yes.	4	alluded to in my statement.
5	Q. And did they, in general, share the same sorts of	5	Q. Amongst any particular teams or in general across the
6	thoughts as you about low staffing and its impact?	6	board?
7	A. Yeah, I think they did share the same views.	7	A. I think some functional heads were probably more engaged
8	Q. Turning to page 7 of your statement, paragraph 24, you	8	with it than others. There were specific people that
9	say:	9	were very defensive, I think, in their stance and their
10	"In my opinion, during the relevant period, the SMT	10	take towards issues being raised.
11	were not a united team and the leadership from the	11	Q. Who?
12	director [Ben Saunders] at the time was not very strong.	12	A. So Michelle Brown was particularly defensive. She would
13	I raised compliance issues with him on numerous	13	quite often, if you raised an issue and that you
14	occasions and asked him to arrange a meeting to discuss	14	know, you're raising an issue from a good place, to say,
15	action plans. When he attended such meetings he was	15	"I've noticed this, just to let you know. It's your
16	shouted down by the SMT and little was done."	16	function. Could you have a look?". Quite often that
17	A. Yes.	17	would be turned around and directed back at you and, you
18	Q. Do you remember which compliance issues you raised?	18	know, another failing in your area would be brought up
19	A. So we had a number of action plans at the time and, you	19	or, you know, "You shouldn't be raising this because
20	know, still do now, referred to as CAPs or consolidated	20	you're not doing this in your area", so you had that
21	action plans. We would have one for internal	21	sort of mentality. Neil Davies did similar things.
22 23	recommendations from our own auditing and one for	22 23	I think, generally, most people were defensive, but
23	external recommendations for HMIP and IMB and	23	I got a feeling that some were not being so people
25	Home Office input. So part of my role was to manage	25	like Stacie Dean was very good and very engaged, but
23	those and to manage the progress and to compile evidence	23	I think she was defensive just because of
	Page 101		Page 103
1			
	in order to look at signing those actions off as	1	the atmosphere, as apposed to trying to be difficult.
2	in order to look at signing those actions off as	1 2	the atmosphere, as opposed to trying to be difficult. O. So you knew then, as a result of the times you raised
2	compliant.	2	Q. So you knew then, as a result of the times you raised
2 3 4	compliant. So monthly, Barry would send out an email to	2 3	Q. So you knew then, as a result of the times you raised it, you say numerous times, that the action plans
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26 (Pages 101 to 104)

1	Q. I want to ask about a specific incident on 13 May 2017	1	options?
2	involving D687. We have heard about this, both in	2	A. Yes.
3	phase 1 at the end of last year and during this phase.	3	Q. But, in fact, it wasn't used, was it?
4	We have seen footage as well. I asked Mr Farrell about	4	A. No, and, I mean, I've said in my statement there's
5	this last week. Mr Collier, who has also provided an	5	a number of errors I made in completing this report and
6	expert report to the inquiry, has commented on it. So	6	I completely hold my hands up to them. I can't comment
7	D687 had been in immigration detention since March 2015	7	now as to why I made them. They weren't a deliberate
8	and he had been in Brook House since October that year.	8	error. I think, in terms of body-worn camera, I think
9	He spoke on the footage, as we have seen, and in his	9	Chris had one.
10	statement, of having lost his brother and not being	10	Q. Yes. Mr Farrell
11	allowed to go to the funeral and he was due on this date	11	A. I think I made an assumption without checking with them
12	we are going to look at to be moved to the Verne, which	12	that they'd turned theirs on, and they hadn't, which is
13	is quite far away from his family.	13	why, when I was writing that report, I ticked "Yes". So
14	A. Yes.	14	there is a number of errors in there that I made, but
15	Q. He went to the toilet and cut off his T-shirt. Do you	15	they weren't sort of deliberate errors at the time.
16	recall the incident?	16	Q. Mr Farrell, I asked, and he looked at the video footage
17	A. Yes, I do recall the incident, yes.	17	and he recognises he was wearing one as well. He
18	Q. Can we look at the use of force documentation, then,	18	thinks, or maybe I suggested, that when you have it on
19	please, <cjs005652>. So this is the front page. We can</cjs005652>	19	there's a red light, and that there is no light on?
20	see your name there. Just to clear up any confusion	20	A. Generally, yes, it makes a beep and there is a light.
21	here, the things that are crossed out, we should ignore;	21	Q. There is no light on and we obviously don't have any
22	is that right? So handcuffs used	22	footage other than Mr Tulley's undercover footage?
23	A. That is generally the way they would be written, yeah.	23	A. Yes.
24	Q. So "Yes" means handcuffs were used and "Camera Used:	24	Q. Page 8, just to set out the background of the event,
25	No". The reason given, which is at the bottom of	25	this is some background by you which says that you were
	Page 105		Page 107
1	the page, is a reason for use of force is "To facilitate	1	duty director that day.
2	transfer/prevent self-harm". That's what "S/H" means,	2	A. Yes.
3	isn't it?	3	Q. It was your second duty director day out of three. You
4	A. Yes.	4	say that a suitable crew had been arranged. Third from
5	Q. It is noted there to be unplanned.	5	the bottom paragraph:
5 6	Q. It is noted there to be unplanned.A. Yes.	5 6	the bottom paragraph: "There were concerns that he would not comply."
6	A. Yes.	6	"There were concerns that he would not comply."
6 7	A. Yes. Q. And he was on an ACDT. Would you have known before the	6 7	"There were concerns that he would not comply." But he did compliantly walk to the discharge waiting
6 7 8	A. Yes. Q. And he was on an ACDT. Would you have known before the incident that he was on an ACDT?	6 7 8	"There were concerns that he would not comply." But he did compliantly walk to the discharge waiting room?
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27 (Pages 105 to 108)

1	Part of my assessment at the time was that ligature and	1	the best interests of everyone there to sort of bring
2	whether it was removable, as opposed to initiating	2	that to a quick and safe resolution by securing that
3	force.	3	ligature.
4	My intention throughout all of that was to remove	4	Q. The other officers had to act, to a certain extent, on
5	that ligature, because by removing the ligature from the	5	instinct, didn't they?
6	rail, it neutralised the incident and the situation.	6	A. Yes. Yes, they did.
7	So, at the time, I was acting in what I thought was the	7	Q. They thought, "We need to restrain this person"?
8	best interest of everyone involved to try and bring it	8	A. Yes.
9	to a very quick and swift end, so my intention when	9	Q. But your intention hadn't been to restrain him; it had
10	I closed the gap was to secure that ligature that was on	10	just been to remove the ligature?
11	the rail.	11	A. Yes.
12	The reason I mention it in there is because it's	12	Q. You say that waiting longer you accept that
13	part of my thought process and part of my risk	13	Mr Collier says that escalation hadn't reached its kind
14	assessment at the time. That's why I've put it in	14	of ultimate point of "it is not going to get any
15	there. I appreciate what Collier says in his report,	15	better". You waiting longer could have prolonged the
16	and, yes, I could have dealt with it differently.	16	risk, and it comes with risks, you say?
17	I could have walked away. I could have planned it. His	17	A. Yes.
18	report suggests that that's without risk and, you know,	18	Q. Would you accept that, given that you say that, if he'd
19	that has its own risks with it. That would have	19	have dropped from the toilet, the knot would not have
20	prolonged the incident by half an hour, 40 minutes, for	20	strangulated him, effectively, that actually the risk
21	us to get more officers present. It would have you	21	level was relatively low at the time?
22	know, we would have had to have entered that area with	22	A. The risk was still relatively low. It might not have
23	a team in PPE, which would have identified what was	23	strangled him. I couldn't be 100 per cent sure. Hence
24	going to happen. So there was a number of different	24	why when I had the opportunity to secure it and remove
25	a number of different things going on in my mind when	25	that risk, I did. Who is to know what would have
	Page 109		Page 111
		1	
1	I was making that decision.	1	happened if he'd dropped. He could have banged his head
1 2	I was making that decision. I know it says that my intent was to initiate force.	1 2	happened if he'd dropped. He could have banged his head on the toilet bowl and suffered a severe head injury.
			., ,,
2	I know it says that my intent was to initiate force.	2	on the toilet bowl and suffered a severe head injury.
2	I know it says that my intent was to initiate force. I didn't — you know, the footage shows that I made —	2	on the toilet bowl and suffered a severe head injury. I don't know. So
2 3 4	I know it says that my intent was to initiate force. I didn't — you know, the footage shows that I made — you know, my direction was towards the ligature.	2 3 4	on the toilet bowl and suffered a severe head injury. I don't know. So Q. You'd also accept that there's risks of instigating an
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28 (Pages 109 to 112)

1	You know, the assessment was that continued	1	A. Force was used, but, in that report, I don't say that
2	engagement was unlikely to de-escalate that incident	2	I did use force.
3	because the trigger for that incident was the removal,	3	Q. But your team used force?
4	was the transfer to another centre. So all the time	4	A. The team used force, yes.
5	that that was still a possibility, it was very unlikely	5	Q. And they didn't know what your intention was?
6	that that situation was going to de-escalate.	6	A. No.
7	Q. If you had waited, it would have been possible to get	7	Q. Do you think it would have been more accurate to say in
8	healthcare to attend, wouldn't it?	8	this form, "I didn't I was planning to remove the
9	A. Yeah, and I you know, that's part of the things	9	ligature".
10	I accept. You know, if I had waited and we had planned	10	A. Yes.
11	it, you know, it would have been — you know, there	11	Q. "My team saw this as the instigation of use of force"?
12	would have been someone recording it and healthcare	12	A. Yes.
13	would have been present, yes.	13	Q. And to say within this form, which is meant to include
14	Q. I appreciate you draw the distinction between planning	14	in it the rationale for using force, "In fact, there was
15	it you have to go away, you have to do a brief, you	15	no rationale for using force, because that was never my
16	have to wear PPE, and you said why that might not have	16	intention"?
17	been appropriate. But is it possible that you could	17	A. Yes, and, looking back, you're right, I could have put
18	have just called healthcare anyway?	18	that in there, and that would have given a better
19	A. Yes, it is, it is, and, again, that's part of my	19	overview of the report.
20	reflection. Healthcare probably should have been there	20	Q. It would have been an accurate interpretation of what
21	before I got there. I should have taken a more	21	happened, wouldn't it?
22	strategic view. I didn't, at the time. I got involved	22	A. It would have been more accurate, yes. I didn't put in
23	in a situation which obviously Collier suggests and	23	there my thought process at the time.
24	that's you know, that's the learning that I've taken	24	Q. So
25	away, definitely, is that I would step back and assess	25	A. Or all of it.
	Page 113		Page 115
	1 agc 113		Tage 113
1	that situation slightly differently this time around.	1	Q your team, who we have heard from some of, their view
2	Q. Would you accept that the relevance of healthcare being	2	was that the rationale for use of force was to prevent
3	there is not just because he's potentially going to be	3	injury and then later to remove him and, in fact, what
4	physically harmed, but also because he's potentially	4	we are hearing is, there was no intention at all to use
5	mentally unwell?	5	force?
6	A. Absolutely, yes. Absolutely.	6	A. It wasn't my intention to use force, no.
7	Q. So you heard him say things like, "I want to die.	7	Q. Should this have been recorded as an event of use of
8	I want to go away in a body bag"?	8	force outwith the use of force requirements; so not as
9	A. I can't remember whether I was there or not when he	9	a last resort, because force is used without any
10	was sort of some of the things he was saying when	10	rationale?
11	I was there. He made it very clear he didn't want to	11	A. Well, there's $-$ I mean, there's still a rationale there
12	leave, and you could see - I could see he was upset.	12	to use force because
13	Q. Distressed?	13	Q. What's the rationale to use force?
14	A. Yes.	14	A. One, there's a ligature present that poses a risk, and
15	Q. And you say you would have known, although obviously you	15	I had an opportunity to sterilise that; two, there is
16	can't remember now, that he was on an ACDT, because it	16	still an enforced transfer to take place. I'm not sure
17	would have been in the handover?	17	why the transfer was taking place at the time.
18	A. Mmm.	18	A suitable crew transfer suggests that — well, it is
19	Q. So you have commented on the inquiry's expert's findings	19	the fact that the Home Office have decided that that
20	there. When you filled in your use of force form, which	20	person needs to transfer, and if they refuse then we are
21	we just looked at, and which has just disappeared from	21	to use force to remove them and hand them over to that
22	the screen, you didn't say in that use of force form	22	escort team. So there was still a valid reason to move
23	that it was never your intention to use force, did you?	23	him from that room and hand him over to the escort team.
24	A. Well, I also don't say that I did use force.	24	Q. That's a retrospective justification, though, isn't it?
25	Q. Force was used?	25	That's not the reason that force was used on him at the
	•		
	Page 114		Page 116

29 (Pages 113 to 116)

1			
1	time that force was used on him?	1	"Authority for initial 24 hours RFA** (Cases of
2	A. I mean, I don't I don't know overly what you want me	2	Urgency).
3	to say in that. You know, I've set out what it was	3	"Person authorising RFA S Dix."
4	that you know, my thought process at the time and my	4	And it gives the date and the time. So he
5	thinking at the time. Yeah. There was a number of -	5	authorised the removal from association. As we have
6	like I said, there was a number of different	6	seen, you are informed of it. What do you do when
7	considerations to make. We had to deliver him to the	7	you're informed of the use of rule 40?
8	escorting team for him to transfer. That was an	8	A. It depends on the situation. Normally, we just discuss
9	instruction from the Home Office. So we if I'd gone	9	what's happened. We discuss the reporting elements,
10	away and planned that use of force and come back, the	10	make sure, you know, everyone is all right, look after
11	use of force would still have taken place to have handed	11	the welfare of the resident and the members of staff.
12	him over to that escort team, potentially, if he was	12	We just talk through the incident, really.
13	still refusing to come out of the room.	13	Q. Do you see this rationale as written here, or is that
14	Q. Potentially, yes.	14	written after you're
15	A. So, yeah, that was the	15	A. It's generally it's not always shared with us before
16	Q. But the actual use of force happened because there was	16	they go on to rule 40, no.
17	confusion among the team of what your movement towards	17	Q. But you have a discussion, do you, before you at the
18	him meant?	18	time of you being told about it, so we saw 8 o'clock in
19	A. Yes.	19	this incident. Is that when you would have had the
20	MS MOORE: Chair, I have just realised, it is 1.01 pm. It	20	discussion?
21	might be now a good time for a break. If we come back	21	A. Yes, so that's when I would have been told what had
22	at 2.00 pm and continue with the evidence of	22	happened in the lead-up and what's happened as a result.
23	Mr Haughton.	23	Q. Do you have to take any action or are you just informed?
24	THE CHAIR: Thank you very much. Thank you, Mr Haughton.	24	A. No, we are just informed.
25	(1.02 pm)	25	Q. Your statement says at 263 that you expect that D1527's
	Page 117		Page 119
1	(The short adjournment)	1	removal from association and constant supervision was
2	(2.00 pm)	2	due to behaviour. Is that a permissible reason to
3	MS MOORE: We continue with the evidence of Mr Haughton.	3	invoke the powers under rule 40?
4	Mr Haughton, you were asked to comment in your	4	A. When I had when I wrote my statement, I didn't have
5	statement about a different event this is involving	5	· ·
1 -	Statement account a different event and is involving		access to this.
6	D1527 and you discuss this at page 59 of your witness		access to this.
6	D1527 and you discuss this at page 59 of your witness	6	Q. I see.
7	statement at paragraphs 263 and 264, quite briefly.	6 7	Q. I see. A. I had access to one page of an observation of a rule 40
7 8	statement at paragraphs 263 and 264, quite briefly. This event relates to what happened on 4 May 2017, so	6 7 8	Q. I see. A. I had access to one page of an observation of a rule 40 document, so I had absolutely no idea about the incident
7 8 9	statement at paragraphs 263 and 264, quite briefly. This event relates to what happened on 4 May 2017, so D1527 had jumped onto the D wing netting. We have seen	6 7 8 9	Q. I see. A. I had access to one page of an observation of a rule 40 document, so I had absolutely no idea about the incident when I wrote my statement.
7 8 9 10	statement at paragraphs 263 and 264, quite briefly. This event relates to what happened on 4 May 2017, so D1527 had jumped onto the D wing netting. We have seen footage of this previously in the inquiry. He was then	6 7 8 9	 Q. I see. A. I had access to one page of an observation of a rule 40 document, so I had absolutely no idea about the incident when I wrote my statement. Q. Yes. I think you did say in your statement that you
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7 8 9 10 11 12 13 14 15 16	statement at paragraphs 263 and 264, quite briefly. This event relates to what happened on 4 May 2017, so D1527 had jumped onto the D wing netting. We have seen footage of this previously in the inquiry. He was then persuaded to come off the netting. He went to sit with two other detainees and, in due course, a rule 40 was authorised. Can we have a look on the screen at <hom000251>, please. This is the DCF1 form in relation to that. We can see from page 1, it is "Search conducted on arrival", et cetera, all of those signatures are "S Dix", that's Mr Steve Dix.</hom000251>	6 7 8 9 10 11 12 13 14 15 16	 Q. I see. A. I had access to one page of an observation of a rule 40 document, so I had absolutely no idea about the incident when I wrote my statement. Q. Yes. I think you did say in your statement that you couldn't remember it, so you were guessing on the basis of (overspeaking)? A. Yes, obviously, seeing the document now, then yes. That behaviour is potentially disruptive, potentially causes a risk to the centre and to the others in it, so it would appear rule 40 is justified. Q. Is rule 40 justified with behaviour that's potentially
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30 (Pages 117 to 120)

		-	
1	Q. That could include if, as a last resort, you can't do	1	looked at to be an example of section 42?
2	anything else about the disruption to the regime and the	2	A. Yes.
3	residents, you say?	3	Q. The manager of a contracted-out detention centre, did
4	A. Yes.	4	you understand Mr Dix to be the manager for the purposes
5	Q. Where did you gain that understanding of the parameters	5	of this rule?
6	of rule 40?	6	A. Yes, for working purposes, it's always as far as
7	A. Just, you know, in general knowledge of sort of	7	I can recall back in history, it's always been the case
8	conducting the role. We needed to sort of upskill	8	that a DCM or a DOM or a team leader had the authority
9	ourselves slightly in it. But there was no I had no	9	to do that.
10	formal training when I moved into the role of DD on the	10	Q. That was what you were told when you took on the role,
11	sort of use of rule 40.	11	not in a training way, but you were told
12	Q. Just to check there on the form, Steve Dix, we have	12	A. Yeah, it was part of you know, I was a DCM or a team
13	heard from him already. We know he was a DCM at this	13	leader before doing the role I did then and it was
14	point, wasn't he?	14	you know, I signed people up for urgent rule 40 at the
15	A. Mmm.	15	time. It was sort of yeah, that's just what we did.
16	Q. Were DCMs entitled to authorise rule 40 per your	16	Q. Fine. If we go to page 7, please, this is the first bit
17	understanding?	17	of the rule I just quoted. Under paragraph 9 again,
18	A. That was the standard working practice, yes.	18	it's rule 40:
19	Q. In any circumstances or in some circumstances?	19	"40(1) where it appears necessary in the interests
20	A. So generally rule 40 is invoked in two different ways.	20	of security or safety that a detained person should not
21	It's either a planned incident, where, for instance,	21	associate with other detained persons, either generally
22	a resident might be leaving on overseas removals the	22	or for particular purposes"
23	next day and there's the potential for disruption, so	23	Then it goes on to say the Secretary of State's
24	authority will be sought. So for any planned use of	24	powers. So when it is necessary for security or safety,
25	rule 40, a case is put to the Home Office and the	25	that doesn't include, does it, when it is necessary to
	Page 121		Page 123
	1 agc 121		1 age 125
		1	
1	Home Office will approve that use of rule 40.	1	avoid disruption to the regime?
1 2	Home Office will approve that use of rule 40. Generally, when a DCM or DOM is making that	1 2	avoid disruption to the regime? A. Significant disruption to regime would have
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2	Generally, when a DCM or DOM is making that	2	A. Significant disruption to regime would have
2	Generally, when a DCM or DOM is making that decision, it's based on the fact that they're in the	2	A. Significant disruption to regime would have a significant impact on safety in the centre.
2 3 4	Generally, when a DCM or DOM is making that decision, it's based on the fact that they're in the middle of managing an incident. So, you know, the	2 3 4	A. Significant disruption to regime would have a significant impact on safety in the centre. Q. Does disruption to the regime always engage the
2 3 4 5	Generally, when a DCM or DOM is making that decision, it's based on the fact that they're in the middle of managing an incident. So, you know, the ability is not there to go away and seek planned use of rule 40. Q. I wonder if we could have on the screen <cjs000676>.</cjs000676>	2 3 4 5	 A. Significant disruption to regime would have a significant impact on safety in the centre. Q. Does disruption to the regime always engage the necessity of the interests of security or safety being
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31 (Pages 121 to 124)

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1	Q. Do you think that that would fulfil your understanding	1	have authorised a full search, to make sure that, where
2	of what disruption means, for the purposes of this rule?	2	possible, we could reduce the risk of that person using
3	A. I can't make an assessment on whether it was because	3	that sort of item to hurt themselves.
4	I wasn't there at the time. The DCMs that attended that	4	Q. Do you know what information you'd have before you are
5	and managed that incident made a decision based on their	5	making that decision? So is it a conversation? Do you
6	assessment. I can't make a comment on what their	6	look at written records?
7	assessment was or wasn't.	7	A. Again, it depends on the situation. If you are in the
8	Q. But you'd agree, I think, as you have suggested, maybe,	8	centre, you've got access to written records and to the
9	it needs to be more than just disruption?	9	sort of database system, so you can go back and look at
10	A. It's whether it - you know, yes, it depends, you know.	10	history. If it's on the phone and you're oncall, you
11	Was there a belief that he could have gone back onto the	11	wouldn't necessarily have access to all of that data.
12	netting? Was there a belief that there could have been,	12	It might be that you have to make a decision based on
13	you know, other issues? I don't know. You know, it's	13	what you've got, the information you've got to hand, and
14	very much done on a risk assessment at the time.	14	not historical stuff. You generally would
15	Q. Mr Dix, in his evidence to the inquiry, on 9 March 2022,	15	I generally would have expected the DCM to give me a bit
16	alluded to a procedure at the time about so 2017	16	of a background on the history of the person.
17	where, if someone was on the netting, the procedure was	17	Q. Help me with the in the centre versus on the phone.
18	for them to go on rule 40. He wasn't sure if that was	18	Is that because, as DD, you might be at one of the other
19	the policy, but he said that, due to the level of	19	centres, even though you're the DD who is in charge?
20	disruption of him being on the netting, people do	20	A. Well, no, it might be at 2 o'clock in the morning.
21	generally go on rule 40, or he said E wing or CSU. Do	21	Q. So it's not always that, when you're the DD, you're
22	you remember that being the general kind of way things	22	there personally?
23	went?	23	A. No.
24	A. I don't remember at the time in that specific	24	Q. Okay.
25	incident. What I can say now is that it's very much not	25	A. No, so if you're duty director, you're on site for
			,
	Page 125		Page 127
1	the case that it's a default move, that someone goes on	1	a period of the day, but then you'd be on call at home.
2	the netting and then they instantly go onto rule 40.	2	Q. And there is no other duty director there? You're the
3	I've been duty director on call on numerous times when	3	duty director and you're on call?
4	people have got onto the netting and not gone onto	4	A. Yes.
5	rule 40, so it is very much situation based.	5	Q. Fine. In this circumstance, the full use of force forms
6	Q. And you don't remember about 2017, whether that was more	6	that we have been through in some detail with the people
7	common for people to go on rule 40 after going onto the	7	who were present and I appreciate that's not one of
8	netting?	8	you have different accounts, so some suggest that
9	A. I can't recall it was quite frequent, from what I can	9	there was an unknown object and some suggest quite
10	recall, of people going onto the netting. I can't say	10	clearly it was a phone battery that had been removed at
11	whether all of them went onto rule 40, whether some did.	11	the time, and so there was nothing on his person because
12	Q. Finally on this, you authorised a strip search which you	12	the phone battery was on the floor and, indeed,
13	discuss in your statement. Can you just help us with	13	I understand nothing was found after the full search.
14	again, I understand you can't remember the details of	14	Would you have looked at the sort of documents like
15	the exact assessment you made, but at the time, in what	15	that, so the use of force accounts of the people who saw
16	circumstances would you be able to authorise a strip	16	him at the time when he was holding the object?
17	search?	17	A. What, at the point of making the decision on the full
18	A. So a full search is, you know, we would authorise that	18	search?
19	based on if there's again, it's risk based. So it's	19	Q. Yes.
20	very much dependent on what's been reported to you at	20	A. Generally, the reports aren't written at that point.
21	the time, when someone is seeking your authorisation.	21	I don't know when the full search took place.
22	In relation to this incident, it would appear that there	22	Q. Yes.
23	was a significant concern that the person had something	23	A. You know, you're asked afterwards and, no, so you won't
24	about their person that they could have used to cause	24	always have those reports.
25	harm to themselves, so in that instance, yes, I would	25	Q. So you go with the sometimes verbal account of normally
	Page 126		Page 128

32 (Pages 125 to 128)

1	the person who is asking you, so Mr Dix in this	1	I don't recall having a signed MOU.
2	A. Yeah, so they will ring you for authorisation and they	2	Q. But you were told to act according to the unsigned, as
3	will give you an account and ask for your authorisation,	3	if it were
4	and if you're not content that there's enough	4	A. Yes. Yeah, I was told to act within the bounds of it,
5	information in there, then you can you know, you can	5	yes.
6	obviously turn around and say, "I don't want to	6	Q. Do you remember who told you to do that?
7	authorise it" or, "You need to come away and give me	7	A. It was there was a direction from the Home Office and
8	some more information that would allow me to justify	8	from senior leaders at Brook that that is how we
9	that".	9	should I should manage the relationship.
10	Q. Thank you. A question I should have asked earlier, when	10	Q. Who from the Home Office?
11	I was asking you about the last event, so when you	11	A. I believe it would have been Paul.
12	mentioned PPE being used	12	Q. Mr Gasson?
13	A. Yes.	13	A. Yes.
14	Q and the need to get kind of dressed up in PPE. It is	14	Q. You mention at 251:
15	another question about policy and what practice was. So	15	"My role was to manage the MOU. Ben Saunders,
16	I asked you about the netting and whether it was policy	16	Neil Davies and the Home Office set the agenda on how
17	to put people on rule 40 after that. I should have also	17	they wanted to manage the relationship and it was my
18	asked you, was it policy at the time that every time you	18	role to follow that through."
19	did a planned use of force, you had to use full PPE?	19	So the same people you have just mentioned there?
20	A. That was the working practice, yes.	20	A. (Witness nods).
21	Q. Is that still the case?	21	Q. You refer in your statement still on 251 to some
22	A. Pretty much, yes.	22	correspondence between yourself and Ms Pincus of GDWG
23	Q. Is that, like, a G4S/Serco policy? Do you understand it	23	A. Yes.
24	to come from somewhere else?	24	Q in which Mr Wilson and Steve Skitt and Paul Gasson
25	A. No, my understanding of it is that that's an HMPPS	25	are all copied in. I won't turn up the various reports
	Page 129		Page 131
	1 agc 127		1 agc 131
1	standard as set out in their manual, or the control and	1	unless you want to look at it, but the short version is
2	restraint manual. I think it I know Mr Collier's	2	Gatwick Detainee Welfare Group were requesting a room in
3	mentioned it, and I think it came as a bit of a surprise	3	which they could hold focus groups with detainees?
4	to a number of us when we read that recommendation.	4	A. Yes.
5	I think the working principle has always been that you	5	Q. I think the idea was to talk about and improve Gatwick
6	use PPE.	6	Detainee Welfare Group's work and you were the one who
7	Q. Okay.	7	refused it. You say in your statement that you
8	A. I think it alludes to the fact I think it mentions	8	recognise that was unhelpful?
9	about a risk assessment, but I don't know. I mean, we	9	A. I recognise the tone was. I think that specific one,
10	have tried to work through it. I don't know what sort	10	the email I sent back to Anna, said, "I have sought
11	of risk assessment you could do. So, yeah, generally,	11	guidance on this", so it wasn't my decision to refuse
12	PPE is always worn for a planned use of force.	12	it.
13	Q. I want to move on now to ask about your relationship	13	Q. That was going to be my next question. Whose decision
14	with the Gatwick Detainee Welfare Group. This is	14	was it?
15			
16	pages 56 and 57 of your statement from paragraph 250	15	A. I don't know who specifically made that decision in that
17	pages 56 and 57 of your statement from paragraph 250 onwards. So you first mention the memorandum of	15 16	A. I don't know who specifically made that decision in that case. I suppose, like I've sort of said, I did feel,
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18	onwards. So you first mention the memorandum of	16	case. I suppose, like I've sort of said, I did feel,
18 19	onwards. So you first mention the memorandum of understanding, so the MOU —	16 17	case. I suppose, like I've sort of said, I did feel, you know, very much like the middle man. I didn't set
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19	onwards. So you first mention the memorandum of understanding, so the MOU – A. Yes. Q. – at 250. We heard from Mr Gasson yesterday, who	16 17 18 19	case. I suppose, like I've sort of said, I did feel, you know, very much like the middle man. I didn't set the agenda for the relationship with Gatwick Detainee Welfare Group.
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19 20 21 22 23 24	onwards. So you first mention the memorandum of understanding, so the MOU — A. Yes. Q. — at 250. We heard from Mr Gasson yesterday, who believed that the MOU had been agreed, but your evidence, and indeed that of Gatwick Detainee Welfare Group, seems to be that it wasn't agreed. A. Yes, that's correct. I don't think I ever — so part of my remit was to look after third parties, or, you know,	16 17 18 19 20 21 22 23 24	case. I suppose, like I've sort of said, I did feel, you know, very much like the middle man. I didn't set the agenda for the relationship with Gatwick Detainee Welfare Group. Q. As to who set the agenda, is that the same people I have just mentioned? A. Yeah, and I think James Wilson references a conversation he had with Ben where Ben raised concerns and conversations with Paul and Neil and Steve Skitt.

33 (Pages 129 to 132)

1	A. Paul, Neil Davies, and then it turned into Steve Skitt.	1	A. It was still raised in — I mean, as you can see from
2	But I think, obviously, Steve you know, Steve, as	2	James's, yeah, they kept raising similar things.
3	a dep, would have taken a steer from Ben.	3	Q. Did you think that was fair?
4	Q. You were I don't want to say "middle man", but you	4	A. I think they I think the Home Office and G4S, in
5	were telling you were communicating with the GDWG but	5	supporting that, had a concern. Is it right that you
6	not always decisions that you'd made on your own?	6	keep raising the same thing? You know, I don't know.
7	A. Yes.	7	I think there were other things that were raised as
8	Q. You say, at 252, that the Home Office and Ben Saunders	8	well. From memory, I believe there was a concern raised
9	were concerned that the GDWG were trying to offer legal	9	that someone from Gatwick Detainee Welfare Group had
10	advice or create a surgery, and they felt that that	10	contacted us requesting multiple drop-ins because they
11	crossed a boundary.	11	were helping to manage someone's mental health and that
12	A. Yes. I think the sorry.	12	they needed to see that person to continue supporting
13	Q. No. Please.	13	them.
14	A. I think the view well, the view very much was that	14	Q. Yes.
15	Gatwick Detainee Welfare Group were there to provide	15	A. I think the concern was that they hadn't raised that
16	a social visit service for residents that didn't have	16	with G4S or with the Home Office, so I think that raised
17	anyone to come and see them. The drop-in sort of	17	some concerns at how — how are we supposed to safeguard
18	sessions were there to triage people, so they were there	18	that person in the centre when that information hasn't
19	as a sort of introduction for them to pair a suitable	19	been shared? You know, our healthcare department
20	volunteer with a suitable resident, to have social	20	wouldn't have known about it, we wouldn't have so
21	visits. Therefore, the view was that, why would you	21	I think that was one that I recall that I think was
22	need more than one visit in that drop-in surgery?	22	brought up as a concern. So I think those things
23	I think it's documented in some of James's bits that	23	combined, the Home Office and had an issue with.
24	there'd been a number of or, you know, G4S at the	24	Q. Just to be clear, when we refer to drop-ins, it's not
25	time and the Home Office raising concerns about the role	25	a drop-in in the normal sense of the word. So Gatwick
	-		
	Page 133		Page 135
1	Gatwick Detainee Welfare Group were taking with	1	Detainee Welfare Group obviously didn't have free access
2	residents in terms of supporting them with legal matters	2	to the centre?
3	and ultimately supporting them in preventing removal.	3	A. No.
4	Q. So, in terms of supporting them with legal matters,	4	Q. And neither did they have a room in which detainees
5	obviously Gatwick Detainee Welfare Group aren't a legal	5	could come and drop in similar to the sort of welfare
6	entity.	6	office that you do have at Brook House?
7	A. No.	7	A. Yes.
8	Q. There is no suggestion, I don't think, that they were	8	Q. It was a prearranged and prebooked room?
9	litigating on their behalf or providing legal advice.	9	A. Yes, it was like a prebooked room in the visits
10	Is this a reference to a witness statement that was made	10	corridor.
11	by a member of GDWG in 2015? Were you aware of that?	11	Q. And they would have to say who they were meeting in that
12	A. Yeah, I think that's what kept being referenced, yes.	12	room. It wasn't drop in for anyone. The difference,
13	Q. This was a detainee who was mentally unwell. The GDWG	13	I think, from a normal visit, is that instead of being
14	member of staff provided a witness statement about his	14	in the public, kind of, big room of the visits hall, it
15	presentation?	15	was a private room?
16	A. Mmm.	16	A. Yeah, it wasn't a social visit in the social visits
17	Q. And he was ultimately, I understand, released from	17	area. It was in a small, contained room.
18	detention and, indeed, there was a claim that was	18	Q. Yes, and detainees could have one of those private
19	successful or was settled, maybe, for unlawful	19	visits to ascertain the sort of support they'd need, who
20	detention?	20	might visit them, et cetera?
21	A. Yeah, I don't know the details of that 2015 one.	21	A. Yes.
22	Q. But it was mentioned?	22	Q. Then they would be allocated a visitor to see in the
23	A. Yes, it's in there.	23	visits hall. Sometimes, as you say, Gatwick Detainee
24	Q. People up to 2018, according to Mr Wilson, were still	24	Welfare Group would ask for a second drop-in, a second
25	talking about it and raising it as a	25	visit?
	Page 134		Page 136
			24 (Dagge 122 to 126)

34 (Pages 133 to 136)

1	A. Yes.	1	drop-ins, yes.
2	Q. We have seen examples of them saying it might be because	2	Q. So they were empty threats?
3	someone shared something concerning on their first	3	A. I would have been surprised if they'd taken away they
4	session, they wanted to discuss it again in private and	4	might not have been. I don't know.
5	the busy visits room wasn't the place to do it, they	5	Q. They weren't, as we understand it, in 2017, but do you
6	hadn't had a full assessment of their needs. That's	6	know whether these discussions or threats to remove the
7	reasonable, isn't it?	7	drop-ins were made not just internally between G4S and
8	A. I don't disagree. But was that - I think where the	8	the Home Office, but actually GDWG were aware of them?
9	concern would be is, was that information shared where	9	Because Mr Wilson recalls being at a meeting he
10	there was a first concern, or were Gatwick Detainee	10	doesn't say you were there with Mr Gasson and
11	Welfare Group keeping that information to themselves and	11	Mr Skitt, where he was told they'll be taken away?
12	managing that resident without sharing it to anyone	12	A. Yeah, I wasn't at that meeting. I was on leave. So
13	else? Because that is really risky. Because what's to	13	I don't know what took place. Obviously what James has
14	say that that resident doesn't go back to his room and	14	provided, he says that, that that's what was said.
15	try to harm himself and we haven't put around the sort	15	Q. But you recall there were discussions at the time about
16	of safeguarding that we should do. So I think that's	16	potentially removing the drop-ins?
17	it was little incidents like that I think were	17	A. Yes, but I don't think they would have been taken away.
18	raising the concern profile.	18	Q. You don't know whether GDWG were made aware or how they
19	Q. Was that shared with Gatwick Detainee Welfare Group, in	19	were made aware that might happen?
20	your view, adequately? Were they told, "The reason we	20	A. No.
21	are worried about these repeated visits is because we	21	Q. I want to ask about your role on complaints now. So you
22	really want you to tell us when you have a concern about	22	describe this at page 11, paragraph 185 onwards, and you
23	a detainee", or were they told, you know, "We have	23	say you oversaw the complaints clerk at Brook House. We
24	agreed one visit per person and that's all you're	24	saw it at the start of your evidence on the organogram.
25	having"?	25	Was that Karen Goulder?
	D 407		D 400
	Page 137		Page 139
1	A. I can't really recall in really great detail those	1	A. Karen.
2	visits that - sorry, those meetings that I attended.	2	Q. In brief, what did your complaints role entail?
3	I believe they were raised, and I believe we were saying	3	A. So it ensured that the process it was there to ensure
4	to James, "Look, you know, those were some of	4	that the process within the sort of DSO was followed, so
5	the concerns we were having". I know James references,	5	it was there to ensure that the complaints we received
6	you know, the 2015 and, you know, references similar	6	from the Home Office on DCF9s were investigated and
7	things being brought up, but that's where the concern	7	responded to and then shared, obviously, with relevant
8	was emanating from, and the concern also was that some	8	people.
9	of the activities that they wanted to get into were very	9	Q. Did you decide who would investigate any given
10	much in conflict with the Home Office priority to remove	10	complaint, or did Karen?
11	people.	11	A. Not generally. It generally wasn't Karen or I that
12	Q. What sort of activities?	12	decided. The general process was that the complaint
13	A. In terms of offering legal support, so putting them in	13	would go to the relevant functional head. So if it was
14	touch with legal providers, providing evidence for case	14	a complaint about something that was happening in
15	notes, bits and pieces like that, I think is what the	15	residential, it would go to Jules for him to decide who
16	concern was.	16	would look at it; if it was a complaint that related to
17	Q. It was contrary to the Home Office's desire to remove	17	property and reception, it would go to the functional
18	people?	18	head for that area.
19	A. I mean, that's my own opinion. I can't speak for the	19	Q. I see. Did you have training on how to manage the
20	Home Office or, you know, what Paul was, but that's	20	complaints system or
21	definitely the feeling I had.	21	A. No.
22	Q. You say, at 255, you think there were discussions around	22	Q handling complaints? Did Karen, do you know?
23	removing the drop-ins but you don't think it would have	23	A. Karen, no, I don't no, there was no we weren't
24	actually occurred?	24	trained on it.
25	A. I would have been shocked if they'd taken away the	25	Q. Were complaints and the responses to them audited or
ı			
	D 400		Th. 4.40
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35 (Pages 137 to 140)

1	quality checked by anyone?	1	comes.
2	A. So I did a 10 per cent audit of complaints, looking at	2	Q. So Sarah Newland, deputy director?
3	whether they fell in line with the DSO. Karen would	3	A. Sarah Newland chairs, and then it's generally I've
4	then send the results of those quality checks out to	4	forgotten their titles now. The operations manager
5	everyone.	5	it's Natasha Barber from the Home Office, generally,
6	Q. The departmental heads?	6	that comes along and other ADs and Steve Hewer often
7	A. Yes, sorry, to the relevant person or the person that	7	comes along.
8	had completed that complaint for sort of, like,	8	Q. Do you look at what happened in the previous set period
9	a lessons learned or, like, sharing of practice. And	9	of time and how do you get an idea of the longer scope?
10	then all the complaint responses were shared back with	10	A. It is an ongoing spreadsheet. It just keeps being added
11	the Home Office, so they were all sent back to their	11	to. So it's not a snapshot of a time period, it is
12	central team.	12	a consecutive like a continuous record.
13	Q. We have heard evidence from Mr Darren Tomsett you	13	Q. Going back to complaints as they were in 2017, just
14	have been provided with, I think, just the relevant page	14	briefly, obviously you have a population who move
15	from his evidence on the topic.	15	around, might leave the centre?
16	A. Yes.	16	A. Mmm.
17	Q. He says, and about him is said, 13 complaints were made	17	Q. What could you or Ms Goulder or any of the people
18	over a three-year period and he was asked, at any stage	18	investigating the complaints do if there's a complaint
19	during those three years, did anyone, not just look at	19	but they can't fully investigate it before the detained
20	the individual complaints, but take a step back and say,	20	person has left?
21	"Mr Tomsett, you have had 13 complaints over this period	21	A. Sometimes it was difficult. We always tried to make
22	of time", and he said no. Did a certain number of	22	contact if we could. So if they'd moved to another
23	complaints against someone trigger any kind of broader	23	centre, we would try and make contact with them there.
24	consideration of what's going on?	24	If they'd been released and there was no address, then
25	A. So there wasn't a system in place for that. There is	25	it was difficult to make contact. Or obviously, if they
	Page 141		Page 143
1	now, and rightly so, and it's monitored really closely.	1	had been removed. So we would yeah. If someone had
2	So we share we have, like, a cultural spreadsheet	2	left and there was no forwarding address, we would still
3	that we share with the Home Office and the SMT and that	3	investigate it and we would still write an outcome to
4	will capture a number of different indicators, but it	4	that investigation and we would still send it back to
5	captures resident complaints, staff complaints,	5	the Home Office. We just couldn't inform the resident
6	grievances, number of uses of force that a potential	6	that there'd been an outcome.
7	individual has taken on. We meet every two weeks to	7	Q. Or hear their account, potentially, if they have left?
8	sort of review that and to look at that. So, yeah,	8	A. Or potentially hear their account. Generally, the
9	there was nothing in place at the time. But	9	accounts are fairly descriptive that they write on the
10	post Panorama, and in the new contract with Serco,	10	DCF9s.
11	there's a lot more scrutiny on it, so it wouldn't be	11	Q. Right.
12	allowed to happen again.	12	A. So you would have to go by that.
13	Q. In relation to the cultural spreadsheet with those data	13	Q. I want to ask you about a specific event. So this is
14	that you mentioned, when did that come into place?	14	your involvement with Mr Instone-Brewer and Mr Fagbo's
15	A. It started to come into place after Panorama. It was	15	disciplinary. The inquiry has seen notes of the 2017
16	part of the Panorama action plan. I think it was the	16	interview with Michelle Brown and you have been asked
17	dep that was that had oversight of that. So all the	17	about it in your statement. She was asked, "Can you
18	sort of relevant complaints were shared and we started	18	tell any more about Mr Instone-Brewer and Mr Fagbo?",
19	to look at it. It's been refined quite significantly	19	and she said:
20	since Serco have taken over.	20	"I think, during 2016, a detainee made a complaint
21	Q. You say you meet every two weeks?	21	against them for poor behaviour, bullying and
l	A. Now we do, yes.	22	inappropriate behaviour which was substantiated.
22	•	1	DCO James Begg investigated and reported to
22 23	Q. Who is at those meetings?	23	De o vames Degg investigated and reported to
		23 24	Jules Williams. It was due to go to disciplinary but
23	Q. Who is at those meetings?	1	
23 24	Q. Who is at those meetings?A. It's chaired by the dep director, Sarah, and the	24	Jules Williams. It was due to go to disciplinary but

36 (Pages 141 to 144)

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1	disciplinary was paused. The grievance took 8 months.	1	A. No, if there was a resident complaint of bad behaviour
2	Stacie Dean was allocated to it but she fell ill.	2	that had been investigated as part of the complaints and
3	Caz Dance-Jones heard it in November 2016 and it was	3	substantiated, that would have then generated, sort of
4	partially substantiated. Dan Haughton had been given	4	within G4S, its own internal sort of disciplinary
5	the disciplinary to do but he forgot to do it."	5	procedure.
6	So according to Ms Michelle Brown, you were supposed	6	Q. Who was in charge of the disciplinary process?
7	to investigate and she says you forgot and she says in	7	A. I mean, it was co-ordinated by senior managers and HR,
8	her recent statement to the inquiry that when she asked	8	so you would have had someone would have said, "This
9	you about these circumstances, you said that the	9	isn't appropriate, I'll issue terms of reference for an
10	investigations didn't occur due to absences and failures	10	investigation". You would have gone through
11	in managing DCO Fagbo's absence. I understand that you	11	a disciplinary hearing and more fact finding, more
12	say you talked about you sorry, it is not the	12	evidence collation. That would generate an outcome or
13	first time you have heard about her saying you forgot,	13	a report to say what the findings were. That report
14	is it?	14	would then be issued to someone to have an outcome, be
15	A. No.	15	that disciplinary, be it no further action, be it
16	Q. You heard that much closer to the time?	16	whatever the action might be.
17	A. She mentioned it, I suppose, there, and I can't remember	17	Q. It could have been someone at your level to whom it was
18	in what setting, I don't know if it was in a meeting or	18	issued to deal with it, but it could have been somebody
19	it was coming out of something. I remember $\mathbf{m}\mathbf{y}-\mathbf{all}$	19	else at your level; is that right?
20	I can recall is my initial gut instinct and my reaction,	20	A. Yeah, I mean, it could have been for the
21	and I won't I said to her, "I don't think I don't	21	investigation, it could have been a DCM that was
22	think you're right". I might not have used that	22	investigating and then it would have come to a senior
23	language. But I remember being quite surprised.	23	manager to do the disciplinary.
24	I didn't recall having it at the time when she mentioned	24	Q. I see. That's the only thing I wanted to ask you on
25	it. It felt like yeah, it felt like she was blaming	25	that. Now, I want to turn to your reaction to Panorama,
	Days 145		Daga 147
	Page 145		Page 147
1	me for forgetting something that I had no knowledge of.	1	so I assume you watched it?
2	I find it looking at it now, I can't recall it.	2	A. I did.
3	I can't recall being issued it to complete. I find it	3	Q. You have watched some of the evidence, I understand, so
4	surprising or hard to believe that a grievance or	4	far given to this inquiry?
5	a disabilinary autooms that would have been issued to me		
	a disciplinary outcome that would have been issued to me	5	A. Yes.
6	by a senior manager or by HR had just been allowed to	5 6	A. Yes.  Q. What's shown on the footage and what we have heard so
6	by a senior manager or by HR had just been allowed to not take place, because that wasn't a common thing. So, surely, if I'd been issued a pack and given an	6 7 8	Q. What's shown on the footage and what we have heard so far paint a picture of a negative culture at Brook House at the time. We see things like swearing and
6 7	by a senior manager or by HR had just been allowed to not take place, because that wasn't a common thing.	6 7	Q. What's shown on the footage and what we have heard so far paint a picture of a negative culture at Brook House
6 7 8	by a senior manager or by HR had just been allowed to not take place, because that wasn't a common thing.  So, surely, if I'd been issued a pack and given an instruction to complete a disciplinary, there would have been a catch-up or a check-in to say, "How are you	6 7 8 9 10	Q. What's shown on the footage and what we have heard so far paint a picture of a negative culture at Brook House at the time. We see things like swearing and disrespectful language used towards detainees, a lack of understanding of people in crisis, perhaps, as well as
6 7 8 9	by a senior manager or by HR had just been allowed to not take place, because that wasn't a common thing. So, surely, if I'd been issued a pack and given an instruction to complete a disciplinary, there would have	6 7 8 9 10	Q. What's shown on the footage and what we have heard so far paint a picture of a negative culture at Brook House at the time. We see things like swearing and disrespectful language used towards detainees, a lack of
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6 7 8 9 10	by a senior manager or by HR had just been allowed to not take place, because that wasn't a common thing.  So, surely, if I'd been issued a pack and given an instruction to complete a disciplinary, there would have been a catch-up or a check-in to say, "How are you getting on with that disciplinary, Dan?" Or at the	6 7 8 9 10 11 12 13	<ul> <li>Q. What's shown on the footage and what we have heard so far paint a picture of a negative culture at Brook House at the time. We see things like swearing and disrespectful language used towards detainees, a lack of understanding of people in crisis, perhaps, as well as the more tangible acts of abuse that we see as well.</li> <li>A. Mmm.</li> <li>Q. We have heard and seen staff who were overworked and</li> </ul>
6 7 8 9 10 11 12 13 14	by a senior manager or by HR had just been allowed to not take place, because that wasn't a common thing.  So, surely, if I'd been issued a pack and given an instruction to complete a disciplinary, there would have been a catch-up or a check-in to say, "How are you getting on with that disciplinary, Dan?" Or at the point I said, "Oh, I forgot about that", I would have	6 7 8 9 10 11 12 13 14	<ul> <li>Q. What's shown on the footage and what we have heard so far paint a picture of a negative culture at Brook House at the time. We see things like swearing and disrespectful language used towards detainees, a lack of understanding of people in crisis, perhaps, as well as the more tangible acts of abuse that we see as well.</li> <li>A. Mmm.</li> <li>Q. We have heard and seen staff who were overworked and felt understaffed. Was this the same as your impression</li> </ul>
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37 (Pages 145 to 148)

olace to 3 ave 4	getting it, and we produced a programme where existing staff would attend the ITC to also get it. So we were upskilling not only the new staff, but the existing
place to 3 ave 4	upskilling not only the new staff, but the existing
ave 4	
	staff, and we tried to prioritise the sort of E wing and
5	CSU staff because that's obviously where it is. But,
- you 6	again, that training acts you know, it is about
tuff that 7	identifying risk with a person and with yourself, so it
	helps you identify mental health concerns with your
	colleagues and yourself so you can look after yourself,
	but it also helps increase your understanding of certain
1	mental health conditions, and it gives you a bit more of
	an insight into the triggers or the signs to look out
	for.
	Q. I know you can't train everyone at once, but is that
	going to be mandatory?
	A. It is now.
17	Q. It is mandatory?
	A. As far as I believe, it's mandatory now. It's part of
as 19	the ITC.
morning. 20	Q. Have you been able to assess the efficacy of that? Do
nd 21	people feel it's helped them to, as you say, identify
ed an 22	concerns?
ie sort of 23	A. I think well, especially for my role now, I believe
iplete. 24	the staff group are brilliant at raising concerns about
cussed 25	vulnerabilities, including mental health. We have done
	Page 151
	so much work around vulnerabilities. It's still not
	we can still do more, we always can, but we get staff
	raising concerns really early about people they're
	concerned about for a number of different reasons, be it
	a withdrawal from regime or sort of a change in
	behaviour. We monitor it. We have got weekly, sort of,
	vulnerability meetings where we manage our sort of real
	risky people. So I think it has had an impact. Does it
	still you know, we look after, at Brook House, some
line in 10	mentally unwell people. You know, we look after people
11	that are on section. Are staff adequately trained to
12	properly manage someone who is under a section? No.
13	But they would need to be clinically trained in order to
e 14	do that. They do an amazing job and have some amazing
Iealth 15	results. In the last year or two, there's a number of
I've 16	different residents that have had very good outcomes
17	based on the staff interaction with them, but they are
18	not clinical staff.
ourse. 19	Q. You rely on the clinical staff that you have there as
20	well?
did 21	A. We rely on the clinical team, yeah, to give us a steer
r bits 22	in how best to try and look after them.
sent us 23	Q. Do you think that your staff are getting an appropriate
n. 24	steer from that team?
vere 25	A. I think it's a lot better than what it was. There's
	delivered   18 as -   19 morning.   20 as -   19 morning.   20 and   21 ed an   22 as exert us   25 as -   24 as -   25 as exert us   26 as -   26

38 (Pages 149 to 152)

1	a lot more multi-disciplinary working that goes on and	1	so it — you know, you naturally — I think you
2	a lot more input from healthcare and the clinical side,	2	naturally lose more people than most industries.
3	yes.	3	I think Serco have improved conditions for staff, but
4	Q. You have said you acknowledge Brook House isn't	4	I think you will always have, you know, conflicts with
5	perfect, you can always do more. You're now assistant	5	pay can you get paid more in other less-pressurised
6	director. If you had to identify a couple of things	6	roles? — and that — I think that drives some of
7	that are next on your list for what you want to achieve	7	the recruitment or some of the retention issues.
8	to continue to improve, what would they be?	8	THE CHAIR: Thank you very much. I have no other questions
9	A. In my remit? The things I'm focusing on at the moment	9	for you. Thank you very much. I know you have been
10	is the care plans for ACDTs and making sure that they	10	with us for a long time today but I'm very grateful for
11	are more holistic and there's better support in there	11	your evidence.
12	for the residents to try and manage their risks. We are	12	A. Not at all.
13	looking at Adults at Risk and trying to really improve	13	(The witness withdrew)
14	staff's basic knowledge of it. It's better than what it	14	MS MOORE: Chair, it is 2.50 pm. If we return at 3.05 pm
15	was. So that's part of a new document and DSO that we	15	for the evidence of Mr Cheeseman.
16	are rolling out called vulnerable adult care plans. So	16	THE CHAIR: Thank you very much.
17	they're - yeah, ACDT care maps, AAR, Adults at Risk,	17	(2.50 pm)
18	and also just looking at — we are just trying to raise	18	(A short break)
19	the profile of safeguarding, really, at the moment.	19	(3.08 pm)
20	MS MOORE: Thank you. I don't have any more questions for	20	MS SIMCOCK: Chair, the witness this afternoon is
21	you, Mr Haughton. The chair may have a question or two	21	Mr Ian Cheeseman.
22	for you.	22	MR IAN CHEESEMAN (affirmed)
23	•	23	Examination by MS SIMCOCK
	THE CHAIR: Thank you, Mr Haughton. Just a couple of very	23	· · · · · · · · · · · · · · · · · · ·
24	brief ones about how things are in Brook House now.		MS SIMCOCK: Can you give your full name to the inquiry,
25	A. Sure.	25	please?
	Page 153		Page 155
,	O C THE CHAID		A X7 144 X 60
1	Questions from THE CHAIR	1	A. Yes, it's Ian Cheeseman.
2	THE CHAIR: What's the minimum number of DCO staff that you	2	Q. Mr Cheeseman, you made a witness statement for the
2 3	THE CHAIR: What's the minimum number of DCO staff that you have on the wings at the moment?	2 3	Q. Mr Cheeseman, you made a witness statement for the purposes of the inquiry, and the reference is
2 3 4	THE CHAIR: What's the minimum number of DCO staff that you have on the wings at the moment?  A. It's — I believe it's three on the wing and one for	2 3 4	Q. Mr Cheeseman, you made a witness statement for the purposes of the inquiry, and the reference is <hom0332154>. I'm going to ask you about some of</hom0332154>
2 3 4 5	THE CHAIR: What's the minimum number of DCO staff that you have on the wings at the moment?  A. It's — I believe it's three on the wing and one for courtyard. So there's four officers to manage the wing	2 3 4 5	Q. Mr Cheeseman, you made a witness statement for the purposes of the inquiry, and the reference is <hom0332154>. I'm going to ask you about some of the topics within that statement, but because I'm going</hom0332154>
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39 (Pages 153 to 156)

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1	was mainly policy work, yes.	1	Brook House.
2	Q. You were a policy advisor and you say that you did not,	2	Q. If you can remember, which stakeholders would you have
3	therefore, have operational functions or direct roles	3	met with?
4	specific to the Brook House Immigration Removal Centre	4	A. There were a range of stakeholder meetings. They're
5	during the relevant period; is that right?	5	detailed in one of the appendices to the to
6	A. That's correct.	6	Stephen Shaw's report. I would have attended a number
7	Q. You again say that you were a policy advisor in the	7	of these. The only one I can remember with any
8	Home Office unit responsible for, among other things,	8	accuracy, the name of the organisation was Women for
9	policy concerning those deemed to be vulnerable in	9	Refugee Women.
10	a detention context; is that right?	10	Q. Did you take steps to inform yourself with an
11	A. Correct.	11	understanding of what the Home Office already knew about
12	Q. A principal responsibility in this context was the	12	problems within immigration detention as it related to
13	framework for developing Home Office policy on making	13	vulnerable people prior to taking up this role?
14	operational decisions on whether to detain an individual	14	A. It happened very quickly. So I think there was only
15	or to continue to detain an individual considered to be	15	possibly a week's pause between me finding out that
16	vulnerable; is that right?	16	I was going to be doing the Shaw review and actually
17	A. Yes.	17	starting. So there wasn't a lot of time to immerse
18	Q. That was the main role that you had prior to your	18	myself in the detail of immigration detention. But
19	retirement?	19	Stephen Shaw was a good teacher and I learned quickly.
20	A. Yes.	20	Q. Because it would have been important to understand why
21	Q. You also, you tell us in your statement, were involved	21	the Shaw review was necessary, wouldn't it?
22	on a secondment to the Shaw review; is that right?	22	A. Oh, I understood that, certainly.
23	A. Yes, it is.	23	Q. What did you understand as to why it was necessary?
24	Q. You were part of his team seconded from the Home Office.	24	A. My understanding was that there had been concerns
25	Do you know why you, in particular, were suggested for	25	growing over a period of time about the provision of
	Page 157		Page 159
1	this role or did you volunteer?	1	welfare for immigration detainees, and specifically the
1 2	this role or did you volunteer?  A. I was working in asylum policy at the time. I had	1 2	welfare for immigration detainees, and specifically the Home Secretary at the time was responding to those
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2		2	
2	A. I was working in asylum policy at the time. I had worked there for about six years, I think. And,	2	Home Secretary at the time was responding to those concerns by requesting asking Mr Shaw to carry out
2 3 4	A. I was working in asylum policy at the time. I had worked there for about six years, I think. And, usually, in the Civil Service, you move around from time	2 3 4	Home Secretary at the time was responding to those concerns by requesting asking Mr Shaw to carry out a review.
2 3 4 5	A. I was working in asylum policy at the time. I had worked there for about six years, I think. And, usually, in the Civil Service, you move around from time to time. And I just needed a new challenge. I put my	2 3 4 5	Home Secretary at the time was responding to those concerns by requesting asking Mr Shaw to carry out a review.  Q. Were you aware of rulings in article 3 cases in the
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40 (Pages 157 to 160)

1	the policy, such that mentally ill detainees would	1	basis for them for the purposes of informing policy
2	remain in detention if they could be satisfactorily	2	formulation for the Adults at Risk policy; is that
3	managed? Do you think you were aware of that issue at	3	right?
4	the time?	4	A. Yes, absolutely.
5	A. I don't recall as a specific issue.	5	Q. The formulation of that policy, the Adults at Risk
6	Q. The court had ruled that the Home Office was required to	6	policy, was primarily your responsibility; is that
7	do an equality impact assessment. They didn't, and,	7	right?
8	instead, the Tavistock review was announced and then the	8	A. Yes. I was working in the policy team that was
9	Shaw review. Were you aware of the Tavistock review and	9	responsible for taking forward certain of Mr Shaw's
10	the Shaw review being in response to these cases of	10	recommendations, primarily numbers 7 to 16, I believe,
11	litigation, at least in part?	11	or 9 to 16.
12	A. I can't say that I necessarily knew that connection.	12	Q. 9 to 16, I think you say in your statement.
13	I may have at the time, but it wasn't a kind of major	13	A. 9 to 16.
14	element in my role in the Shaw review.	14	Q. We will come to those in a moment.
15	Q. Were you aware, prior to starting, of the parliamentary	15	A. Yes.
16	inquiry in 2015?	16	Q. Shaw found that there were systemic failings in the
17	A. I can't remember.	17	rule 35 process. He had said that it didn't do what it
18	Q. Because that inquiry had identified, amongst other	18	was intended to do, which was to protect vulnerable
19	things, inadequate health screening, inadequate	19	people. Were you aware of that as a key finding at the
20	healthcare, and safeguards for identifying vulnerability	20	time?
21	and mental ill-health and defects in the rule 35	21	A. Yes.
22	process. Were you aware of those as issues that had	22	Q. He considered that the cause of that finding was a lack
23	been identified prior to the Shaw review?	23	of trust by the Home Office in the GPs completing the
24	A. I can't say that I was aware within the context you've	24	rule 35 reports and in the system itself that the
25	just described.	25	Home Office had created. Were you aware of that?
	Page 161		Page 163
1	Q. Were you aware at the time that the Home Office response	1	A. I don't remember that specifically, but, you know,
2	to the parliamentary inquiry was that they would address	2	I accept that that is the case.
2	to the parliamentary inquiry was that they would address those issues in the Shaw review?	2	I accept that that is the case.  Q. Did you agree with it?
2 3 4	to the parliamentary inquiry was that they would address those issues in the Shaw review?  A. I may have been, but I can't remember at this distance	2 3 4	I accept that that is the case. Q. Did you agree with it? A. I'm not sure that I personally would have had the
2 3 4 5	to the parliamentary inquiry was that they would address those issues in the Shaw review?  A. I may have been, but I can't remember at this distance of time.	2 3 4 5	I accept that that is the case.  Q. Did you agree with it?  A. I'm not sure that I personally would have had the evidence to agree or disagree at that point.
2 3 4 5 6	to the parliamentary inquiry was that they would address those issues in the Shaw review?  A. I may have been, but I can't remember at this distance of time.  Q. If you weren't aware at the time, given you were the	2 3 4 5 6	<ul> <li>I accept that that is the case.</li> <li>Q. Did you agree with it?</li> <li>A. I'm not sure that I personally would have had the evidence to agree or disagree at that point.</li> <li>Q. Mr Shaw said that training or redesigning the rule 35</li> </ul>
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41 (Pages 161 to 164)

1	Q. He recommended, as a result, that key categories of	1	an insurance that far fewer vulnerable people were
2	vulnerability should be retained but that a further	2	segregated or, indeed, detained initially if they were
3	clause should be added to the list that was in place at	3	going to be subject to segregation whilst in detention?
4	the time to reflect the dynamic nature of vulnerability	4	A. I can see your point and that may well be the case, but,
5	and thus encompass persons otherwise identified as being	5	as I said, the purpose of the policy was to provide
6	sufficiently vulnerable that their continued detention	6	a framework for making decisions I described. You could
7	would be injurious to their welfare and that such	7	argue that the policy should have gone wider than that
8	a clause also would be helpful in relation to those with	8	and dealt with other issues. But
9	a disability. Presumably, you appreciated that	9	Q. Did you think it should have done?
10	recommendation at the time?	10	A. I didn't consider that.
11	A. Yes, indeed.	11	Q. Do you now think it should have done?
12	Q. He had also found that there was a failure by	12	A. I don't have a view.
13	Home Office staff to appreciate the difficulties faced	13	Q. The Shaw review also there was a sub-review by
14	by people suffering from PTSD and to recognise that	14	Jeremy Johnson of counsel in relation to article 3 cases
15	detention can be re-traumatising. Was that something	15	which found that common features among the article 3
16	that you were aware of as a finding at the time?	16	cases going through the courts included as serious
17	A. Yes.	17	mental illness was not identified or treated,
18	Q. Professor Bosworth carried out a literature review in	18	deterioration in detention leading to severe mental
19	relation to the Shaw review. That literature review	19	illness and also incidents of use of force or
20	found that detention, of itself, was harmful to those	20	segregation inappropriately which related to systemic
21	with vulnerabilities and mental health and Mr Shaw in	21	issues as to failures or breach of policy and couldn't
22	his review accepted those findings. Were you aware of	22	simply be ascribed to individual decision makers. Were
23	that at the time?	23	you aware of that conclusion?
24	A. Yeah, I think there was a general acceptance that	24	A. I'm sorry, that was rather long. Would you mind
25	detention had the potential to impact negatively on	25	repeating it?
23	determine the potential to impact negatively of		repening iv
	Page 165		Page 167
1	people, particularly those with mental health	1	Q. Of course. So a sub-review was conducted into article 3
2	conditions.	2	cases. That found that there were certain common
3	Q. Shaw was also particularly concerned that segregation	3	features to a number of those cases. The first was that
4	may, on occasions, become the default location for those	4	serious mental illness had not been identified or
5	with serious mental health problems, and without mental	5	treated. Were you aware of that?
6	health care, which he said was not consonant with	6	A. Not explicitly, no.
7	detainees' welfare and may represent cruel and unusual	7	Q. Secondly, the review found that, in a number of cases,
8	punishment. He found segregation facilities were not	8	there had been a deterioration in detention leading to
9	suitable for any detainees with a serious mental health	9	severe mental illness. Were you aware of that?
10	condition. Were you aware of that at the time?	10	A. Again, I may well have been at the time, but I can't
11	A. Yes, but it wouldn't have been something that I majored	11	remember considering that at the time.
12	on because it wasn't directly related to the policy work	12	Q. Importantly, Mr Johnson's review concluded that there
13	I undertook subsequently.	13	were systemic issues as to a failure or breach of policy
14	Q. Didn't you think that the fact that segregation was	14	and that those features couldn't solely be ascribed to
15	found to be unsuitable for vulnerable detainees with	15	individual decision makers. Were you aware of that,
16	serious mental health conditions was relevant to an	16	that there was a systemic element?
17	Adults at Risk policy?	17	A. I'm not sure, to be honest. A systemic element in terms
18	A. The purpose of the policy was to provide a framework for	18	of decision makers —
19	making decisions about the detention, or ongoing	19	Q. In terms of failures or breaches of policy, not
20	detention, of vulnerable people. The segregation policy	20	individual failures?
21	was an operational issue.	21	A. I'm aware of the fact that, under the policy that
22	Q. But wasn't it important to know and to consider, when	22	existed at the time in respect of decisions on detention
44	and the state of a state of the	23	of vulnerable people, there was inconsistency of
23	making detention decisions, that if mentally unwell		
	detainees were being segregated, and that had particular	24	application because of the wording of the policy, and
23	•	24 25	application because of the wording of the policy, and that was what the Adults at Risk policy was partly, at
23 24	detainees were being segregated, and that had particular		

42 (Pages 165 to 168)

1	least designed to address. So in terms of	1	
2	least, designed to address. So, in terms of	2	responsibility for the operation of the policy that
	inconsistency, certainly, yes, I was aware of that, but	3	preceded the Adults at Risk policy. But after the
3	systemic, I can't speak to that, I don't think.	4	Adults at Risk policy had been implemented, then if
4	Q. As you've mentioned in your witness statement at	5	I saw a case, I would go to the line managers.
5	paragraph 5, you were responsible for developing the		Q. You say "if you saw a case"?
6	Home Office policy on operational decisions on whether	6	A. Yes.
7	to detain, and to continue to detain, someone who was	7	Q. How would the case come to your attention?
8	considered to be vulnerable. Would that policy	8	A. There may be circumstances in — well, there are two
9	development involve drawing on lessons learned from	9	circumstances, mainly, I think. First of all, if
10	casework experience?	10	a casework team was unsure about how to manage
11	A. Yes. I mean, certainly the development of the policy	11	a particular case, and especially in the early days of
12	involved operational colleagues and would have taken	12	the policy, they would come to my team for advice on,
13	into account the practicalities of decision making and	13	for example, the level of the policy the individual
14	the experiences of decision making.	14	should be placed at, and there would be other
15	Q. Would the policy development also have included drawing	15	circumstances later on where we may be may have been
16	on lessons learned from previous litigation?	16	reviewing the management of cases to do audits of it,
17	A. Obviously, we were keen not to develop a policy that	17	for example in order to develop policy further, when
18	would fall foul of the law, and so the policy would have	18	I would have seen cases that I would have kind of
19	been checked by lawyers to that effect.	19	questioned.
20	Q. Would it have involved learning on lessons from	20	Q. Where there was a failure to implement policy or
21	inspections by independent oversight bodies such as	21	a policy was wrongly construed, who is that information
22	HMIP, IMB or the ICIBI?	22	fed back to?
23	A. Yes, we would have been aware of most or if not all	23	A. Sorry, by me, you mean?
24	things that would have had a relevance or a bearing on	24	Q. Yes. Well, by who and to who?
25	it. So views of NGOs and views of external bodies.	25	A. Oh, I see. Well, it would depend. I mean, there were
	Page 169		Page 171
1	Q. So you would have taken all of those things into account	1	various caseworking areas in the Home Office, and still
2	when formulating the policy for the protection of	2	are, I presume, and I had contacts in each of them at
3	vulnerable detainees?	3	a fairly senior level. So if I saw a case that gave me
4	A. Yes, in the broadest sense, yes.	4	pause, then I would speak to my contact in that area and
5	Q. In looking at some of those in a little more detail,	5	leave it to them to engage with the relevant casework
6	then, and how the policy was formulated, what process	6	team.
7	was in place to feed back to individual decision makers	7	Q. Were you taking proactive steps to make sure you were
8	the findings of article 3 mistreatment by a court or	8	aware of relevant cases?
9	failures to implement policy lawfully leading to	9	A. There were, in each of the caseworking areas, individual
10	unlawful detention? What was the process of feeding	10	senior managers with responsibility for safeguarding
11	those outcomes back to the people making the decisions?	11	matters and responsibility for oversight and audit of
12	A. Are you talking pre Adults at Risk policy or after that	12	those the operation of the caseworking team would
13	was implemented?	13	fall to them. Sorry, I may have forgotten your
14	Q. Well, pre or post?	14	question.
15	A. I think the answer is going to be the same, actually.	15	Q. Were you taking proactive you said
16	Forgive me. All I can talk about is what I would have	16	A. Oh, I see.
17	done had I seen a case in which I felt that the	17	Q "I would bring it to the person's attention or the
18	caseworker had dealt with it inappropriately, which is	18	manager's attention, if I was aware of the case"?
19	to feed that back through either the line management	19	A. Yes.
20	chain or through colleagues in immigration enforcement	20	Q. Were you taking proactive steps to make sure you were
21	who were overseeing implementation of the policy.	21	aware of cases that were relevant to the detention
22	Q. Did you do that at the time?	22	decisions in relation to vulnerable people?
23	A. Not pre Adults at Risk policy, because, from the moment	23	A. Thanks for reminding me. Only no, no. I mean,
24	I stopped working on the Shaw review, I started working	24	proactive in the terms of, was I actively seeking out
25	on the Adults at Risk policy. So I had no	25	reports or detention reviews in order to assess them?
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L	1 agc 170		1 agc 1/2

43 (Pages 169 to 172)

1	No. But, as I mentioned, subsequently, when we would	1	to this, I don't know, but when the Adults at Risk
2	have been developing the policy, we would have asked for	2	policy was implemented, we were immediately judicially
3	a number of cases on a number of occasions. But that	3	reviewed by Medical Justice on the basis that the on
4	would have been for the purpose of developing policy	4	the basis of the definition of "torture" that we'd
5	rather than auditing the -	5	applied in the policy. I happened to be on jury service
6	Q. Yes. When you were there talking about cases, you're	6	when that was happening, so I don't quite know how we
7	talking about internal casework within the Home Office?	7	got that information. But we were served with
8	A. Yes.	8	a pre-action protocol and the case went to court and an
9	Q. I'm also asking about cases that have been through the	9	initial finding was made.
10	courts, where a decision has been made, a judgment has	10	So, obviously, my job then was to attend the hearing
11	been issued, which either has criticised an individual	11	
12		12	and respond to the interim judgment of Lord Justice
	decision maker, or the decisions being made, or found	13	Ouseley, as he was at the time, and take the necessary
13	a policy implementation to have been unlawful. How	13	temporary action to address the judge's findings.
14	would you become aware of case law litigation through		Q. We might come to it in a little bit more detail later,
15	the courts of that nature?	15	but thank you.
16	A. In the Home Office, there was a team, or a whole area,	16	A. Sure.
17	which — whose responsibility was to keep an eye on	17	Q. Was there any process to inform and feed back court
18	litigation, and they	18	rulings to the people on the ground, whether that was
19	Q. How did that feed into policy in relation to the	19	G4S management or healthcare management, at all?
20	detention of vulnerable people which you were	20	A. If a judgment required us to change policy in any way,
21	responsible for?	21	then we would have amended the policy documents and the
22	A. Because any litigation that related to my area of	22	Detention Services Orders if necessary, and they would
23	responsibility would be raised with me by the team that	23	have been usually disseminated to the healthcare staff
24	kept a weather eye on ongoing litigation.	24	and operational staff at immigration removal centres
25	Q. Was there a formal process for doing that?	25	through Detention Services, which is part of Immigration
	Page 173		Page 175
		ļ	<u> </u>
1	A. I mean, if I'm brutally honest, it kind of it felt	1	Removal Service.
1 2	A. I mean, if I'm brutally honest, it kind of it felt semi-formal, in that I usually found out about	1 2	Removal Service.  Q. So it wouldn't be the ruling itself, "There's been this
	•		
2	semi-formal, in that I usually found out about	2	Q. So it wouldn't be the ruling itself, "There's been this
2 3	semi-formal, in that I usually found out about litigation that was relevant to me, but it didn't	2 3	Q. So it wouldn't be the ruling itself, "There's been this court case", it would be, "Here's a new policy that's
2 3 4	semi-formal, in that I usually found out about litigation that was relevant to me, but it didn't necessarily always come in the same way. It was —	2 3 4	Q. So it wouldn't be the ruling itself, "There's been this court case", it would be, "Here's a new policy that's been changed, you need to act according to this one
2 3 4 5	semi-formal, in that I usually found out about litigation that was relevant to me, but it didn't necessarily always come in the same way. It was — Q. It was ad hoc?	2 3 4 5	Q. So it wouldn't be the ruling itself, "There's been this court case", it would be, "Here's a new policy that's been changed, you need to act according to this one now"?
2 3 4 5 6	semi-formal, in that I usually found out about litigation that was relevant to me, but it didn't necessarily always come in the same way. It was — Q. It was ad hoc?  A. To a degree. I mean, I don't remember a time when we	2 3 4 5 6	<ul> <li>Q. So it wouldn't be the ruling itself, "There's been this court case", it would be, "Here's a new policy that's been changed, you need to act according to this one now"?</li> <li>A. Again, to take the torture example, we were required to</li> </ul>
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1	responsibility for each of the recommendations according	1	a yes, but my primary objective was to develop a policy
2	to who had responsibility for them and then there would	2	that allowed for balanced decision making in respect of
3	be a process of corporate consideration of	3	vulnerable people in immigration detention.
4	the department's response to each of the individual	4	Q. If we come, then, to the Shaw review recommendations
5	recommendations.	5	that you were directly responsible for, and you say in
6	Q. How was the process what was the process for feedback	6	your statement at paragraph 12 that they were primarily
7	back to you as to whether, as the person formulating	7	recommendations 9 to 16, and those recommendations were
8	policy and, therefore, presumably reviewing whether	8	essentially the foundation of the Adults at Risk policy
9	policies needed to be changed, from how it was operating	9	which was central to the Home Office response to the
10	on the ground? Was there a process by which you	10	Shaw review, weren't they?
11	understood whether the policy was achieving its purpose	11	A. Can I have a look at recommendations 9 to 16?
12	and was operating effectively?	12	Q. Yes, of course.
13	A. Yes, I mean, we had very, very good communications and	13	A. Is it tab 3? I can't remember.
14	engagement with operational colleagues and colleagues	14	Q. It may well be. It is also <inq000060> at page 195.</inq000060>
15	who oversaw operational practices and processes, and so	15	Perhaps we can have it on screen.
16	any requirement to change policy or consideration of	16	A. So recommendations 9 to 16. The first few are well,
17	a requirement to change policy would have been	17	some of them are about specific conditions. Other ones
18	undertaken as a corporate operation, basically. So I,	18	are more general.
19	as a policy maker, would not be operating from a pure	19	Q. So number 9, please?
20	policy sense; I would be operating with full knowledge	20	A. Number 9. So
21	of what the operational position was, the operational	21	Q. So here, as you say, there were some that related to
22	needs and the operational situation.	22	specific categories of individuals. There we see
23	Q. You mentioned your operational colleagues. What was the	23	victims of rape and other sexual or gender-based
24	department and what level of role was feeding back to	24	violence, at number 9. We can also see, at number 10,
25	you?	25	a presumptive exclusion from detention for pregnant
	Page 177		Page 179
1	A. The grande de von meen 2	1	warman and the recommendation was that the appropriative
1 2	A. The grade, do you mean?  O. Yes.	2	women, and the recommendation was that the presumptive
3		3	exclusion was replaced with an absolute exclusion.
4	A. Forgive me if I can't remember the name of the unit, but	4	A. Yes.  Q. We see at recommendation 11:
5	there was a unit within immigration enforcement that was	5	"I recommend that the words 'which cannot be
6	responsible for, if I remember correctly, oversight of	6	
7	the operation of the Adults at Risk policy by	7	satisfactorily managed in detention are removed from the section of the EIG that covers those suffering from
8	caseworkers. And our main contacts were there and they	8	serious mental illness."
9	provided a kind of umbrella of all of the operational	9	
	practices, in caseworking terms.		Recommendation 12:
10	Q. In relation to learning from things that had gone wrong,	10	"I recommend that those with a diagnosis of
11	were you aware that there had been some cases previously	11	post-traumatic stress disorder should be presumed
12	where there had been coronial inquests into deaths in	12	unsuitable for detention."
13	immigration detention that had made various findings of	13	Those with learning difficulties — over the page,
14	failures in relation to those who were mentally unwell	14	please. Transexual people. A recommendation that the
15	and the management of them under ACDT as a management	15	wording in paragraph 55.10 of the EIG in respect of
16	tool and failures in the rule 35 process? Were you	16	elderly people be tightened to include a specific upper
17	aware of those at the time?	17	age limit.
18	A. I was aware that there had been cases of deaths in	18	And, at number 16, that a further clause should be
19	immigration detention. It wasn't something I was	19	added to the list in paragraph 55.10 of the EIG to
	directly involved with.	20	reflect the dynamic nature of vulnerability and thus
20	Q. Wasn't it important for you to know, in the formulation	21	encompass "persons otherwise identified as being
21		. ~~	curticiantia rauparable that their continued detention
21 22	of the Adults at Risk policy, where something as	22	sufficiently vulnerable that their continued detention
21 22 23	of the Adults at Risk policy, where something as critical as a death had occurred due to failures in	23	would be injurious to their welfare".
21 22 23 24	of the Adults at Risk policy, where something as	23 24	would be injurious to their welfare".  If you also just come down to the one right at the
21 22 23	of the Adults at Risk policy, where something as critical as a death had occurred due to failures in	23	would be injurious to their welfare".
21 22 23 24	of the Adults at Risk policy, where something as critical as a death had occurred due to failures in safeguards for vulnerable people?	23 24	would be injurious to their welfare".  If you also just come down to the one right at the

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1	"I recommend that the Home Office immediately	1	consultation on a policy?
2	consider an alternative to the current rule 35	2	A. I think there may be in certain types of
3	mechanism. This should include whether doctors	3	consultation, there may be a kind of statutory
4	independent of the IRC system (for example, forensic	4	requirement. I may be wrong. But certain consultations
5	medical examiners) would be more appropriate to conduct	5	are given three months, I believe, for certain things.
6	the assessments as well as the training implications."	6	Often, it's the case that, because there was a desire
7	And number 22 underneath, that rule 35 should be	7	not because there is a desire not to delay things,
8	applied to those detainees held in prisons as well as	8	that sometimes things are compressed, and so
9	IRCs. Do you see those?	9	Q. Do you think that happened here?
10	A. I do.	10	A. I think I can't remember the exact timescales.
11	Q. Although perhaps you weren't directly responsible for	11	I think we started working on the Adults at Risk policy
12	the implementation of recommendations 21 and 22, rule 35	12	obviously around the time that Stephen Shaw reported, or
13	works in tandem with the Adults at Risk policy, doesn't	13	when the Home Office received the report, which was
14	it?	14	a few months before it was published, and the Adults at
15	A. Yeah, to a degree. I mean, it's the it's the only	15	Risk policy went live in September 2016, I believe.
16	statutory reporting mechanism from IRCs of people who	16	Q. So stakeholders who were consulted were required to
17	are vulnerable in any way.	17	respond over the summer recess; is that right?
18	Q. Were you aware, when the Shaw review and its findings	18	A. Well, I think — as you will see from having read the
19	and recommendations were published, that the minister	19	Adults at Risk policy, it is quite complex in many ways,
20	publicly accepted the recommendations, promised to	20	and the development of policy I found, in my experience,
21	reduce numbers of vulnerable people in detention and	21	is quite a long, drawn-out process, because there's an
22	promised improvements in the safeguards with a more	22	awful lot that needs to be taken into account. You're
23	protective policy?	23	trying to, especially in the immigration area and the
24	A. I think the minister used the term "accepted the broad	24	Adults at Risk policy, you're trying to create
25	thrust of the recommendations".	25	a delicate balance between immigration control and
l	Page 181		Page 183
 I			
1	Q. But the idea was to reduce numbers of vulnerable people	1	protection of the vulnerable. And that is not an easy
2	in detention?	2	task. It's very complex. And so the there were time
3	A. Yes.	3	pressures to get it done and get it out there, and what
4	Q. And to improve the safeguards with a more protective	4	that meant, I think, possibly in practice, was that the
5	policy?	5	amount of time that stakeholders had to consider it was
6	A. Absolutely.	6	compressed more than it may have been ideally.
7	Q. That was the aim of the Adults at Risk policy which you	7	Q. You would have been aware at the time that concerns were
8	implemented; is that right?	8	being raised by, amongst others, Medical Justice before
9	A. Indeed.	9	the policy was implemented, that it didn't accurately
10	Q. So far as you're concerned, did the Adults at Risk	10	reflect Shaw's recommendations. Do you remember that
11	policy achieve that goal?	11	from the time?
12	A. I think, in terms of reducing the number of vulnerable	12	A. I don't remember specifically Medical Justice's views,
13	people in detention, there may have been an unforeseen	13	but it would
14	result, in that, because we had effectively broadened	14	Q. Do you remember concerns being raised that it didn't
15	the scope of what it meant to be vulnerable, that had	15	reflect Shaw's recommendations?
16	the impact of actually increasing I can't remember	16	A. Yeah. I mean, and when you look at it, it doesn't
17	the data, but this is an impressionistic view that	17	reflect Shaw's recommendations because Mr Shaw didn't
18	I have from my time there. It may have been the case	18	recommend the Adults at Risk policy. He recommended
19	that the number of people actually classified as	19	finessing of the existing policy, essentially.
20	vulnerable, because of the broadening of the definition	20	Q. Yes.
	of "vulnerability", effectively, meant that there were	21	A. But the Home Office decided to go down a different path.
21	• •	~~	
21 22	more people who were classified as vulnerable than would	22	Q. Yes. And so the policy that we see as the Adults at
21 22 23	more people who were classified as vulnerable than would have been under the previous policy.	23	Risk policy was implemented, despite it not reflecting
21 22 23 24	more people who were classified as vulnerable than would have been under the previous policy.  Q. Just dealing with the consultation on the Adults at Risk	23 24	Risk policy was implemented, despite it not reflecting Shaw's recommendations and despite concerns raised at
21 22 23	more people who were classified as vulnerable than would have been under the previous policy.	23	Risk policy was implemented, despite it not reflecting

46 (Pages 181 to 184)

1	A. Yes.	1	Q. No, go ahead, please.
2	Q. Can we just look at some of the concerns that were	2	A. I think the view was taken that the type of harm that we
3	raised, then, and get your view upon them?	3	were looking to address and capture in the definition of
4	A. Of course.	4	"torture" was more likely to have been carried out by
5	Q. The Adults at Risk policy, as you have mentioned	5	a state actor.
6	previously, briefly sought to narrow the definition of	6	Q. But you accept that, on some occasions, it wasn't?
7	torture to state actors or with state complicity, which	7	A. Yes, and I also accept, of course, that Lord Justice
8	was not a recommendation of the Shaw review. Is that	8	Ouseley found that the definition we had applied was not
9	right?	9	appropriate, was unlawful. He did, however, say that it
10	A. That's correct.	10	was perfectly reasonable for the Home Office to pursue
11	Q. Narrowing the definition of who is a victim of torture	11	a definition of torture that was different from the EO
12	isn't going to strengthen protections for vulnerable	12	definition.
13	people, is it; it's going to reduce them?	13	Q. Does that attitude by the Home Office indicate an
14	A. The reason we did that was that concerns had been raised	14	unwillingness to learn lessons from litigation, or
15	by the operational business about the way in which the	15	something else?
16	existing definition — the ${ m EO}$ casework — litigation	16	A. Are you talking about the litigation in respect of EO?
17	decision definition, sorry, was used. It was based	17	Q. Yes. Is this an example of an unwillingness by the
18	on three limbs: severity, intent and purpose. What was	18	Home Office to learn lessons from litigation?
19	happening is that there were many cases I hesitate to	19	A. I don't think I'd quite put it like that. I mean, the
20	say "many", actually. There were certainly cases in	20	way I'd put it is that the Home Office had operated the
21	which - and I can give you an example of the sort of	21	EO definition for, at that point, what, three, four or
22	case, if that would be helpful.	22	five years, and, operationally, found that it was
23	Q. Yes.	23	flawed, and so the Home Office sought to find
24	A. So, for example, a common this is an indicative case	24	a different way of approaching torture. I don't think
25	rather than an actual case, but there were many cases	25	that that necessarily represents ignoring the EO
	Page 185		Page 187
1	like this, or a number of cases like this, where, for	1	judgment, but trying to find a better way of doing it.
2	example, a farmer and another farmer had a dispute over	2	Q. Looking, then, at a different aspect of concerns raised
3	land or over property or over livestock, and one farmer	3	with you about the Adults at Risk policy, the policy
4	assaulted the other farmer. Now, that kind of situation	4	effectively moved away from the category-based approach
5	may well have met the three limbs of the existing	5	to the assessment of vulnerability and replaced it with
6	definition, in that it could well have been severe he	6	indicators of risk and evidence levels, didn't it?
7	could have cracked the fella's skull. There was	7	A. It did, but I don't think that that represents a moving
8	certainly intent, because the person meant to do it.	8	away from the category-based approach, because the
9	And there was a reason, punishment, for doing it. So it	9	policy clearly set out the categories of individuals who
10	met the three limbs. So in legal terms, that met the	10	would be regarded as vulnerable.
11	definition of torture.	11	Q. But they were categories of individuals who were
12	But the view the Home Office took was that it didn't	12	indicated to be at risk, weren't they?
13	actually amount to an act of torture, and so the	13	A. Yes.
14	Home Office was seeing a number of cases where that was	14	Q. And then what was then required was evidence levels at
15	the situation. So the view was taken that, by employing	15	levels 1, 2 or 3 of independent evidence; that's right,
16	the formulation of an an action by a state agent or	16	isn't it?
17	on behalf of a state agent, that would cut out that kind	17	A. Level 1 wouldn't have been independent evidence. That
18	of case from the definition.	18	was self-declaration.
19	Q. But the concern being raised was that the risk of harm	19	Q. Self-declaration. Levels 2 and 3?
20	in detention to someone who has been the subject of	20	A. Yes.
21	torture is not defined by who the perpetrator is, but,	21	Q. Level 1 not usually resulting in release from detention?
22	as you say, under the test, by the nature of the abuse	22	A. No
23	against them?	23	Q. Whereas the other two may do?
24	A. Yes. I mean, I think the view sorry, I didn't mean	24	A. The principle was that the higher the level of evidence
25	to interrupt you.	25	of risk, the more compelling the immigration factors
		<	
	Page 186		Page 188

47 (Pages 185 to 188)

1	would have to be in order to justify detention. This is	1	be something that caseworkers would be able to apply in
2	all, you know, based on first principles of detention,	2	a much more uniform way.
3	that detention should only be used for the purposes	3	Q. Concerns were certainly raised with you about the move
4	of if it was necessary in order to effect removal and	4	away from category-based the category-based approach
5	that, under the Hardial Singh principle, it should be	5	to an indicators of risk plus evidence of harm, though,
6	only if there is a realistic prospect of removal within	6	weren't they, and that that effectively went back to
7	a reasonable timescale.	7	a practice of whether someone could be satisfactorily
8	Q. This wasn't in accordance with Shaw's recommendations,	8	managed within detention. Do you agree with that?
9	though, was it, because what he had recommended was	9	A. Yeah, I think so. I mean, the "satisfactorily managed"
10	keeping the categories, but effectively adding to	10	issue is interesting, because the EIG 55.10 referred to
11	them	11	"satisfactorily managed" in respect of people with
12	A. Yes.	12	mental health conditions and physical health conditions.
13	Q further categories of vulnerability, and we went	13	We actually removed that from the formulation, to
14	through some of them PTSD, pregnant women, learning	14	a degree, in the Adults at Risk policy, but I was
15	disabilities, et cetera.	15	reminded this morning, when I read the document that was
16	A. Yes.	16	provided to me this morning, which was the 2016 version
17	Q. Under the categories-based approach, people who fell	17	of the caseworker guidance, that it was kind of still
18	within those categories were presumed to be inherently	18	there but in another form.
19	unsuitable for detention due to their vulnerabilities,	19	Q. Yes.
20	weren't they?	20	A. And so I mean, I have to kind of agree with you, that
21	A. They were held to be unsuitable for detention other than	21	it wasn't removed.
22	in very exceptional circumstances.	22	Q. Yes, and wasn't the concern about that that it
23	Q. Yes, in very exceptional circumstances. Those	23	perpetuated a "wait and see" approach in relation to
24	categories of people unsuitable for detention were	24	harm, such that harm would then actually be caused to
25	consistent with what Professor Bosworth had found in her	25	vulnerable detainees in detention, rather than routing
	Page 189		Page 191
1	sub-review, which was accepted by the Home Office; would	1	them out of detention because they were inherently
2	you agree?	2	likely to suffer harm because of the category that they
3	A. I believe so, yes.	3	were in?
4	Q. So requiring evidence of harm, then, goes against the	4	A. I'm not sure I quite understand. Are you relating that
5	principle that the categories of people are inherently	5	to the "satisfactorily managed" formulation?
6	at risk of harm in detention and shouldn't be detained,	6	Q. Yes.
7	doesn't it? It provides an extra hurdle?	7	A. I'm not quite sure I see the connection there, to be
8	A. I'm not sure that it does, because, as I said, the	8	honest.
9	categories in fact, an enhanced list of categories,	9	Q. If there was a connection, that is certainly the
10	in line with Mr Shaw's comments, and going further, in	10	opposite of what Shaw was trying to achieve, wasn't it?
11	fact, for example, in the case of individuals with	11	He was trying to route vulnerable people out of
12	mental health conditions, where the previous category	12	detention to ensure that harm wasn't caused to them by
13	referred to people with serious mental health conditions	13	protecting them with safeguards. Would you agree with
14	and the Adults at Risk policy referred to any mental	14	that?
15	health condition. I think the category-based approach	15	A. Well, Mr Shaw's recommendations in respect of the policy
16	was maintained in the Adults at Risk policy, but the	16	were well, yes, I mean, I can't disagree with that,
17	policy was I mean, the purpose of the policy was to	17	yes, sorry.
18	address — or one of the purposes was to address the	18	Q. In terms of that move away from the category approach,
19	fact that the "very exceptional circumstances"	19	to the extent that it was, in that there was now an
20	formulation was vague and was subject to inconsistent	20	indicators of risk coupled with evidence of harm and
21	application across the Home Office, and so we were	21	this satisfactory management criteria retained in some
22	looking to put in place a policy which achieved the	22	form, whose decision was that? Was that your decision
23	balance between immigration control and vulnerability,	23	or did it come from elsewhere in the Home Office?
24	but was I know it is, in some respects, an inherently	24	A. I was responsible for holding the pen on the policy, but
25	complex policy, but the overall effect was designed to	25	it was developed in conjunction with a range of
L	Page 190	<u></u>	Page 192

48 (Pages 189 to 192)

1	collective cover the Home Office both encurtional and	1	mustician under mile 24 and mile 25 to for that to	
1 2	colleagues across the Home Office, both operational and	1 2	provision under rule 34 and rule 35 to for that to come out at the outset of detention?	
3	policy decisions. I mean, the Adults at Risk policy was	3	A. I don't recall that.	
	a statutory policy. There was a requirement in the 2016	4 Q. If that is right, that would certainly mean that it's		
4 5	Immigration Act for the Home Secretary to publish	5		
	guidance on the management of Adults at Risk in	6	crucial that rules 34 and 35 are acting in conjunction	
6 7	immigration detention. The statutory guidance was in	7	at that time, at the outset of detention, wouldn't it?	
	line with that and that would have been signed off by		A. So could you tell me again what the Home Office said?	
8	ministers.	8	Q. The Home Office had opposed the existence of a duty to	
9	Q. If we just look then, briefly, at rules 34 and 35 that	9	undertake medical screening for torture before	
10	work somewhat in conjunction with the Adults at Risk	10	detention, so that screening wasn't carried out before	
11	policy, were you aware at the time that rules 34 and 35	11	someone went into detention, which makes the safeguard	
12	are required to work together as key safeguards such	12	at the outset of detention under rules 34 and 35 all the	
13	that a rule 34 examination within 24 hours of a detainee	13	more important, doesn't it?	
14	arriving in an IRC can result in a rule 35 report, and	14	A. Are you talking about in asylum cases?	
15	indeed should, in appropriate circumstances?	15	Q. In detention cases. In those going into detention?	
16	A. Yes, I'm aware of the connection between rule 34 and	16	A. But you mentioned before detention.	
17	rule 35. I think well, I'll say that I was aware of	17	Q. Yes, prior to detention.	
18	the fact that issues raised at a rule 34 appointment	18	A. But whilst an individual was being considered for	
19	could potentially lead to a rule 35 appointment.	19	detention, you mean?	
20	Q. And they should, if one was indicated, shouldn't they,	20	Q. Well, before a person comes into detention, no screening	
21	because the importance of those two rules working	21	is undertaken to ascertain	
22	together is to identify people who are vulnerable to	22	A. Oh, I see.	
23	risk of harm in detention at the outset of their	23	Q. – whether they should be detained at all because they	
24	detention; that's right, isn't it?	24	are a victim of torture, and the reason the Home Office	
25	A. I mean, my impression of rule 34 was that it was partly	25	felt able to do that was by relying upon rule 34 and	
	Page 193		Page 195	
1	about that, but also partly about identifying whether an	1	rule 35 acting in conjunction at the outset of	
2	individual had particular needs in detention.	2	detention. Were you aware of that	
3	Q. Yes. Certainly that in addition, but it was an	3	MR BLAKE: Chair, sorry to intervene here, I'm not aware of	
4	important safeguard to ensure that the Home Office were	4	where that allegation comes from. It may well exist but	
5	notified about vulnerabilities in relation to a detainee	5	perhaps the witness can be taken to where the allegation	
6	at the outset of their detention, so they could factor	6	comes from so he can have the context?	
7	those into their decisions as to whether to detain the	7	MS SIMCOCK: I will move on and, if necessary, we can come	
8	person at all, weren't they?	8	back to it following this witness's evidence.	
9	A. Well, I would have I think detention reviews were	1		
		9	<u> </u>	
I 10	, , , , , , , , , , , , , , , , , , ,	9	In relation to rule 35, when the Adults at Risk	
10	carried out at fairly frequent intervals, certainly at	10	In relation to rule 35, when the Adults at Risk policy was brought in, there were no amendments made to	
11	carried out at fairly frequent intervals, certainly at the start of detention. But	10 11	In relation to rule 35, when the Adults at Risk policy was brought in, there were no amendments made to the rule 35 Detention Centre Rules, were there?	
11 12	carried out at fairly frequent intervals, certainly at the start of detention. But Q. But in the appropriate case, this should have been the	10 11 12	In relation to rule 35, when the Adults at Risk policy was brought in, there were no amendments made to the rule 35 Detention Centre Rules, were there?  A. No.	
11 12 13	carried out at fairly frequent intervals, certainly at the start of detention. But Q. But in the appropriate case, this should have been the first time, shouldn't it, as a result of that	10 11 12 13	In relation to rule 35, when the Adults at Risk policy was brought in, there were no amendments made to the rule 35 Detention Centre Rules, were there?  A. No.  Q. We heard from doctors, and indeed healthcare management	
11 12 13 14	carried out at fairly frequent intervals, certainly at the start of detention. But  Q. But in the appropriate case, this should have been the first time, shouldn't it, as a result of that appointment?	10 11 12 13 14	In relation to rule 35, when the Adults at Risk policy was brought in, there were no amendments made to the rule 35 Detention Centre Rules, were there?  A. No.  Q. We heard from doctors, and indeed healthcare management and from Medical Justice, from their experience of	
11 12 13 14 15	carried out at fairly frequent intervals, certainly at the start of detention. But Q. But in the appropriate case, this should have been the first time, shouldn't it, as a result of that appointment? A. I would have expected, if concerns were identified by	10 11 12 13 14 15	In relation to rule 35, when the Adults at Risk policy was brought in, there were no amendments made to the rule 35 Detention Centre Rules, were there?  A. No.  Q. We heard from doctors, and indeed healthcare management and from Medical Justice, from their experience of casework that the rule 34 assessment was routinely not	
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11 12 13 14 15 16	carried out at fairly frequent intervals, certainly at the start of detention. But  Q. But in the appropriate case, this should have been the first time, shouldn't it, as a result of that appointment?  A. I would have expected, if concerns were identified by the member of medical staff carrying out the rule 34 appointment, if they had concerns, they would refer	10 11 12 13 14 15 16 17	In relation to rule 35, when the Adults at Risk policy was brought in, there were no amendments made to the rule 35 Detention Centre Rules, were there?  A. No.  Q. We heard from doctors, and indeed healthcare management and from Medical Justice, from their experience of casework that the rule 34 assessment was routinely not leading to a rule 35 report, even where disclosures had been made, and that a further appointment needed to be	
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1	A. I don't recall.	1	complete would add that information on to the
2	Q. That's a concern, isn't it, if part of the safeguards	2	rule 35(3) report.
3	for vulnerable people in being picked up is rule 34 and	3	Now, as far as I was concerned, certainly, and I
4	rule 35 at the outset of detention, in the absence of	4	well, I have seen something that suggested that the
5	a screening tool prior to detention? If that assessment	5	Home Office policy was that there should be separate
6	isn't being made until some days, or even weeks,	6	reports. I mean, I think that was a bit of a grey area.
7	afterwards, that would be concerning, wouldn't it?	7	The important thing for me was that the information was
8	A. It could be potentially, yes.	8	received by the Home Office and my expectation would be
9	Q. Because it would be delaying the identification of	9	that and I know some very, very good IRC doctors who
10	particularly vulnerable people likely to be harmed by	10	used the rule 35(3) report as a means of reporting on
11	detention?	11	rule 35(1) as well, and my expectation would have been
12	A. Yeah. I mean, we were keen for individuals with	12	that, had a caseworker received a rule 35(3) report that
13	vulnerabilities to be picked up as early as possible, of	13	went on to say the individual's health is likely to
14	course.	14	suffer, they would have placed that individual at
15	Q. In relation to rule 35, were you aware that the system	15	level 3 of the Adults at Risk policy.
16	under rules 35(1) and (2) wasn't operating effectively	16	Q. Dr Oozeerally gave some evidence that he had raised
17	in the relevant period or indeed afterwards, in that	17	concerns with the Home Office that rule 35 wasn't
18	there were very, very few rule 35(1) reports carried out	18	working, and he, in his witness statement, certainly
19	and no rule 35(2) reports at all?	19	mentioned conversations he had with you in particular.
20	A. I am pretty sure I would have had access to data on the	20	Do you remember the content of those conversations?
21	number of reports. I don't know whether I would have	21	A. Well, no. I mean, I've kind of been partly reminded by
22	seen the data in respect of the relevant period at the	22	having seen Dr Oozeerally's evidence on Friday. My
23	time. I honestly don't know. But obviously I've seen	23	recollection is that Dr Oozeerally was present at
24	it now. And, I mean, I think there's a couple of issues	24	a training session I and a colleague from the
25	here. I mean, with rule 35(1), I believe there were two	25	immigration enforcement delivered at Brook House.
	, (//		
	Page 197		Page 199
1	reports in the period.	1	I think it was in October 2017. I may have the date
2	Q. There were eight reports in 2017.	2	wrong. And at the end of the session, Dr Oozeerally and
3	A. Eight.	3	I had a conversation. He came up to me and suggested
4	Q. And no rule 35(2) reports.	4	that he had some ideas for improving the system.
5	A. None.	5	Subsequently, we had email exchanges, and I attended
6	Q. None.	6	a meeting with Dr Oozeerally and Dr Chaudhary along with
7	A. Rule 35(1) obviously requires — I can't remember the	7	some Home Office colleagues I don't know when that
8	exact wording, but it requires doctors to report of	8	was; it was in the Home Office in which he expanded
9	cases where the individual's health is likely to suffer	9	on his ideas and sought Home Office buy-in.
10	in detention, along those lines.	10	As I say, I can't remember in detail what the ideas
11	Q. Exactly.	11	were. I think they were about separating out the
12	A. I think what was happening was that the vast majority of	12	therapeutic functions of doctors from the reporting
13	people who sought a rule 35 report or were identified as	13	functions and maybe having an independent medical
14	being being the subject of a rule 35 report were	14	assessment within the Home Office.
15	claiming to have been tortured, and I believe that there	15	Q. Were you aware at the time of the low numbers of both of
16	were different practices among doctors, among different	16	those levels of report?
17	immigration removal centres, where some, if they were	17	A. I may have been. I don't know.
18	presented with someone who had claimed torture and they	18	Q. If you were aware, would it have been a concern to you
19	considered that the individual may have been a victim of	19	in the formulation of this policy that those two limbs
20	torture, which is the threshold	20	of the rule weren't being used as required?
1	Q. They would do a rule 35(3) report.	21	A. Not expressly, because I think I would have assumed
21			that the absence of rule 35(1) reports was because
21 22	A. They would do a rule 35(3) report. Now, if the doctor	22	
	A. They would do a rule 35(3) report. Now, if the doctor further considered that the individual's health was	23	people were using rule 35(3) reports to report
22			• • • • • • • • • • • • • • • • • • • •
22 23	further considered that the individual's health was	23	people were using rule 35(3) reports to report
22 23 24	further considered that the individual's health was likely to suffer in detention, some would complete a separate rule 35(1) report, whereas others would	23 24	people were using rule 35(3) reports to report rule 35(1)s, effectively, and, as far as rule 35(2) was concerned, I was aware that the ACDT process had
22 23 24	further considered that the individual's health was likely to suffer in detention, some would complete	23 24	people were using rule 35(3) reports to report rule 35(1)s, effectively, and, as far as rule 35(2) was

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1	effectively well, ran alongside rule 35(2) but had in	1	can be satisfactorily managed in detention, doesn't it?
2	some ways kind of replaced the reporting need because	2	A. I suppose that's one way of looking at it, but it's also
3	Part Cs were used to report cases of suicide and	3	considering whether it's actually more dangerous to
4	self-harm, of suicidal ideation and self-harm, and that	4	release someone than it is to keep them in detention.
5	any conversation needed by caseworkers to consider cases	5	I'm not for a second suggesting that it's preferable to
6	under the Adults at Risk policy would be getting through	6	keep someone in detention rather than release them.
7	through Part Cs or by other communication methods.	7	Q. Yes. But doesn't
8	I think it is also important to remember that suicidal	8	A. But it does sorry. It does mean that special
9	ideation and acts of self-harm does not in itself fall	9	considerations would have to be put in place to ensure
10	within the Adults at Risk policy, although it may be	10	the safeguarding of the individual on release.
11	indicative that an individual is suffering from a mental	11	Q. But doesn't it also encourage a higher threshold for the
12	health condition, and an act of self-harm or attempted	12	completing of a rule 35(1) report? Because it
13	suicide may lead to serious physical health conditions	13	encourages you to say, "Well, I don't need to make one
14	which will bring someone within the scope of the policy.	14	if they can be satisfactorily managed in detention"?
15	Q. Do you agree that there seems to be something of	15	A. I must confess, I hadn't considered that before, but
16	a disconnect between rule 35, particularly under limbs	16	I suppose it does.
17	(1) and (2), particularly, for example, where someone	17	Q. Similarly, the rule 35(2) template says rule 35(2)
18	isn't a victim of torture but falls within those rules,	18	says that concerns should be raised where there's
19	and the Adults at Risk policy?	19	a suspicion of suicidal intentions. That's a relatively
20	A. I guess to a degree, and I think, you know, from what	20	low threshold, would you agree?
21	I've been reading over the past couple of weeks, the	21	A. Yes.
22	number of	22	Q. There is no requirement in the rule to consider whether
23	Q. It seems to be the case that there's still a disconnect?	23	those suicidal intentions or risk of suicide can be
24	A. The number of rule 35(1) reports does give pause for	24	managed in detention. That doesn't appear in the rule
25	thought, if nothing else.	25	itself, does it?
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	1 ligo 201	-	1 1 1 2 2 3 3 3
1	Q. Yes. In relation to the template that one has to fill	1	A. No.
2	in under rule 35(1), were you involved with, or	2	Q. Why, then, does the template ask about satisfactory
3	responsible for, the development of the rule 35	3	management of suicide risk and refer to management on an
4	templates?	4	ACDT?
5	A. No, I don't think so. I think rule 35 had been in place	5	A. Presumably, in order to ensure that the right care is
6	since 2001. I'm not sure about the development of	6	being given to the individual, but I don't know. I'm
7	the templates, but I don't think I was involved. I was	7	speculating.
8	later on, when we were considering amending the rule	8	Q. Again, doesn't that encourage consideration of whether
9	the rule 35 process, in my last months in the	9	someone who has suicidal intentions can be managed in
10	Home Office.	10	detention and, therefore, there's no need to complete
11	Q. The template in relation to rule 35(1) asks whether	11	a rule 35(2) report?
12	remedial action can be taken to minimise the risks to	12	A. I suppose that could be one way of interpreting it.
13	health in detention, at section 5(2). That, again,	13	Q. We heard some evidence that the GPs, particularly in
14	forms part of re-introducing whether ill-health can	14	Brook House but potentially wider than that, had come to
15	satisfactorily be managed in detention, doesn't it?	15	the view that it was acceptable to communicate concerns
16	A. I never really thought very much about that, but the way	16	about detainees' vulnerabilities, including self-harm or
17	you say it, I suppose so, yes.	17	suicidal intentions, through Part C, instead of rule 35.
18	Q. It's certainly clear that that's how the doctors in	18	Was that something you were aware of at the time you
19	Brook House were applying it, from Dr Oozeerally and	19	formulated the Adults at Risk policy?
20	Dr Chaudhary's evidence.	20	A. I can't remember it explicitly, but certainly I would
21	In relation to the template at section 5(4), there's	21	have been operating and we would have been operating in
22	a further question about whether release will adversely	22	the knowledge that rule 35 was limited in terms of
23	impact on detainee health as compared to treatment	23	the categories of vulnerability that could be reported
24	available in detention. That, again, brings in	24	under it, and so I certainly would have been aware of
25	whether encourages consideration of whether someone	25	the fact that Part C and other less formal or more
1	_	5	
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formal communications from doctors to caseworkers would  have been needed in order to allow for the reporting of  other vulnerabilities, and I was — I think I was  satisfied that that was in place.  Part C was certainly being used. Was Part C encouraged  by the Home Office as an alternative to using rule 35?  A. I don't think I'd go as far as saying actively  encouraged or discouraged, but it was —  Q. It was known about?  A. It was known about. yes, and it was simply a means of  healthcare staff in IRCs reporting vulnerabilities to  the Home Office.  Q. But including where someone's health was being harmed as  a result of detention and also where someone was  a result of detention and also where someone was  which I think we accepted was — certainly when I was  but I think we accepted that that was kind of a key part  of this.  At the time at which we were ready to publish the  DSO, when we'd just about sorted out the arrangemen  10 proposed arrangements for identifying and supporting  individuals who lacked capacity in detention, we hadn  11 individuals who lacked capacity in detention, we hadn  12 the Home Office.  Q. But including where someone's health was being harmed as  a result of detention and also where someone was  a result of detention and also where someone was  but it is not a result of detention and also where someone was  a Part C would be used in lieu of a rule 35(1) report,  but I can understand totally why a rule 35(3) would be  used to report rule 35(1) concerns.  Q. Thank you. Moving on, then, if we just look at mental  22 capacity. You were responsible for, at least involved  23 in, the drafting of the DSO04 2020 on mental  24 vulnerability, I think, from paragraph 16 of your  25 statement?  Page 205  Page 207  1 their detention and removal from association, the DSO  vas published?	rt nts or g 't re
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25 statement?  Page 205  Page 207  1 A. Yes.  25 not being able to participate in the decisions about  Page 207  1 their detention and removal from association, the DSO	
Page 205 Page 207  1 A. Yes. 1 their detention and removal from association, the DSO	
1 A. Yes. 1 their detention and removal from association, the DSO	
1 A. Yes. 1 their detention and removal from association, the DSO	
2 Q. This was the DSO that was drafted in response to the 2 was published?	
3 ruling of the Court of Appeal in the case of VC. Were 3 A. Yes.	
4 you aware of that? 4 Q. And the gap remains?	
5 A. Yes. 5 A. Well, until such time as it could be plugged. I mean	n,
6 Q. In that case, the court had found a breach of 6 I can't speak to	
7 the Equality Act duties by the Home Office and 7 Q. I understand you've retired.	
8 discrimination against vulnerable detainees on the 8 A what's happened since I retired, but that work w	vas
9 grounds of disability because no adequate measures were 9 ongoing at the time.	
in place to ensure that those who may lack mental 10 Q. You say in your statement you didn't have a role in	
capacity were not at a disadvantage in relation to their 11 developing DSOs or policies concerning food and fluid	1
12 ability to participate in decisions relating to 12 refusal; is that right?	
detention and removal from association under rule 40. 13 A. That's correct.	
14 Is that right? 14 Q. But isn't that a policy that's relevant to Adults at	
15 A. I think so, yes. 15 Risk and the Adults at Risk policy?	
16 Q. The inquiry heard some evidence that, in fact, following 16 A. In the same way as self-harm and attempted suicid	le are
that litigation, the gap, effectively, hasn't been 17 not, in themselves, part of the Adults at Risk policy,	).
plugged and concerns are still being raised by those 18 the same consideration applies to food and fluid refu	usal
such as Medical Justice because of the lack of 19 and also to substance misuse, in that, again, they ma	ay
20 independent advocacy assistance for detainees who may 20 <b>be indicative of a mental health problem and they m</b>	nay
21 lack capacity. 21 lead on to a serious physical health condition, but —	
22 A. Yes. 22 and I can explain the reasoning for that, if it would	be
23 Q. Do you have any comment upon why that is? 23 helpful?	
24 A. I can't remember when the judgment was, but we found the 24 Q. Briefly, given the time.	
production of guidance, the Detention Services Order, to 25 A. It will be very brief. It's that those – those	
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1			
1	conditions, for want of a better expression, we did not	1	A. That's correct.
2	want to promote in any way by all of the indicators	2	Q. We heard from Medical Justice and Freedom from torture
3	in the Adults at Risk policy are conditions that people	3	about some concerns that they have in relation to those
4	experience or suffer from. We did not want to have any	4	reforms as being potentially regressive and reducing
5	activity in the Adults at Risk policy that could	5	rather than promoting the protection of vulnerable
6	incentivise an individual to harm themselves,	6	detainees. Do you have any particular comment about
7	essentially.	7	that?
8	Q. I see.	8	A. Well, I could talk to all three of them, but if you have
9	A. I know not everybody would agree with that view, but	9	specific questions.
10	that's the view we took.	10	Q. Yes. I will go, then, to some of the detail of each
11	Q. Thank you. In relation to segregation, then, again,	11	one. So we heard evidence about the medico-legal
12	briefly, the Shaw review had found a systemic misuse of	12	reports' quality standards and that where a report
13	segregation on mentally unwell people and expressed some	13	doesn't meet those standards, it's effectively
14	concern about that, and Medical Justice have certainly	14	disregarded, or at least afforded very limited weight.
15	given evidence that segregation is known to be harmful	15	A. Mmm-hmm.
16	to those people who are mentally unwell. Would you	16	Q. Do "disregarded" and "afforded very limited weight"
17	agree with that?	17	effectively amount to the same thing, in your view?
18	A. I wouldn't disagree.	18	A. No, no, certainly not. I understand that the standards
19	Q. You had no involvement in the formulation of the rule 40	19	are now part of the policy, because I know that
20	or rule 42 policy, did you?	20	because I looked at the existing policy the other day.
21	A. No, I didn't.	21	Q. Yes, they are.
22	Q. Again, why isn't consideration given to the connection	22	A. That wasn't the case when I left. But the principle was
23	between use of segregation and the Adults at Risk	23	that some of the standards should, in themselves, mean
24	policy? It seems to be, again, that there's	24	that reports should be disregarded because the way in
25	a disconnect?	25	which the report had been produced was clearly not up to
	Page 209		Page 211
1	A. I mean, it certainly wasn't a primary part of our	1	the appropriate standard. But there were reasons to
2	thinking in the Adults at Risk policy.	2	question either the veracity or the way in which the
1 2			
3	Q. No.	3	report had been produced. Whereas other issues, such
4	A. But I understand that segregation is used for various	3 4	report had been produced. Whereas other issues, such as, you know, checking your previous medical history,
4 5	A. But I understand that segregation is used for various reasons, and not just because an individual may be	3 4 5	report had been produced. Whereas other issues, such as, you know, checking your previous medical history, may and I can't remember where that failed, but may
4 5 6	A. But I understand that segregation is used for various reasons, and not just because an individual may be Q. Mentally unwell?	3 4 5 6	report had been produced. Whereas other issues, such as, you know, checking your previous medical history, may — and I can't remember where that failed, but may have been less important than the actual way in which
4 5 6 7	<ul> <li>A. But I understand that segregation is used for various reasons, and not just because an individual may be</li> <li>Q. Mentally unwell?</li> <li>A. Mentally ill.</li> </ul>	3 4 5 6 7	report had been produced. Whereas other issues, such as, you know, checking your previous medical history, may — and I can't remember where that failed, but may have been less important than the actual way in which a report would be regarded.
4 5 6 7 8	<ul> <li>A. But I understand that segregation is used for various reasons, and not just because an individual may be</li> <li>Q. Mentally unwell?</li> <li>A. Mentally ill.</li> <li>Q. Was any consideration given to the limits that need to</li> </ul>	3 4 5 6 7 8	report had been produced. Whereas other issues, such as, you know, checking your previous medical history, may and I can't remember where that failed, but may have been less important than the actual way in which a report would be regarded.  Q. Because there is a concern that, in circumstances where
4 5 6 7 8 9	<ul> <li>A. But I understand that segregation is used for various reasons, and not just because an individual may be</li> <li>Q. Mentally unwell?</li> <li>A. Mentally ill.</li> <li>Q. Was any consideration given to the limits that need to be imposed upon the use of segregation, particularly on</li> </ul>	3 4 5 6 7 8 9	report had been produced. Whereas other issues, such as, you know, checking your previous medical history, may and I can't remember where that failed, but may have been less important than the actual way in which a report would be regarded.  Q. Because there is a concern that, in circumstances where the report is still of high quality, and is therefore
4 5 6 7 8 9	<ul> <li>A. But I understand that segregation is used for various reasons, and not just because an individual may be</li> <li>Q. Mentally unwell?</li> <li>A. Mentally ill.</li> <li>Q. Was any consideration given to the limits that need to be imposed upon the use of segregation, particularly on vulnerable people, in the formulation of the Adults at</li> </ul>	3 4 5 6 7 8 9	report had been produced. Whereas other issues, such as, you know, checking your previous medical history, may — and I can't remember where that failed, but may have been less important than the actual way in which a report would be regarded.  Q. Because there is a concern that, in circumstances where the report is still of high quality, and is therefore still of value in identifying vulnerabilities and those
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53 (Pages 209 to 212)

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1	Q. But it said in the standards "may result in the report	1	A. These are the proposals?
2	being afforded very limited weight"?	2	Q. Yes. So that effectively results in a removing of
3	A. One of the main things we were seeing, and I do remember	3	the level 1 self declaration, doesn't it?
4	this, that reports were being submitted by medical	4	A. I'm trying to remember the details. But I know it was
5	practitioners via legal firms, and they were being	5	based on an assessment of the likelihood of
6	received seven, ten days after the report had been	6	the individual suffering harm. I can't remember the
7	written, whilst, at the same time, the report was saying	7	detail of that.
8	that the individual was at immediate risk, immediate	8	Q. Well, if that is right, and what now, to be classed
9	serious risk, because of detention. The issue that that	9	as an Adult at Risk, if the proposal for change was to
10	raised was that the author of the report was willing to	10	occur, if that is right, in order to be classed as an
11	attest to the fact that the individual was suffering	11	Adult at Risk, one would have to have independent
12	harm, yet was willing to let them stay in detention for	12	evidence of harm, then that results, doesn't it, in
13	the time it took them to write the report and submit it	13	those who simply are self declaring not being
14	to the Home Office.	14	investigated and notified to the Home Office,
15	Now, we took the view and I don't think this is	15	potentially leading to a category of vulnerable people
16	unreasonable that if those concerns were so real,	16	not being explored and reviewed for detention decisions?
17	they should have been raised with healthcare by the	17	Isn't that a concern?
18	visiting practitioner immediately.	18	A. Could you remind me of what the proposed level 1 said?
19	Q. I see. At the time, the standards were said to be	19	There were three likelihoods of risk. Was it the high
20	necessary by the Home Office because the Home Office had	20	likelihood of risk, a medium or moderate and low
21	received a large number of reports that had fallen below	21	likelihood?
22	the expected professional standards	22	Q. Under the proposal for change or
23	A. Yes.	23	A. No, the proposal for change.
24	Q and there was effectively an abuse of the system	24	Q. So, yes, there was a proposal that no longer was there
25	happening, a strategic approach, which is effectively	25	to be a self-declaration
20	imppening, a samegic approach, which is effectively	20	W de a sen declaration
	Page 213		Page 215
1	what you have just described. Is that what you're	1	A. Yes, okay.
2	saying?	2	Q as an Adult at Risk and that's what I'm asking you
3	A. I think so. I don't like to bandy the word "abuse"	3	about at the moment, that in order to be classed as an
4	around, but the practices we saw certainly gave us cause	4	Adult at Risk, one had to have not only self-declared
5	for concern about the way in which these reports were	5	but also to have independent evidence. Doesn't that
6	being employed.	6	result in a category of people not being investigated
7	Q. The ICIBI reported in their 2021 inspection report	7	and considered as vulnerable?
8	reporting on the year 2020, and they recommended that	8	A. If the new level 1 would be people with a low likelihood
9	the Home Office investigate and share their findings	9	of harm, they would have to be identified in the first
10	with staff and key stakeholders. Were you aware of	10	place to be assessed as that. But I don't see that that
11	that?	11	necessarily precludes individuals from raising
12	A. That was in?	12	a vulnerability, and then that would automatically lead
13	Q. So it was reporting in 2021 but related to 2020.	13	to healthcare in the IRC assessing that and deciding
14	A. I wasn't at work in 2021.	14	whether — what the likelihood of harm was.
15	Q. You had already retired by then?	15	Q. But it doesn't lead to them being categorised if it
16	A. Yes.	16	is simply a self-declaration
17	Q. The Home Office, so far as we know, hasn't investigated	17	A. But if that self-declaration leads to them being
18	and shared their findings. Again, would that cause	18	assessed by a healthcare a member of healthcare and
19	a concern?	19	then that healthcare member of healthcare then making
20	A. I can't speak for the approach the Home Office is taking	20	an assessment of the likelihood of the individual
21	now.	21	suffering harm, that will inevitably be either low,
22	Q. In removing under the new policy, an individual	22	moderate or high, and so that would lead to an
23	wouldn't be categorised as an Adult at Risk unless they	23	assessment. You have to forgive me. If you had asked
24	had a professional assessment to support it, so level 2	24	me that two years ago I would have been able to tell you
25	evidence?	25	off the bat, but that's me kind of conjecturing on what
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54 (Pages 213 to 216)

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1	I think the situation would have been.	1	a detention review whenever anything was reported under
2	Q. The Shaw review identified originally a culture of	2	it, if working in tandem with reports from healthcare
3	disbelief in healthcare. Did you take account of that	3	that an individual is suffering from harm, the Adults at
4	in any way in the Adults at Risk policy?	4	Risk policy should be responsive to that.
5	A. I'm not sure in his first report he said that?	5	Q. If it isn't, what's the explanation for that?
6	Q. Yes.	6	A. Well, either the information isn't getting through or
7	A. I don't recall that and I don't recall that being part	7	Q. It is not operating effectively on the ground?
8	of my consideration.	8	A. I guess, yes.
9	Q. We know that various bodies continued to remain	9	Q. The IMB report in 2021 reporting on 2020 found
10	concerned about aspects of the policy and critical of it	10	"a continued failure to identify vulnerabilities" and
11	and the safeguards in place following its introduction	11	that "the Adults at Risk evidence levels had not been
12	following Shaw. That included Shaw in his second review	12	addressed". The concern about the evidence levels being
13	in 2018 and included the ICIBI, the IMB and the HMIP in	13	that the levels relate to the amount of evidence that
14	various reports post 2017, and I just want to look at,	14	the detainee is required to produce
15	again very briefly, some of those particular concerns	15	A. Yes.
16	and criticisms.	16	Q and not to their assessed level of vulnerability, and
17	Various reports have identified that rule 35	17	that this has been worsened by high numbers of
18	continued to be systemically dysfunctional. There were	18	vulnerable detainees. Do you have any particular
19	delays reported in appointments with GPs in 2020, there	19	comment on that finding?
20	had been a dramatic increase in the number of rule 35(3)	20	A. Yeah, there are a couple of things there which I may
21	reports in Brook House, and indeed, in 2020, there	21	forget as I go through them. The first thing is, the
22	remained only two rule 35(1) reports and still no	22	policy was designed to be evidence based, because our
23	rule 35(2) reports, despite high levels of self-harm,	23	view was that the best way of assessing an individual's
24	high levels of ACDTs open and including with detainees	24	vulnerability was on the basis of the evidence that was
25	on constant watch indicating a high risk of suicide. Do	25	available, medical evidence predominantly, but any other
	Page 217		Page 219
1	you agree that the rule 35 system continues to operate	1	evidence social workers or whoever, professional
2	dysfunctionally?	2	evidence, we accepted. Gosh, I'm so sorry. You
3	A. I have no idea. I haven't worked there for 15,	3	couldn't say it again and then I can remember?
4	16 months.	4	Q. I can certainly, yes. So the concern was that there was
5	Q. If those things are right, that must be correct, mustn't	5	a continued failure to identify vulnerabilities and the
6	it?	6	concern related to the evidence levels, that the amount
7	A. That's an inference you could draw.	7	of they required the evidence to be required to
8	Q. In relation to the second Shaw review, that found that	8	be produced by the detainee and not to their assessed
9	there were still detainees in IRCs who should not have	9	level of vulnerability?
10	been in detention and that the Adults at Risk policy	10	A. Yeah. I mean, I think I'd say on that that the
11	appeared to have made matters worse, not better. Do you	11	proposals we were working on in 2020 were at least
12	have any comment upon that?	12	partly designed to really focus on the harm that an
13	A. No.	13	individual was likely to suffer. So still retaining the
14	Q. The IMB 2020 report reporting on 2019 found that the	14	kind of evidence element, in that it would be based on
15	Adults at Risk system failed to capture deterioration in	15	reports from doctors, but really, really focusing on
16	a detainee's condition and did not adequately capture an	16	what the issue was with the individual and whether they
17	individual's level of vulnerability and they failed,	17	were going to suffer harm in detention. So I think that
18	therefore, to adequately safeguard vulnerable detainees	18	kind of half-addresses that concern. But obviously
19	at Brook House. Do you have any comment on that?	19	I don't know whether the policy has been put in place,
20	A. Only inasmuch as — I mean, I have to disagree in	20	but I don't think it has.
21	general terms with the comments about the Adults at Risk	21	Q. Finally, then, the inquiry has heard a considerable
22	policy failing to keep pace with potential deterioration	22	amount of evidence about a toxic culture existing in
23	in the individual's condition. It was certainly	23	Brook House in 2017 involving, amongst other things,
24	designed to be flexible, to be dynamic, as Stephen Shaw	24	institutionalised racism and the dehumanisation of
25	recommended, and combined with the fact that it required	25	detainees and we have all seen the Panorama footage.
		25	detainees and we have all seen the Panorama footage.  Page 220

1	I take it you have seen that as well?	1	but I have very helpfully been referred to the reference	
2	A. Yes, I have.	2	that the Home Office raised with me.	
3	Q. Do you consider, in your view, that any deficiencies in	3	Further examination by MS SIMCOCK	
4	the policies in dealing with vulnerable detainees, such	4 5	MS SIMCOCK: Mr Cheeseman, I had asked you about the	
5	as the Adult at Risk policy, and the defects in the		importance of the rule 34 and rule 35 rules acting in	
6			conjunction with each other at the outset of detention	
7	to mistreatment of vulnerable detainees?	7	in screening for vulnerability.	
8	A. I have no reason to think that they do.	8	A. Yes.	
9	MS SIMCOCK: Thank you. Chair, those are all the questions	9	Q. Given that there isn't a screening tool prior to	
10	I have for this witness. Do you have any questions?	10	detention in relation to screening out victims of	
11	Questions from THE CHAIR	11	torture, the reference came in the context of the case	
12	THE CHAIR: Thank you, Ms Simcock. Thank you very much,	12	of D&K in 2006 where there had been argument about	
13	Mr Cheeseman. I just have one question in relation to	13	whether there was a duty to provide such screening prior	
14	something slightly earlier on in your evidence.	14	to detention at common law. The court found that there	
15	Ms Simcock asked you about contact that you had from	15	hadn't. The Secretary of State for the Home Department	
16	Dr Oozeerally and then you recalled, having heard his	16	had opposed the imposition of such a duty at common law	
17	evidence, and gave some information about that.	17	in that case. As I said, the court found that there was	
18	A. Yes.	18	no duty in law. But that also led the court to find	
19	THE CHAIR: Do you recall ever having any conversations,	19	that that screening role of rule 34 and rule 35 at the	
20	contact, emails, meetings, any other correspondence with	20	outset of detention was therefore all the more vital.	
21	other GPs from other IRCs expressing concerns about	21	Does that assist you in any way?	
22	rule 35?	22	A. I'm sorry, I really don't understand the question. I do	
23	A. I can't remember expressly. There may well have been.	23	apologise.	
24	I didn't have a direct line to many GPs, and I don't	24	Q. Wouldn't you agree that, given that there's no screening	
25	recall ever having any phone calls from any, other	25	tool and no duty to screen in relation to vulnerability	
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	1 age 221		1 agc 223	
1	than $-$ or emails from others, other than Dr Oozeerally.	1	and victims of torture prior to their detention, that	
2	We had engagement, as part of policy development, with	2	the rule 34 and rule 35 safeguards at the outset of	
3	a couple of GPs in Harmondsworth and Colnbrook and one	3	detention are all the more important?	
4	in Dungavel, but I can't remember any explicit examples.	4	A. In the terms that you've put it, yes.	
5	THE CHAIR: Would your expectation was there a structure,	5	Q. And given that the Home Office, at least in 2006,	
6	I guess is my question, for how medical practitioners	6	appeared to oppose such a duty to screen beforehand,	
7	would feed in concerns related to the policy in an	7	does that indicate a Home Office attitude in relation to	
8	ongoing capacity, as opposed to a consultation when the	8	the vulnerability detention decisions in relation to	
9	policy was first written?	9	vulnerable people at the outset of detention?	
10	A. Yeah, there was a head I think I'm not sure	10	A. Does it indicate the?	
11	whether he covered all the IRCs or just the near-London	11	Q. Well, is there an attitude that there's no necessity to	
12	ones, but there was, within Detention Services,	12	screen for this type of vulnerability, either prior to	
13	a colleague who acted as kind of the liaison between	13	or at the outset of detention, in order to route those	
14	healthcare within IRCs, the rest of immigration	14	people out of detention? They prefer a "wait and see"	
15	enforcement and policy, and we had very, very good	15	approach to see if harm actually occurs whilst the	
16	connections with him, and I would probably have heard of	16	person is in detention?	
17	concerns through him.	17	A. Thanks for putting it in those terms, because it does	
18	THE CHAIR: Can you remember that person's name?	18	make it easier for me to address this in some way.	
19	A. Yeah, yeah, I think his name has been mentioned before,	19	This isn't an issue that I was directly involved in.	
20	Terry Gibbs.	20	I think the approach that I would have advocated is, as	
21	THE CHAIR: Terry Gibbs?	21	I think I mentioned earlier, that it's good to have as	
22	A. Yes.	22	much information about an individual's vulnerability at	
23	THE CHAIR: Thank you very much. I have no other questions,	23	as early a stage as is possible. There are processes in	
24	Mr Cheeseman. Do you have a follow-up, Ms Simcock?	24	place you've got the detention gatekeeper, you've	
25	MS SIMCOCK: I do, chair, not from anything you have asked	25	got there is screening in certain areas, certainly in	
	D 202		D 221	
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23 tt, 3.			·
1	asylum and some — and that catches some cases. I don't	1	Questions from THE CHAIR154
2	know about national removals command. But the principle	2	
3	for me would be, get the information as quickly as you	3	MR IAN CHEESEMAN (affirmed)155
4	can. Sometimes, of course, an individual's	4	
5	vulnerabilities don't emerge until they are actually in	5	Examination by MS SIMCOCK155
6	detention. But I'm not sure it necessarily reflects an	6	·
7	unwillingness on the part — if this is what you are	7	Questions from THE CHAIR221
8	suggesting, and I'm not certain it is an	8	
9	unwillingness on the part of the Home Office to gather	9	Further examination by MS SIMCOCK223
10	that information. If there are reasons why particular	10	·
11	types of screening at particular stages don't happen,	11	
12	then I'm afraid you'll need to ask the Home Office about	12	
13	that rather than me.	13	
14	Q. Yes. Isn't the danger, though, and the concern, that if	14	
15	there isn't screening happening prior to detention, and	15	
16	the rule 34 safeguard is failing, that that's leading to	16	
17	vulnerable people who shouldn't be being detained being	17	
18	harmed in detention because of the fact they are being	18	
19	detained?	19	
20	A. I suppose, if you accept that rule 34 is the kind of	20	
21	fallback	21	
22	Q. Yes?	22	
23	A. — the kind of —	23	
24	Q. Indeed.	24	
25	A. — gate, and if it's true that it is not operating	25	
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1	properly, then your concerns would be valid, I suppose.		
2	MS SIMCOCK: Thank you very much. Thank you, chair.		
3	THE CHAIR: Thank you very much. Thank you very much,		
4	Mr Cheeseman. My apologies we have kept you slightly		
5	longer.		
6	A. No problem at all.		
7	THE CHAIR: But it has been very important to hear from you		
8	and I'm very grateful for your evidence.		
9	MS SIMCOCK: 10.00 o'clock tomorrow.		
10	THE CHAIR: Thank you very much.		
11	(4.48 pm)		
12	(The hearing was adjourned to		
13	Thursday, 17 March 2022 at 10.00 am)		
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