

<p>1 Wednesday, 6 April 2022</p> <p>2 (10.00 am)</p> <p>3 (Proceedings delayed)</p> <p>4 (10.08 am)</p> <p>5 THE CHAIR: Good morning. Thank you. Mr Bunting?</p> <p>6 Closing statement by MR BUNTING</p> <p>7 MR BUNTING: The BBC, chair is, the nation's public service</p> <p>8 broadcaster, it is impartial, and independent, it aims</p> <p>9 to inform, educate and entertain millions of people in</p> <p>10 the UK and around the world. It has played a role as</p> <p>11 a core participant in this inquiry so as to ensure that</p> <p>12 you, chair, have access to all relevant material and so</p> <p>13 that you are able to explore all of the public interest</p> <p>14 issues that the BBC's Panorama documentary "Undercover:</p> <p>15 Britain's Immigration Secrets" revealed.</p> <p>16 This documentary was an example of the BBC's</p> <p>17 accurate, impartial and informative programming which is</p> <p>18 required under its charter and under its editorial</p> <p>19 guidelines. In these closing submissions, chair, the</p> <p>20 BBC makes two points, and both points go directly to the</p> <p>21 question of what evidence you can rely on when you are</p> <p>22 assessing the credibility of the allegations in this</p> <p>23 inquiry.</p> <p>24 Those two points are as follows, chair: first,</p> <p>25 Callum Tulley's footage speaks for itself; second,</p> <p>Page 1</p>	<p>1 evidence, he could find a disproportionate use of force,</p> <p>2 and, where he didn't have any footage, he wasn't.</p> <p>3 As he put it to the inquiry under questioning from</p> <p>4 Ms Townshend, video evidence emphasised two things in</p> <p>5 particular, "Video footage" as he put it, "is essential</p> <p>6 to get a true reflection of the incident, but also about</p> <p>7 the use of force report writing. It needs to be to</p> <p>8 a better standard and more descriptive of the actual</p> <p>9 events".</p> <p>10 Callum Tulley's video evidence is, therefore, the</p> <p>11 best available evidence to enable you to assess the</p> <p>12 issues in the terms of reference, and it is no doubt for</p> <p>13 that reason, chair, that the inquiry has seen various</p> <p>14 attempts to undermine it. We had three suggestions</p> <p>15 during the evidence in phase 2 that the footage had been</p> <p>16 doctored, edited or dubbed. Those suggestions came from</p> <p>17 Yan Paschali, Derek Murphy and John Connolly.</p> <p>18 Chair, those discussions were false.</p> <p>19 All three men had good reason to insist that the</p> <p>20 footage was wrong because it revealed that they had</p> <p>21 committed serious misconduct -- Yan Paschali assaulting</p> <p>22 D1527; Derek Murphy swearing at and demeaning detainees;</p> <p>23 John Connolly using the most serious of racist epithets.</p> <p>24 Indeed, chair, none of the three men were actually</p> <p>25 able to explain how or where the footage had been</p> <p>Page 3</p>
<p>1 Callum Tulley was a witness of truth.</p> <p>2 Starting with the footage, chair, throughout this</p> <p>3 inquiry, we have watched it again and again.</p> <p>4 It has allowed us to see and hear what life in</p> <p>5 Brook House was actually like. It reveals incidents of</p> <p>6 the most troubling nature, including racist language,</p> <p>7 casually used in staff conversations and to detainees;</p> <p>8 a casual disregard for detainees, including as regards</p> <p>9 food refusal, petty, personal insults; violence praised</p> <p>10 in staff discussions and threatened in the most lurid of</p> <p>11 terms; and the disproportionate use of force, including,</p> <p>12 most graphically, the D1527 incident on 25 April 2017.</p> <p>13 Callum Tulley's footage, chair, both that which was</p> <p>14 broadcast and that is which was not, is important, it is</p> <p>15 important because it vindicates the editorial decision</p> <p>16 to broadcast the Panorama documentary which revealed</p> <p>17 serious misconduct and which was a proper piece of</p> <p>18 public interest reporting. But it is also important</p> <p>19 because it goes directly to the heart of this inquiry's</p> <p>20 terms of reference. The inquiry wouldn't know the</p> <p>21 incidents it depicts but for that footage.</p> <p>22 To make that point good, chair, you need to go no</p> <p>23 further than the inquiry's use of force expert,</p> <p>24 Mr Jon Collier, whose oral evidence explored the</p> <p>25 importance of video evidence. Where he had such</p> <p>Page 2</p>	<p>1 edited. When he was asked where the footage had been</p> <p>2 edited, Derek Murphy had no answer. The best he could</p> <p>3 offer, chair, was that "the light changes in the</p> <p>4 background", and he confirmed under questioning that the</p> <p>5 timestamp on the footage hadn't been interfered with.</p> <p>6 When he was asked how he said the footage had been</p> <p>7 dubbed, John Connolly sought to suggest that the footage</p> <p>8 had perhaps indicated that he had said N word in a lift.</p> <p>9 He then, immediately, accepted that he wasn't right</p> <p>10 about that. And then, when he was asked why he had said</p> <p>11 the footage was edited, John Connolly frankly admitted</p> <p>12 that "it was probably just hopefulness" on his part.</p> <p>13 Chair, the BBC has made all relevant footage</p> <p>14 available to the inquiry. It is digital. It shows what</p> <p>15 happened with a continuing timestamp on the footage, and</p> <p>16 at no stage, chair, are there any unexplained breaks in</p> <p>17 that timestamp.</p> <p>18 Finally, chair, in terms of the footage, as</p> <p>19 Callum Tulley confirmed in his oral evidence in phase 2,</p> <p>20 he didn't edit or doctor the footage, nor did he</p> <p>21 encourage anyone else to, and nor did anyone else in the</p> <p>22 BBC, chair.</p> <p>23 That is the footage. Let me turn to my second</p> <p>24 point. The second point that the BBC emphasises is</p> <p>25 another simple one, Callum Tulley was a witness of</p> <p>Page 4</p>

<p>1 truth. You have heard some of the reasons for that 2 submission elegantly adumbrated by Mr Armstrong 3 yesterday, but the BBC emphasises four particular points 4 to support that submission. The first, Callum Tulley 5 gave evidence for the longest period of time of any 6 witness: four days in phase 1 and another afternoon in 7 phase 2.</p> <p>8 At no stage during that long period of time chair, 9 did he stumble, argue or seek to deceive.</p> <p>10 Second, the evidence that Callum Tulley gave was 11 consistent. His oral evidence reflected his own written 12 witness statement which itself reflected his earlier 13 written witness statements to the NMC and the police and 14 which itself reflected his earlier contemporaneous video 15 diaries.</p> <p>16 More importantly chair, his evidence was also 17 consistent with the video footage. The footage that he 18 recorded not only supports his account of the incidents 19 it depicts, but it also supports his account of the 20 wider culture at Brook House over the wider period that 21 he describes.</p> <p>22 Third, chair, the manner in which he gave evidence 23 was clear. His evidence was nuanced. He didn't seek to 24 overegg the point. He didn't seek to make allegations 25 that were unsupported by the wider evidence. He didn't</p> <p style="text-align: center;">Page 5</p>	<p>1 You may consider, chair, Mr Donnelly's response to 2 that criticism to be somewhat extreme. When he was 3 taken through that incident by counsel to the inquiry, 4 Mr Donnelly, in fact, accepted that Callum Tulley's 5 evidence about the delay was, to use his words, 6 "accurate". Mr Donnelly also had no answer as to why he 7 had never admitted that Callum Tulley had pointed out 8 the ligature at the time.</p> <p>9 The second example of unfair criticism; Dave Webb. 10 He criticised Callum Tulley in suggesting that 11 Callum Tulley was, in fact, the head officer during 12 a use of force incident involving D149 on 31 May 2017, 13 and that Callum Tulley was, therefore, responsible for 14 not giving a warning about the use of a pain-inducing 15 technique.</p> <p>16 Of course, Mr Webb also had a motive for seeking to 17 undermine Callum Tulley. Amongst other matters, 18 Callum Tulley filmed Mr Webb telling colleagues to use 19 a shield as an offensive weapon and alleging that he had 20 badly injured D149. And of course, chair, the 21 suggestion that Callum Tulley had been the head officer 22 in that D149 incident, was as false as it was 23 surprising.</p> <p>24 The contemporaneous use of force incident shows that 25 Callum Tulley wasn't even present during that incident,</p> <p style="text-align: center;">Page 7</p>
<p>1 seek to make political points. Let me give one example 2 of that, chair. Callum Tulley was careful in his 3 witness statement for the Nursing and Midwifery Council 4 to explain what Jo Buss would have been able to see and 5 hear and what he was certain she was not able to see and 6 hear. But, of course, Jo Buss was not satisfied with 7 that and she still sought to unfairly criticise 8 Callum Tulley in her witness statement. Chair, you will 9 have seen how her criticisms and how her wider evidence 10 unravelled during her oral evidence from Ms Simcock.</p> <p>11 Then the final point to make this point good, chair, 12 the criticisms that were made of Callum Tulley were 13 baseless and, to develop that point, we can forensically 14 examine some of the criticisms that the officers sought 15 to make of him. I am going to give five examples in 16 these closing submissions.</p> <p>17 First, Chris Donnelly. He suggested in his second 18 witness statement that Callum Tulley had a "preconceived 19 political and professional agenda" and a "naive 20 misunderstanding of the environment he worked in". He 21 sought to stick by that extreme criticism in his oral 22 evidence. This was Mr Donnelly's response, of course, 23 to Callum Tulley's suggestion that Chris Donnelly had 24 delayed in providing medical assistance to a detainee 25 who had a ligature around his neck.</p> <p style="text-align: center;">Page 6</p>	<p>1 and that was for good reason. The officers who were 2 using force were seeking to transfer D149 because he was 3 accused of having tried to steal Callum Tulley's keys.</p> <p>4 Third criticism, chair; Yan Paschali. He made 5 a number of false assertions about Callum Tulley.</p> <p>6 Firstly, he alleged that Callum Tulley had failed to 7 comply with his duties as constant observations officer 8 as regards D1527, and yet the inquiry knows, because it 9 has the constant observation records, that Callum Tulley 10 wasn't the officer who was in charge of constant 11 observations for D1527; Clayton Fraser was.</p> <p>12 Second, Yan Paschali suggested, in the first time in 13 oral evidence, that he had completed a use of force form 14 in respect of the D1527 incident, but that Callum Tulley 15 had taken that report and destroyed it. Simply to state 16 that conspiracy theory, chair, is to undermine it.</p> <p>17 There is not a shred of evidence to support it. 18 Callum Tulley denied it, and of course he had no reason 19 to make any such use of force form disappear.</p> <p>20 Yan Paschali also suggested that Callum Tulley "had 21 no duty of care". He sought to contrast that with his 22 own "duty of care", which he said he had demonstrated in 23 removing a ligature from D1527 during that central 24 incident. There was, of course, a problem with 25 Yan Paschali's evidence on this, chair, D1527 didn't</p> <p style="text-align: center;">Page 8</p>

<p>1 even have a ligature around his neck when Yan Paschali 2 was on the scene. 3 The fourth criticism, chair, is that of 4 Derek Murphy, and a number of the other officers who 5 sought to suggest that they had told Callum Tulley tall 6 stories because he seemed to have an appetite for them. 7 It is striking, chair, that each of these officers 8 should independently come up with this "telling 9 Callum Tulley tall stories" excuse for their own 10 apparent misconduct. Even yesterday, we had this 11 allegation repeated by Nathan Ring in his closing 12 submissions. In any event, chair, that suggestion 13 cannot be sustained. We know that because we can see 14 some of those tall stories being told on the footage. 15 Derek Murphy, number one, he suggested he had told 16 Callum Tulley fairy stories when responding to footage 17 of him calling a detainee a "little prick" and with 18 Derek Murphy saying he was going to "come and smash the 19 fucking shit out of you". 20 In fact, when we look at that footage, it shows that 21 Derek Murphy wasn't telling the story to Callum Tulley 22 but to DCO Andy Jennings. Callum Tulley's footage shows 23 that he entered the conversation halfway through and 24 that Derek Murphy wasn't even facing Callum Tulley at 25 the time that he said it. Another tall story.</p> <p style="text-align: center;">Page 9</p>	<p>1 personal attack and that, chair, is precisely what has 2 happened now that he has done so. 3 To conclude therefore, chair, Callum Tulley's 4 footage speaks for itself. Callum Tulley was also, 5 himself, a witness of truth. Unless I can assist you 6 further, those are the closing submissions of the BBC. 7 THE CHAIR: Thank you very much, Mr Bunting, thank you. 8 We are now going to be hearing from Ms Mannion, 9 which is going to be remotely, so we will hopefully be 10 able to move to that smoothly. 11 Ms Mannion, can you hear me? 12 MS MANNION: Hello. Can you hear me, chair? 13 THE CHAIR: We can hear you and see you. Thank you very 14 much. 15 MS MANNION: Firstly, thank you for letting me appear in 16 this way, I am extremely grateful. 17 THE CHAIR: No problem, thank you. 18 Closing statement by MS MANNION 19 MS MANNION: Chair, you have heard powerful and important 20 submissions yesterday on behalf of detained persons and 21 other organisations as to the events within the relevant 22 period and as to systemic issues. I hope I will be 23 forgiven, in these oral submissions on behalf of 24 Her Majesty's Inspectorate of Prisons, for addressing 25 you more narrowly on four topics relating to inspection.</p> <p style="text-align: center;">Page 11</p>
<p>1 Derek Murphy's next suggestion: he said he had told 2 tall stories to Callum Tulley when he was responding to 3 an allegation that Derek Murphy had said to another 4 detainee, "Tell him, if he keeps going, I am going to 5 smash the fucking shit out of him" and "I am going to 6 smash you right up". On this occasion, chair, we can 7 see the footage, we can see who Derek Murphy was talking 8 to, not Callum Tulley but Gary Croucher. 9 The last assertion, chair, the last criticism, which 10 was made the most often of all, is the criticism that 11 Callum Tulley had recorded the footage for his own 12 professional advancement or financial gain. Of course, 13 that assertion was made by officers and also, 14 regrettably, by senior management. It was an assertion 15 that was baseless. Callum Tulley explained to you, on 16 a number of occasions, that he had no dream to become 17 a journalist, but that he had felt compelled to speak to 18 the BBC about what he had witnessed at Brook House and 19 all of the evidence suggests, chair, that Callum Tulley 20 acted in good faith and in the public interest. 21 The purpose of exploring that criticism is clear, 22 chair. First, it doesn't stand up to scrutiny, as we 23 have seen. Second, it provides evidence of the culture 24 at Brook House. Callum Tulley told you, chair, that he 25 always feared that if he blew the whistle, he would face</p> <p style="text-align: center;">Page 10</p>	<p>1 My first topic will be as to the important role 2 played by inspection generally as a safeguard to protect 3 against mistreatment; secondly, as to the 2016 4 inspection of Brook House in particular; and, thirdly, 5 and very briefly, I will highlight the changes made 6 following Panorama; and finally I am going to turn, 7 again very briefly, to potential further improvements. 8 My first topic, safeguard -- inspection, sorry, as 9 a safeguard. It is chair, well recognised in domestic 10 and international law that independent inspection of 11 places of detention provides a powerful safeguard to 12 detect mistreatment. Independent visits to places of 13 detention is a central tenet of OPCAT. Why? 14 Dr Hindpal Singh Bhui, in his live evidence, was asked 15 almost as his first question, "What was the purpose of 16 an inspection?" He replied, and I quote: 17 "I think it has multiple purposes. One of the most 18 important is to make sure that nothing is hidden, that 19 what goes on inside immigration detention is open to 20 public scrutiny and that the views of detainees, the 21 experiences of people in detention are publicised. It 22 is also about improvement. It is making sure that 23 centres that aren't doing well enough in terms of 24 keeping people safe, providing respectful conditions, 25 providing enough activities and providing enough support</p> <p style="text-align: center;">Page 12</p>

<p>1 for them, that those things are highlighted and they</p> <p>2 have an opportunity to improve on areas where we think</p> <p>3 they are not doing well enough. These are the purposes,</p> <p>4 but, to evaluate inspection as a safeguard, it is also</p> <p>5 important to understand what an inspection is and what</p> <p>6 it does."</p> <p>7 I highlight this because it would be wrong to treat</p> <p>8 as if they are limits or weaknesses or flaws of</p> <p>9 inspection matters which are outside of inspection,</p> <p>10 which are the responsibility of others.</p> <p>11 It follows from your approach that you appreciate</p> <p>12 the distinction between the arrangements within</p> <p>13 Brook House and the role of external oversight bodies</p> <p>14 but that distinction is important. The first stage,</p> <p>15 chair, is local management, here by G4S and the</p> <p>16 Home Office. They are responsible for day-to-day</p> <p>17 running of the centre, including complying with</p> <p>18 individual Detention Centre Rules and processes and</p> <p>19 policies within the centre.</p> <p>20 They are responsible for ensuring compliance in</p> <p>21 familiar ways, the adequacy and success of which you are</p> <p>22 investigating, such as training, guidance, systems,</p> <p>23 management, supervision and so on. At the second stage,</p> <p>24 the Home Office and G4S are also responsible for</p> <p>25 monitoring that compliance, including Home Office</p> <p style="text-align: center;">Page 13</p>	<p>1 experience. They decide what they will look at,</p> <p>2 including the paperwork and processes in the centre.</p> <p>3 They set out, in a number of ways, to hear the voice and</p> <p>4 find out the experiences of those held in detention</p> <p>5 centres. They have total access and they know what they</p> <p>6 are doing. If they pick up evidence of an issue or</p> <p>7 a problem -- for example, from intelligence or</p> <p>8 a disclosure in an anonymous survey or a confidential</p> <p>9 interview -- they follow it through. This is the</p> <p>10 triangulation method you have heard about.</p> <p>11 As Dr Bhui explained in his live evidence, that</p> <p>12 method does not simplistically mean that information is</p> <p>13 only accepted if it is verified by multiple sources and</p> <p>14 discarded or ignored otherwise. Triangulation is about</p> <p>15 taking information received or obtained and seeing</p> <p>16 whether it is supported or verified by other sources,</p> <p>17 thereby strengthening the conclusion drawn from the</p> <p>18 information. As Dr Bhui put it, "All triangulation</p> <p>19 methodology really is, is making sure you have looked</p> <p>20 for as much evidence as possible to back up a finding."</p> <p>21 Aiming to verify information by multiple sources is</p> <p>22 a strength of the process, giving HMIP reports the</p> <p>23 rigour which means they ought to be taken seriously.</p> <p>24 Single voices are not ignored or discounted, they can</p> <p>25 still found a conclusion, where appropriate, and</p> <p style="text-align: center;">Page 15</p>
<p>1 contract monitoring and, again, chair, you are</p> <p>2 investigating the adequacy of that form of oversight.</p> <p>3 The third stage is internal audit. This is the</p> <p>4 provision of assurance. You will no doubt consider the</p> <p>5 extent to which this was being done and the</p> <p>6 effectiveness of governance structures within the</p> <p>7 Home Office and G4S.</p> <p>8 HMIP's role sits beyond these three stages. It is</p> <p>9 wholly independent of the organisations it inspects and</p> <p>10 its function is not one of ensuring compliance with</p> <p>11 rules or regulations. As you know, HMIP undertakes</p> <p>12 regular inspections of immigration removal centres and</p> <p>13 reports on the treatments of detained persons and</p> <p>14 conditions in those centres as judged against its own</p> <p>15 human-rights-driven expectations for appropriate</p> <p>16 conditions for detained persons.</p> <p>17 As was explained by Dr Bhui, HMIP's role, in</p> <p>18 essence, is "to do occasional deep-dive suspensions, to</p> <p>19 provide a good systemic analysis of what is happening in</p> <p>20 the institution and then we pass that information to</p> <p>21 others."</p> <p>22 HMIP does this by bringing in an experienced and</p> <p>23 professional team of researchers and inspectors. They</p> <p>24 have a range of relevant specialisms and expertise and</p> <p>25 draw from their different complementary backgrounds and</p> <p style="text-align: center;">Page 14</p>	<p>1 a prompt inquiry and follow-up, and contribute to the</p> <p>2 overall assessment, even if a specific finding is not</p> <p>3 able to be made. They are included in the process of</p> <p>4 feeding back to managers throughout the inspection, and</p> <p>5 they may appear, as I say, in the final report.</p> <p>6 For inspections to act as a safeguard, it is</p> <p>7 important that HMIP reaches robust, well evidenced</p> <p>8 conclusions. And there are two core reasons, chair.</p> <p>9 Firstly, HMIP expects inspected establishments to</p> <p>10 act on its findings. The inspectorate needs to be able</p> <p>11 to ensure those inspected, and the public, that its</p> <p>12 conclusions are sound and solidly based and, therefore,</p> <p>13 should be acted upon. To drive change, HMIP reports</p> <p>14 must be seen as authoritative.</p> <p>15 Secondly, there is little value in a report which</p> <p>16 does nothing more than recount the various information</p> <p>17 it has obtained. Without a systemic analysis of the</p> <p>18 evidence and clear findings, a report is less likely to</p> <p>19 be understandable to the public, less likely to be acted</p> <p>20 upon by institutions and, ultimately, less likely to</p> <p>21 improve outcomes for detained persons.</p> <p>22 In summary, the safeguard HMIP inspections provide</p> <p>23 is a strong and valuable one. Inspections are capable</p> <p>24 of driving change and improvements in the circumstances</p> <p>25 of persons who are detained, if used appropriately by</p> <p style="text-align: center;">Page 16</p>

4 (Pages 13 to 16)

<p>1 contractors and the Home Office.</p> <p>2 It must, therefore, be understood that it is not</p> <p>3 a weakness of inspection that inspectors strive to</p> <p>4 support findings with multiple sources; it is</p> <p>5 a strength. This method gives the reports authority and</p> <p>6 demands a proper response to the findings. It is not</p> <p>7 a weakness that inspections only occur periodically.</p> <p>8 The role is not one of day-to-day monitoring or</p> <p>9 oversight, but deep and thorough spot inspection by</p> <p>10 a wholly independent body. External day-to-day</p> <p>11 monitoring is also, chair, a valuable safeguard, but it</p> <p>12 is one which offers different insights and it is</p> <p>13 provided by other bodies. It is not a weakness that</p> <p>14 HMIP does not have enforcement powers. Enforcement</p> <p>15 responsibility would interfere with HMIP's essential and</p> <p>16 fundamental independence from those inspected.</p> <p>17 However, this does not mean that HMIP does not feel</p> <p>18 frustration if its recommendations are not acted upon,</p> <p>19 and meaningfully -- Dr Bhui made that clear in his</p> <p>20 evidence to you -- but this does not make HMIP</p> <p>21 recommendations futile or expose the limitation of</p> <p>22 inspections, it is a failure of implementation.</p> <p>23 If a concern is raised by the inspectorate, the</p> <p>24 answer to it must come from those responsible for the</p> <p>25 management, running, compliance and oversight of the</p> <p style="text-align: center;">Page 17</p>	<p>1 2016 inspection.</p> <p>2 Second, for the same reasons, there is no proper</p> <p>3 basis to find that there was a failure in the adequacy</p> <p>4 of inspections as a mechanism to detect mistreatment in</p> <p>5 2016.</p> <p>6 Third, there are important and relevant findings</p> <p>7 which were made in 2016 and which should have led to</p> <p>8 consideration, review and improvements, and I will take</p> <p>9 you, chair, to a small number.</p> <p>10 Fourth, and without stepping back from the</p> <p>11 submissions I have just made to you, you can confidently</p> <p>12 conclude that HMIP is an organisation which listens,</p> <p>13 responds to feedback, has improved and continues to</p> <p>14 proactively improve.</p> <p>15 Turning then to 2016, chair, there is at least one</p> <p>16 material difference between Brook House in November 2016</p> <p>17 and during the relevant period. That is staffing</p> <p>18 levels. As you know, between September 2016</p> <p>19 and April 2017, staff from neighbouring Tinsley House</p> <p>20 were relocated to Brook House. The Home Office witness,</p> <p>21 Michelle Smith, confirmed there were no understaffing</p> <p>22 days as against contract minimums in October</p> <p>23 and November 2016, and, I quote:</p> <p>24 "It was only upon the reopening of Tinsley House did</p> <p>25 staffing hours become a problem."</p> <p style="text-align: center;">Page 19</p>
<p>1 establishment. The inspection report provides</p> <p>2 a detailed analysis of the state of an immigration</p> <p>3 removal centre. It is then for the contractor and the</p> <p>4 Home Office to consider and take any appropriate action.</p> <p>5 As a final point before I leave this topic, chair,</p> <p>6 I should add that it should not be understood that HMIP</p> <p>7 recommendations are routinely ignored. They are not.</p> <p>8 For the most part, they are accepted and taken seriously</p> <p>9 by establishments, and this leads to improvements.</p> <p>10 Also, HMIP reports provide a rich source of information</p> <p>11 to the public and non-governmental organisations, who</p> <p>12 can themselves use the evidence in those reports, and</p> <p>13 HMIP's recommendations, to seek to bring about</p> <p>14 improvements.</p> <p>15 Chair, I turn now to my second topic, and from the</p> <p>16 general to the specific and the question of whether the</p> <p>17 2016 HMIP inspection itself was able to detect</p> <p>18 mistreatment.</p> <p>19 For the reasons I will shortly develop, HMIP will</p> <p>20 invite to you make the following key findings. First,</p> <p>21 because of the sparsity of the evidence and because of</p> <p>22 some significant differences between the conditions at</p> <p>23 Brook House in November 2016 and in the relevant period,</p> <p>24 you cannot safely find that HMIP missed a subculture of</p> <p>25 abuse or mistreatment as seen on Panorama during the</p> <p style="text-align: center;">Page 18</p>	<p>1 It was more than a matter of just meeting contracted</p> <p>2 levels. Steve Skitt of G4S confirmed that staffing in</p> <p>3 the 2016 window was "Very high, as you essentially had</p> <p>4 two centres' worth of staff working at one centre."</p> <p>5 Callum Tulley's notebooks, whilst mentioning</p> <p>6 a feeling of hostility in the centre, acknowledged that</p> <p>7 many of the consequences of understaffing were absent</p> <p>8 from the centre in the window up to the inspection,</p> <p>9 recording, on 10 October 2016, that this was "somewhat</p> <p>10 softening the impact of the Brook House population</p> <p>11 increase". You will note, of course that</p> <p>12 notwithstanding the relatively high staff levels at the</p> <p>13 time of the inspection, the report nonetheless mentions</p> <p>14 that staff were still "under pressure and busy".</p> <p>15 Dr Bhui was challenged by counsel to the inquiry as</p> <p>16 to why the report did not include a finding that there</p> <p>17 was a lack of staff. Dr Bhui did not agree that such</p> <p>18 a finding should have been made, explaining as to</p> <p>19 understaffing, and I quote:</p> <p>20 "I think almost certainly, in my view, it would have</p> <p>21 emerged quite strongly from other evidence if that was</p> <p>22 a big concern at the time we inspected."</p> <p>23 Chair, understaffing also wasn't a feature of the</p> <p>24 window running up to the inspection. The relatively</p> <p>25 high-level of staff had been in place since</p> <p style="text-align: center;">Page 20</p>

<p>1 the September. In 2016, at the time of the HMIP</p> <p>2 inspection, the average length of detention in</p> <p>3 Brook House was 48 days and 78 per cent of detainees had</p> <p>4 been in the centre for less than two months.</p> <p>5 This means that the great majority of those who were</p> <p>6 detained in Brook House at the time of the HMIP</p> <p>7 inspection will have not known anything other than the</p> <p>8 higher Tinsley House supplemented staffing numbers. The</p> <p>9 22 per cent who had been in Brook House longer had still</p> <p>10 benefited from higher staff levels for some weeks before</p> <p>11 inspectors arrived.</p> <p>12 The difference in staffing levels is important</p> <p>13 because of the evidence you have heard from detained</p> <p>14 persons and from staff about the consequences of</p> <p>15 understaffing. Activities could not be opened,</p> <p>16 courtyards stayed shut, everyday queries and requests</p> <p>17 from detained persons, for cleaning products or paper or</p> <p>18 any other small thing, went unanswered. You have heard</p> <p>19 that this increased levels of tension among detained</p> <p>20 persons, which itself was capable of triggering</p> <p>21 incidents of aggravation or apparent aggression. Such</p> <p>22 incidents drew staff time and attention and thereby</p> <p>23 exacerbated the cycle as staff numbers and time were yet</p> <p>24 further reduced.</p> <p>25 Staff, too, were caught in the cycle. You have</p> <p style="text-align: center;">Page 21</p>	<p>1 This undermines the suggestion that HMIP missed</p> <p>2 a culture of abuse, active in November 2016, and it also</p> <p>3 undermined any suggestion that inspection is, in</p> <p>4 conjunction with other safeguards, an inadequate</p> <p>5 safeguard to detect such abuse.</p> <p>6 Chair, I now turn to important findings which were</p> <p>7 made in 2016 and draw out a small number of matters</p> <p>8 which have taken up time in the evidence, and these are</p> <p>9 understanding, firstly, the healthy establishment test</p> <p>10 scores; secondly, the physical environment at</p> <p>11 Brook House, including the additional 60 beds; thirdly,</p> <p>12 the use of force; and, fourthly, healthcare.</p> <p>13 Firstly, understanding HMIP's four healthy</p> <p>14 establishment test scores. In each of these tests in</p> <p>15 2016, Brook House was given a score of "reasonably</p> <p>16 good". This phrase does not mean the centre was</p> <p>17 reasonably good. What it means is set out in the report</p> <p>18 itself, and I quote:</p> <p>19 "There is evidence of adverse outcomes for detainees</p> <p>20 in only a small number of areas. For the majority,</p> <p>21 there are no significant concerns. Procedures to</p> <p>22 safeguard outcomes are in place."</p> <p>23 The then chief inspector, Peter Clarke, made clear</p> <p>24 that the 2016 inspection was an encouraging one. This</p> <p>25 comment should not be divorced from its context. In his</p> <p style="text-align: center;">Page 23</p>
<p>1 heard a great deal of evidence about tiredness,</p> <p>2 frustration and short fuses amongst the staff,</p> <p>3 consequential upon the understaffing situation. For</p> <p>4 example, Owen Syred stated in his written evidence that</p> <p>5 shortages left staff feeling overwhelmed, undervalued</p> <p>6 and absolutely worn out, and it negatively impacted on</p> <p>7 the welfare of detainees, including the mental health of</p> <p>8 detainees, because of the lack of staff available to</p> <p>9 listen.</p> <p>10 Of course staffing levels are not the only important</p> <p>11 factor, but in this case, the higher staffing levels may</p> <p>12 have made a contribution to the information which HMIP</p> <p>13 obtained at the time of the inspection, including during</p> <p>14 group interviews, at which detained persons described</p> <p>15 relationships with staff as a strength of the centre.</p> <p>16 Likewise, 77 per cent of detainees surveyed said that</p> <p>17 staff treated them with respect, and that increased to</p> <p>18 84 per cent amongst those who did not speak English.</p> <p>19 Overall, therefore, there are good reasons to</p> <p>20 conclude that the better staffing levels at the time of</p> <p>21 the 2016 inspection meant that, at that time, the centre</p> <p>22 was in a better state, affecting positively the data</p> <p>23 received by HMIP and the evidence accrued in respect of,</p> <p>24 most obviously, the safety of and respect for detained</p> <p>25 persons.</p> <p style="text-align: center;">Page 22</p>	<p>1 written evidence, Owen Syred, who first worked at</p> <p>2 Brook House in 2009, stated that, in 2010, Brook House</p> <p>3 was a "dreadful place", and he remembers, at that time,</p> <p>4 that HMIP inspectors did not feel safe. Dr Bhui</p> <p>5 explains in his second written statement that the 2010</p> <p>6 inspection report, Brook House received the worst</p> <p>7 possible rating for safety, one of "poor", and it was</p> <p>8 assessed as "not sufficiently good" for all other tests.</p> <p>9 And in the 2013 report, the preparation for release test</p> <p>10 was "not sufficiently good".</p> <p>11 That history makes clear that things were better at</p> <p>12 the time of the inspection, in 2016, compared to earlier</p> <p>13 reports.</p> <p>14 The report clearly explains that the four sections</p> <p>15 of the report dealing with each of the four healthy</p> <p>16 establishment tests contain "a detailed account of our</p> <p>17 findings against our expectations".</p> <p>18 A proper read of these findings makes clear that the</p> <p>19 report is densely packed with information which should</p> <p>20 have led to a consideration, review and action by the</p> <p>21 establishment and the Home Office.</p> <p>22 It has, therefore, been disheartening to hear</p> <p>23 witnesses for organisations with responsibility for</p> <p>24 compliance, monitoring or governance refer to HMIP as</p> <p>25 somehow having given Brook House a clean bill of health</p> <p style="text-align: center;">Page 24</p>

<p>1 following the 2016 inspection. It should not have been</p> <p>2 possible to read the 2016 findings and conclude that</p> <p>3 Brook House had no work to do.</p> <p>4 My second point from the 2016 report, HMIP has been</p> <p>5 highly critical of the physical environment at</p> <p>6 Brook House. You have heard a lot of evidence from</p> <p>7 witnesses at all levels about this and you may find in</p> <p>8 due course that the physical environment at Brook House</p> <p>9 was facilitative to some of the ill-treatment you are</p> <p>10 investigating. If you do do this, it is important that</p> <p>11 when you then come to consider the effectiveness of the</p> <p>12 safeguard of inspection, it being appreciated that these</p> <p>13 points were raised powerfully and promptly by HMIP. The</p> <p>14 introduction to the report noted:</p> <p>15 "The residential units very closely resembled the</p> <p>16 conditions found in prisons and these were exacerbated</p> <p>17 by poor ventilation and unsatisfactory sanitary</p> <p>18 facilities."</p> <p>19 And within the key findings, it was stated:</p> <p>20 "The residential units remain stark and impersonal</p> <p>21 in design. Apart from paintings by detainees, the</p> <p>22 environment had not been softened. Many cells lacked</p> <p>23 curtains and many in-cell toilets were not curtained</p> <p>24 off. Many cells had ingrained dirt, especially in the</p> <p>25 toilets, and those on C wing were in the worst</p> <p style="text-align: center;">Page 25</p>	<p>1 not get anything like a clean bill of health. HMIP made</p> <p>2 a number of findings about the use of force which was</p> <p>3 observed during the 2016 inspection, including: one, use</p> <p>4 of force had increased in the six months up to the</p> <p>5 inspection window as compared with the six months</p> <p>6 running up to the 2013 inspection; two, use of force was</p> <p>7 used proportionately and as a last resort in most, but</p> <p>8 not all, cases; three, echoing evidence you have</p> <p>9 recently heard from Jon Collier, HMIP inspectors found</p> <p>10 that video footage revealed mixed practice: some</p> <p>11 incidents took too long to resolve once force had been</p> <p>12 initiated and a description was given of</p> <p>13 an inappropriate use of force, and that was the use of</p> <p>14 a shield to restrain a passive detainee; fourth, video</p> <p>15 footage also revealed that waist restraint belts may not</p> <p>16 have been used as a last resort by Tascor; and, five,</p> <p>17 a use of force observed during the inspection itself was</p> <p>18 described as "chaotic".</p> <p>19 These findings led to a recommendation by HMIP that</p> <p>20 all use of force should be necessary, proportionate and</p> <p>21 competently applied. There should be no confusion, this</p> <p>22 recommendation was made because it was the view of</p> <p>23 inspectors that this was not always happening in</p> <p>24 Brook House in November 2016, as indeed Dr Bhui also</p> <p>25 confirmed to you in his live evidence.</p> <p style="text-align: center;">Page 27</p>
<p>1 condition. The lack of ventilation was the most common</p> <p>2 complaint and many cells were too stuffy overnight."</p> <p>3 The condition of the residential units led to one of</p> <p>4 the two main concerns and recommendations in the 2016</p> <p>5 report.</p> <p>6 Dr Bhui underlines the significance of these</p> <p>7 recommendations in his evidence, explaining that</p> <p>8 Brook House "is a centre which looks and feels like</p> <p>9 a prison and it is designed like a prison. As we have</p> <p>10 said many times, that is inappropriate for a detainee</p> <p>11 population."</p> <p>12 The chief inspector also said in the introduction to</p> <p>13 the 2016 report that the proposal to bring in the third</p> <p>14 beds installed already in two-person cells into use "has</p> <p>15 the potential to adversely affect the conditions in</p> <p>16 which some detainees are held". And the inspectors</p> <p>17 agreed it would lead to a decline in living standards.</p> <p>18 As to this, Dr Bhui explained that a formal</p> <p>19 recommendation was not appropriate because the change</p> <p>20 had not yet happened, or even been approved, but this</p> <p>21 was a caution in stark terms. It is hard to see how, at</p> <p>22 that stage, HMIP could have put its concern more clearly</p> <p>23 or prominently.</p> <p>24 My third point, I want to draw out HMIP's</p> <p>25 conclusions on the use of force because this, too, did</p> <p style="text-align: center;">Page 26</p>	<p>1 The report also noted as to governance of use of</p> <p>2 force that managers reviewed all incidents to learn and</p> <p>3 disseminate lessons and it was described as "very good".</p> <p>4 At this distance, little more detail is available within</p> <p>5 HMIP as to the exact systems in place during the</p> <p>6 inspection period as opposed to the relevant period.</p> <p>7 The inquiry has heard that improvement of use of force</p> <p>8 governance had been a focus for Lee Hanford during his</p> <p>9 period as director in 2016, March to July, and that use</p> <p>10 of force matters were often escalated to the SMT and</p> <p>11 other specific leadership team meetings.</p> <p>12 The answer is not clear, but these matters might</p> <p>13 indicate that governance had deteriorated subsequent to</p> <p>14 the HMIP inspection.</p> <p>15 Dr Bhui was asked whether HMIP might have missed</p> <p>16 evidence of abuse in light of the contents of the</p> <p>17 anonymous detainee survey. In 2016, the survey included</p> <p>18 responses from four detained persons that they had been</p> <p>19 physically assaulted by a member of staff. Of course</p> <p>20 this is a piece of evidence to be taken seriously, but</p> <p>21 that survey result is not enough on its own to safely</p> <p>22 conclude that there was a culture of abuse of the type</p> <p>23 seen on Panorama. Some of these responses may have been</p> <p>24 describing what were, in fact, lawful uses of force, the</p> <p>25 survey responses alone don't give us enough to know, but</p> <p style="text-align: center;">Page 28</p>

7 (Pages 25 to 28)

<p>1 as I have already mentioned, what they do do is prompt</p> <p>2 further research and inquiry.</p> <p>3 My fourth and final point on the topic of the 2016</p> <p>4 inspection. In relation to healthcare, the 2016 report</p> <p>5 raised relevant concerns. Rule 35 reports "did not</p> <p>6 provide an adequate safeguard for detainees with</p> <p>7 post-traumatic stress disorder (PTSD)", and recommended</p> <p>8 that "where a detainee claims they have been tortured,</p> <p>9 the rule 35 report should include an assessment of</p> <p>10 PTSD."</p> <p>11 The report also raised concerns about the healthcare</p> <p>12 complaints system, compromising medical confidentiality</p> <p>13 and in relation to the need for reasonable access to</p> <p>14 translated information about health services and health</p> <p>15 and wellbeing. Nonetheless, Dr Bhui was asked about</p> <p>16 a small number of other areas where, candidly, he</p> <p>17 accepted that findings might have been more critical or</p> <p>18 would now have been more critical.</p> <p>19 These were in respect of reporting detainee feedback</p> <p>20 more strongly, whether the specific criticism which HMIP</p> <p>21 made in 2019 about the lack of rule 35(1) and (2)</p> <p>22 reports might also have been made in 2016, and whether</p> <p>23 it was too positive to describe half the staff having</p> <p>24 received mental health training as "commendable". He</p> <p>25 accepted these points, though you may conclude that this</p> <p style="text-align: center;">Page 29</p>	<p>1 evidence, and I quote:</p> <p>2 "We offer every single detainee an interview. We</p> <p>3 have no systematic way of ensuring that every person who</p> <p>4 is vulnerable speaks to us, but they have certainly got</p> <p>5 the opportunity to come forward. We identify people</p> <p>6 through other means as well. So, for example, the</p> <p>7 safeguarding inspector might identify someone through</p> <p>8 a rule 35 and we might make a point of going to speak to</p> <p>9 that person."</p> <p>10 Second, all staff are now given the opportunity to</p> <p>11 respond to an anonymous survey that they can complete</p> <p>12 outside the establishment and, where staff identify</p> <p>13 themselves, they can follow up discussions and</p> <p>14 interviews may be arranged. A range of access to staff</p> <p>15 allows HMIP to better identify problems in leadership,</p> <p>16 staffing levels, morale and culture which may affect</p> <p>17 outcomes for detained persons.</p> <p>18 In view of the evidence concerning the difficulty</p> <p>19 that staff faced in coming forward with concerns, you</p> <p>20 may consider that an anonymous staff survey is</p> <p>21 a valuable tool in assessing the state of affairs at</p> <p>22 an immigration removal centre.</p> <p>23 Third, NGOs are now proactively contacted by</p> <p>24 inspectors at the outset of inspections and expressly</p> <p>25 invited to contribute information and put detained and</p> <p style="text-align: center;">Page 31</p>
<p>1 is good evidence of HMIP's ongoing willingness to</p> <p>2 improve, but these observations do not undermine the</p> <p>3 overall validity of the 2016 report.</p> <p>4 Chair, my third headline topic is the changes which</p> <p>5 were made in response to Panorama. In HMIP's opening</p> <p>6 statement, I explained a little about the enhanced</p> <p>7 methodology which HMIP brought in following Panorama.</p> <p>8 As Dr Bhui explains in his first statement, HMIP</p> <p>9 reviewed its methodology with a view to whether it could</p> <p>10 increase the likelihood of identifying individual</p> <p>11 incidents of mistreatment and systemic risks in IRCs.</p> <p>12 You have detailed evidence about the changes in</p> <p>13 Dr Bhui's witness statement and how they came about, as</p> <p>14 well as the careful review of the efficacy which</p> <p>15 followed.</p> <p>16 The enhancements were designed to encourage greater</p> <p>17 engagement and so obtain more information from detained</p> <p>18 persons, staff and third party organisations. There is</p> <p>19 now a greater opportunity for detained persons and staff</p> <p>20 to tell inspectors in confidence about concerns over</p> <p>21 safety or treatment. First, every detained person is</p> <p>22 now often interviewed with an inspector, using</p> <p>23 interpretation where needed. This opportunity is also</p> <p>24 extended to persons who were recently detained in the</p> <p>25 centre in question, as Dr Bhui explained in his live</p> <p style="text-align: center;">Page 30</p>	<p>1 formerly detained persons with whom they are in contact</p> <p>2 in touch with HMIP inspectors. Systematic contact with</p> <p>3 non-governmental organisations strengthens flows of</p> <p>4 communication and intelligence, assists in giving leads</p> <p>5 to follow and further works to ensure that the voices of</p> <p>6 detained persons are heard by inspectors.</p> <p>7 Overall, HMIP's enhanced methodology provides</p> <p>8 greater opportunity for inspectors to identify potential</p> <p>9 concerns. HMIP believes the enhancements will better</p> <p>10 enable it to detect a culture or subculture of abusive</p> <p>11 practice. These changes were designed and driven by</p> <p>12 HMIP and they were already in place by mid October 2017.</p> <p>13 You may consider that HMIP reacted commendably swiftly</p> <p>14 to Panorama. In his evidence in phase 1, Nathan Ward</p> <p>15 stated that HMIP was, "the only organisation following</p> <p>16 Panorama to actively want to learn and sit down", which</p> <p>17 we did, and we met following Panorama.</p> <p>18 Since that time, HMIP has also introduced a focus on</p> <p>19 leadership when undertaking inspections. In his witness</p> <p>20 statement, HMCIP, Charlie Taylor, said this would be</p> <p>21 carefully considered in view of the importance of good</p> <p>22 leadership at an immigration removal centre for outcomes</p> <p>23 for detained persons.</p> <p>24 Most recently, HMIP has consulted on changes to the</p> <p>25 ways in which it makes recommendations. The suggestion</p> <p style="text-align: center;">Page 32</p>

<p>1 is to replace around 30 recommendations per inspection 2 with a smaller number of key concerns. These concerns 3 will still identify what must be resolved by the centre, 4 and the Home Office, and an action plan will be required 5 that sets out exactly how and when identified problems 6 will be remedied. As Dr Bhui explained in his evidence, 7 the idea is to reduce the scope for expected 8 establishments to claim success in responding to 9 recommendations, when they had just picked off 10 low-hanging fruit. The new key concerns would all be 11 important matters and demand action, but the body of the 12 inspection report will remain replete with other 13 information which establishments will be inspected to 14 study carefully.</p> <p>15 Chair, my final topic, very briefly, further 16 improvements. As I indicated to you back in opening 17 in November of last year, HMIP is listening and 18 following this inquiry closely. It always strives to 19 improve. I draw out four short examples which were 20 raised during the hearings.</p> <p>21 Firstly, the receipt of intelligence. Under the 22 enhanced methodology, HMIP now proactively approaches 23 non-governmental organisations and advocacy groups, 24 ahead of inspections to ask for information and to help 25 in making contact with those who may wish to speak to</p> <p style="text-align: center;">Page 33</p>	<p>1 involvement that might harm its independence. However, 2 as Dr Bhui confirmed, HMIP will reflect upon whether DCO 3 training can be considered as part of its thematic work.</p> <p>4 Finally, HMIP will consider whether the evidence 5 presented during the inquiry can form a useful training 6 case study for its own inspectors, particularly in 7 relation to reviewing use of force incidents and 8 assessing the effectiveness of rule 35 reports.</p> <p>9 Chair, I conclude these closing remarks by saying 10 this. Independent inspection is an essential and 11 effective safeguard to detect abuse. The inspection of 12 Brook House Immigration Removal Centre in November 2016 13 was delivered by a professional inspectorate, committed 14 to, and effective in, improving outcomes for persons 15 held in detention. Even though there may have been 16 relevant differences in the conditions in 2017 from 17 those during the inspection in 2016, HMIP made findings 18 and recommendations which should have led to changes and 19 improvements.</p> <p>20 In the wake of Panorama, HMIP reacted promptly to 21 the possibility it might have missed something during 22 the 2016 inspection, making sensible and meaningful 23 enhancements to its methodology.</p> <p>24 It continues in the same vein to this day, building 25 on what it does well but open to changes which will help</p> <p style="text-align: center;">Page 35</p>
<p>1 the inspectorate. HMIP also makes it clear that it is 2 willing to receive intelligence and information through 3 other means; its email address and phone number are 4 already advertised in places of detention and during 5 inspections. However, more could be done here to ensure 6 that HMIP consistently receives information which might 7 be relevant, firstly, to assessing when a further 8 inspection is required of a particular place, and, 9 secondly, informing inquiries and findings during 10 an inspection.</p> <p>11 HMIP will continue to reflect on what information, 12 and in what form, would most be useful to it to achieve 13 those aims.</p> <p>14 Secondly, the voice and reported experience of the 15 detained person. I have explained the triangulation 16 methodology and its value, but this does not mean that 17 the voice of detained persons should not be clear from 18 the report. Dr Bhui candidly expressed his view that 19 there was value in giving more space to this within the 20 healthcare sections of the report and, chair, this is 21 already under discussion within HMIP.</p> <p>22 Thirdly, Professor Bosworth suggested that HMIP 23 might have a role in the training of DCOs. It would not 24 be appropriate for HMIP to be involved in the management 25 or oversight of DCO training or have any other type of</p> <p style="text-align: center;">Page 34</p>	<p>1 it do better and set out what it always sets out to do: 2 improve outcomes for detained persons.</p> <p>3 Chair, thank you very much.</p> <p>4 THE CHAIR: Thank you very much, Ms Mannion. Mr Dixey?</p> <p>5 Closing statement by MR DIXEY</p> <p>6 MR DIXEY: Chair, I make this closing statement on behalf of 7 the Independent Monitoring Board. In addition, we will 8 provide you with written submissions which will address, 9 in greater detail, the issues which have arisen from the 10 evidence that has been adduced.</p> <p>11 As I said in our opening remarks, the IMB welcomes 12 this inquiry. As anticipated, it has provided 13 an opportunity to formerly detained persons to speak 14 openly about their experiences whilst at Brook House.</p> <p>15 The inquiry has posed fundamental questions of how 16 the immigration detention system operated in 2017, and 17 continues to operate today.</p> <p>18 As the Brook House IMB said in its 2017 annual 19 report, it was horrified by the behaviour shown in 20 Panorama. It is now apparent that the mistreatment and 21 abuse within Brook House was even more widespread than 22 was shown during Panorama. The conduct which this 23 inquiry has revealed is reprehensible and inexcusable. 24 There can be no doubt that, in light of the evidence 25 which you have seen and heard, at least some formerly</p> <p style="text-align: center;">Page 36</p>

<p>1 detained persons were subjected to treatment that was</p> <p>2 inhuman and degrading. Some behaviour went well beyond</p> <p>3 even that.</p> <p>4 This inquiry has uncovered a culture of -- amongst</p> <p>5 Brook House staff and management that failed to secure</p> <p>6 the safety and basic dignity of detained persons. That</p> <p>7 culture went beyond isolated incidents by a small number</p> <p>8 of staff. The inquiry has revealed evidence that</p> <p>9 unacceptable conduct and attitudes had become normalised</p> <p>10 within the staff at Brook House. There was a culture</p> <p>11 amongst staff of not reporting concerns about their</p> <p>12 colleagues internally, as well as to the IMB and other</p> <p>13 external bodies.</p> <p>14 Indeed, there is a substantial quantity of evidence</p> <p>15 which supports a finding that some members of centre</p> <p>16 staff acted so as to keep abuse hidden. Uses of force</p> <p>17 were not reported, paperwork was not completed, or was</p> <p>18 completed inaccurately, body-worn video was not</p> <p>19 activated and, as Callum Tulley explained, abuse</p> <p>20 frequently occurred out of the sight of CCTV.</p> <p>21 It is difficult to accept that such behaviour was</p> <p>22 limited to a small number of junior staff. The evidence</p> <p>23 clearly suggests that some frontline managers accepted</p> <p>24 or colluded with this behaviour and that senior</p> <p>25 management did not exercise effective oversight. On</p> <p style="text-align: center;">Page 37</p>	<p>1 were people in organisations external to, and</p> <p>2 independent of, the centre and Home Office. Therefore,</p> <p>3 we submit that the reason why abuse was not identified</p> <p>4 is not simply a question of independence.</p> <p>5 It is clear from the perspective of the detained</p> <p>6 population that there were significant barriers to</p> <p>7 reporting concerns to the IMB and others. Again, the</p> <p>8 causes of those barriers are complex, but they include:</p> <p>9 firstly, a concern that, if a complaint were made, it</p> <p>10 might prejudice a detained person's immigration status</p> <p>11 or that they would otherwise be subject to reprisals;</p> <p>12 second, a lack of awareness of the IMB and its role;</p> <p>13 third, the misconception that the IMB was part of the</p> <p>14 centre management or Home Office; and, four, language</p> <p>15 barriers. All are matters of concern to the IMB and it</p> <p>16 is working hard to address these barriers.</p> <p>17 Before turning to the criticisms which have been</p> <p>18 made of the IMB in 2017, it is important to set out the</p> <p>19 role and purpose of the IMB. It is important to do so</p> <p>20 because the evidence from certain witnesses to the</p> <p>21 inquiry has revealed a significant misunderstanding of</p> <p>22 the IMB's role.</p> <p>23 We recognise that that misunderstanding is at least</p> <p>24 in part because of the way in which some board members</p> <p>25 summarise their role when interviewed by Kate Lampard</p> <p style="text-align: center;">Page 39</p>
<p>1 Day 6 of the inquiry, Mr Tulley gave evidence, amongst</p> <p>2 a number of other days. During that evidence, he agreed</p> <p>3 with counsel to the inquiry that mistreatment might be</p> <p>4 considered to arise in three ways: first, the deliberate</p> <p>5 acts of physical and verbal abuse of the kind shown on</p> <p>6 Panorama; second, the harms caused by the nature of the</p> <p>7 immigration process, including the uncertain length of</p> <p>8 detention; and, third, the impact of the physical</p> <p>9 environment or conditions of detention.</p> <p>10 In 2016 and 2017, the IMB had reported on, and</p> <p>11 raised concerns about, the second and third of those</p> <p>12 factors. However, it is now painfully apparent that the</p> <p>13 IMB, along with other oversight bodies and the onsite</p> <p>14 Home Office contract monitors did not identify and</p> <p>15 prevent the abuse and mistreatment of the first kind.</p> <p>16 The IMB is not unique in not identifying the</p> <p>17 deliberate acts of physical and verbal abuse of the kind</p> <p>18 shown on Panorama. Along with HMIP, you have received</p> <p>19 evidence from Anton Bole of the Forward Trust,</p> <p>20 Dr Dominic Aitken and Jamie MacPherson of the Gatwick</p> <p>21 Detainee Welfare Group, all of whom were unaware of the</p> <p>22 abuse shown on Panorama. The fact that all of these</p> <p>23 people and organisations were unaware of what was</p> <p>24 revealed indicates that the reasons why this abuse</p> <p>25 remained hidden are complex and multi-factorial. These</p> <p style="text-align: center;">Page 38</p>	<p>1 and Ed Marsden. You will recall that Professor Bosworth</p> <p>2 was asked about the quoted comments that the IMB were,</p> <p>3 "monitors really, rather than resolvers of problems."</p> <p>4 As Professor Bosworth put it, such a description</p> <p>5 oversimplifies the IMB's role. We agree; it does</p> <p>6 oversimplify the IMB's role. Ms Colbran addressed this</p> <p>7 exact point in her witness statement, at paragraph 188.</p> <p>8 She explains that the way she expressed herself during</p> <p>9 the interview with Ms Lampard and Mr Marsden was</p> <p>10 demonstrably inaccurate. She and the board spent</p> <p>11 a considerable amount of time in Brook House resolving</p> <p>12 problems for detained people. As she puts it, "We saw</p> <p>13 that as a major part of our role."</p> <p>14 This characterisation also does not accord with the</p> <p>15 material which has been placed before you. As the 2017</p> <p>16 annual report shows, in that year, the IMB received 123</p> <p>17 written applications; in 2016, it received 87 such</p> <p>18 applications. During rota visits, board members dealt</p> <p>19 with a much higher number of concerns raised with them</p> <p>20 orally. There are, within the papers, many instances of</p> <p>21 board members seeking to resolve the problems of the</p> <p>22 detained men which were raised with the IMB.</p> <p>23 It is, we submit, to misunderstand the IMB's role,</p> <p>24 to suggest that members only concerned themselves with</p> <p>25 the heating, cleanliness and the absence of complaint</p> <p style="text-align: center;">Page 40</p>

<p>1 forms. These are important matters to detained persons;</p> <p>2 however, the evidence before the inquiry clearly shows</p> <p>3 the IMB was engaged in much more besides this.</p> <p>4 IMB members were far more than passive observers</p> <p>5 within the centre and regularly raised matters of</p> <p>6 concern with those responsible for the care of those</p> <p>7 detained.</p> <p>8 As members of the local community, IMB members are</p> <p>9 the public's eyes and ears within places of detention.</p> <p>10 Board members' regular presence in an establishment</p> <p>11 gives them a unique insight into the day-to-day</p> <p>12 experience of detained persons. Their work complements,</p> <p>13 but does not replicate, the work of other members of the</p> <p>14 National Preventive Mechanism, such as HMIP and the PPO.</p> <p>15 As Professor Bosworth explained in her evidence, there</p> <p>16 is great value in having transparent and reliable</p> <p>17 information of what happens within closed environments</p> <p>18 such as Brook House.</p> <p>19 IMB members, who are a regular, albeit not</p> <p>20 permanent, presence, bring their varied life experience</p> <p>21 to bear on what they see and find, to record the actual</p> <p>22 outcomes for those in detention. Their reports form</p> <p>23 a crucial part of the civic dialogue concerning</p> <p>24 detention and the experiences of those who are detained.</p> <p>25 You have received two statements from the chair of</p> <p style="text-align: center;">Page 41</p>	<p>1 and annually in their annual reports.</p> <p>2 Addressing, if I may, the IMB's 2017 annual report</p> <p>3 itself, the IMB accepts that the 2017 annual report</p> <p>4 should have been more critical and challenging. The IMB</p> <p>5 accepts that, in light of what is now known, it was</p> <p>6 plainly wrong to say that the centre kept detained</p> <p>7 persons as safe as it could. Whilst the IMB's 2016 and</p> <p>8 2017 annual reports were broadly positive, it is wrong</p> <p>9 to read them as raising no issues about the safety of</p> <p>10 the centre or the treatment of detained persons during</p> <p>11 those respective reporting years. In both the 2016 and</p> <p>12 2017 annual reports, the IMB identified serious issues</p> <p>13 which required the attention of the minister, the</p> <p>14 Home Office and the centre.</p> <p>15 To refer to just some of those issues within the</p> <p>16 2016 and 2017 annual reports only, in 2016, the board</p> <p>17 raised concerns about delays in access to mental health</p> <p>18 treatment. It raised concerns about locating those with</p> <p>19 mental health issues on the CSU. In 2016, the board</p> <p>20 raised concerns and required a response on the use of</p> <p>21 night transfers, because the board did not believe that</p> <p>22 the impact on the care and welfare of individual</p> <p>23 detained men was being taken into account.</p> <p>24 In 2016, the board specifically challenged the</p> <p>25 length of time people were detained at Brook House. In</p> <p style="text-align: center;">Page 43</p>
<p>1 the NPM -- the National Preventive Mechanism --</p> <p>2 John Wadham. The IMB notes and agrees with Mr Wadham's</p> <p>3 observations in his second statement. I quote:</p> <p>4 "The external oversight [as he outlines] offered by</p> <p>5 national and international bodies cannot, alone, prevent</p> <p>6 all ill-treatment occurring in detention. As identified</p> <p>7 by leading academics, it is not realistic to presume</p> <p>8 that one institution, whether that be the SPT [the UN</p> <p>9 Subcommittee on the Prevention of Torture], at the</p> <p>10 international level, or the NPM, at the national level,</p> <p>11 will be able to achieve this single-handedly. It needs</p> <p>12 to be placed within the broader context of factors that</p> <p>13 play a part."</p> <p>14 Boards do not have a regulatory role. They can</p> <p>15 alert managers to problems and can offer advice and</p> <p>16 recommendations to the centre management, the</p> <p>17 Home Office or the minister. However, they are not</p> <p>18 responsible for the running of the centre or the</p> <p>19 oversight of contractual responsibilities.</p> <p>20 They can alert those who are responsible, the</p> <p>21 minister and the department, to any concerns. They do</p> <p>22 so weekly through their rota reports, monthly in</p> <p>23 meetings with centre and Home Office managers,</p> <p>24 periodically to senior Home Office officials or</p> <p>25 ministers, where there are issues of particular concern,</p> <p style="text-align: center;">Page 42</p>	<p>1 2016, the board recorded its concerns about the</p> <p>2 preparations to add the additional 60 beds and acquire</p> <p>3 three men to share one room. It raised similar concerns</p> <p>4 in 2014 and 2015. In 2016, the board highlighted that</p> <p>5 it was concerned by the handling of rule 35 requests and</p> <p>6 reports. In 2017, the board identified as areas for</p> <p>7 improvement to increase staffing levels, to improve the</p> <p>8 operation of the Adults at Risk policy, to implement</p> <p>9 advanced mental health training for staff who interact</p> <p>10 with vulnerable detained persons.</p> <p>11 In 2017, the board recorded concerns about the</p> <p>12 availability of drugs and alcohol within the centre.</p> <p>13 In that context, the IMB has become increasingly</p> <p>14 concerned to hear the evidence in this inquiry from some</p> <p>15 senior members of the Home Office and G4S as to the</p> <p>16 reliance placed upon both the IMB and HMIP to identify</p> <p>17 and report matters of concern up to and including abuse.</p> <p>18 To mention just three examples, if I may, first, you</p> <p>19 heard evidence from Michelle Smith. During the relevant</p> <p>20 period, she was the service delivery manager within the</p> <p>21 Home Office and responsible for overseeing performance</p> <p>22 under the contract at Brook House.</p> <p>23 You may think, having heard her evidence, that the</p> <p>24 Home Office had contracted out not just the running of</p> <p>25 the centre, but also its contractual oversight. That is</p> <p style="text-align: center;">Page 44</p>

<p>1 notwithstanding the fact that the IMB were not privy to</p> <p>2 the contract which the Home Office contract managers</p> <p>3 were meant to be monitoring, nor were the IMB members</p> <p>4 a permanent presence on site.</p> <p>5 Second, you heard evidence from Peter Neden,</p> <p>6 Jerry Petherick and Gordon Brockington, all of whom</p> <p>7 sought to rely on parts of HMIP and IMB reports or, as</p> <p>8 counsel to the inquiry suggested to Mr Brockington,</p> <p>9 seeking refuge in Peter Clarke's finding that</p> <p>10 Brook House was "reasonably good". Mr Neden accepted</p> <p>11 that G4S overrelied on the reports of external</p> <p>12 organisations.</p> <p>13 You may wonder how it is that a company the size of</p> <p>14 G4S, employing as many people as it did, operating</p> <p>15 a contract valued in the millions, say they came to rely</p> <p>16 quite so heavily on occasional HMIP visits and the nine</p> <p>17 unpaid members of the IMB.</p> <p>18 Third, you heard evidence from Philip Dove, who</p> <p>19 sought to rely on the IMB, HMIP and CQC, to monitor</p> <p>20 healthcare provision at Brook House. Putting to one</p> <p>21 side that the IMB does not have access to healthcare</p> <p>22 records, the IMB did raise concerns about healthcare</p> <p>23 provision, including about the application of rule 35.</p> <p>24 In respect of the IMB, arguably, the most serious</p> <p>25 criticisms are those which have questioned its</p> <p style="text-align: center;">Page 45</p>	<p>1 with caution Professor Bosworth's criticisms of the IMB</p> <p>2 in 2017, as set out in her report and oral evidence.</p> <p>3 First, it is not clear to us that Professor Bosworth</p> <p>4 had read the three statements submitted to you by</p> <p>5 Dame Anne Owers, Ms Colbran or Ms Molyneux.</p> <p>6 Second, Professor Bosworth had watched some of</p> <p>7 Ms Molyneux's oral evidence but none of Ms Colbran's.</p> <p>8 As you will recall, it was Ms Colbran who was the chair</p> <p>9 during the relevant period.</p> <p>10 Third, as Professor Bosworth explained when</p> <p>11 questioned by counsel to the inquiry, she was wrong</p> <p>12 about certain factual matters upon which she had relied</p> <p>13 in her statement; in particular, Professor Bosworth</p> <p>14 wrongly attributed to certain IMB members apparent</p> <p>15 criticism of some detained men and was wrong to say that</p> <p>16 IMB members "sat on a variety of centre committees."</p> <p>17 Those factual matters are important because it is</p> <p>18 those factual matters which led Professor Bosworth to</p> <p>19 conclude, in her first report, that there was a shared</p> <p>20 culture between officers and the 2017 board, and that</p> <p>21 the organisation was, "not fully independent and thus</p> <p>22 not performing adequately as a safeguard for human</p> <p>23 rights".</p> <p>24 During her oral evidence, John Connolly's</p> <p>25 observation in respect of the IMB, that "most of them</p> <p style="text-align: center;">Page 47</p>
<p>1 independence, in particular those made within the Verita</p> <p>2 report and by Professor Bosworth in her first report and</p> <p>3 oral evidence.</p> <p>4 As to the criticism made in the Verita report, the</p> <p>5 IMB took, and continues to take, seriously the</p> <p>6 suggestion that the board was overempathetic. This</p> <p>7 criticism appears to have been formed primarily on the</p> <p>8 basis of accounts of interactions between the IMB and</p> <p>9 GDWG, to which I will come shortly, and comments within</p> <p>10 the Verita interviews which were themselves not</p> <p>11 reflective of the totality of the board's role.</p> <p>12 As Dame Anne Owers has explained in her first</p> <p>13 statement, based on the evidence available to Ms Lampard</p> <p>14 and Mr Marsden, she can understand why they concluded</p> <p>15 there was a tendency to overempathise with centre</p> <p>16 managers and Home Office staff.</p> <p>17 However, we submit the board was independent, albeit</p> <p>18 the perception that it was not is a matter of great</p> <p>19 concern and did prompt action.</p> <p>20 Turning to Professor Bosworth's evidence, I make</p> <p>21 these submissions conscious that Professor Bosworth is</p> <p>22 an eminent academic with considerable experience and</p> <p>23 expertise on the issues which you, chair, will consider;</p> <p>24 however, it is you who has read, seen and listened to</p> <p>25 all evidence in this inquiry. We invite to you approach</p> <p style="text-align: center;">Page 46</p>	<p>1 were ex-prison officers", was put to Professor Bosworth.</p> <p>2 Putting to one side any reservations one may have about</p> <p>3 relying upon Mr Connolly as a reliable historian, this</p> <p>4 is plainly not correct. One of the then board was</p> <p>5 a former prison governor, there were no ex-prison</p> <p>6 officers. There were, amongst those, people with</p> <p>7 backgrounds in the law, teaching, and nursing.</p> <p>8 We accept that the use of language is important. We</p> <p>9 accept that, within the documents created by the IMB</p> <p>10 members in 2017, there are instances where the language</p> <p>11 used was inappropriate. One such example was put to</p> <p>12 Ms Colbran during her evidence. She immediately</p> <p>13 accepted such language was not appropriate.</p> <p>14 As for the IMB's relationship with GDWG, it is now</p> <p>15 clear that both organisations were -- it is clear, now</p> <p>16 clear, that both organisations were unclear about each</p> <p>17 other's respective roles, objectives and working</p> <p>18 methods. We submit that the IMB's engagement with GDWG</p> <p>19 was well intentioned but was open to misinterpretation</p> <p>20 and misunderstanding.</p> <p>21 The IMB has since been shocked to learn of the</p> <p>22 extent to which the relationship between GDWG, G4S and</p> <p>23 the Home Office had broken down. James Wilson's</p> <p>24 evidence about his treatment by G4S and Home Office</p> <p>25 managers is particularly troubling.</p> <p style="text-align: center;">Page 48</p>

<p>1 This was not known to the IMB at the time. Further,</p> <p>2 as Ms Molyneux accepted in her first witness statement,</p> <p>3 the IMB was too affected by the criticisms made by the</p> <p>4 centre and Home Office managers of GDWG. She has</p> <p>5 explained the steps which have been taken since to</p> <p>6 improve the two organisations' relations.</p> <p>7 We invite you to reject the criticism that the IMB</p> <p>8 had a shared culture with officers and was not fully</p> <p>9 independent.</p> <p>10 I turn now to the present and future. We have</p> <p>11 placed before you evidence as to the current position,</p> <p>12 both locally within the Brook House IMB and nationally.</p> <p>13 Both locally and nationally, IMBs have reflected on what</p> <p>14 Panorama showed and then what Ms Lampard and Mr Marsden</p> <p>15 concluded. There is now a much greater focus on</p> <p>16 training, specific to immigration detention, focusing on</p> <p>17 separation, Adults at Risk and mental health.</p> <p>18 That training draws on the expertise and experiences</p> <p>19 of those outside as well as within the IMB, including</p> <p>20 those with lived experience of immigration detention.</p> <p>21 The Brook House IMB, in particular, refocused on</p> <p>22 monitoring vulnerable detained persons, Adults at Risk</p> <p>23 and staff culture and behaviour.</p> <p>24 In addition to quarterly chairs' forums, there are</p> <p>25 weekly calls between the chairs of the IMBs for</p> <p style="text-align: center;">Page 49</p>	<p>1 reports criticised the pre-Brexit charter flights;</p> <p>2 failures in the Adults at Risk policy and rule 35</p> <p>3 policies and practices; Home Office DET staff not</p> <p>4 serving removal directions in person during the Covid-19</p> <p>5 pandemic; and delays relating to providing bail</p> <p>6 accommodation.</p> <p>7 You will be aware that in October 2020, the chairs</p> <p>8 of the Brook House IMB and the charter flight monitoring</p> <p>9 team wrote to the Minister for Immigration Compliance</p> <p>10 and Courts under rules 61(3) and (5) to raise serious</p> <p>11 concerns about the inhumane treatment of detained</p> <p>12 persons.</p> <p>13 The IMB is not afraid to challenge, where</p> <p>14 appropriate, and will continue to do so. This inquiry</p> <p>15 offers an opportunity not only to cast light on the</p> <p>16 reasons for the appalling treatment in one immigration</p> <p>17 removal centre, but also to reshape the immigration</p> <p>18 detention system in a way which better promotes humane</p> <p>19 and decent treatment for those living within it.</p> <p>20 You have received a range of recommendations which</p> <p>21 you will consider with care. In our written</p> <p>22 submissions, we will provide our observations on the</p> <p>23 reforms which might be made. At this stage, however, we</p> <p>24 confine ourselves to three.</p> <p>25 First, it is imperative that the safeguards against</p> <p style="text-align: center;">Page 51</p>
<p>1 immigration removal centres. These have proven to be</p> <p>2 an excellent opportunity to share experiences and</p> <p>3 learning amongst the chairs of the boards for IRCs.</p> <p>4 This permits boards, through their chairs, to better</p> <p>5 contextualise their experiences and compare what they</p> <p>6 are observing against best practice and the practices in</p> <p>7 other establishments.</p> <p>8 You will have seen that in Professor Bosworth's</p> <p>9 first report, she recommends that the IMB develops</p> <p>10 a rights-based approach and scrutiny document rather</p> <p>11 than one based on the layout of the centre.</p> <p>12 You have received evidence from Dame Anne Owers and</p> <p>13 Mary Molyneux as to the new template developed for both</p> <p>14 rota and annual reports. This focuses on four areas set</p> <p>15 out in the national monitoring framework, which reflect</p> <p>16 international and domestic human rights standards for</p> <p>17 the treatment of those in detention. The rota template</p> <p>18 requires boards to make a judgment against each of</p> <p>19 these. This steers boards towards placing their</p> <p>20 detailed findings within that human-rights-based</p> <p>21 context.</p> <p>22 Both before and since the relevant period, the</p> <p>23 Brook House IMB and the National Chair have reported on</p> <p>24 and made recommendations at Brook House and more widely.</p> <p>25 By way of example, the 2019 and 2020 Brook House annual</p> <p style="text-align: center;">Page 50</p>	<p>1 the inappropriate use of detention, which appear to have</p> <p>2 broken down at Brook House, the use of rules 34 and 35,</p> <p>3 and the Adults at Risk policy, must be strengthened.</p> <p>4 The IMB will, in any event, continue to focus carefully</p> <p>5 on how these operate in practice.</p> <p>6 Second, to ensure that detained people have access</p> <p>7 to meaningful support in dealings with those in the</p> <p>8 Home Office who are making decisions affecting their</p> <p>9 lives. Caseworkers should be on site, on at least</p> <p>10 a periodic basis. There should be meaningful access to</p> <p>11 legal advice, including significant improvements to</p> <p>12 mobile telephone reception, IT facilities, and access to</p> <p>13 interpreters for legal appointments.</p> <p>14 Third, the IMB reiterates a recommendation made by</p> <p>15 it for many years, that because of the profound impact</p> <p>16 which detention has on individuals, a time limit for</p> <p>17 immigration detention should be introduced.</p> <p>18 Chair, unless I can assist further, that is the</p> <p>19 closing statement on behalf of the IMB.</p> <p>20 THE CHAIR: Thank you very much, Mr Dixey.</p> <p>21 Thank you. I am going to suggest we take our</p> <p>22 15-minute break now and then we will be returning when</p> <p>23 we will hear from you, Ms White.</p> <p>24 Thank you. We will return at 11.35. Thank you.</p> <p>25 (11.20 am)</p> <p style="text-align: center;">Page 52</p>

<p>1 (A short break)</p> <p>2 (11.42 am)</p> <p>3 Closing statement by MS WHITE</p> <p>4 MS WHITE: Practice Plus Group, PPG, welcomes the work of</p> <p>5 this inquiry and the significant benefit it has given</p> <p>6 PPG as the incoming provider of healthcare services at</p> <p>7 Gatwick IRC in informing the current and future</p> <p>8 practice.</p> <p>9 PPG fully recognises the significant issues in the</p> <p>10 provision of healthcare at Brook House in the relevant</p> <p>11 period which have been revealed by this inquiry. PPG</p> <p>12 supplies this statement with a view to showing what work</p> <p>13 has been done to date to address those issues and what</p> <p>14 work remains outstanding.</p> <p>15 Since assuming responsibility for healthcare</p> <p>16 in September 2021, PPG is endeavouring to firstly</p> <p>17 improve the level of staffing at Brook House, by</p> <p>18 increasing the volume and variety of clinical roles</p> <p>19 within the combined nursing service, mental health and</p> <p>20 primary care and within the team of healthcare</p> <p>21 assistants; secondly, to increase the provision of</p> <p>22 mental health care, through, for example, low- and</p> <p>23 medium-intensity trauma-based psychological</p> <p>24 interventions, led by a psychologist and an assistant</p> <p>25 psychologist; thirdly, to improve the availability of</p> <p>Page 53</p>	<p>1 Finally, PPG provides trauma-informed training for</p> <p>2 the mental health team and bespoke mental health</p> <p>3 assessment training for secure environments.</p> <p>4 The intention is for all healthcare staff at Gatwick</p> <p>5 to be given a trauma-informed training package to ensure</p> <p>6 greater awareness of the prevalence and impact of trauma</p> <p>7 on detainees and to reduce the risk of accidental</p> <p>8 retraumatisation.</p> <p>9 In spite of these improvements, PPG recognises that</p> <p>10 many of the issues raised by the inquiry are not</p> <p>11 amenable to quick-fix solutions and require longer-term</p> <p>12 change. As Dr Bromley explained, significant further</p> <p>13 work is ongoing. In particular, firstly, PPG is</p> <p>14 developing bespoke reception screening training for</p> <p>15 teams assessing new arrivals. This will emphasise the</p> <p>16 purpose and importance of the initial screening and of</p> <p>17 communicating this to patients and of encouraging better</p> <p>18 attendance at rule 34 appointments.</p> <p>19 It will also train all staff in the identification</p> <p>20 of conditions which may be detrimentally affected by</p> <p>21 detention, and which require assessment under rule 35,</p> <p>22 to encourage a more proactive approach to identifying</p> <p>23 patients who may be at risk due to detention. This</p> <p>24 bespoke reception screening training is due for roll-out</p> <p>25 by the end of May 2022.</p> <p>Page 55</p>
<p>1 translation services by agreeing an additional contract</p> <p>2 with thebigword in addition to LanguageLine, which can</p> <p>3 be used during patient consultations; fourthly, to</p> <p>4 improve the level of training at Brook House, by</p> <p>5 offering all clinical staff the opportunity to undertake</p> <p>6 the introduction to Health In Justice Course delivered</p> <p>7 by Stafford University; and, fifthly, to maintain the</p> <p>8 continuity and stability of GP care via its</p> <p>9 sub-contracted provider DoctorPA Limited. This has</p> <p>10 avoided short-term disruption to the service, although</p> <p>11 as you know, chair, PPG is working towards a model</p> <p>12 incorporating more employed GPs.</p> <p>13 In addition, all staff are required to complete two</p> <p>14 online training sessions on self-harm and suicidal</p> <p>15 thought as part of their induction. PPG has introduced</p> <p>16 multi-professional complex case clinics, MPCCC,</p> <p>17 involving clinical leaders and multidisciplinary members</p> <p>18 in a weekly discussion of patients with complex needs.</p> <p>19 These discussions feed into weekly vulnerable persons</p> <p>20 meetings to ensure the full clinical picture is taken</p> <p>21 into account when considering a detainee's ongoing</p> <p>22 fitness for detention.</p> <p>23 All detainees placed on constant supervision undergo</p> <p>24 a mental health assessment to ensure that mental health</p> <p>25 needs are identified and, wherever possible, met.</p> <p>Page 54</p>	<p>1 Secondly, PPG is reviewing the initial reception</p> <p>2 screening template to ensure that vulnerabilities are</p> <p>3 properly identified and is working with Serco to pilot</p> <p>4 second reception screens as a further opportunity to</p> <p>5 pick up any needs not identified on the initial</p> <p>6 screening, including any Adults at Risk or individuals</p> <p>7 who may need to be considered for a rule 35(1), (2) or</p> <p>8 (3) report. Any individual identified as vulnerable</p> <p>9 becomes the subject of a supported living plan and is</p> <p>10 discussed at the weekly vulnerable persons meetings</p> <p>11 chaired by Serco and attended by healthcare and the</p> <p>12 Home Office.</p> <p>13 Thirdly, PPG is working with external training</p> <p>14 organisations to develop bespoke training on suicide</p> <p>15 intervention, which is called Assist, on mental health</p> <p>16 assessment, and on healthcare responsibilities in</p> <p>17 control and restraint. That is training specifically</p> <p>18 designed for secure and detained settings, recognising</p> <p>19 that staff knowledge across these areas is in need of</p> <p>20 improvement.</p> <p>21 Fourthly, PPG is in the process of developing</p> <p>22 bespoke rule 34 and rule 35 training for GPs, to ensure</p> <p>23 high-quality assessments and reports. This training is</p> <p>24 due for delivery in July 2022 and will be delivered,</p> <p>25 both as part of the induction of new GPs and as</p> <p>Page 56</p>

<p>1 an annual refresher. It will cover the Adults at Risk</p> <p>2 guidance and signs and symptoms of trauma and torture,</p> <p>3 drawing on guidance from the Faculty of Forensic and</p> <p>4 Legal medicine. PPG is also planning to develop a new</p> <p>5 quality audit, which will be peer reviewed, to examine</p> <p>6 the quality of rule 35 reports.</p> <p>7 Finally, PPG is working with Stafford University to</p> <p>8 develop a more bespoke version of their calls for staff</p> <p>9 working in IRCs as opposed to prisons, using learning</p> <p>10 from the first six months of its contract to identify</p> <p>11 current gaps and training and induction.</p> <p>12 As for rule 35, PPG recognises the disconnect</p> <p>13 between the absence of rule 35(2) reports in recent</p> <p>14 months as in the relevant period and the significant</p> <p>15 number of detainees who have been on constant</p> <p>16 supervision due to suicidal thoughts or self-harm.</p> <p>17 The intention is for the approach to rule 35 at</p> <p>18 Gatwick to be subject to wholesale review, alongside</p> <p>19 Heathrow IRC in April 2022, so that both sites operate</p> <p>20 a robust rule 35 pathway which has had the benefit of</p> <p>21 peer review and redesign to meet the needs of detainees</p> <p>22 at those sites.</p> <p>23 PPG also fully appreciates your concern, chair, to</p> <p>24 ensure that some immediate action is taken in respect of</p> <p>25 those currently in detention who may be vulnerable</p> <p style="text-align: center;">Page 57</p>	<p>1 custom and practice, which will require further</p> <p>2 discussions, training and clinical supervision, as</p> <p>3 outlined in her evidence to this inquiry.</p> <p>4 In terms of broader objectives, PPG is committed to</p> <p>5 the continual improvement of its service at Gatwick,</p> <p>6 whilst recognising that there are some factors outside</p> <p>7 its control. These include the physical capacity of the</p> <p>8 site, the policies and procedures developed and owned by</p> <p>9 other bodies, such as the Home Office and Serco, and the</p> <p>10 paucity of education and training materials nationwide</p> <p>11 which are bespoke to the environment of an IRC.</p> <p>12 To date, it has been very difficult to obtain and</p> <p>13 deliver training on rule 34 or rule 35. PPG continues</p> <p>14 to work with providers across the country to develop</p> <p>15 bespoke training for IRCs and in particular for the site</p> <p>16 at Gatwick which has not hitherto been available.</p> <p>17 Beyond these objectives, PPG recognises the need for</p> <p>18 cultural change at Brook House, including on the part of</p> <p>19 healthcare. PPG hopes and anticipates that better</p> <p>20 training will promote better understanding and awareness</p> <p>21 of vulnerabilities on the part of detainees and the</p> <p>22 safeguards which must be upheld in an IRC in order to</p> <p>23 detect detainees from harm.</p> <p>24 PPG regards clinical supervision, reflective</p> <p>25 practice groups and peer reviews as essential routes for</p> <p style="text-align: center;">Page 59</p>
<p>1 and/or in need of a rule 35 report.</p> <p>2 To that end, Dr Bromley has supplied a further short</p> <p>3 witness statement in which she has confirmed, in answer</p> <p>4 to your questions and those of your counsel, that both</p> <p>5 GPs have been reminded by the head of healthcare,</p> <p>6 Sandra Calver, of the need to complete rule 35 reports</p> <p>7 wherever indicated and have been actively encouraged by</p> <p>8 both Ms Calver and Dr Bromley to undertake rule 35</p> <p>9 assessments.</p> <p>10 The joint letter from the Home Office and</p> <p>11 NHS England received last Friday, 1 April, has been</p> <p>12 shared with the GPs. As a temporary solution, until</p> <p>13 a rule 35 pathway is developed, firstly, when an ACDT is</p> <p>14 opened, a rule 35(1) appointment will be booked for that</p> <p>15 day or the following day. Additionally, all patients</p> <p>16 are reviewed by the mental health team when an ACDT is</p> <p>17 opened.</p> <p>18 Secondly, DoctorPA Limited have been instructed to</p> <p>19 undertake rule 35(2) assessments for all patients on</p> <p>20 constant supervision. As of this last Friday afternoon,</p> <p>21 only one patient was on constant supervision and he was</p> <p>22 due to be seen for a rule 35(2) appointment the</p> <p>23 following day, Saturday, 2 April.</p> <p>24 Despite these interim steps, Dr Bromley remains of</p> <p>25 the view that there is a need to challenge and change</p> <p style="text-align: center;">Page 58</p>	<p>1 all healthcare staff to reflect on their attitudes and</p> <p>2 approach to the delivery of care, including delivery of</p> <p>3 desensitisation and compassion fatigue highlighted by</p> <p>4 Dr Hard. The overall goal is to develop a more</p> <p>5 integrated patient service, and this is the subject of</p> <p>6 sustained effort on the part of PPG.</p> <p>7 PPG also places particular reliance on strong and</p> <p>8 effective leadership in progressing the objectives</p> <p>9 outlined in this statement and hopes that the focus</p> <p>10 supplied by this inquiry will enhance these efforts.</p> <p>11 Just finally, chair, PPG is well experienced in the</p> <p>12 provision of healthcare and has only been in possession</p> <p>13 for a relatively short period. PPG recognises, firstly,</p> <p>14 the opportunities for improvement as the new provider</p> <p>15 and is ready and willing to accept the challenge and</p> <p>16 make changes in line with its contract and the inquiry's</p> <p>17 findings. Secondly, that with a programme of continued</p> <p>18 improvement and feedback, high standards can and will be</p> <p>19 obtained.</p> <p>20 Thank you, chair.</p> <p>21 THE CHAIR: Thank you very much, Ms White. Thank you.</p> <p>22 Mr Blake, I believe you might want 30 seconds to get</p> <p>23 the lectern?</p> <p>24 MR BLAKE: Thank you very much.</p> <p>25 THE CHAIR: Thank you.</p> <p style="text-align: center;">Page 60</p>

<p>1 MR BLAKE: Thank you, chair.</p> <p>2 Closing statement by MR BLAKE</p> <p>3 MR BLAKE: The inquiry hasn't yet produced its report, but</p> <p>4 it has already achieved a great deal. The inquiry has</p> <p>5 helped to shine a light on issues, the importance of</p> <p>6 which may not have been fully appreciated or fully</p> <p>7 understood. The questioning by Ms Simcock on the issue</p> <p>8 of rule 34 and rule 35, for example, has identified</p> <p>9 problems with the interpretation and application of</p> <p>10 those rules.</p> <p>11 As you know, the Home Office, together with the NHS,</p> <p>12 have written to the healthcare commissioners and</p> <p>13 providers to provide urgent clarification arising from</p> <p>14 what we have heard over the past few weeks. The</p> <p>15 Home Office is committed to reviewing rule 35 and the</p> <p>16 ACDT process.</p> <p>17 There are other areas which were known to the</p> <p>18 Home Office but which the inquiry has made even clearer:</p> <p>19 understaffing; the lack of a contractual power to</p> <p>20 penalise mistreatment; the imbalance between penalties</p> <p>21 for escape and penalties for harm; the imbalance in the</p> <p>22 weighting between commercial and operational objectives;</p> <p>23 and the imbalance that is caused by an overreliance on</p> <p>24 self-reporting and insufficient auditing.</p> <p>25 We hope that the inquiry will recognise that the new</p> <p style="text-align: center;">Page 61</p>	<p>1 acted upon. You heard from Mohammed Khan, who</p> <p>2 emotionally said at the end of his evidence that his</p> <p>3 parents were immigrants and that he sees it as the PSU's</p> <p>4 role to uncover wrongdoing and get to the bottom of it.</p> <p>5 You might think that the PSU is in good hands with him</p> <p>6 at the helm.</p> <p>7 Similarly, the IMB, HMIP and others, the fact that</p> <p>8 you have heard critical comments about the Home Office</p> <p>9 from some of their reports is itself evidence that the</p> <p>10 systems of oversight are working and, indeed, are</p> <p>11 improving. The fact that the problems were not spotted</p> <p>12 by those organisations during the relevant period was</p> <p>13 not used by the Home Office in some way to shift the</p> <p>14 blame -- that is a misunderstanding there and I would</p> <p>15 like to clear that up. It was simply to show how</p> <p>16 challenging it can be to uncover mistreatment. How</p> <p>17 differently staff may have been acting around the</p> <p>18 Home Office, around the inspection bodies, to how they</p> <p>19 act amongst themselves in the corridor before they use</p> <p>20 force, or in the staff areas.</p> <p>21 The Home Office welcomes scrutiny from those bodies</p> <p>22 and others. You heard from Mr Riley that he has</p> <p>23 previously asked Professor Bosworth to come in and look</p> <p>24 at the culture of different areas, since he has taken up</p> <p>25 post. The Verita report, whose transcripts have been</p> <p style="text-align: center;">Page 63</p>
<p>1 contract, the new provider, will go some way to address</p> <p>2 these historic problems that arose from an old contract</p> <p>3 that was based on an outdated approach. Improved</p> <p>4 staffing, improved contract, improved focus on welfare.</p> <p>5 We hope that the inquiry will recognise the work on</p> <p>6 staff culture that has been undertaken by Mr Riley, and</p> <p>7 the wide range of other changes, from improving</p> <p>8 auditing, the recommendations, including data gathering,</p> <p>9 regarding complaints against DCOs, improvements in the</p> <p>10 physical estate, and improvements in training.</p> <p>11 The Immigration Minister described the treatment</p> <p>12 shown on Panorama as "appalling" and Mr Riley has</p> <p>13 delivered a clear apology to this inquiry.</p> <p>14 Having recognised and been open to the problems that</p> <p>15 the inquiry has exposed, there is a good story to tell</p> <p>16 in many respects and we ask that the inquiry considers</p> <p>17 this alongside identified problems. For example, the</p> <p>18 Home Office does not shy away from scrutiny; the PSU got</p> <p>19 it absolutely right when it substantiated complaints</p> <p>20 against Nathan Ring, Yan Paschali, allegations of</p> <p>21 collusion and of derogatory comments by G4S staff in the</p> <p>22 case of D1527.</p> <p>23 There are legitimate questions to ask about why the</p> <p>24 complaints system didn't lead to an earlier complaint to</p> <p>25 the PSU, but once it reached them, it undoubtedly was</p> <p style="text-align: center;">Page 62</p>	<p>1 heavily relied upon in this inquiry, was another example</p> <p>2 of scrutiny that has been welcomed by the Home Office.</p> <p>3 And your own non-statutory inquiry was a further example</p> <p>4 of the Home Office opening up its doors.</p> <p>5 When you consider the Home Office as an institution,</p> <p>6 which you have been urged to do by the representatives</p> <p>7 of those who were detained, we ask you to consider all</p> <p>8 of this, because an institution that invites such</p> <p>9 scrutiny is not an institution that intends to do wrong.</p> <p>10 And, of course, the Home Office does not so intend.</p> <p>11 When considering institutional issues, at the</p> <p>12 Home Office, you will no doubt consider the position of</p> <p>13 Tinsley House, which has been held up by some witnesses</p> <p>14 as an example of the high standards that are implemented</p> <p>15 by the Home Office. Reverend Ward described it as</p> <p>16 a "much calmer environment". He said Tinsley staff were</p> <p>17 very different. Tinsley House is run by the same team</p> <p>18 at the Home Office as Brook House. You will also</p> <p>19 consider the evidence of Owen Syred, who we know cared,</p> <p>20 and cares a lot, for the welfare of detained persons.</p> <p>21 He worked with the Home Office on a secondment. He</p> <p>22 said he had a unique insight into his Home Office</p> <p>23 colleagues, he got on with them and they always behaved</p> <p>24 professionally. He said that the Home Office had</p> <p>25 a difficult job to do but acted with compassion. You</p> <p style="text-align: center;">Page 64</p>

<p>1 might think that his honest and open evidence is at odds</p> <p>2 with some of the overblown rhetoric that was obtained in</p> <p>3 some of the speeches that have been given yesterday.</p> <p>4 As I said in my opening speech, some of the changes</p> <p>5 that you are likely to recommend are likely to be more</p> <p>6 mundane and less political. The change to rule 35 is</p> <p>7 one of those which might have profound changes for</p> <p>8 detained persons, even if one of the recommendations is</p> <p>9 simply improving the form that is completed or</p> <p>10 allocating more time to those appointments.</p> <p>11 The Home Office's full submissions will be set out</p> <p>12 clearly in our written submissions, and I don't want to</p> <p>13 take up much more time today simply for the purpose of</p> <p>14 speaking. I should make it clear that we do not agree</p> <p>15 with the various submissions that have been made to you</p> <p>16 regarding the role that article 3 should play in your</p> <p>17 determination, and we will set that out more fully in</p> <p>18 our written submissions as we have been invited to do</p> <p>19 so.</p> <p>20 Putting those legal submissions to one side, we know</p> <p>21 that you will approach the evidence that you have heard</p> <p>22 carefully, conscientiously and fairly.</p> <p>23 Our primary objective throughout this inquiry has</p> <p>24 been to make sure our witnesses are treated fairly and</p> <p>25 have the opportunity to give their best evidence,</p> <p style="text-align: center;">Page 65</p>	<p>1 mind that it is the careful, considered and reflective</p> <p>2 evidence coming from the mouths of witnesses, not simply</p> <p>3 the acceptance of propositions that have been put to</p> <p>4 them, that really counts.</p> <p>5 Phil Riley was a good example on Monday of a witness</p> <p>6 who has been asked and been able to give considered and</p> <p>7 properly answered questions and I ask you to consider</p> <p>8 the honest and open evidence, also of Paul Gasson in</p> <p>9 relation to his dealings with GDWG. Importantly, when</p> <p>10 you look at the evidence, I ask you to consider whether</p> <p>11 evidence, where a witness has simply said yes, or that</p> <p>12 they couldn't recall in response to repeated</p> <p>13 propositions, is useful evidence and we say it is not.</p> <p>14 Third, I ask that you are mindful of the</p> <p>15 complexities in certain decision-making processes that</p> <p>16 you simply don't have the evidence to address. It has</p> <p>17 been repeatedly suggested, for example, that certain</p> <p>18 individuals would not have been detained if they had had</p> <p>19 a rule 35 form completed. That doesn't, in our</p> <p>20 submission, necessarily follow.</p> <p>21 Do you know the countervailing immigration factors,</p> <p>22 including the detail in relation to their offending and</p> <p>23 the need to protect the public from harm? That is</p> <p>24 something you will have to ask yourself.</p> <p>25 Fourth, I ask that you are mindful of any potential</p> <p style="text-align: center;">Page 67</p>
<p>1 sometimes in response to demanding timeframes or in the</p> <p>2 face of criticism and cross-examination.</p> <p>3 All I want to do, at this stage, is highlight five</p> <p>4 headline points for you, chair, to bear in mind when</p> <p>5 considering the evidence. First, a great deal of</p> <p>6 evidence has been heard in the form of witness</p> <p>7 statements that have been read and that have not been</p> <p>8 tested. The Home Office doesn't see it as its role to</p> <p>9 play the role of the defence, akin to a trial or civil</p> <p>10 litigation. That is not the purpose of a public</p> <p>11 inquiry. Probing questions that we proposed in phase 1</p> <p>12 were not accepted because that is the approach that the</p> <p>13 inquiry wanted to take and that is certainly within your</p> <p>14 discretion, chair. But what we do, is ask you to apply</p> <p>15 appropriate care in your consideration of untested</p> <p>16 allegations.</p> <p>17 Look, for example, at what happened in phase 1,</p> <p>18 where D1581 had previously relied on a written statement</p> <p>19 of someone we know as D390, who said he was beaten with</p> <p>20 batons. That simply was not right. We saw the footage,</p> <p>21 and that shows the danger in making conclusions based on</p> <p>22 written accounts alone.</p> <p>23 Second, and consistent with the approach that has</p> <p>24 been taken with the evidence of those who were detained,</p> <p>25 GDWG, Medical Justice and others, I ask you to bear in</p> <p style="text-align: center;">Page 66</p>	<p>1 unintended consequences of recommendations. We heard on</p> <p>2 Monday about Stephen Shaw's recommendation following the</p> <p>3 fire in Yarl's Wood, that the physical infrastructure</p> <p>4 needed to be strengthened and that that resulted in</p> <p>5 Brook House being built to its specification. As</p> <p>6 Phil Riley said, there is a balance to be struck between</p> <p>7 listening to what is said by experts and balancing it</p> <p>8 against other factors. There is no simple solution, and</p> <p>9 pulling in one direction might affect something else.</p> <p>10 Fifth, and finally, I will end where I began and ask</p> <p>11 you to be mindful of what is achievable: end to</p> <p>12 immigration detention or the imposition of a definitive</p> <p>13 time limit is simply not achievable, even if it were</p> <p>14 within the terms of reference, and we say it isn't. As</p> <p>15 I said in my opening, this inquiry, an inquiry that</p> <p>16 makes focused but important findings, is just as</p> <p>17 important, just as valuable, in fact more so, to the</p> <p>18 wellbeing of those who were detained. The one that</p> <p>19 makes bold but unrealistic proposals.</p> <p>20 The Home Office has full confidence that you, chair,</p> <p>21 will approach what is a very difficult task with</p> <p>22 the careful, thoughtful and sensitive manner that you</p> <p>23 have personally shown to witnesses throughout this</p> <p>24 inquiry. Thank you very much.</p> <p>25 THE CHAIR: Thank you, Mr Blake.</p> <p style="text-align: center;">Page 68</p>

<p>1 Mr Sharland, thank you.</p> <p>2 MR SHARLAND: Good afternoon, chair. My microphone is</p> <p>3 flashing red. Ah, I have a functioning microphone.</p> <p>4 Closing statement by MR SHARLAND</p> <p>5 MR SHARLAND: Good afternoon, chair. I make the following</p> <p>6 closing statement on behalf of G4S Care and</p> <p>7 Justice Services (UK) Limited as well as G4S Healthcare</p> <p>8 Service (UK) Limited. It will be supplemented, in due</p> <p>9 course, by G4S's written closing submissions, which will</p> <p>10 address the details of the matters under consideration</p> <p>11 by the inquiry. The written closing submissions will</p> <p>12 address the correct approach to article 3 of the</p> <p>13 European Convention on Human Rights. On this, G4S</p> <p>14 disagree with the suggested approach as set out in CTT's</p> <p>15 note, but we understand that the appropriate time to</p> <p>16 address this is in our written closing submissions.</p> <p>17 The written closing submissions will also address</p> <p>18 each of the 50 or so incidents of concern, detailed in</p> <p>19 the inquiry's spreadsheet provided at the outset, as</p> <p>20 well as the various broader issues relating to both the</p> <p>21 provision of custodial and health services during the</p> <p>22 relevant period.</p> <p>23 In this oral statement, however, I would like to</p> <p>24 address a number of key themes that have emerged in the</p> <p>25 course of the inquiry hearing a wide range of evidence,</p> <p style="text-align: center;">Page 69</p>	<p>1 The inquiry should be under no illusion that G4S,</p> <p>2 its staff, personally and as a corporate body, had been</p> <p>3 undertaking substantial soul searching since the conduct</p> <p>4 shown in Panorama came to light. As its senior</p> <p>5 witnesses made plain -- indeed, as well as many of the</p> <p>6 more junior staff, including DCOs and DCMs -- all feel</p> <p>7 a true duty of care towards detained persons, not simply</p> <p>8 in the legal sense but in the practical and moral one</p> <p>9 too.</p> <p>10 What the Panorama documentary showed was that the</p> <p>11 company had let down a number of those individuals, let</p> <p>12 down a number of those individuals very badly. More</p> <p>13 than that, had been unaware of having done so. It is</p> <p>14 both those elements which have caused the company and</p> <p>15 its staff, of all grades, serious concern and regret.</p> <p>16 As such, more than just recognising that conduct as</p> <p>17 abhorrent behaviour and apologising on behalf of G4S to</p> <p>18 those who suffered mistreatment, Mr Brockington pointed</p> <p>19 out that G4S looked forward to receiving the conclusions</p> <p>20 of the inquiry, and I add, in particular, it looks</p> <p>21 forward to the recommendations that the inquiry may make</p> <p>22 to ensure no such conduct occurs again at Brook House or</p> <p>23 indeed at any other IRC.</p> <p>24 The inquiry's lens is, by its terms of reference,</p> <p>25 focused on a particular IRC and a particular period in</p> <p style="text-align: center;">Page 71</p>
<p>1 covering life in Brook House, as well as the conduct of</p> <p>2 staff who worked there during the relevant period.</p> <p>3 It is important, however, for me to start today, as</p> <p>4 I did in my opening statement on behalf of G4S, with</p> <p>5 an apology. These are not just my words, but the words</p> <p>6 of G4S's corporate witnesses to this inquiry.</p> <p>7 Mr Gordon Brockington, in particular, spoke about being</p> <p>8 personally appalled by what he saw on Panorama and that</p> <p>9 he, and G4S itself, were exceptionally sorry for the</p> <p>10 shocking mistreatment that was shown on that programme.</p> <p>11 That sense of contrition was not, of course, limited</p> <p>12 to Mr Brockington. Mr Peter Neden, during the relevant</p> <p>13 period, the regional president for the UK and Ireland at</p> <p>14 G4S, explained that he was deeply sorry for there having</p> <p>15 clearly been a failure in the system that did not</p> <p>16 uncover the mistreatment of detainees.</p> <p>17 He added that it was absolutely clear that he and</p> <p>18 the management team of G4S failed in their</p> <p>19 responsibility to keep people safe in Brook House.</p> <p>20 Mr Jerry Petherick, who was, during the relevant</p> <p>21 period, managing director of G4S Custodial and Detention</p> <p>22 Services, too, also accepted his own responsibility for</p> <p>23 what had happened, because he was, as he put it, "at the</p> <p>24 top of the pyramid and there is no one tougher on me</p> <p>25 than myself".</p> <p style="text-align: center;">Page 70</p>	<p>1 time. Its findings will necessarily be set by those</p> <p>2 parameters, but its recommendations will no doubt be of</p> <p>3 substantially wider application than to one particular</p> <p>4 IRC. Of course, G4S no longer operates Brook House or</p> <p>5 any of the other IRCs, but it is responsible for</p> <p>6 a number of other environments within the broader</p> <p>7 detention estate. It is for that reason in particular</p> <p>8 that it looks forward to learning from this inquiry.</p> <p>9 A consistent theme of the evidence heard by the</p> <p>10 inquiry is the effect that "most staff were hard working</p> <p>11 but ..." or "the vast majority of use of forces were</p> <p>12 appropriate but ..."</p> <p>13 The focus of this inquiry is, understandably, not on</p> <p>14 those majority of cases when staff were working hard in</p> <p>15 difficult circumstances, when detained persons were</p> <p>16 treated with dignity and respect, and where force was</p> <p>17 used appropriately and as a last resort. G4S</p> <p>18 appreciates that the inquiry was not established to</p> <p>19 concentrate on those cases, even if they applied to the</p> <p>20 majority of personnel or instances.</p> <p>21 By its terms of reference, the inquiry is to "reach</p> <p>22 conclusions with regard to the treatment of detainees</p> <p>23 where there is credible evidence of mistreatment."</p> <p>24 The focus of the inquiry's lens in those instances</p> <p>25 and cases where there is credible evidence and</p> <p style="text-align: center;">Page 72</p>

<p>1 mistreatment, its focus is not a holistic assessment on 2 the performance of any individual staff member or G4S or 3 any other contractor or the Home Office. However, with 4 that said, the vast majority of cases of interaction 5 between staff and detained persons that are 6 characterised by respect and dignity should not be 7 forgotten and are important context to the findings that 8 the inquiry may make in respect of those instances where 9 there is credible evidence of mistreatment, to recognise 10 that such instances were the exception and not the rule.</p> <p>11 As the 2017 report on Brook House from Her Majesty's 12 Chief Inspector of Prisons recorded:</p> <p>13 "In our survey, about three-quarters of detainees 14 had a positive view of the attitudes and behaviour of 15 staff and the proportion was higher for those who did 16 not speak English."</p> <p>17 Yesterday, Mr Stanton, on behalf of Mr Syred, 18 stated, in relation to the issue of balance:</p> <p>19 "There was a small minority of staff who conducted 20 themselves as Yan Paschali and Derek Murphy did. By and 21 large, staff at Brook House behaved well and treated 22 residents with care, dignity and compassion. There are 23 no recordings of officers and detainees chatting, having 24 a coffee, sharing a joke or playing pool. However, 25 these were everyday occurrences at Brook House."</p> <p style="text-align: center;">Page 73</p>	<p>1 about the issue of culture at Brook House, and the 2 inquiry has heard much about a macho environment and 3 a "man up" attitude. Neither of which were, of course, 4 conducive to the operation of a safe centre.</p> <p>5 Further, when it comes to culture, the answer is 6 simply not a raft of new policies. Indeed, when the 7 inquiry comes to consider a number of key areas, such as 8 complaint handling and whistleblowing, whilst there may 9 be room for lessons to be learned in the formulation of 10 these policies, on paper, at least, many of them were 11 sound, not least G4S's "Speak Out" whistleblowing 12 policy, which was advertised, and utilised independent, 13 external investigators to minimise any disincentive to 14 report.</p> <p>15 However, as the inquiry has been shown, however well 16 intentioned or well designed on paper, these channels 17 did not work at Brook House. The process of translating 18 well designed policies into a healthy culture of not 19 only good practice, but of reporting concerns, is 20 difficult, but it is critical.</p> <p>21 In the context of an operation which has been 22 outsourced by central government, no doubt much scrutiny 23 will be focused on the contractual arrangements between 24 G4S and the Home Office and, where relevant, the health 25 contract.</p> <p style="text-align: center;">Page 75</p>
<p>1 G4S agreed with Mr Syred that this should not be 2 forgotten. This is not just a matter of fairness, or 3 balance, but it will inform the inquiry's approach to 4 the recommendations that it may make, to maximise the 5 effectiveness of those recommendations. There has been 6 a debate between witnesses as to the extent to which 7 poor conduct at Brook House was down to "a few bad 8 apples". The relevance of any misconduct being set in 9 the proper context of a wider pattern of genuinely 10 hard-working, fair and compassionate staff is 11 an important one.</p> <p>12 The inquiry, when making recommendations to the 13 future, will need to consider those measures which will 14 properly identify any relevant bad apples as 15 distinguished from the good or, in relation to some 16 issues, where the problem is more systemic, such that 17 more root and branch change is required either at 18 Brook House alone or, perhaps more likely, across the 19 IRC estate.</p> <p>20 Many of the questions that the inquiry will seek to 21 answer are not easy. G4S know this is first hand, as it 22 has turned its mind to a number of those issues or 23 similar ones, both before and after the airing of 24 Panorama. A key theme of the evidence heard by the 25 inquiry, the evidence the inquiry has heard, has been</p> <p style="text-align: center;">Page 74</p>	<p>1 Even though the contract for the operation of 2 Brook House between G4S and the Home Office is no longer 3 in force, and the Serco operation is governed by a new 4 contract on different terms, some important 5 recommendations can be made on issues of principle, in 6 particular, no doubt, as to how service levels and 7 penalty regimes can be designed to ensure they operate 8 as an effective means to incentivise compliance and, 9 more than that, that they do so effectively; for 10 example, minimising the extent to which a contractor 11 marks their own homework, at the very least, without 12 proper oversight by the Home Office.</p> <p>13 Of course, the inquiry will recall that G4S did not 14 agree or negotiate the terms of the contract that were 15 in force during the relevant period but, rather, took 16 over the contract that had been agreed between the 17 Home Office and GSL.</p> <p>18 The terms of that contract were set by the 19 procurement exercise designed by the Home Office. The 20 inquiry will no doubt recall evidence from a number of 21 witnesses, including Mr Riley, that, at the time the 22 initial contract was procured, the focus was very much 23 on minimising the cost to central government. This is 24 quite clear from the government's decision to have 25 50 per cent of the bidding scoring based on the cost of</p> <p style="text-align: center;">Page 76</p>

<p>1 the contract to the Home Office. Such an approach to</p> <p>2 procurement inevitably leads bidders to focus on costs</p> <p>3 in an attempt to be awarded the contract in line with</p> <p>4 what was essentially being asked for of them by the</p> <p>5 awarding body. This was recognised by the Home Office</p> <p>6 documentation, in relation to the procurement, exhibited</p> <p>7 to Reverend Ward's witness statement, which noted that</p> <p>8 the winning bid from GSL, which was the lowest yearly</p> <p>9 price, was 35 per cent below the relevant budget.</p> <p>10 Such an approach can be contrasted with that taken</p> <p>11 in relation to the 2019 contract where only 25 per cent</p> <p>12 of the bid scoring was based on cost.</p> <p>13 This differential approach to the procurement</p> <p>14 process inevitably led to very different bids, with more</p> <p>15 focus on the quality of provision.</p> <p>16 G4S did not think it appropriate to bid at the low</p> <p>17 level adopted by GSL in the original procurement</p> <p>18 exercise, but it was nonetheless bound by the terms of</p> <p>19 the contract with the Home Office based upon GSL's bid</p> <p>20 after it purchased GSL. As a matter of procurement law,</p> <p>21 the terms of G4S's bid became irrelevant once the</p> <p>22 Home Office accepted GSL's bid. This remained the case</p> <p>23 as a matter of law when G4S subsequently took over GSL.</p> <p>24 The procurement law regime prevented G4S from seeking to</p> <p>25 substantially renegotiate the terms of the contract with</p> <p style="text-align: center;">Page 77</p>	<p>1 was not identified by the regulatory and oversight</p> <p>2 bodies whose role it was precisely to look for and find</p> <p>3 evidence of it.</p> <p>4 It is appropriate to say something about the proper</p> <p>5 scope of the inquiry. As I have already observed, the</p> <p>6 terms of reference of this inquiry quite properly set</p> <p>7 the boundaries of its investigation around a particular</p> <p>8 period of time at a particular institution. That does</p> <p>9 not prevent its recommendations and conclusions being of</p> <p>10 broader application, which is part of the reason why G4S</p> <p>11 will be listening carefully to them. However, as the</p> <p>12 chair previously recognised, in your determination on</p> <p>13 scope, for example, this inquiry is not a policy forum</p> <p>14 on immigration detention, nor has it been tasked with</p> <p>15 addressing questions on whether time limits should be</p> <p>16 placed on immigration detention.</p> <p>17 Certain elements of the architecture of the</p> <p>18 immigration infrastructure, particularly those set out</p> <p>19 by law, are reference points by which the inquiry will</p> <p>20 need to frame its recommendations.</p> <p>21 Other elements of the Brook House environment are</p> <p>22 not inherent within the immigration detention estate or</p> <p>23 its underpinning legal framework and are open to the</p> <p>24 inquiry's comments, criticisms and recommendations,</p> <p>25 particularly where the inquiry has heard evidence of</p> <p style="text-align: center;">Page 79</p>
<p>1 the Home Office once it was signed by GSL.</p> <p>2 The inquiry should not, however, view the operation</p> <p>3 of the penalty regime under the contract as a key factor</p> <p>4 in why the behaviour of concern at Brook House was not</p> <p>5 brought to light. Although the contract provided for</p> <p>6 G4S to self-report on certain aspects of contractual</p> <p>7 non-compliance, and the National Audit Office found that</p> <p>8 G4S did so accurately self-report, that regime did not</p> <p>9 focus on the kinds of behaviour captured on the Panorama</p> <p>10 programme. There were, however, a number of other</p> <p>11 mechanisms, in addition to the complaints and</p> <p>12 whistleblowing frameworks, that should have picked up on</p> <p>13 any mistreatment through the Home Office's monitoring of</p> <p>14 the centre, both on the ground and centrally, as well as</p> <p>15 through the IMB and Her Majesty's Inspectorate for</p> <p>16 Prisons.</p> <p>17 The fact that these bodies did not identify such</p> <p>18 problems on the ground -- and, indeed, IMB witnesses</p> <p>19 were surprised, for example, by what was seen on</p> <p>20 Panorama -- demonstrates the difficulty in creating</p> <p>21 effective oversight and monitoring structures which will</p> <p>22 both disincentivise misconduct before it occurs and also</p> <p>23 identify it when it has taken place. Any criticism of</p> <p>24 G4S that such misconduct did not come to the attention</p> <p>25 of G4S must be understood against the backdrop that it</p> <p style="text-align: center;">Page 78</p>	<p>1 differing practice, either at other IRCs or subsequently</p> <p>2 at Brook House itself.</p> <p>3 By way of example, and returning to the point that</p> <p>4 what lies at the heart of the operation of an IRC and</p> <p>5 which is difficult to measure and even to regulate, is</p> <p>6 its culture, the inquiry has heard that Brook House was,</p> <p>7 to a very considerable extent, defined by its oppressive</p> <p>8 physical architecture, built to the specifications of</p> <p>9 a category B prison, albeit without the education</p> <p>10 facilities and space for activities that would be</p> <p>11 available in such a prison.</p> <p>12 Space, generally, and particularly outside, is in</p> <p>13 short supply. Its location, only 200 metres from one of</p> <p>14 Gatwick's runways, with the associated noise, further</p> <p>15 increased the oppressive and stressful environment. For</p> <p>16 an environment which is not intended to punish but</p> <p>17 rather to house and to do so for a short period only,</p> <p>18 the inquiry may well conclude that the austerity of the</p> <p>19 physical architecture had deleterious effects on those</p> <p>20 inside it.</p> <p>21 That final point is an important one, understanding</p> <p>22 the position of those, as pointed out by G4S in its</p> <p>23 opening statement, to be at the heart of this inquiry,</p> <p>24 namely, those persons detained in Brook House.</p> <p>25 What was striking throughout much of the evidence</p> <p style="text-align: center;">Page 80</p>

<p>1 heard by the inquiry was the consistent account of what</p> <p>2 were the primary concerns of those detained in</p> <p>3 Brook House during the relevant period, as recalled by</p> <p>4 various and varied witnesses. It was chiefly, and</p> <p>5 understandably, their immigration case rather than</p> <p>6 treatment within Brook House. Recalling that detained</p> <p>7 persons were held at Brook House prior to their removal,</p> <p>8 many not wishing to be removed, it is quite reasonable</p> <p>9 that many detainees would be anxious and stressed about</p> <p>10 their immigration case; the question of if and when they</p> <p>11 would be removed, as well as difficulties obtaining</p> <p>12 information from decision makers about those issues.</p> <p>13 The inquiry will recall that the average length of</p> <p>14 detention at Brook House had increased prior to the</p> <p>15 relevant period, placing additional stress on detainees.</p> <p>16 In that context, it is important for the inquiry to</p> <p>17 recall that G4S did not determine who was detained at</p> <p>18 Brook House, nor did it determine how long they would be</p> <p>19 detained for. It was not responsible for escorting</p> <p>20 detained persons as part of the removal directions and</p> <p>21 was not involved in casework regarding detained persons'</p> <p>22 immigration status. These were the key issues for</p> <p>23 detainees and their primary sources of concern and,</p> <p>24 sometimes, distress. G4S was not responsible for these</p> <p>25 matters, often knew nothing of them, yet it was G4S</p> <p style="text-align: center;">Page 81</p>	<p>1 estate.</p> <p>2 Such a change created a perfect storm during the</p> <p>3 relevant period which it is clear both custodial and</p> <p>4 healthcare struggled to cope with. This of course does</p> <p>5 not in any way justify the abhorrent behaviour by</p> <p>6 a small number of G4S staff but it is important context</p> <p>7 to consider when considering what happened in</p> <p>8 Brook House during the relevant period.</p> <p>9 In that regard, the physical architecture of</p> <p>10 Brook House again plays an important role. Time-served</p> <p>11 offenders were transferred from a prison to</p> <p>12 an environment which looked remarkably similar to the</p> <p>13 prison from which they had come and but where staff</p> <p>14 lacked the powers of prison officers and, crucially,</p> <p>15 lacked the ability to incentivise good behaviour and</p> <p>16 disincentivise bad behaviour through a system of</p> <p>17 privileges or removing privileges. To a detained</p> <p>18 population that could already be frustrated by the</p> <p>19 stresses of their immigration cases, the inability of</p> <p>20 staff to use carrots and sticks could, and from the</p> <p>21 evidence heard by the inquiry did, lead to numerous</p> <p>22 instances in which detained persons not only challenged</p> <p>23 the staff but abused them verbally and physically.</p> <p>24 To be clear, that does not in any way at all justify</p> <p>25 or excuse any mistreatment of detained persons by staff.</p> <p style="text-align: center;">Page 83</p>
<p>1 staff who found themselves dealing on the front line</p> <p>2 with detained persons and queries, often simply unable</p> <p>3 to assist and in an understandable position of</p> <p>4 ignorance.</p> <p>5 Another aspect of the culture of Brook House as</p> <p>6 an IRC was its challenging environment. Staff in</p> <p>7 a position of authority were present among a detained</p> <p>8 population understandably concerned about their</p> <p>9 immigration cases, often frustrated by a lack of</p> <p>10 progress or knowledge of the same, and including</p> <p>11 a considerable proportion, at least at the relevant</p> <p>12 time, of time-served foreign national offenders who had</p> <p>13 come to the IRC from the prison estate. As Mr Hanford</p> <p>14 explained in his oral evidence to the inquiry, as</p> <p>15 a result of government austerity shortly prior to the</p> <p>16 relevant period, prisons were closing and the prisons</p> <p>17 estate was no longer able to accommodate a large number</p> <p>18 of time-served foreign national prisoners. The</p> <p>19 proportion of such time-served foreign national</p> <p>20 prisoners at Brook House increased from approximately</p> <p>21 5 per cent in 2013 to between 50 and 55 per cent in</p> <p>22 2017. This increase coincided with a spice epidemic</p> <p>23 which had started in the prison estate and had then</p> <p>24 migrated to the IRCs, in part as a result of the</p> <p>25 transfer to IRCs of such prisoners from the prison</p> <p style="text-align: center;">Page 82</p>	<p>1 There is of course an inherent power imbalance between</p> <p>2 those in authority and those detained persons in their</p> <p>3 care, with staff who were responsible to look after</p> <p>4 detained persons and not vice versa. However, it does</p> <p>5 demonstrate the inherently challenging nature of the</p> <p>6 detained environment, particularly in respect of matters</p> <p>7 over which G4S had no control.</p> <p>8 These considerations, understanding which are</p> <p>9 inherent in a system where individuals may be detained</p> <p>10 against their will and those which are perhaps</p> <p>11 exacerbated by matters which are not pre-determined by</p> <p>12 immigration law and policy, will be central to the</p> <p>13 inquiry's process of making recommendations which will</p> <p>14 have a real impact on the detained population.</p> <p>15 This inquiry has heard extensive evidence on various</p> <p>16 matters relating to healthcare, and in particular care</p> <p>17 of detainees with mental health problems. It is not</p> <p>18 possible to address such matters in the detail necessary</p> <p>19 in these short oral closing submissions. However,</p> <p>20 I would like to touch on one particular issue, namely</p> <p>21 rule 35 of the immigration Detention Centre Rules.</p> <p>22 G4S accepts that during the relevant period, and</p> <p>23 indeed both before and after the relevant period, the</p> <p>24 approach adopted by healthcare staff, and in particular</p> <p>25 the GPs, did not accord with the language of rule 35; in</p> <p style="text-align: center;">Page 84</p>

<p>1 particular, G4S, that there was a failure to complete</p> <p>2 reports under the first two limbs of rule 35 where</p> <p>3 detainees met the criteria under these two limbs. The</p> <p>4 inquiry will of course need to determine where primary</p> <p>5 responsibility for this failure lies.</p> <p>6 When considering this issue, the inquiry will no</p> <p>7 doubt bear in mind a number of matters, including,</p> <p>8 first, the fact that the number of rule 35(1) and 35(2)</p> <p>9 reports completed at Brook House during the relevant</p> <p>10 period was not dissimilar to the number completed at</p> <p>11 other IRCs at this time. Further, it appears from the</p> <p>12 oral evidence to the inquiry that, five years later,</p> <p>13 under the new provider PPG nothing has really changed.</p> <p>14 Secondly, healthcare staff and G4S raise the lack of</p> <p>15 training of rule 35 with the Home Office on more than</p> <p>16 one occasion. However, there were real challenges to</p> <p>17 obtaining such training from the Home Office. This was</p> <p>18 not a new problem, nor does it appear to be limited to</p> <p>19 Brook House. Stephen Shaw in his 2016 report at</p> <p>20 paragraph 4.116 noted that one of the concerns</p> <p>21 healthcare staff at IRCs generally had was that "on site</p> <p>22 teams were not sufficiently trained to complete them."</p> <p>23 Thirdly, Ms Calver in her oral evidence confirmed</p> <p>24 that the Home Office had not raised concerns about the</p> <p>25 lack of rule 35(1) or (2) reports during the relevant</p> <p style="text-align: center;">Page 85</p>	<p>1 There is no such similar guidance to healthcare</p> <p>2 providers on the first two limbs of rule 35 in that</p> <p>3 guidance.</p> <p>4 When considering whether the failure to complete</p> <p>5 rule 35 reports on every occasion that the threshold set</p> <p>6 out in rule 35 was met led indirectly to any</p> <p>7 mistreatment, it is important to bear in mind the very</p> <p>8 low release rate following submission of such reports to</p> <p>9 the Home Office, which according to Stephen Shaw in his</p> <p>10 2016 review was in the region of 10 to 20 per cent.</p> <p>11 Again, G4S does not suggest that any of these</p> <p>12 matters, either individually or collectively, negate its</p> <p>13 responsibility or that of the medical staff to act in</p> <p>14 accordance with rule 35, and other relevant Detention</p> <p>15 Centre Rules. However, it does believe that such</p> <p>16 matters are highly relevant when considering the context</p> <p>17 and who else shares responsibility for the way in which</p> <p>18 Brook House healthcare staff, like staff at other IRCs</p> <p>19 during the relevant period and subsequently, operated</p> <p>20 rule 35.</p> <p>21 To conclude where G4S began in its opening statement</p> <p>22 to the inquiry, it is the detained persons who are, as</p> <p>23 much as any government or corporate body, the true</p> <p>24 audience for the inquiry's reports and conclusions to</p> <p>25 ensure that those detained in Brook House in 2017 have</p> <p style="text-align: center;">Page 87</p>
<p>1 period, or indeed before or after the relevant period,</p> <p>2 notwithstanding that they were well aware of the number</p> <p>3 of incidents of self-harm, suicide attempts and the</p> <p>4 number of detainees placed on ACDTs at Brook House</p> <p>5 during that period. Further, the Home Office did not</p> <p>6 generally raise concerns about the content or quality of</p> <p>7 the rule 35 reports that were completed.</p> <p>8 Fourthly, Ms Calver in her oral evidence to the</p> <p>9 inquiry explained that she had set up an IRC forum to</p> <p>10 discuss rule 35 issues with the healthcare staff at</p> <p>11 other IRCs. The Home Office attended this forum and</p> <p>12 approved the rule 35(2) pathway drafted by Ms Calver.</p> <p>13 Ms Calver understood that, as a result of that approval,</p> <p>14 this pathway document was rolled out elsewhere in the</p> <p>15 IRC estate.</p> <p>16 Fifthly, and finally, the relevant Home Office</p> <p>17 guidance, namely DSO09 of 2016, focuses to</p> <p>18 a considerable extent on rule 35(3) reports rather than</p> <p>19 35(2) and (1) reports. For example on page 7, the</p> <p>20 guidance states that:</p> <p>21 "It is important that nurses and other healthcare</p> <p>22 professionals are aware that they must report to an IRC</p> <p>23 medical practitioner any detainee who claims to have</p> <p>24 been a victim of torture or gives an indication that</p> <p>25 this might have been the case."</p> <p style="text-align: center;">Page 86</p>	<p>1 been heard and listened to, and to ensure that the</p> <p>2 lessons of Brook House are learned so that those in the</p> <p>3 detention estate at present and in future should not</p> <p>4 suffer the kind of treatment witnessed on Panorama.</p> <p>5 G4S, again, apologises for the conduct of its staff</p> <p>6 where they carried out that mistreatment and, more</p> <p>7 broadly, for its own deficiencies in failing to identify</p> <p>8 the mistreatment before or after it occurred. It</p> <p>9 recognises that, while learning lessons is vital, that</p> <p>10 may be of little comfort to those who have already</p> <p>11 suffered. G4S is grateful to all those who have given</p> <p>12 evidence to the inquiry, in particular those who have</p> <p>13 been detained at Brook House, as well as to the chair,</p> <p>14 her legal team and all those staff supporting the</p> <p>15 inquiry.</p> <p>16 Thank you, chair.</p> <p>17 THE CHAIR: Thank you, Mr Sharland.</p> <p>18 Closing remarks by THE CHAIR</p> <p>19 THE CHAIR: That concludes phase 2 hearings in this inquiry.</p> <p>20 I would again like to thank you all the core</p> <p>21 participants and their legal representatives, as well as</p> <p>22 the inquiry staff for ensuring the smooth running of the</p> <p>23 hearings.</p> <p>24 I would also like again to thank the IDRC for</p> <p>25 hosting us, as well as RTS for their technical support</p> <p style="text-align: center;">Page 88</p>

<p>1 and I am grateful to the transcribers and the evidence</p> <p>2 handler for their assistance throughout the hearings.</p> <p>3 Finally, thank you to the ushers and the staff from</p> <p>4 Hestia for their support.</p> <p>5 I am very grateful for the high-levels of engagement</p> <p>6 that there has been before and during the inquiry</p> <p>7 hearings.</p> <p>8 The inquiry received a number of statements from</p> <p>9 formerly detained men, four of whom were able to give</p> <p>10 live evidence. Many of these men are highly vulnerable</p> <p>11 and have provided detailed statements giving their</p> <p>12 accounts of mistreatment and other experiences at</p> <p>13 Brook House and elsewhere. I appreciate just how</p> <p>14 challenging this must have been for them and each will</p> <p>15 be considered for the purposes of my report.</p> <p>16 The inquiry has also heard live evidence from 74</p> <p>17 other witnesses and for each person that gave evidence</p> <p>18 to the inquiry I recognise that it has not been an easy</p> <p>19 experience but it has been of considerable value to me</p> <p>20 and to the whole inquiry.</p> <p>21 I wish to express my gratitude to all of the</p> <p>22 witnesses who have come to give evidence over the past</p> <p>23 seven weeks.</p> <p>24 Whilst it has not been possible or necessary to call</p> <p>25 each person who has provided a statement to give</p> <p style="text-align: center;">Page 89</p>	<p>1 Brook House.</p> <p>2 I would like to conclude my remarks by acknowledging</p> <p>3 that behind each and every one of those ciphers is</p> <p>4 a human being who should have been treated with respect</p> <p>5 and dignity. Neither I nor the wider inquiry have lost</p> <p>6 sight of that.</p> <p>7 Thank you.</p> <p>8 (12.37 pm)</p> <p>9 (The inquiry concluded)</p> <p>10</p> <p>11</p> <p>12 I N D E X</p> <p>13</p> <p>14 Closing statement by MR BUNTING1</p> <p>15 Closing statement by MS MANNION11</p> <p>16 Closing statement by MR DIXEY36</p> <p>17 Closing statement by MS WHITE53</p> <p>18 Closing statement by MR BLAKE61</p> <p>19 Closing statement by MR SHARLAND69</p> <p>20 Closing remarks by THE CHAIR88</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> <p style="text-align: center;">Page 91</p>
<p>1 evidence in person, each of those will be considered</p> <p>2 when preparing my report, alongside the rest of the</p> <p>3 evidence received in the course of the inquiry.</p> <p>4 I have listened very carefully to the oral</p> <p>5 submissions that I have heard over last two days and</p> <p>6 I look forward to receiving the written submissions by</p> <p>7 29 April, which I will of course also consider with</p> <p>8 great care. The inquiry team will then provide</p> <p>9 an update on the overarching timetable in due course.</p> <p>10 Finally, I would like to say this. We have heard at</p> <p>11 times some very technical information regarding the</p> <p>12 contract, the systems, the rules and the processes in</p> <p>13 place at Brook House. We have also heard evidence about</p> <p>14 the role and the structures of oversight and monitoring</p> <p>15 mechanisms in place for IRCs.</p> <p>16 In the course of these inquiry hearings, we have</p> <p>17 heard evidence in person or read in and seen footage of</p> <p>18 men suffering mistreatment and in distressing</p> <p>19 situations. We have also heard directly, or read</p> <p>20 transcripts of, swearing and abusive language directed</p> <p>21 at detainees.</p> <p>22 So, although for reasons of necessity we have had to</p> <p>23 refer to those formerly detained men at Brook House</p> <p>24 using ciphers, I want to emphasise that at the very</p> <p>25 centre of this inquiry are the men who were detained at</p> <p style="text-align: center;">Page 90</p>	

A				
abhorrent 71:17 83:5	accounts 46:8 66:22 89:12	addressed 40:6	alert 42:15,20	85:11
ability 83:15	accrued 22:23	addressing 11:24 43:2 79:15	allegation 9:11 10:3	appetite 9:6
able 1:13 3:25 6:4 6:5 11:10 16:3 16:10 18:17 42:11 67:6 82:17 89:9	accurate 1:17 7:6	adduced 36:10	allegations 1:22 5:24 62:20 66:16	apples 74:8,14
	accurately 78:8	adequacy 13:21 14:2 19:3	alleged 8:6	application 45:23 61:9 72:3 79:10
absence 40:25 57:13	accused 8:3	adequate 29:6	alleging 7:19	applications 40:17 40:18
absent 20:7	ACDT 58:13,16 61:16	adequately 47:22	allocating 65:10	applied 27:21 72:19
absolutely 22:6 62:19 70:17	ACDTs 86:4	admitted 4:11 7:7	allowed 2:4	apply 66:14
abuse 18:25 23:2,5 28:16,22 35:11 36:21 37:16,19 38:5,15,17,22,24 39:3 44:17	achievable 68:11 68:13	adopted 77:17 84:24	allows 31:15	appointment 58:14,22
abused 83:23	achieve 34:12 42:11	Adults 44:8 49:17 49:22 51:2 52:3 56:6 57:1	alongside 57:18 62:17 90:2	appointments 52:13 55:18 65:10
abusive 32:10 90:20	achieved 61:4	adumbrated 5:2	amenable 55:11	appreciate 13:11 89:13
academic 46:22	acknowledged 20:6	advanced 44:9	amount 40:11	appreciated 25:12 61:6
academics 42:7	acknowledging 91:2	advancement 10:12	analysis 14:19 16:17 18:2	appreciates 57:23 72:18
accept 37:21 48:8 48:9 60:15	acquire 44:2	adverse 23:19	and/or 58:1	approach 13:11 46:25 50:10 55:22 57:17 60:2 62:3 65:21 66:12 66:23 68:21 69:12,14 74:3 77:1,10,13 84:24
acceptance 67:3	act 16:6,10 63:19 87:13	adversely 26:15	Andy 9:22	approaches 33:22
accepted 4:9 7:4 15:13 18:8 29:17 29:25 37:23 45:10 48:13 49:2 66:12 70:22 77:22	acted 10:20 16:13 16:19 17:18 37:16 63:1 64:25	advertised 34:4 75:12	Anne 46:12 47:5 50:12	appropriate 14:15 15:25 18:4 26:19 34:24 48:13 51:14 66:15 69:15 72:12 77:16 79:4
accepts 43:3,5 84:22	acting 63:17	advice 42:15 52:11	annual 36:18 40:16 43:1,2,3,8 43:12,16 50:14 50:25 57:1	apologises 88:5
access 1:12 15:5 29:13 31:14 43:17 45:21 52:6 52:10,12	action 18:4 24:20 33:4,11 46:19 57:24	advocacy 33:23	annually 43:1	apologising 71:17
accidental 55:7	acts 38:5,17	affairs 31:21	anonymous 15:8 28:17 31:11,20	apology 62:13 70:5
accommodate 82:17	actual 3:8 41:21	affect 26:15 31:16 68:9	answer 4:2 7:6 17:24 28:12 58:3 74:21 75:5	appear 11:15 16:5 52:1 85:18
accommodation 51:6	add 18:6 44:2 71:20	afraid 51:13	answers 67:7	appears 46:7
accord 40:14 84:25	added 70:17	afternoon 5:6 58:20 69:2,5	anticipated 36:12	
account 5:18,19 24:16 43:23 54:21 81:1	addition 36:7 49:24 54:2,13 78:11	agenda 6:19	anticipates 59:19	
	additional 23:11 44:2 54:1 81:15	aggravation 21:21	Anton 38:19	
	Additionally 58:15	aggression 21:21	anxious 81:9	
	address 34:3 36:8 39:16 53:13 62:1 67:16 69:10,12 69:16,17,24 84:18	agree 20:17 40:5 65:14 76:14	Apart 25:21	
		agreed 26:17 38:2 74:1 76:16	apologises 88:5	
		agreeing 54:1	apologising 71:17	
		agrees 42:2	apology 62:13 70:5	
		Ah 69:3	appalled 70:8	
		ahead 33:24	appalling 51:16 62:12	
		Aiming 15:21	apparent 9:10 21:21 36:20 38:12 47:14	
		aims 1:8 34:13	appear 11:15 16:5 52:1 85:18	
		airing 74:23	appears 46:7	
		Aitken 38:20		
		akin 66:9		
		albeit 41:19 46:17 80:9		
		alcohol 44:12		

56:19 61:17 63:20,24 75:7 arguably 45:24 argue 5:9 arisen 36:9 arising 61:13 Armstrong 5:2 arose 62:2 arranged 31:14 arrangements 13:12 75:23 arrivals 55:15 arrived 21:11 article 65:16 69:12 asked 4:1,6,10 12:14 28:15 29:15 40:2 63:23 67:6 77:4 aspect 82:5 aspects 78:6 assaulted 28:19 assaulting 3:21 assertion 10:9,13 10:14 assertions 8:5 assess 3:11 assessed 24:8 assessing 1:22 31:21 34:7 35:8 55:15 assessment 16:2 29:9 54:24 55:3 55:21 56:16 73:1 assessments 56:23 58:9,19 assist 11:5 52:18 56:15 82:3 assistance 6:24 89:2 assistant 53:24 assistants 53:21 assists 32:4 associated 80:14 assuming 53:15 assurance 14:4 attack 11:1 attempt 77:3 attempts 3:14 86:3 attendance 55:18	attended 56:11 86:11 attention 21:22 43:13 78:24 attitude 75:3 attitudes 37:9 60:1 73:14 attributed 47:14 audience 87:24 audit 14:3 57:5 78:7 auditing 61:24 62:8 austerity 80:18 82:15 authoritative 16:14 authority 17:5 82:7 84:2 availability 44:12 53:25 available 3:11 4:14 22:8 28:4 46:13 59:16 80:11 average 21:2 81:13 avoided 54:10 awarded 77:3 awarding 77:5 aware 51:7 86:2 86:22 awareness 39:12 55:6 59:20 <hr/> B B 80:9 back 15:20 16:4 19:10 33:16 backdrop 78:25 background 4:4 backgrounds 14:25 48:7 bad 74:7,14 83:16 badly 7:20 71:12 bail 51:5 balance 68:6 73:18 74:3 balancing 68:7 barriers 39:6,8,15	39:16 based 16:12 46:13 50:11 62:3 66:21 76:25 77:12,19 baseless 6:13 10:15 basic 37:6 basis 19:3 46:8 52:10 batons 66:20 BBC 1:7,20 4:13 4:22,24 5:3 10:18 11:6 BBC's 1:14,16 bear 41:21 66:4,25 85:7 87:7 beaten 66:19 beds 23:11 26:14 44:2 began 68:10 87:21 behalf 11:20,23 36:6 52:19 69:6 70:4 71:17 73:17 behaved 64:23 73:21 behaviour 36:19 37:2,21,24 49:23 71:17 73:14 78:4 78:9 83:5,15,16 believe 43:21 60:22 87:15 believes 32:9 belts 27:15 benefit 53:5 57:20 benefited 21:10 bespoke 55:2,14 55:24 56:14,22 57:8 59:11,15 best 3:11 4:2 50:6 65:25 better 3:8 22:20,22 24:11 31:15 32:9 36:1 50:4 51:18 55:17 59:19,20 beyond 14:8 37:2 37:7 59:17 Bhui 12:14 14:17 15:11,18 17:19 20:15,17 24:4	26:6,18 27:24 28:15 29:15 30:8 30:25 33:6 34:18 35:2 Bhui's 30:13 bid 77:8,12,16,19 77:21,22 bidders 77:2 bidding 76:25 bids 77:14 big 20:22 bill 24:25 27:1 Blake 60:22,24 61:1,2,3 68:25 91:17 blame 63:14 blew 10:25 board 36:7 39:24 40:10,18,21 41:10 43:16,19 43:21,24 44:1,4,6 44:11 46:6,17 47:20 48:4 board's 46:11 boards 42:14 50:3 50:4,18,19 bodies 13:13 17:13 37:13 38:13 42:5 59:9 63:18,21 78:17 79:2 body 17:10 33:11 71:2 77:5 87:23 body-worn 37:18 bold 68:19 Bole 38:19 booked 58:14 Bosworth 34:22 40:1,4 41:15 46:2,21 47:3,6,10 47:13,18 48:1 63:23 Bosworth's 46:20 47:1 50:8 bottom 63:4 bound 77:18 boundaries 79:7 branch 74:17 break 52:22 53:1 breaks 4:16	briefly 12:5,7 33:15 bring 18:13 26:13 41:20 bringing 14:22 Britain's 1:15 broadcast 2:14,16 broadcaster 1:8 broader 42:12 59:4 69:20 72:6 79:10 broadly 43:8 88:7 Brockington 45:6 45:8 70:7,12 71:18 broken 48:23 52:2 Bromley 55:12 58:2,8,24 Brook 2:5 5:20 10:18,24 12:4 13:13 18:23 19:16,20 20:10 21:3,6,9 23:11,15 24:2,2,6,25 25:3 25:6,8 26:8 27:24 35:12 36:14,18,21 37:5 37:10 40:11 41:18 43:25 44:22 45:10,20 49:12,21 50:23 50:24,25 51:8 52:2 53:10,17 54:4 59:18 64:18 68:5 70:1,19 71:22 72:4 73:11 73:21,25 74:7,18 75:1,17 76:2 78:4 79:21 80:2 80:6,24 81:3,6,7 81:14,18 82:5,20 83:8,10 85:9,19 86:4 87:18,25 88:2,13 89:13 90:13,23 91:1 brought 30:7 78:5 budget 77:9 building 35:24 built 68:5 80:8
---	--	--	--	--

Bunting 1:5,6,7 11:7 91:13 Buss 6:4,6 busy 20:14 <hr/> C <hr/> C 25:25 call 89:24 called 56:15 calling 9:17 calls 49:25 57:8 Callum 1:25 2:1 2:13 3:10 4:19 4:25 5:4,10 6:2,8 6:12,18,23 7:4,7 7:10,11,13,17,18 7:21,25 8:3,5,6,9 8:14,18,20 9:5,9 9:16,21,22,24 10:2,8,11,15,19 10:24 11:3,4 20:5 37:19 calmer 64:16 Calver 58:6,8 85:23 86:8,12,13 candidly 29:16 34:18 capable 16:23 21:20 capacity 59:7 captured 78:9 care 8:21,22 41:6 43:22 51:21 53:20,22 54:8 60:2 66:15 69:6 71:7 73:22 84:3 84:16 90:8 cared 64:19 careful 6:2 30:14 67:1 68:22 carefully 32:21 33:14 52:4 65:22 79:11 90:4 cares 64:20 carried 88:6 carrots 83:20 case 22:11 35:6 54:16 62:22 77:22 81:5,10 86:25	cases 27:8 72:14 72:19,25 73:4 82:9 83:19 casework 81:21 Caseworkers 52:9 cast 51:15 casual 2:8 casually 2:7 category 80:9 caught 21:25 caused 38:6 61:23 71:14 causes 39:8 caution 26:21 47:1 CCTV 37:20 cells 25:22,24 26:2 26:14 cent 21:3,9 22:16 22:18 76:25 77:9 77:11 82:21,21 87:10 central 8:23 12:13 75:22 76:23 84:12 centrally 78:14 centre 13:17,18,19 15:2 18:3 20:4,6 20:8 21:4 22:15 22:21 23:16 26:8 30:25 31:22 32:22 33:3 35:12 37:15 39:2,14 41:5 42:16,18,23 43:6,10,14 44:12 44:25 46:15 47:16 49:4 50:11 51:17 75:4 78:14 84:21 87:15 90:25 centres 12:23 14:12,14 15:5 50:1 centres' 20:4 certain 6:5 39:20 47:12,14 67:15 67:17 78:6 79:17 certainly 20:20 31:4 66:13 chair 1:5,7,12,19	1:24 2:2,13,22 3:13,18,24 4:3,13 4:16,18,22 5:8,16 5:22 6:2,8,11 7:1 7:20 8:4,16,25 9:3,7,12 10:6,9 10:19,22,24 11:1 11:3,7,12,13,17 11:19 12:9 13:15 14:1 16:8 17:11 18:5,15 19:9,15 20:23 23:6 30:4 33:15 34:20 35:9 36:3,4,6 41:25 46:23 47:8 50:23 52:18,20 54:11 57:23 60:11,20 60:21,25 61:1 66:4,14 68:20,25 69:2,5 79:12 88:13,16,17,18 88:19 91:19 chaired 56:11 chairs 49:25 50:3 50:4 51:7 chairs' 49:24 challenge 51:13 58:25 60:15 challenged 20:15 43:24 83:22 challenges 85:16 challenging 43:4 63:16 82:6 84:5 89:14 change 16:13,24 26:19 55:12 58:25 59:18 65:6 74:17 83:2 changed 85:13 changes 4:3 12:5 30:4,12 32:11,24 35:18,25 60:16 62:7 65:4,7 channels 75:16 chaotic 27:18 characterisation 40:14 characterised 73:6 charge 8:10	Charlie 32:20 charter 1:18 51:1 51:8 chatting 73:23 chief 23:23 26:12 73:12 chiefly 81:4 Chris 6:17,23 ciphers 90:24 91:3 circumstances 16:24 72:15 civic 41:23 civil 66:9 claim 33:8 claims 29:8 86:23 clarification 61:13 Clarke 23:23 Clarke's 45:9 Clayton 8:11 clean 24:25 27:1 cleaning 21:17 cleanliness 40:25 clear 5:23 10:21 16:18 17:19 23:23 24:11,18 28:12 34:1,17 39:5 47:3 48:15 48:15,16 62:13 63:15 65:14 70:17 76:24 83:3 83:24 clearer 61:18 clearly 24:14 26:22 37:23 41:2 65:12 70:15 clinical 53:18 54:5 54:17,20 59:2,24 clinics 54:16 closed 41:17 closely 25:15 33:18 closing 1:6,19 6:16 9:11 11:6,18 35:9 36:5,6 52:19 53:3 61:2 69:4,6,9,11,16,17 82:16 84:19 88:18 91:13,14 91:15,16,17,18	91:19 coffee 73:24 coincided 82:22 Colbran 40:6 47:5 47:8 48:12 Colbran's 47:7 colleagues 7:18 37:12 64:23 collectively 87:12 Collier 2:24 27:9 colluded 37:24 collusion 62:21 combined 53:19 come 9:8,18 17:24 25:11 31:5 46:9 63:23 78:24 82:13 83:13 89:22 comes 75:5,7 comfort 88:10 coming 31:19 67:2 commendable 29:24 commendably 32:13 comment 23:25 comments 40:2 46:9 62:21 63:8 79:24 commercial 61:22 commissioners 61:12 committed 3:21 35:13 59:4 61:15 committees 47:16 common 26:1 communicating 55:17 communication 32:4 community 41:8 company 45:13 71:11,14 compare 50:5 compared 24:12 27:5 compassion 60:3 64:25 73:22 compassionate
--	--	---	--	---

<p>74:10 compelled 10:17 competently 27:21 complaint 26:2 39:9 40:25 62:24 75:8 complaints 29:12 62:9,19,24 78:11 complementary 14:25 complements 41:12 complete 31:11 54:13 58:6 85:1 85:22 87:4 completed 8:13 37:17,18 65:9 67:19 85:9,10 86:7 complex 38:25 39:8 54:16,18 complexities 67:15 compliance 13:20 13:25 14:10 17:25 24:24 51:9 76:8 comply 8:7 complying 13:17 compromising 29:12 concentrate 72:19 concern 17:23 20:22 26:22 39:9 39:15 41:6 42:25 44:17 46:19 57:23 69:18 71:15 78:4 81:23 concerned 40:24 44:5,14 82:8 concerning 31:18 41:23 concerns 23:21 26:4 29:5,11 30:20 31:19 32:9 33:2,2,10 37:11 38:11 39:7 40:19 42:21 43:17,18 43:20 44:1,3,11 45:22 51:11</p>	<p>75:19 81:2 85:20 85:24 86:6 conclude 11:3 19:12 22:20 25:2 28:22 29:25 35:9 47:19 80:18 87:21 91:2 concluded 46:14 49:15 91:9 concludes 88:19 conclusion 15:17 15:25 conclusions 16:8 16:12 26:25 66:21 71:19 72:22 79:9 87:24 condition 26:1,3 conditions 12:24 14:14,16 18:22 25:16 26:15 35:16 38:9 55:20 conducive 75:4 conduct 36:22 37:9 70:1 71:3 71:16,22 74:7 88:5 conducted 73:19 confidence 30:20 68:20 confidential 15:8 confidentiality 29:12 confidently 19:11 confine 51:24 confirmed 4:4,19 19:21 20:2 27:25 35:2 58:3 85:23 confusion 27:21 conjunction 23:4 Connolly 3:17,23 4:7,11 48:3 Connolly's 47:24 conscientiously 65:22 conscious 46:21 consequences 20:7 21:14 68:1 consequential 22:3 consider 7:1 14:4</p>	<p>18:4 25:11 31:20 32:13 35:4 46:23 51:21 64:5,7,12 64:19 67:7,10 74:13 75:7 83:7 90:7 considerable 40:11 46:22 80:7 82:11 86:18 89:19 consideration 19:8 24:20 66:15 69:10 considerations 84:8 considered 32:21 35:3 38:4 56:7 67:1,6 89:15 90:1 considering 54:21 64:11 66:5 83:7 85:6 87:4,16 considers 62:16 consistent 5:11,17 66:23 72:9 81:1 consistently 34:6 conspiracy 8:16 constant 8:7,9,10 54:23 57:15 58:20,21 consultations 54:3 consulted 32:24 contact 32:1,2 33:25 contacted 31:23 contain 24:16 contemporaneous 5:14 7:24 content 86:6 contents 28:16 context 23:25 42:12 44:13 50:21 73:7 74:9 75:21 81:16 83:6 87:16 contextualise 50:5 continual 59:5 continue 34:11 51:14 52:4</p>	<p>continued 60:17 continues 19:13 35:24 36:17 46:5 59:13 continuing 4:15 continuity 54:8 contract 14:1 19:22 38:14 44:22 45:2,2,15 54:1 57:10 60:16 62:1,2,4 75:25 76:1,4,14,16,18 76:22 77:1,3,11 77:19,25 78:3,5 90:12 contracted 20:1 44:24 contractor 18:3 73:3 76:10 contractors 17:1 contractual 42:19 44:25 61:19 75:23 78:6 contrast 8:21 contrasted 77:10 contribute 16:1 31:25 contribution 22:12 contrition 70:11 control 56:17 59:7 84:7 Convention 69:13 conversation 9:23 conversations 2:7 cope 83:4 core 1:11 16:8 88:20 corporate 70:6 71:2 87:23 correct 48:4 69:12 corridor 63:19 cost 76:23,25 77:12 costs 77:2 Council 6:3 counsel 7:3 20:15 38:3 45:8 47:11 58:4 countervailing</p>	<p>67:21 country 59:14 counts 67:4 course 6:6,22 7:16 7:20 8:18,24 10:12 20:11 22:10 25:8 28:19 54:6 64:10 69:9 69:25 70:11 72:4 75:3 76:13 83:4 84:1 85:4 90:3,7 90:9,16 Courts 51:10 courtyards 21:16 cover 57:1 covering 70:1 Covid-19 51:4 CQC 45:19 created 48:9 83:2 creating 78:20 credibility 1:22 credible 72:23,25 73:9 criteria 85:3 critical 25:5 29:17 29:18 43:4 63:8 75:20 criticise 6:7 criticised 7:10 51:1 criticism 6:21 7:2 7:9 8:4 9:3 10:9 10:10,21 29:20 46:4,7 47:15 49:7 66:2 78:23 criticisms 6:9,12 6:14 39:17 45:25 47:1 49:3 79:24 cross-examination 66:2 Croucher 10:8 crucial 41:23 crucially 83:14 CSU 43:19 CTI's 69:14 cultural 59:18 culture 5:20 10:23 23:2 28:22 31:16 32:10 37:4,7,10</p>
--	---	--	--	--

47:20 49:8,23 62:6 63:24 75:1 75:5,18 80:6 82:5 current 49:11 53:7 57:11 currently 57:25 curtained 25:23 curtains 25:23 custodial 69:21 70:21 83:3 custom 59:1 cycle 21:23,25	decision-making 67:15 decisions 52:8 decline 26:17 deep 17:9 deep-dive 14:18 deeply 70:14 defence 66:9 deficiencies 88:7 defined 80:7 definitive 68:12 degrading 37:2 delay 7:5 delayed 1:3 6:24 delays 43:17 51:5 deleterious 80:19 deliberate 38:4,17 deliver 59:13 delivered 35:13 54:6 56:24 62:13 delivery 44:20 56:24 60:2,2 demand 33:11 demanding 66:1 demands 17:6 demeaning 3:22 demonstrably 40:10 demonstrate 84:5 demonstrated 8:22 demonstrates 78:20 denied 8:18 densely 24:19 department 42:21 depicts 2:21 5:19 Derek 3:17,22 4:2 9:4,15,18,21,24 10:1,3,7 73:20 derogatory 62:21 describe 29:23 described 22:14 27:18 28:3 62:11 64:15 describes 5:21 describing 28:24 description 27:12 40:4	descriptive 3:8 desensitisation 60:3 design 25:21 designed 26:9 30:16 32:11 56:18 75:16,18 76:7,19 Despite 58:24 destroyed 8:15 DET 51:3 detail 28:4 36:9 67:22 84:18 detailed 18:2 24:16 30:12 50:20 69:18 89:11 details 69:10 detained 11:20 14:13,16 16:21 16:25 21:6,13,17 21:19 22:14,24 28:18 30:17,19 30:21,24 31:17 31:25 32:1,6,23 34:15,17 36:2,13 37:1,6 39:5,10 40:12,22 41:1,7 41:12,24 43:6,10 43:23,25 44:10 47:15 49:22 51:11 52:6 56:18 64:7,20 65:8 66:24 67:18 68:18 71:7 72:15 73:5 80:24 81:2 81:6,17,19,20,21 82:2,7 83:17,22 83:25 84:2,4,6,9 84:14 87:22,25 88:13 89:9 90:23 90:25 detainee 6:24 9:17 10:4 26:10 27:14 28:17 29:8,19 31:2 38:21 86:23 detainee's 54:21 detainees 2:7,8 3:22 12:20 21:3	22:7,8,16 23:19 25:21 26:16 29:6 54:23 55:7 57:15 57:21 59:21,23 70:16 72:22 73:13,23 81:9,15 81:23 84:17 85:3 86:4 90:21 detect 12:12 18:17 19:4 23:5 32:10 35:11 59:23 detention 12:11,13 12:19,21 13:18 15:4 21:2 34:4 35:15 36:16 38:8 38:9 41:9,22,24 42:6 49:16,20 50:17 51:18 52:1 52:16,17 54:22 55:21,23 57:25 68:12 70:21 72:7 79:14,16,22 81:14 84:21 87:14 88:3 deteriorated 28:13 determination 65:17 79:12 determine 81:17 81:18 85:4 detrimentally 55:20 develop 6:13 18:19 56:14 57:4,8 59:14 60:4 developed 50:13 58:13 59:8 developing 55:14 56:21 develops 50:9 dialogue 41:23 diaries 5:15 difference 19:16 21:12 differences 18:22 35:16 different 14:25 17:12 63:24 64:17 76:4 77:14 differential 77:13	differently 63:17 differing 80:1 difficult 37:21 59:12 64:25 68:21 72:15 75:20 80:5 difficulties 81:11 difficulty 31:18 78:20 digital 4:14 dignity 37:6 72:16 73:6,22 91:5 directed 90:20 direction 68:9 directions 51:4 81:20 directly 1:20 2:19 90:19 director 28:9 70:21 dirt 25:24 disagree 69:14 disappear 8:19 discarded 15:14 disclosure 15:8 disconnect 57:12 discounted 15:24 discretion 66:14 discuss 86:10 discussed 56:10 discussion 34:21 54:18 discussions 2:10 3:18 31:13 54:19 59:2 disheartening 24:22 disincentive 75:13 disincentivise 78:22 83:16 disorder 29:7 disproportionate 2:11 3:1 disregard 2:8 disruption 54:10 disseminate 28:3 dissimilar 85:10 distance 28:4 distinction 13:12
--	---	--	---	---

13:14 distinguished 74:15 distress 81:24 distressing 90:18 divorced 23:25 Dixey 36:4,5,6 52:20 91:15 doctor 4:20 doctored 3:16 DoctorPA 54:9 58:18 document 50:10 86:14 documentary 1:14 1:16 2:16 71:10 documentation 77:6 documents 48:9 doing 12:23 13:3 15:6 domestic 12:9 50:16 Dominic 38:20 Donnelly 6:17,23 7:4,6 Donnelly's 6:22 7:1 doors 64:4 doubt 3:12 14:4 36:24 64:12 72:2 75:22 76:6,20 85:7 Dove 45:18 Dr 12:14 14:17 15:11,18 17:19 20:15,17 24:4 26:6,18 27:24 28:15 29:15 30:8 30:13,25 33:6 34:18 35:2 38:20 55:12 58:2,8,24 60:4 drafted 86:12 draw 14:25 23:7 26:24 33:19 drawing 57:3 drawn 15:17 draws 49:18	dreadful 24:3 dream 10:16 drew 21:22 drive 16:13 driven 32:11 driving 16:24 drugs 44:12 DSO09 86:17 dubbed 3:16 4:7 due 25:8 55:23,24 56:24 57:16 58:22 69:8 90:9 duties 8:7 duty 8:21,22 71:7 <hr/> E E 91:12 earlier 5:12,14 24:12 62:24 ears 41:9 easy 74:21 89:18 echoing 27:8 Ed 40:1 edit 4:20 edited 3:16 4:1,2 4:11 editorial 1:18 2:15 educate 1:9 education 59:10 80:9 effect 72:10 effective 35:11,14 37:25 60:8 76:8 78:21 effectively 76:9 effectiveness 14:6 25:11 35:8 74:5 effects 80:19 efficacy 30:14 effort 60:6 efforts 60:10 either 74:17 80:1 87:12 elegantly 5:2 elements 71:14 79:17,21 email 34:3 emerged 20:21 69:24 eminent 46:22	emotionally 63:2 emphasise 55:15 90:24 emphasised 3:4 emphasises 4:24 5:3 employed 54:12 employing 45:14 enable 3:11 32:10 encourage 4:21 30:16 55:22 encouraged 58:7 encouraging 23:24 55:17 endeavouring 53:16 enforcement 17:14 17:14 engaged 41:3 engagement 30:17 48:18 89:5 England 58:11 English 22:18 73:16 enhance 60:10 enhanced 30:6 32:7 33:22 enhancements 30:16 32:9 35:23 ensure 1:11 16:11 32:5 34:5 52:6 54:20,24 55:5 56:2,22 57:24 71:22 76:7 87:25 88:1 ensuring 13:20 14:10 31:3 88:22 entered 9:23 entertain 1:9 environment 6:20 23:10 25:5,8,22 38:9 59:11 64:16 75:2 79:21 80:15 80:16 82:6 83:12 84:6 environments 41:17 55:3 72:6 epidemic 82:22 epithets 3:23	escalated 28:10 escape 61:21 escorting 81:19 especially 25:24 essence 14:18 essential 3:5 17:15 35:10 59:25 essentially 20:3 77:4 established 72:18 establishment 18:1 23:9,14 24:16,21 31:12 41:10 establishments 16:9 18:9 33:8 33:13 50:7 estate 62:10 72:7 74:19 79:22 82:13,17,23 83:1 86:15 88:3 European 69:13 evaluate 13:4 event 9:12 52:4 events 3:9 11:21 everyday 21:16 73:25 evidence 1:21 2:24 2:25 3:1,4,10,11 3:15 4:19 5:5,10 5:11,16,22,23,25 6:9,10,22 7:5 8:13,17,25 10:19 10:23 12:14 15:6 15:11,20 16:18 17:20 18:12,21 20:21 21:13 22:1 22:4,23 23:8,19 24:1 25:6 26:7 27:8,25 28:16,20 30:1,12 31:1,18 32:14 33:6 35:4 36:10,24 37:8,14 37:22 38:1,2,19 39:20 41:2,15 44:14,19,23 45:5 45:18 46:3,13,20 46:25 47:2,7,24 48:12,24 49:11	50:12 59:3 63:2 63:9 64:19 65:1 65:21,25 66:5,6 66:24 67:2,8,10 67:11,13,16 69:25 72:9,23,25 73:9 74:24,25 76:20 79:3,25 80:25 82:14 83:21 84:15 85:12,23 86:8 88:12 89:1,10,16 89:17,22 90:1,3 90:13,17 evidenced 16:7 ex-prison 48:1,5 exacerbated 21:23 25:16 84:11 exact 28:5 40:7 exactly 33:5 examine 6:14 57:5 example 1:16 6:1 7:9 15:7 22:4 31:6 48:11 50:25 53:22 61:8 62:17 64:1,3,14 66:17 67:5,17 76:10 78:19 79:13 80:3 86:19 examples 6:15 33:19 44:18 excellent 50:2 exception 73:10 exceptionally 70:9 excuse 9:9 83:25 exercise 37:25 76:19 77:18 exhibited 77:6 expectations 14:15 24:17 expected 33:7 expects 16:9 experience 15:1 34:14 41:12,20 46:22 49:20 89:19 experienced 14:22 60:11 experiences 12:21
---	--	---	---	---

15:4 36:14 41:24 49:18 50:2,5 89:12 expert 2:23 expertise 14:24 46:23 49:18 experts 68:7 explain 3:25 6:4 explained 10:15 14:17 15:11 26:18 30:6,25 33:6 34:15 37:19 41:15 46:12 47:10 49:5 55:12 70:14 82:14 86:9 explaining 20:18 26:7 explains 24:5,14 30:8 40:8 explore 1:13 explored 2:24 exploring 10:21 expose 17:21 exposed 62:15 express 89:21 expressed 34:18 40:8 expressly 31:24 extended 30:24 extensive 84:15 extent 14:5 48:22 74:6 76:10 80:7 86:18 external 13:13 17:10 37:13 39:1 42:4 45:11 56:13 75:13 extreme 6:21 7:2 extremely 11:16 eyes 41:9	63:7,11 68:17 78:17 85:8 factor 22:11 78:3 factors 38:12 42:12 59:6 67:21 68:8 factual 47:12,17 47:18 Faculty 57:3 failed 8:6 37:5 70:18 failing 88:7 failure 17:22 19:3 70:15 85:1,5 87:4 failures 51:2 fair 74:10 fairly 65:22,24 fairness 74:2 fairy 9:16 faith 10:20 false 3:18 7:22 8:5 familiar 13:21 far 41:4 fatigue 60:3 feared 10:25 feature 20:23 feed 54:19 feedback 19:13 29:19 60:18 feeding 16:4 feel 17:17 24:4 71:6 feeling 20:6 22:5 feels 26:8 felt 10:17 Fifth 68:10 fifthly 54:7 86:16 filmed 7:18 final 6:11 16:5 18:5 29:3 33:15 80:21 finally 4:18 12:6 35:4 55:1 57:7 60:11 68:10 86:16 89:3 90:10 financial 10:12 find 3:1 15:4 18:24 19:3 25:7 41:21	79:2 finding 15:20 16:2 20:16,18 37:15 45:9 findings 16:10,18 17:4,6 18:20 19:6 23:6 24:17 24:18 25:2,19 27:2,19 29:17 34:9 35:17 50:20 60:17 68:16 72:1 73:7 fire 68:3 first 1:24 5:4 6:17 8:12 10:22 12:1 12:8,15 13:14 18:20 24:1 30:8 30:21 38:4,15 44:18 46:2,12 47:3,19 49:2 50:9 51:25 57:10 66:5 74:21 85:2 85:8 87:2 firstly 8:6 11:15 16:9 23:9,13 33:21 34:7 39:9 53:16 55:13 58:13 60:13 fitness 54:22 five 6:15 27:16 66:3 fives 85:12 flashing 69:3 flaws 13:8 flight 51:8 flights 51:1 flows 32:3 focus 28:8 32:18 49:15 52:4 60:9 62:4 72:13,24 73:1 76:22 77:2 77:15 78:9 focused 68:16 71:25 75:23 focuses 50:14 86:17 focusing 49:16 follow 15:9 31:13 32:5 67:20	follow-up 16:1 followed 30:15 following 12:6 18:20 25:1 30:7 32:15,17 33:18 58:15,23 68:2 69:5 87:8 follows 1:24 13:11 food 2:9 footage 1:25 2:2 2:13,21 3:2,5,15 3:20,25 4:1,5,6,7 4:11,13,15,18,20 4:23 5:17,17 9:14,16,20,22 10:7,11 11:4 27:10,15 66:20 90:17 force 2:11,23 3:1,7 7:12,24 8:2,13,19 23:12 26:25 27:2 27:4,6,11,13,17 27:20 28:2,7,10 28:24 35:7 37:16 63:20 72:16 76:3 76:15 forces 72:11 foreign 82:12,18 82:19 Forensic 57:3 forensically 6:13 forgiven 11:23 forgotten 73:7 74:2 form 8:13,19 14:2 34:12 35:5 41:22 65:9 66:6 67:19 formal 26:18 formed 46:7 former 48:5 formerly 32:1 36:13,25 89:9 90:23 forms 41:1 formulation 75:9 forum 79:13 86:9 86:11 forums 49:24 forward 31:5,19	38:19 71:19,21 72:8 90:6 found 15:25 25:16 27:9 78:7 82:1 four 5:3,6 11:25 23:13 24:14,15 28:18 33:19 39:14 50:14 89:9 fourth 9:3 19:10 27:14 29:3 67:25 fourthly 23:12 54:3 56:21 86:8 frame 79:20 framework 50:15 79:23 frameworks 78:12 frankly 4:11 Fraser 8:11 frequently 37:20 Friday 58:11,20 front 82:1 frontline 37:23 fruit 33:10 frustrated 82:9 83:18 frustration 17:18 22:2 fucking 9:19 10:5 full 54:20 65:11 68:20 fully 47:21 49:8 53:9 57:23 61:6 61:6 65:17 function 14:10 functioning 69:3 fundamental 17:16 36:15 further 2:23 11:6 12:7 21:24 29:2 32:5 33:15 34:7 49:1 52:18 55:12 56:4 58:2 59:1 64:3 75:5 80:14 85:11 86:5 fuses 22:2 futile 17:21 future 49:10 53:7 74:13 88:3
F				G
face 10:25 66:2 faced 31:19 facilitative 25:9 facilities 25:18 52:12 80:10 facing 9:24 fact 7:4,11 9:20 28:24 38:22 45:1				

<p>G4S 13:15,24 14:7 20:2 44:15 45:11 45:14 48:22,24 62:21 69:6,7,13 70:4,9,14,18,21 71:1,17,19 72:4 72:17 73:2 74:1 74:21 75:24 76:2 76:13 77:16,23 77:24 78:6,8,24 78:25 79:10 80:22 81:17,24 81:25 83:6 84:7 84:22 85:1,14 87:11,21 88:5,11 G4S's 69:9 70:6 75:11 77:21 gain 10:12 gaps 57:11 Gary 10:8 Gasson 67:8 gathering 62:8 Gatwick 38:20 53:7 55:4 57:18 59:5,16 Gatwick's 80:14 GDWG 46:9 48:14 48:18,22 49:4 66:25 67:9 general 18:16 generally 12:2 80:12 85:21 86:6 genuinely 74:9 give 6:1,15 28:25 65:25 67:6 89:9 89:22,25 given 23:15 24:25 27:12 31:10 53:5 55:5 65:3 88:11 gives 17:5 41:11 86:24 giving 7:14 15:22 32:4 34:19 89:11 go 1:20 2:22 62:1 goal 60:4 goes 2:19 12:19 going 6:15 9:18 10:4,4,5 11:8,9 12:6 31:8 52:21</p>	<p>good 1:5 2:22 3:19 6:11 8:1 10:20 14:19 22:19 23:16,17 24:8,10 28:3 30:1 32:21 45:10 62:15 63:5 67:5 69:2,5 74:15 75:19 83:15 Gordon 45:6 70:7 governance 14:6 24:24 28:1,8,13 governed 76:3 government 75:22 76:23 82:15 87:23 government's 76:24 governor 48:5 GP 54:8 GPs 54:12 56:22 56:25 58:5,12 84:25 grades 71:15 graphically 2:12 grateful 11:16 88:11 89:1,5 gratitude 89:21 great 21:5 22:1 41:16 46:18 61:4 66:5 90:8 greater 30:16,19 32:8 36:9 49:15 55:6 ground 78:14,18 group 22:14 38:21 53:4 groups 33:23 59:25 GSL 76:17 77:8,17 77:20,23 78:1 GSL's 77:19,22 guidance 13:22 57:2,3 86:17,20 87:1,3 guidelines 1:19</p> <hr/> <p style="text-align: center;">H</p> <hr/> <p>half 29:23 halfway 9:23</p>	<p>hand 74:21 handler 89:2 handling 44:5 75:8 hands 63:5 Hanford 28:8 82:13 happened 4:15 11:2 26:20 66:17 70:23 83:7 happening 14:19 27:23 happens 41:17 hard 26:21 39:16 60:4 72:10,14 hard-working 74:10 harm 35:1 59:23 61:21 67:23 harms 38:6 head 7:11,21 58:5 headline 30:4 66:4 health 22:7 24:25 27:1 29:14,14,24 43:17,19 44:9 49:17 53:19,22 54:6,24,24 55:2,2 56:15 58:16 69:21 75:24 84:17 healthcare 23:12 29:4,11 34:20 45:20,21,22 53:6 53:10,15,20 55:4 56:11,16 58:5 59:19 60:1,12 61:12 69:7 83:4 84:16,24 85:14 85:21 86:10,21 87:1,18 healthy 23:9,13 24:15 75:18 hear 2:4 6:5,6 11:11,12,13 15:3 24:22 44:14 52:23 heard 5:1 11:19 15:10 21:13,18 22:1 25:6 27:9 28:7 32:6 36:25</p>	<p>44:19,23 45:5,18 61:14 63:1,8,22 65:21 66:6 68:1 72:9 74:24,25 75:2 79:25 80:6 81:1 83:21 84:15 88:1 89:16 90:5 90:10,13,17,19 hearing 11:8 69:25 hearings 33:20 88:19,23 89:2,7 90:16 heart 2:19 80:4,23 Heathrow 57:19 heating 40:25 heavily 45:16 64:1 held 15:4 26:16 35:15 64:13 81:7 Hello 11:12 helm 63:6 help 33:24 35:25 helped 61:5 Hestia 89:4 hidden 12:18 37:16 38:25 high 20:3,12 60:18 64:14 high-level 20:25 high-levels 89:5 high-quality 56:23 higher 21:8,10 22:11 40:19 73:15 highlight 12:5 13:7 66:3 highlighted 13:1 44:4 60:3 highly 25:5 87:16 89:10 Hindpal 12:14 historian 48:3 historic 62:2 history 24:11 hitherto 59:16 HMCIP 32:20 HMIP 14:11,22 15:22 16:7,9,13 16:22 17:14,17 17:20 18:6,10,17</p>	<p>18:19,24 19:12 21:1,6 22:12,23 23:1 24:4,24 25:4,13 26:22 27:1,9,19 28:5,14 28:15 29:20 30:7 30:8 31:15 32:2 32:9,12,13,15,18 32:24 33:17,22 34:1,6,11,21,22 34:24 35:2,4,17 35:20 38:18 41:14 44:16 45:7 45:16,19 63:7 HMIP's 14:8,17 17:15 18:13 23:13 26:24 30:1 30:5 32:7 holistic 73:1 Home 13:16,24,25 14:7 17:1 18:4 19:20 24:21 33:4 38:14 39:2,14 42:17,23,24 43:14 44:15,21 44:24 45:2 46:16 48:23,24 49:4 51:3 52:8 56:12 58:10 59:9 61:11 61:15,18 62:18 63:8,13,18,21 64:2,4,5,10,12,15 64:18,21,22,24 65:11 66:8 68:20 73:3 75:24 76:2 76:12,17,19 77:1 77:5,19,22 78:1 78:13 85:15,17 85:24 86:5,11,16 87:9 homework 76:11 honest 65:1 67:8 hope 11:22 61:25 62:5 hopefully 11:9 hopefulness 4:12 hopes 59:19 60:9 horrified 36:19 hostility 20:6</p>
--	--	---	--	--

hosting 88:25 hours 19:25 house 2:5 5:20 10:18,24 12:4 13:13 18:23 19:16,19,20,24 20:10 21:3,6,8,9 23:11,15 24:2,2,6 24:25 25:3,6,8 26:8 27:24 35:12 36:14,18,21 37:5 37:10 40:11 41:18 43:25 44:22 45:10,20 49:12,21 50:23 50:24,25 51:8 52:2 53:10,17 54:4 59:18 64:13 64:17,18 68:5 70:1,19 71:22 72:4 73:11,21,25 74:7,18 75:1,17 76:2 78:4 79:21 80:2,6,17,24 81:3 81:6,7,14,18 82:5 82:20 83:8,10 85:9,19 86:4 87:18,25 88:2,13 89:13 90:13,23 91:1 human 47:22 50:16 69:13 91:4 human-rights-b... 50:20 human-rights-d... 14:15 humane 51:18 <hr/> I <hr/> idea 33:7 identification 55:19 identified 33:5 39:3 42:6 43:12 44:6 54:25 56:3 56:5,8 61:8 62:17 79:1 identify 31:5,7,12 31:15 32:8 33:3 38:14 44:16	57:10 74:14 78:17,23 88:7 identifying 30:10 38:16 55:22 IDRC 88:24 ignorance 82:4 ignored 15:14,24 18:7 ill-treatment 25:9 42:6 illusion 71:1 IMB 36:11,18 37:12 38:10,13 38:16 39:7,12,13 39:15,18,19 40:2 40:16,22 41:3,4,8 41:19 42:2 43:3 43:4,12 44:13,16 45:1,3,7,17,19,21 45:22,24 46:5,8 47:1,14,16,25 48:9,21 49:1,3,7 49:12,19,21 50:9 50:23 51:8,13 52:4,14,19 63:7 78:15,18 IMB's 39:22 40:5 40:6,23 43:2,7 48:14,18 imbalance 61:20 61:21,23 84:1 IMBs 49:13,25 immediate 57:24 immediately 4:9 48:12 immigrants 63:3 immigration 1:15 12:19 14:12 18:2 31:22 32:22 35:12 36:16 38:7 39:10 49:16,20 50:1 51:9,16,17 52:17 62:11 67:21 68:12 79:14,16,18,22 81:5,10,22 82:9 83:19 84:12,21 impact 20:10 38:8 43:22 52:15 55:6	84:14 impacted 22:6 impartial 1:8,17 imperative 51:25 impersonal 25:20 implement 44:8 implementation 17:22 implemented 64:14 importance 2:25 32:21 55:16 61:5 important 2:14,15 2:18 11:19 12:1 12:18 13:5,14 16:7 19:6 21:12 22:10 23:6 25:10 33:11 39:18,19 41:1 47:17 48:8 68:16,17 70:3 73:7 74:11 76:4 80:21 81:16 83:6 83:10 86:21 87:7 importantly 5:16 67:9 imposition 68:12 improve 13:2 16:21 19:14 30:2 33:19 36:2 44:7 49:6 53:17,25 54:4 improved 19:13 62:3,4,4 improvement 12:22 28:7 44:7 56:20 59:5 60:14 60:18 improvements 12:7 16:24 18:9 18:14 19:8 33:16 35:19 52:11 55:9 62:9,10 improving 35:14 62:7 63:11 65:9 in-cell 25:23 inability 83:19 inaccurate 40:10 inaccurately 37:18 inadequate 23:4	inappropriate 26:10 27:13 48:11 52:1 incentivise 76:8 83:15 incident 2:12 3:6 7:3,12,22,24,25 8:14,24 incidents 2:5,21 5:18 21:21,22 27:11 28:2 30:11 35:7 37:7 69:18 86:3 include 20:16 29:9 39:8 59:7 included 16:3 28:17 including 2:6,8,11 13:17,25 15:2 22:7,13 23:11 27:3 38:7 44:17 45:23 49:19 52:11 56:6 59:18 60:2 62:8 67:22 71:6 76:21 82:10 85:7 incoming 53:6 incorporating 54:12 increase 20:11 30:10 44:7 53:21 82:22 increased 21:19 22:17 27:4 80:15 81:14 82:20 increasing 53:18 increasingly 44:13 independence 17:16 35:1 39:4 46:1 independent 1:8 12:10,12 14:9 17:10 35:10 36:7 39:2 46:17 47:21 49:9 75:12 independently 9:8 indicate 28:13 indicated 4:8 33:16 58:7	indicates 38:24 indication 86:24 indirectly 87:6 individual 13:18 30:10 43:22 56:8 73:2 individually 87:12 individuals 52:16 56:6 67:18 71:11 71:12 84:9 induction 54:15 56:25 57:11 inevitably 77:2,14 inexcusable 36:23 inform 1:9 74:3 information 14:20 15:12,15,18,21 16:16 18:10 22:12 24:19 29:14 30:17 31:25 33:13,24 34:2,6,11 41:17 81:12 90:11 informative 1:17 informing 34:9 53:7 infrastructure 68:3 79:18 ingrained 25:24 inherent 79:22 84:1,9 inherently 84:5 inhuman 37:2 inhumane 51:11 initial 55:16 56:1,5 76:22 initiated 27:12 injured 7:20 inquiries 34:9 inquiry 1:11,23 2:3,20 3:3,13 4:14 7:3 8:8 16:1 20:15 28:7 29:2 33:18 35:5 36:12 36:15,23 37:4,8 38:1,3 39:21 41:2 44:14 45:8 46:25 47:11 51:14 53:5,11
--	--	--	---	---

55:10 59:3 60:10 61:3,4,18,25 62:5 62:13,15,16 64:1 64:3 65:23 66:11 66:13 68:15,15 68:24 69:11,25 70:6 71:1,20,21 72:8,10,13,18,21 73:8 74:12,20,25 74:25 75:2,7,15 76:13,20 78:2 79:5,6,13,19,25 80:6,18,23 81:1 81:13,16 82:14 83:21 84:15 85:4 85:6,12 86:9 87:22 88:12,15 88:19,22 89:6,8 89:16,18,20 90:3 90:8,16,25 91:5,9 inquiry's 2:19,23 60:16 69:19 71:24 72:24 74:3 79:24 84:13 87:24 inside 12:19 80:20 insight 41:11 64:22 insights 17:12 insist 3:19 inspected 16:9,11 17:16 20:22 33:13 inspection 11:25 12:2,4,8,10,16 13:4,5,9,9 16:4 17:3,9 18:1,17 19:1 20:8,13,24 21:2,7 22:13,21 23:3,24 24:6,12 25:1,12 27:3,5,6 27:17 28:6,14 29:4 33:1,12 34:8,10 35:10,11 35:17,22 63:18 inspections 14:12 16:6,22,23 17:7 17:22 19:4 31:24 32:19 33:24 34:5	inspector 23:23 26:12 30:22 31:7 73:12 inspectorate 11:24 16:10 17:23 34:1 35:13 78:15 inspectors 14:23 17:3 21:11 24:4 26:16 27:9,23 30:20 31:24 32:2 32:6,8 35:6 inspects 14:9 installed 26:14 instances 40:20 48:10 72:20,24 73:8,10 83:22 institution 14:20 42:8 64:5,8,9 79:8 institutional 64:11 institutions 16:20 instructed 58:18 insufficient 61:24 insults 2:9 integrated 60:5 intelligence 15:7 32:4 33:21 34:2 intend 64:10 intended 80:16 intends 64:9 intention 55:4 57:17 intentioned 48:19 75:16 interact 44:9 interaction 73:4 interactions 46:8 interest 1:13 2:18 10:20 interfere 17:15 interfered 4:5 interim 58:24 internal 14:3 internally 37:12 international 12:10 42:5,10 50:16 interpretation 30:23 61:9	interpreters 52:13 intervention 56:15 interventions 53:24 interview 15:9 31:2 40:9 interviewed 30:22 39:25 interviews 22:14 31:14 46:10 introduced 32:18 52:17 54:15 introduction 25:14 26:12 54:6 investigating 13:22 14:2 25:10 investigation 79:7 investigators 75:13 invite 18:20 46:25 49:7 invited 31:25 65:18 invites 64:8 involved 34:24 81:21 involvement 35:1 involving 7:12 54:17 IRC 53:7 57:19 59:11,22 71:23 71:25 72:4 74:19 80:4 82:6,13 86:9,15,22 IRCs 30:11 50:3 57:9 59:15 72:5 80:1 82:24,25 85:11,21 86:11 87:18 90:15 Ireland 70:13 irrelevant 77:21 isolated 37:7 issue 15:6 61:7 73:18 75:1 84:20 85:6 issues 1:14 3:12 11:22 36:9 42:25 43:9,12,15,19 46:23 53:9,13	55:10 61:5 64:11 69:20 74:16,22 76:5 81:12,22 86:10 <hr/> J <hr/> James 48:23 Jamie 38:20 Jennings 9:22 Jerry 45:6 70:20 Jo 6:4,6 job 64:25 John 3:17,23 4:7 4:11 42:2 47:24 joint 58:10 joke 73:24 Jon 2:24 27:9 journalist 10:17 judged 14:14 judgment 50:18 July 28:9 56:24 junior 37:22 71:6 Justice 54:6 66:25 69:7 justify 83:5,24 <hr/> K <hr/> Kate 39:25 keep 37:16 70:19 keeping 12:24 keeps 10:4 kept 43:6 key 18:20 25:19 33:2,10 69:24 74:24 75:7 78:3 81:22 keys 8:3 Khan 63:1 kind 38:5,15,17 88:4 kinds 78:9 knew 81:25 know 2:20 9:13 14:11 15:5 19:18 28:25 54:11 61:11 64:19 65:20 66:19 67:21 74:21 knowledge 56:19 82:10	known 21:7 43:5 49:1 61:17 knows 8:8 <hr/> L <hr/> lack 20:17 22:8 26:1 29:21 39:12 61:19 82:9 85:14 85:25 lacked 25:22 83:14 83:15 Lampard 39:25 40:9 46:13 49:14 language 2:6 39:14 48:8,10,13 84:25 90:20 LanguageLine 54:2 large 73:21 82:17 law 12:10 48:7 77:20,23,24 79:19 84:12 lawful 28:24 layout 50:11 lead 26:17 62:24 83:21 leaders 54:17 leadership 28:11 31:15 32:19,22 60:8 leading 42:7 leads 18:9 32:4 77:2 learn 28:2 32:16 48:21 learned 75:9 88:2 learning 50:3 57:9 72:8 88:9 leave 18:5 lectern 60:23 led 19:7 24:20 26:3 27:19 35:18 47:18 53:24 77:14 87:6 Lee 28:8 left 22:5 legal 52:11,13 57:4 65:20 71:8 79:23 88:14,21 legitimate 62:23
---	---	---	--	---

length 21:2 38:7 43:25 81:13 lens 71:24 72:24 lessons 28:3 75:9 88:2,9 letter 58:10 letting 11:15 level 42:10,10 53:17 54:4 77:17 levels 19:18 20:2 20:12 21:10,12 21:19 22:10,11 22:20 25:7 31:16 44:7 76:6 lies 80:4 85:5 life 2:4 41:20 70:1 lift 4:8 ligature 6:25 7:8 8:23 9:1 light 4:3 28:16 36:24 43:5 51:15 61:5 71:4 78:5 likelihood 30:10 Likewise 22:16 limbs 85:2,3 87:2 limit 52:16 68:13 limitation 17:21 limited 37:22 54:9 58:18 69:7,8 70:11 85:18 limits 13:8 79:15 line 60:16 77:3 82:1 listen 22:9 listened 46:24 88:1 90:4 listening 33:17 68:7 79:11 listens 19:12 litigation 66:10 little 9:17 16:15 28:4 30:6 88:10 live 12:14 15:11 27:25 30:25 89:10,16 lived 49:20 lives 52:9 living 26:17 51:19 56:9	local 13:15 41:8 locally 49:12,13 locating 43:18 location 80:13 long 5:8 27:11 81:18 longer 21:9 72:4 76:2 82:17 longer-term 55:11 longest 5:5 look 9:20 15:1 63:23 66:17 67:10 79:2 84:3 90:6 looked 15:19 71:19 83:12 looks 26:8 71:20 72:8 lost 91:5 lot 25:6 64:20 low 77:16 87:8 low- 53:22 low-hanging 33:10 lowest 77:8 lurid 2:10	managers 16:4 28:2 37:23 42:15 42:23 45:2 46:16 48:25 49:4 managing 70:21 manner 5:22 68:22 Mannion 11:8,11 11:12,15,18,19 36:4 91:14 March 28:9 marks 76:11 Marsden 40:1,9 46:14 49:14 Mary 50:13 material 1:12 19:16 40:15 materials 59:10 matter 20:1 46:18 74:2 77:20,23 matters 7:17 13:9 23:7 28:10,12 33:11 39:15 41:1 41:5 44:17 47:12 47:17,18 69:10 81:25 84:6,11,16 84:18 85:7 87:12 87:16 maximise 74:4 mean 15:12 17:17 23:16 34:16 meaningful 35:22 52:7,10 meaningfully 17:19 means 15:23 21:5 23:17 31:6 34:3 76:8 meant 22:21 45:3 measure 80:5 measures 74:13 mechanism 19:4 41:14 42:1 mechanisms 78:11 90:15 medical 6:24 29:12 66:25 86:23 87:13 medicine 57:4	medium-intensity 53:23 meet 57:21 meeting 20:1 meetings 28:11 42:23 54:20 56:10 member 28:19 73:2 members 37:15 39:24 40:18,21 40:24 41:4,8,8,13 41:19 44:15 45:3 45:17 47:14,16 48:10 54:17 members' 41:10 men 3:19,24 40:22 43:23 44:3 47:15 89:9,10 90:18,23 90:25 mental 22:7 29:24 43:17,19 44:9 49:17 53:19,22 54:24,24 55:2,2 56:15 58:16 84:17 mention 44:18 mentioned 29:1 mentioning 20:5 mentions 20:13 met 32:17 54:25 85:3 87:6 method 15:10,12 17:5 methodology 15:19 30:7,9 32:7 33:22 34:16 35:23 methods 48:18 metres 80:13 Michelle 19:21 44:19 microphone 69:2 69:3 mid 32:12 Midwifery 6:3 migrated 82:24 millions 1:9 45:15 mind 66:4 67:1	74:22 85:7 87:7 mindful 67:14,25 68:11 minimise 75:13 minimising 76:10 76:23 minimums 19:22 minister 42:17,21 43:13 51:9 62:11 ministers 42:25 minority 73:19 misconception 39:13 misconduct 2:17 3:21 9:10 74:8 78:22,24 misinterpretation 48:19 missed 18:24 23:1 28:15 35:21 mistreatment 12:3 12:12 18:18,25 19:4 30:11 36:20 38:3,15 61:20 63:16 70:10,16 71:18 72:23 73:1 73:9 78:13 83:25 87:7 88:6,8 89:12 90:18 misunderstand 40:23 misunderstanding 6:20 39:21,23 48:20 63:14 mixed 27:10 mobile 52:12 model 54:11 Mohammed 63:1 Molyneux 47:5 49:2 50:13 Molyneux's 47:7 Monday 67:5 68:2 monitor 45:19 monitoring 13:25 14:1 17:8,11 24:24 36:7 45:3 49:22 50:15 51:8 78:13,21 90:14 monitors 38:14
---	---	---	--	---

<p>40:3 monthly 42:22 months 21:4 27:4 27:5 57:10,14 moral 71:8 morale 31:16 morning 1:5 motive 7:16 mouths 67:2 move 11:10 MPCCC 54:16 multi-factorial 38:25 multi-professional 54:16 multidisciplinary 54:17 multiple 12:17 15:13,21 17:4 mundane 65:6 Murphy 3:17,22 4:2 9:4,15,18,21 9:24 10:3,7 73:20 Murphy's 10:1</p> <hr/> <p style="text-align: center;">N</p> <p>N 4:8 91:12 naive 6:19 narrowly 11:25 Nathan 9:11 32:14 62:20 nation's 1:7 national 41:14 42:1,5,10 50:15 50:23 78:7 82:12 82:18,19 nationally 49:12 49:13 nationwide 59:10 nature 2:6 38:6 84:5 necessarily 67:20 72:1 necessary 27:20 84:18 89:24 necessity 90:22 neck 6:25 9:1 Neden 45:5,10 70:12</p>	<p>need 2:22 29:13 56:7,19 58:1,6,25 59:17 67:23 74:13 79:20 85:4 needed 30:23 68:4 needs 3:7 16:10 42:11 54:18,25 56:5 57:21 negate 87:12 negatively 22:6 negotiate 76:14 neighbouring 19:19 Neither 75:3 91:5 never 7:7 new 33:10 50:13 55:15 56:25 57:4 60:14 61:25 62:1 75:6 76:3 85:13 85:18 NGOs 31:23 NHS 58:11 61:11 night 43:21 nine 45:16 NMC 5:13 noise 80:14 non-compliance 78:7 non-government... 18:11 32:3 33:23 non-statutory 64:3 normalised 37:9 note 20:11 69:15 notebooks 20:5 noted 25:14 28:1 77:7 85:20 notes 42:2 notwithstanding 20:12 45:1 86:2 November 18:23 19:16,23 23:2 27:24 33:17 35:12 NPM 42:1,10 nuanced 5:23 number 8:5 9:4,15 10:16 15:3 19:9 23:7,20 27:2 29:16 33:2 34:3</p>	<p>37:7,22 38:2 40:19 57:15 69:24 71:11,12 72:6 74:22 75:7 76:20 78:10 82:17 83:6 85:7 85:8,10 86:2,4 89:8 numbers 21:8,23 numerous 83:21 nurses 86:21 nursing 6:3 48:7 53:19</p> <hr/> <p style="text-align: center;">O</p> <p>objective 65:23 objectives 48:17 59:4,17 60:8 61:22 observation 8:9 47:25 observations 8:7 8:11 30:2 42:3 51:22 observed 27:3,17 79:5 observers 41:4 observing 50:6 obtain 30:17 59:12 obtained 15:15 16:17 22:13 60:19 65:2 obtaining 81:11 85:17 obviously 22:24 occasion 10:6 85:16 87:5 occasional 14:18 45:16 occasions 10:16 occur 17:7 occurred 37:20 88:8 occurrences 73:25 occurring 42:6 occurs 71:22 78:22 October 19:22 20:9 32:12 51:7 odds 65:1 offenders 82:12</p>	<p>83:11 offending 67:22 offensive 7:19 offer 4:3 31:2 42:15 offered 42:4 offering 54:5 offers 17:12 51:15 Office 13:16,24,25 14:7 17:1 18:4 19:20 24:21 33:4 38:14 39:2,14 42:17,23,24 43:14 44:15,21 44:24 45:2 46:16 48:23,24 49:4 51:3 52:8 56:12 58:10 59:9 61:11 61:15,18 62:18 63:8,13,18,21 64:2,4,5,10,12,15 64:18,21,22,24 66:8 68:20 73:3 75:24 76:2,12,17 76:19 77:1,5,19 77:22 78:1,7 85:15,17,24 86:5 86:11,16 87:9 Office's 65:11 78:13 officer 7:11,21 8:7 8:10 officers 6:14 8:1 9:4,7 10:13 47:20 48:1,6 49:8 73:23 83:14 officials 42:24 old 62:2 once 27:11 62:25 77:21 78:1 ones 74:23 ongoing 30:1 54:21 55:13 online 54:14 onsite 38:13 OPCAT 12:13 open 12:19 35:25 48:19 62:14 65:1 67:8 79:23</p>	<p>opened 21:15 58:14,17 opening 30:5 33:16 36:11 64:4 65:4 68:15 70:4 80:23 87:21 openly 36:14 operate 36:17 52:5 57:19 76:7 operated 36:16 87:19 operates 72:4 operating 45:14 operation 44:8 75:4,21 76:1,3 78:2 80:4 operational 61:22 opportunities 60:14 opportunity 13:2 30:19,23 31:5,10 32:8 36:13 50:2 51:15 54:5 56:4 65:25 opposed 28:6 57:9 oppressive 80:7,15 oral 2:24 4:19 5:11 6:10,21 8:13 11:23 46:3 47:2 47:7,24 69:23 82:14 84:19 85:12,23 86:8 90:4 orally 40:20 order 59:22 organisation 19:12 32:15 47:21 organisations 11:21 14:9 18:11 24:23 30:18 32:3 33:23 38:23 39:1 45:12 48:15,16 56:14 63:12 organisations' 49:6 original 77:17 other's 48:17 ought 15:23 outcomes 16:21</p>
---	---	--	--	--

23:19,22 31:17 32:22 35:14 36:2 41:22 outdated 62:3 outlined 59:3 60:9 outlines 42:4 outset 31:24 69:19 outside 13:9 31:12 49:19 59:6 80:12 outsourced 75:22 outstanding 53:14 overall 16:2 22:19 30:3 32:7 60:4 overarching 90:9 overblown 65:2 overegg 5:24 overempathetic 46:6 overempathise 46:15 overnight 26:2 overreliance 61:23 overrelied 45:11 overseeing 44:21 oversight 13:13 14:2 17:9,25 34:25 37:25 38:13 42:4,19 44:25 63:10 76:12 78:21 79:1 90:14 oversimplifies 40:5 oversimplify 40:6 overwhelmed 22:5 Owen 22:4 24:1 64:19 Owers 46:12 47:5 50:12 owned 59:8 <hr/> P <hr/> package 55:5 packed 24:19 page 86:19 pain-inducing 7:14 painfully 38:12 paintings 25:21 pandemic 51:5	Panorama 1:14 2:16 12:6 18:25 28:23 30:5,7 32:14,16,17 35:20 36:20,22 38:6,18,22 49:14 62:12 70:8 71:4 71:10 74:24 78:9 78:20 88:4 paper 21:17 75:10 75:16 papers 40:20 paperwork 15:2 37:17 paragraph 40:7 85:20 parameters 72:2 parents 63:3 part 4:12 18:8 35:3 39:13,24 40:13 41:23 42:13 54:15 56:25 59:18,21 60:6 79:10 81:20 82:24 participant 1:11 participants 88:21 particular 3:5 5:3 12:4 34:8 42:25 46:1 47:13 49:21 55:13 59:15 60:7 70:7 71:20,25,25 72:3,7 76:6 79:7 79:8 84:16,20,24 85:1 88:12 particularly 35:6 48:25 79:18,25 80:12 84:6 parts 45:7 party 30:18 Paschali 3:17,21 8:4,12,20 9:1 62:20 73:20 Paschali's 8:25 pass 14:20 passive 27:14 41:4 pathway 57:20 58:13 86:12,14 patient 54:3 58:21	60:5 patients 54:18 55:17,23 58:15 58:19 pattern 74:9 paucity 59:10 Paul 67:8 peer 57:5,21 59:25 penalise 61:20 penalties 61:20,21 penalty 76:7 78:3 people 1:9 12:21 12:24 31:5 38:23 39:1 40:12 43:25 45:14 48:6 52:6 70:19 perception 46:18 perfect 83:2 performance 44:21 73:2 performing 47:22 period 5:5,8,20 11:22 18:23 19:17 28:6,6,9 44:20 47:9 50:22 53:11 57:14 60:13 63:12 69:22 70:2,13,21 71:25 76:15 79:8 80:17 81:3,15 82:16 83:3,8 84:22,23 85:10 86:1,1,5 87:19 periodic 52:10 periodically 17:7 42:24 permanent 41:20 45:4 permits 50:4 person 30:21 31:3 31:9 34:15 51:4 89:17,25 90:1,17 person's 39:10 personal 2:9 11:1 personally 68:23 70:8 71:2 personnel 72:20 persons 11:20 14:13,16 16:21	16:25 21:14,17 21:20 22:14,25 28:18 30:18,19 30:24 31:17 32:1 32:6,23 34:17 35:14 36:2,13 37:1,6 41:1,12 43:7,10 44:10 49:22 51:12 54:19 56:10 64:20 65:8 71:7 72:15 73:5 80:24 81:7,20 82:2 83:22,25 84:2,4 87:22 persons' 81:21 perspective 39:5 Peter 23:23 45:5,9 70:12 Petherick 45:6 70:20 petty 2:9 phase 3:15 4:19 5:6,7 32:14 66:11,17 88:19 Phil 67:5 68:6 Philip 45:18 phone 34:3 phrase 23:16 physical 23:10 25:5,8 38:5,8,17 59:7 62:10 68:3 80:8,19 83:9 physically 28:19 83:23 pick 15:6 56:5 picked 33:9 78:12 picture 54:20 piece 2:17 28:20 pilot 56:3 place 20:25 23:22 24:3 28:5 32:12 34:8 78:23 90:13 90:15 placed 40:15 42:12 44:16 49:11 54:23 79:16 86:4 places 12:11,12 34:4 41:9 60:7	placing 50:19 81:15 plain 71:5 plainly 43:6 48:4 plan 33:4 56:9 planning 57:4 play 42:13 65:16 66:9 played 1:10 12:2 playing 73:24 plays 83:10 Plus 53:4 pm 91:8 point 2:22 4:24,24 5:24 6:11,11,13 18:5 25:4 26:24 29:3 31:8 40:7 80:3,21 pointed 7:7 71:18 80:22 points 1:20,20,24 5:3 6:1 25:13 29:25 66:4 79:19 police 5:13 policies 13:19 51:3 59:8 75:6,10,18 policy 44:8 51:2 52:3 75:12 79:13 84:12 political 6:1,19 65:6 pool 73:24 poor 24:7 25:17 74:7 population 20:10 26:11 39:6 82:8 83:18 84:14 posed 36:15 position 49:11 64:12 80:22 82:3 82:7 positive 29:23 43:8 73:14 positively 22:22 possession 60:12 possibility 35:21 possible 15:20 24:7 25:2 54:25 84:18 89:24
---	--	---	--	--

post 63:25 post-traumatic 29:7 potential 12:7 26:15 32:8 67:25 power 61:19 84:1 powerful 11:19 12:11 powerfully 25:13 powers 17:14 83:14 PPG 53:4,6,9,11 53:16 54:11,15 55:1,9,13 56:1,13 56:21 57:4,7,12 57:23 59:4,13,17 59:19,24 60:6,7 60:11,13 85:13 PPO 41:14 practical 71:8 practice 27:10 32:11 50:6 52:5 53:4,8 59:1,25 75:19 80:1 practices 50:6 51:3 practitioner 86:23 praised 2:9 pre-Brexit 51:1 pre-determined 84:11 precisely 11:1 79:2 preconceived 6:18 prejudice 39:10 preparation 24:9 preparations 44:2 preparing 90:2 presence 41:10,20 45:4 present 7:25 49:10 82:7 88:3 presented 35:5 president 70:13 pressure 20:14 presume 42:7 prevalence 55:6 prevent 38:15 42:5 79:9 prevented 77:24	Prevention 42:9 Preventive 41:14 42:1 previously 63:23 66:18 79:12 price 77:9 prick 9:17 primarily 46:7 primary 53:20 65:23 81:2,23 85:4 principle 76:5 prior 81:7,14 82:15 prison 26:9,9 48:5 80:9,11 82:13,23 82:25 83:11,13 83:14 prisoners 82:18,20 82:25 prisons 11:24 25:16 57:9 73:12 78:16 82:16,16 privileges 83:17 83:17 privy 45:1 proactive 55:22 proactively 19:14 31:23 33:22 probably 4:12 Probing 66:11 problem 8:24 11:17 15:7 19:25 74:16 85:18 problems 31:15 33:5 40:3,12,21 42:15 61:9 62:2 62:14,17 63:11 78:18 84:17 procedures 23:21 59:8 Proceedings 1:3 process 15:22 16:3 38:7 56:21 61:16 75:17 77:14 84:13 processes 13:18 15:2 67:15 90:12 procured 76:22	procurement 76:19 77:2,6,13 77:17,20,24 produced 61:3 products 21:17 professional 6:19 10:12 14:23 35:13 professionally 64:24 professionals 86:22 Professor 34:22 40:1,4 41:15 46:2,20,21 47:1,3 47:6,10,13,18 48:1 50:8 63:23 profound 52:15 65:7 programme 60:17 70:10 78:10 programming 1:17 progress 82:10 progressing 60:8 prominently 26:23 promote 59:20 promotes 51:18 prompt 16:1 29:1 46:19 promptly 25:13 35:20 proper 2:17 17:6 19:2 24:18 74:9 76:12 79:4 properly 56:3 67:7 74:14 79:6 proportion 73:15 82:11,19 proportionate 27:20 proportionately 27:7 proposal 26:13 proposals 68:19 proposed 66:11 propositions 67:3 67:13 protect 12:2 67:23	proven 50:1 provide 14:19 16:22 18:10 29:6 36:8 51:22 61:13 90:8 provided 17:13 36:12 69:19 78:5 89:11,25 provider 53:6 54:9 60:14 62:1 85:13 providers 59:14 61:13 87:2 provides 10:23 12:11 18:1 32:7 55:1 providing 6:24 12:24,25,25 51:5 provision 14:4 45:20,23 53:10 53:21 60:12 69:21 77:15 PSU 62:18,25 63:5 PSU's 63:3 psychological 53:23 psychologist 53:24 53:25 PTSD 29:7,10 public 1:7,13 2:18 10:20 12:20 16:11,19 18:11 66:10 67:23 public's 41:9 publicised 12:21 pulling 68:9 punish 80:16 purchased 77:20 purpose 10:21 12:15 39:19 55:16 65:13 66:10 purposes 12:17 13:3 89:15 put 3:3,5 15:18 26:22 31:25 40:4 48:1,11 67:3 70:23 puts 40:12 Putting 45:20 48:2	65:20 pyramid 70:24 <hr/> Q quality 57:5,6 77:15 86:6 quantity 37:14 quarterly 49:24 queries 21:16 82:2 question 1:21 12:15 18:16 30:25 39:4 81:10 questioned 45:25 47:11 questioning 3:3 4:4 61:7 questions 36:15 58:4 62:23 66:11 67:7 74:20 79:15 quick-fix 55:11 quite 20:21 45:16 76:24 79:6 81:8 quote 12:16 19:23 20:19 23:18 31:1 42:3 quoted 40:2 <hr/> R racist 2:6 3:23 raft 75:6 raise 45:22 51:10 85:14 86:6 raised 17:23 25:13 29:5,11 33:20 38:11 40:19,22 41:5 43:17,18,20 44:3 55:10 85:24 raising 43:9 range 14:24 31:14 51:20 62:7 69:25 rate 87:8 rating 24:7 reach 72:21 reached 62:25 reaches 16:7 reacted 32:13 35:20 read 24:18 25:2 43:9 46:24 47:4 66:7 90:17,19
---	--	---	---	--

ready 60:15 real 84:14 85:16 realistic 42:7 really 15:19 40:3 67:4 85:13 reason 3:13,19 8:1 8:18 39:3 72:7 79:10 reasonable 29:13 81:8 reasonably 23:15 23:17 45:10 reasons 5:1 16:8 18:19 19:2 22:19 38:24 51:16 90:22 recall 40:1 47:8 67:12 76:13,20 81:13,17 recalled 81:3 Recalling 81:6 receipt 33:21 receive 34:2 received 15:15 22:23 24:6 29:24 38:18 40:16,17 41:25 50:12 51:20 58:11 89:8 90:3 receives 34:6 receiving 71:19 90:6 reception 52:12 55:14,24 56:1,4 recognise 39:23 61:25 62:5 73:9 89:18 recognised 12:9 62:14 77:5 79:12 recognises 53:9 55:9 57:12 59:17 60:13 88:9 recognising 56:18 59:6 71:16 recommend 65:5 recommendation 26:19 27:19,22 52:14 68:2 recommendations	17:18,21 18:7,13 26:4,7 32:25 33:1,9 35:18 42:16 50:24 51:20 62:8 65:8 68:1 71:21 72:2 74:4,5,12 76:5 79:9,20,24 84:13 recommended 29:7 recommends 50:9 record 41:21 recorded 5:18 10:11 44:1,11 73:12 recording 20:9 recordings 73:23 records 8:9 45:22 recount 16:16 red 69:3 redesign 57:21 reduce 33:7 55:7 reduced 21:24 refer 24:24 43:15 90:23 reference 2:20 3:12 68:14 71:24 72:21 79:6,19 reflect 34:11 35:2 50:15 60:1 reflected 5:11,12 5:14 49:13 reflection 3:6 reflective 46:11 59:24 67:1 refocused 49:21 reforms 51:23 refresher 57:1 refuge 45:9 refusal 2:9 regard 72:22 83:9 regarding 62:9 65:16 81:21 90:11 regards 2:8 8:8 59:24 regime 77:24 78:3 78:8 regimes 76:7	region 87:10 regional 70:13 regret 71:15 regrettably 10:14 regular 14:12 41:10,19 regularly 41:5 regulate 80:5 regulations 14:11 regulatory 42:14 79:1 reiterates 52:14 reject 49:7 relating 11:25 51:5 69:20 84:16 relation 29:4,13 35:7 67:9,22 73:18 74:15 77:6 77:11 relations 49:6 relationship 48:14 48:22 relationships 22:15 relatively 20:12,24 60:13 release 24:9 87:8 relevance 74:8 relevant 1:12 4:13 11:21 14:24 18:23 19:6,17 28:6 29:5 34:7 35:16 44:19 47:9 50:22 53:10 57:14 63:12 69:22 70:2,12,20 74:14 75:24 76:15 77:9 81:3 81:15 82:11,16 83:3,8 84:22,23 85:9,25 86:1,16 87:14,16,19 reliable 41:16 48:3 reliance 44:16 60:7 relied 47:12 64:1 66:18 relocated 19:20 rely 1:21 45:7,15	45:19 relying 48:3 remain 25:20 33:12 remained 38:25 77:22 remains 53:14 58:24 remarkably 83:12 remarks 35:9 36:11 88:18 91:2 91:19 remedied 33:6 remembers 24:3 reminded 58:5 remotely 11:9 removal 14:12 18:3 31:22 32:22 35:12 50:1 51:4 51:17 81:7,20 removed 81:8,11 removing 8:23 83:17 renegotiate 77:25 reopening 19:24 repeated 9:11 67:12 repeatedly 67:17 replace 33:1 replete 33:12 replicate 41:13 replied 12:16 report 3:7 8:15 16:5,15,18 18:1 20:13,16 23:17 24:6,9,14,15,19 25:4,14 26:5,13 28:1 29:4,9,11 30:3 33:12 34:18 34:20 36:19 40:16 43:2,3 44:17 46:2,2,4 47:2,19 50:9 56:8 58:1 61:3 63:25 73:11 75:14 85:19 86:22 89:15 90:2 reported 34:14 37:17 38:10	50:23 reporting 2:18 29:19 37:11 39:7 43:11 75:19 reports 14:13 15:22 16:13 17:5 18:10,12 24:13 29:5,22 35:8 41:22 42:22 43:1 43:8,12,16 44:6 45:7,11 50:14 51:1 56:23 57:6 57:13 58:6 63:9 85:2,9,25 86:7,18 86:19 87:5,8,24 reprehensible 36:23 representatives 64:6 88:21 reprisals 39:11 requests 21:16 44:5 require 55:11,21 59:1 required 1:18 33:4 34:8 43:13,20 54:13 74:17 requires 50:18 research 29:2 researchers 14:23 resembled 25:15 reservations 48:2 reshape 51:17 residential 25:15 25:20 26:3 residents 73:22 resolve 27:11 40:21 resolved 33:3 resolvers 40:3 resolving 40:11 resort 27:7,16 72:17 respect 8:14 22:17 22:23,24 29:19 45:24 47:25 57:24 72:16 73:6 73:8 84:6 91:4 respectful 12:24
--	---	---	---	---

<p>respective 43:11 48:17 respects 62:16 respond 31:11 responding 9:16 10:2 33:8 responds 19:13 response 6:22 7:1 17:6 30:5 43:20 66:1 67:12 responses 28:18 28:23,25 responsibilities 42:19 56:16 responsibility 13:10 17:15 24:23 53:15 70:19,22 85:5 87:13,17 responsible 7:13 13:16,20,24 17:24 41:6 42:18 42:20 44:21 72:5 81:19,24 84:3 rest 90:2 restrain 27:14 restraint 27:15 56:17 result 28:21 82:15 82:24 86:13 resulted 68:4 retraumatisation 55:8 return 52:24 returning 52:22 80:3 revealed 1:15 2:16 3:20 27:10,15 36:23 37:8 38:24 39:21 53:11 reveals 2:5 Reverend 64:15 77:7 review 19:8 24:20 30:14 57:18,21 87:10 reviewed 28:2 30:9 57:5 58:16 reviewing 35:7</p>	<p>56:1 61:15 reviews 59:25 rhetoric 65:2 rich 18:10 right 4:9 10:6 62:19 66:20 rights 47:23 50:16 69:13 rights-based 50:10 rigour 15:23 Riley 62:6,12 63:22 67:5 68:6 76:21 Ring 9:11 62:20 risk 44:8 49:17,22 51:2 52:3 55:7 55:23 56:6 57:1 risks 30:11 robust 16:7 57:20 role 1:10 12:1 13:13 14:8,17 17:8 34:23 39:12 39:19,22,25 40:5 40:6,13,23 42:14 46:11 63:4 65:16 66:8,9 79:2 83:10 90:14 roles 48:17 53:18 roll-out 55:24 rolled 86:14 room 44:3 75:9 root 74:17 rota 40:18 42:22 50:14,17 routes 59:25 routinely 18:7 RTS 88:25 rule 29:5,9,21 31:8 35:8 44:5 45:23 51:2 55:18,21 56:7,22,22 57:6 57:12,13,17,20 58:1,6,8,13,14,19 58:22 59:13,13 61:8,8,15 65:6 67:19 73:10 84:21,25 85:2,8 85:15,25 86:7,10 86:12,18 87:2,5,6</p>	<p>87:14,20 rules 13:18 14:11 51:10 52:2 61:10 84:21 87:15 90:12 run 64:17 running 13:17 17:25 20:24 27:6 42:18 44:24 88:22 runways 80:14</p> <hr/> <p>S</p> <p>safe 12:24 24:4 43:7 70:19 75:4 safeguard 12:2,8,9 12:11 13:4 16:6 16:22 17:11 23:5 23:22 25:12 29:6 35:11 47:22 safeguarding 31:7 safeguards 23:4 51:25 59:22 safely 18:24 28:21 safety 22:24 24:7 30:21 37:6 43:9 Sandra 58:6 sanitary 25:17 sat 47:16 satisfied 6:6 Saturday 58:23 saw 40:12 66:20 70:8 saying 9:18 35:9 scene 9:2 scope 33:7 79:5,13 score 23:15 scores 23:10,14 scoring 76:25 77:12 screening 55:14,16 55:24 56:2,6 screens 56:4 scrutiny 10:22 12:20 50:10 62:18 63:21 64:2 64:9 75:22 searching 71:3 second 1:25 4:23 4:24 5:10 6:17</p>	<p>7:9 8:12 10:23 13:23 18:15 19:2 24:5 25:4 31:10 38:6,11 39:12 42:3 45:5 47:6 52:6 56:4 66:23 secondly 12:3 16:15 23:10 34:9 34:14 53:21 56:1 58:18 60:17 85:14 secondment 64:21 seconds 60:22 Secrets 1:15 sections 24:14 34:20 secure 37:5 55:3 56:18 see 2:4 6:4,5 9:13 10:7,7 11:13 26:21 41:21 66:8 seeing 15:15 seek 5:9,23,24 6:1 18:13 74:20 seeking 7:16 8:2 40:21 45:9 77:24 seen 3:13 6:9 10:23 16:14 18:25 28:23 36:25 46:24 50:8 58:22 78:19 90:17 sees 63:3 self-harm 54:14 57:16 86:3 self-report 78:6,8 self-reporting 61:24 senior 10:14 37:24 42:24 44:15 71:4 sense 70:11 71:8 sensible 35:22 sensitive 68:22 separation 49:17 September 19:18 21:1 53:16 Serco 56:3,11 59:9 76:3 serious 2:17 3:21</p>	<p>3:23 43:12 45:24 51:10 71:15 seriously 15:23 18:8 28:20 46:5 service 1:7 44:20 53:19 54:10 59:5 60:5 69:8 76:6 services 29:14 53:6 54:1 69:7 69:21 70:22 serving 51:4 sessions 54:14 set 15:3 23:17 36:1 39:18 47:2 50:14 65:11,17 69:14 72:1 74:8 76:18 79:6,18 86:9 87:5 sets 33:5 36:1 settings 56:18 seven 89:23 share 44:3 50:2 shared 47:19 49:8 58:12 shares 87:17 sharing 73:24 Sharland 69:1,2,4 69:5 88:17 91:18 Shaw 85:19 87:9 Shaw's 68:2 shield 7:19 27:14 shift 63:13 shine 61:5 shit 9:19 10:5 shocked 48:21 shocking 70:10 short 22:2 33:19 53:1 58:2 60:13 80:13,17 84:19 short-term 54:10 shortages 22:5 shortly 18:19 46:9 82:15 show 63:15 showed 49:14 71:10 showing 53:12 shown 36:19,22 38:5,18,22 62:12</p>
---	--	---	---	---

68:23 70:10 71:4 75:15 shows 4:14 7:24 9:20,22 40:16 41:2 66:21 shred 8:17 shut 21:16 shy 62:18 side 45:21 48:2 65:20 sight 37:20 91:6 signed 78:1 significance 26:6 significant 18:22 23:21 39:6,21 52:11 53:5,9 55:12 57:14 signs 57:2 Simcock 6:10 61:7 similar 44:3 74:23 83:12 87:1 Similarly 63:7 simple 4:25 68:8 simplistically 15:12 simply 8:15 39:4 63:15 65:9,13 66:20 67:2,11,16 68:13 71:7 75:6 82:2 Singh 12:14 single 15:24 31:2 single-handedly 42:11 sit 32:16 site 45:4 52:9 59:8 59:15 85:21 sites 57:19,22 sits 14:8 situation 22:3 situations 90:19 six 27:4,5 57:10 size 45:13 Skitt 20:2 small 19:9 21:18 23:7,20 29:16 37:7,22 73:19 83:6 smaller 33:2	smash 9:18 10:5,6 Smith 19:21 44:19 smooth 88:22 smoothly 11:10 SMT 28:10 softened 25:22 softening 20:10 solidly 16:12 solution 58:12 68:8 solutions 55:11 somewhat 7:2 20:9 sorry 12:8 70:9,14 sought 4:7 6:7,14 6:21 8:21 9:5 45:7,19 soul 71:3 sound 16:12 75:11 source 18:10 sources 15:13,16 15:21 17:4 81:23 space 34:19 80:10 80:12 sparsity 18:21 speak 10:17 22:18 31:8 33:25 36:13 73:16 75:11 speaking 65:14 speaks 1:25 11:4 31:4 specialisms 14:24 specific 16:2 18:16 28:11 29:20 49:16 specifically 43:24 56:17 specification 68:5 specifications 80:8 speech 65:4 speeches 65:3 spent 40:10 spice 82:22 spite 55:9 spoke 70:7 spot 17:9 spotted 63:11 spreadsheet 69:19 SPT 42:8 stability 54:8	staff 2:7,10 19:19 20:4,12,14,17,25 21:10,14,22,23 21:25 22:2,5,8,15 22:17 28:19 29:23 30:18,19 31:10,12,14,19 31:20 37:5,8,10 37:11,16,22 44:9 46:16 49:23 51:3 54:5,13 55:4,19 56:19 57:8 60:1 62:6,21 63:17,20 64:16 70:2 71:2 71:6,15 72:10,14 73:2,5,15,19,21 74:10 82:1,6 83:6,13,20,23,25 84:3,24 85:14,21 86:10 87:13,18 87:18 88:5,14,22 89:3 staffing 19:17,25 20:2 21:8,12 22:10,11,20 31:16 44:7 53:17 62:4 Stafford 54:7 57:7 stage 4:16 5:8 13:14,23 14:3 26:22 51:23 66:3 stages 14:8 stand 10:22 standard 3:8 standards 26:17 50:16 60:18 64:14 Stanton 73:17 stark 25:20 26:21 start 70:3 started 82:23 Starting 2:2 state 8:15 18:2 22:22 31:21 stated 22:4 24:2 25:19 32:15 73:18 statement 1:6 5:12 6:3,8,18 11:18	24:5 30:6,8,13 32:20 36:5,6 40:7 42:3 46:13 47:13 49:2 52:19 53:3,12 58:3 60:9 61:2 66:18 69:4,6,23 70:4 77:7 80:23 87:21 89:25 91:13,14 91:15,16,17,18 statements 5:13 41:25 47:4 66:7 89:8,11 states 86:20 status 39:10 81:22 stayed 21:16 steal 8:3 steers 50:19 Stephen 68:2 85:19 87:9 stepping 19:10 steps 49:5 58:24 Steve 20:2 stick 6:21 sticks 83:20 stories 9:6,9,14,16 10:2 storm 83:2 story 9:21,25 62:15 strength 15:22 17:5 22:15 strengthened 52:3 68:4 strengthening 15:17 strengthens 32:3 stress 29:7 81:15 stressed 81:9 stresses 83:19 stressful 80:15 striking 9:7 80:25 strive 17:3 strives 33:18 strong 16:23 60:7 strongly 20:21 29:20 struck 68:6 structures 14:6	78:21 90:14 struggled 83:4 study 33:14 35:6 stuff 26:2 stumble 5:9 sub-contracted 54:9 Subcommittee 42:9 subculture 18:24 32:10 subject 39:11 56:9 57:18 60:5 subjected 37:1 submission 5:2,4 67:20 87:8 submissions 1:19 6:16 9:12 11:6 11:20,23 19:11 36:8 46:21 51:22 65:11,12,15,18 65:20 69:9,11,16 69:17 84:19 90:5 90:6 submit 39:3 40:23 46:17 48:18 submitted 47:4 subsequent 28:13 subsequently 77:23 80:1 87:19 substantial 37:14 71:3 substantially 72:3 77:25 substantiated 62:19 success 13:21 33:8 suffer 88:4 suffered 71:18 88:11 suffering 90:18 sufficiently 24:8 24:10 85:22 suggest 4:7 9:5 40:24 52:21 87:11 suggested 6:17 8:12,20 9:15 34:22 45:8 67:17
---	---	--	---	--

69:14 suggesting 7:10 suggestion 6:23 7:21 9:12 10:1 23:1,3 32:25 46:6 suggestions 3:14 3:16 suggests 10:19 37:23 suicidal 54:14 57:16 suicide 56:14 86:3 summarise 39:25 summary 16:22 supervision 13:23 54:23 57:16 58:20,21 59:2,24 supplemented 21:8 69:8 supplied 58:2 60:10 supplies 53:12 supply 80:13 support 5:4 8:17 12:25 17:4 52:7 88:25 89:4 supported 15:16 56:9 supporting 88:14 supports 5:18,19 37:15 sure 12:18,22 15:19 65:24 surprised 78:19 surprising 7:23 survey 15:8 28:17 28:17,21,25 31:11,20 73:13 surveyed 22:16 suspensions 14:18 sustained 9:13 60:6 swearing 3:22 90:20 swiftly 32:13 symptoms 57:2 Syred 22:4 24:1 64:19 73:17 74:1	system 29:12 36:16 51:18 62:24 70:15 83:16 84:9 systematic 31:3 32:2 systemic 11:22 14:19 16:17 30:11 74:16 systems 13:22 28:5 63:10 90:12	59:4 68:14 71:24 72:21 76:4,14,18 77:18,21,25 79:6 test 23:9,14 24:9 tested 66:8 tests 23:14 24:8,16 thank 1:5 11:7,7 11:13,15,17 36:3 36:4 52:20,21,24 52:24 60:20,21 60:21,24,25 61:1 68:24,25 69:1 88:16,17,20,24 89:3 91:7 thebigword 54:2 thematic 35:3 theme 72:9 74:24 themes 69:24 theory 8:16 thing 21:18 things 3:4 13:1 24:11 think 12:17 13:2 20:20 44:23 63:5 65:1 77:16 third 5:22 8:4 14:3 19:6 26:13,24 30:4,18 31:23 38:8,11 39:13 45:18 47:10 52:14 67:14 thirdly 12:4 23:11 34:22 53:25 56:13 85:23 thorough 17:9 thought 54:15 thoughtful 68:22 thoughts 57:16 threatened 2:10 three 3:14,19,24 14:8 27:8 38:4 44:3,18 47:4 51:24 three-quarters 73:13 threshold 87:5 time 5:5,8 7:8 8:12 9:25 20:13,22 21:1,6,22,23	22:13,20,21 23:8 24:3,12 32:18 40:11 43:25 49:1 52:16 65:10,13 68:13 69:15 72:1 76:21 79:8,15 82:12 85:11 time-served 82:12 82:18,19 83:10 timeframes 66:1 times 26:10 90:11 timestamp 4:5,15 4:17 timetable 90:9 Tinsley 19:19,24 21:8 64:13,16,17 tiredness 22:1 today 36:17 65:13 70:3 toilets 25:23,25 told 9:5,14,15 10:1 10:24 tool 31:21 top 70:24 topic 12:1,8 18:5 18:15 29:3 30:4 33:15 topics 11:25 torture 42:9 57:2 86:24 tortured 29:8 total 15:5 totality 46:11 touch 32:2 84:20 tougher 70:24 Townshend 3:4 train 55:19 trained 85:22 training 13:22 29:24 34:23,25 35:3,5 44:9 49:16,18 54:4,14 55:1,3,5,14,24 56:13,14,17,22 56:23 57:11 59:2 59:10,13,15,20 62:10 85:15,17 transcribers 89:1 transcripts 63:25	90:20 transfer 8:2 82:25 transferred 83:11 transfers 43:21 translated 29:14 translating 75:17 translation 54:1 transparent 41:16 trauma 55:6 57:2 trauma-based 53:23 trauma-informed 55:1,5 treat 13:7 treated 22:17 65:24 72:16 73:21 91:4 treatment 30:21 37:1 43:10,18 48:24 50:17 51:11,16,19 62:11 72:22 81:6 88:4 treatments 14:13 trial 66:9 triangulation 15:10,14,18 34:15 tried 8:3 triggering 21:20 troubling 2:6 48:25 true 3:6 71:7 87:23 Trust 38:19 truth 2:1 5:1 11:5 Tulley 2:1 4:19,25 5:4,10 6:2,8,12 6:18 7:7,10,11,13 7:17,18,21,25 8:5 8:6,9,14,18,20 9:5,9,16,21,24 10:2,8,11,15,19 10:24 11:4 37:19 38:1 Tulley's 1:25 2:13 3:10 6:23 7:4 8:3 9:22 11:3 20:5 turn 4:23 12:6 18:15 23:6 49:10
---	--	---	---	---

<p>turned 74:22 turning 19:15 39:17 46:20 two 1:20,24 3:4 16:8 20:4 21:4 26:4 27:6 41:25 49:6 54:13 85:2 85:3 87:2 90:5 two-person 26:14 type 28:22 34:25</p> <hr/> <p style="text-align: center;">U</p> <p>UK 1:10 69:7,8 70:13 ultimately 16:20 UN 42:8 unable 82:2 unacceptable 37:9 unanswered 21:18 unaware 38:21,23 71:13 uncertain 38:7 unclear 48:16 uncover 63:4,16 70:16 uncovered 37:4 Undercover 1:14 undergo 54:23 underlines 26:6 undermine 3:14 7:17 8:16 30:2 undermined 23:3 undermines 23:1 underpinning 79:23 understaffing 19:21 20:7,19,23 21:15 22:3 61:19 understand 13:5 46:14 69:15 understandable 16:19 82:3 understandably 72:13 81:5 82:8 understanding 23:9,13 59:20 80:21 84:8 understood 17:2 18:6 61:7 78:25 86:13</p>	<p>undertake 54:5 58:8,19 undertaken 62:6 undertakes 14:11 undertaking 32:19 71:3 undervalued 22:5 undoubtedly 62:25 unexplained 4:16 unfair 7:9 unfairly 6:7 unintended 68:1 unique 38:16 41:11 64:22 units 25:15,20 26:3 University 54:7 57:7 unpaid 45:17 unravelling 6:10 unrealistic 68:19 unsatisfactory 25:17 unsupported 5:25 untested 66:15 update 90:9 upheld 59:22 urged 64:6 urgent 61:13 use 2:11,23 3:1,7 7:5,12,14,18,24 8:13,19 18:12 23:12 26:14,25 27:2,3,6,13,13,17 27:20 28:1,7,9 35:7 43:20 48:8 52:1,2 63:19 72:11 83:20 useful 34:12 35:5 67:13 uses 28:24 37:16 ushers 89:3 utilised 75:12</p> <hr/> <p style="text-align: center;">V</p> <p>validity 30:3 valuable 16:23 17:11 31:21 68:17</p>	<p>value 16:15 34:16 34:19 41:16 89:19 valued 45:15 varied 41:20 81:4 variety 47:16 53:18 various 3:13 16:16 65:15 69:20 81:4 84:15 vast 72:11 73:4 vein 35:24 ventilation 25:17 26:1 verbal 38:5,17 verbally 83:23 verified 15:13,16 verify 15:21 Verita 46:1,4,10 63:25 versa 84:4 version 57:8 vice 84:4 victim 86:24 video 2:25 3:4,5,10 5:14,17 27:10,14 37:18 view 20:20 27:22 30:9 31:18 32:21 34:18 53:12 58:25 73:14 78:2 views 12:20 vindicates 2:15 violence 2:9 visits 12:12 40:18 45:16 vital 88:9 voice 15:3 34:14 34:17 voices 15:24 32:5 volume 53:18 vulnerabilities 56:2 59:21 vulnerable 31:4 44:10 49:22 54:19 56:8,10 57:25 89:10</p> <hr/> <p style="text-align: center;">W</p> <p>Wadham 42:2</p>	<p>Wadham's 42:2 waist 27:15 wake 35:20 want 26:24 32:16 60:22 65:12 66:3 90:24 wanted 66:13 Ward 32:14 64:15 Ward's 77:7 warning 7:14 wasn't 3:2 4:9 7:25 8:10 9:21,24 20:23 watched 2:3 47:6 way 11:16 31:3 39:24 40:8 50:25 51:18 62:1 63:13 80:3 83:5,24 87:17 ways 13:21 15:3 32:25 38:4 weakness 17:3,7 17:13 weaknesses 13:8 weapon 7:19 Webb 7:9,16,18 Wednesday 1:1 weekly 42:22 49:25 54:18,19 56:10 weeks 21:10 61:14 89:23 weighting 61:22 welcomed 64:2 welcomes 36:11 53:4 63:21 welfare 22:7 38:21 43:22 62:4 64:20 wellbeing 29:15 68:18 went 21:18 37:2,7 whilst 20:5 36:14 43:7 59:6 75:8 89:24 whistle 10:25 whistleblowing 75:8,11 78:12 White 52:23 53:3 53:4 60:21 91:16</p>	<p>wholesale 57:18 wholly 14:9 17:10 wide 62:7 69:25 widely 50:24 wider 5:20,20,25 6:9 72:3 74:9 91:5 widespread 36:21 willing 34:2 60:15 willingness 30:1 Wilson's 48:23 window 20:3,8,24 27:5 wing 25:25 winning 77:8 wish 33:25 89:21 wishing 81:8 witness 2:1 4:25 5:6,12,13 6:3,8 6:18 11:5 19:20 30:13 32:19 40:7 49:2 58:3 66:6 67:5,11 77:7 witnessed 10:18 88:4 witnesses 24:23 25:7 39:20 64:13 65:24 67:2 68:23 70:6 71:5 74:6 76:21 78:18 81:4 89:17,22 wonder 45:13 Wood 68:3 word 4:8 words 7:5 70:5,5 work 25:3 35:3 41:12,13 53:4,12 53:14 55:13 59:14 62:5 75:17 worked 6:20 24:1 64:21 70:2 working 20:4 39:16 48:17 54:11 56:3,13 57:7,9 63:10 72:10,14 works 32:5 world 1:10 worn 22:6</p>
--	--	---	---	---

<p>worst 24:6 25:25</p> <p>worth 20:4</p> <p>wouldn't 2:20</p> <p>writing 3:7</p> <p>written 5:11,13 22:4 24:1,5 36:8 40:17 51:21 61:12 65:12,18 66:18,22 69:9,11 69:16,17 90:6</p> <p>wrong 3:20 13:7 43:6,8 47:11,15 64:9</p> <p>wrongdoing 63:4</p> <p>wrongly 47:14</p> <p>wrote 51:9</p> <hr/> <p>X</p> <p>X 91:12</p> <hr/> <p>Y</p> <p>Yan 3:17,21 8:4,12 8:20,25 9:1 62:20 73:20</p> <p>Yarl's 68:3</p> <p>year 33:17 40:16</p> <p>yearly 77:8</p> <p>years 43:11 52:15 85:12</p> <p>yesterday 5:3 9:10 11:20 65:3 73:17</p> <hr/> <p>Z</p> <hr/> <p>0</p> <hr/> <p>1</p> <p>1 5:6 32:14 58:11 66:11,17 86:19 91:13</p> <p>10 20:9 87:10</p> <p>10.00 1:2</p> <p>10.08 1:4</p> <p>11 91:14</p> <p>11.20 52:25</p> <p>11.35 52:24</p> <p>11.42 53:2</p> <p>12.37 91:8</p> <p>123 40:16</p> <p>15-minute 52:22</p>	<p>188 40:7</p> <hr/> <p>2</p> <p>2 3:15 4:19 5:7 29:21 56:7 58:23 85:25 88:19</p> <p>20 87:10</p> <p>200 80:13</p> <p>2009 24:2</p> <p>2010 24:2,5</p> <p>2013 24:9 27:6 82:21</p> <p>2014 44:4</p> <p>2015 44:4</p> <p>2016 12:3 18:17,23 19:1,5,7,15,16,18 19:23 20:3,9 21:1 22:21 23:2 23:7,15,24 24:12 25:1,2,4 26:4,13 27:3,24 28:9,17 29:3,4,22 30:3 35:12,17,22 38:10 40:17 43:7 43:11,16,16,19 43:24 44:1,4 85:19 86:17 87:10</p> <p>2017 2:12 7:12 19:19 32:12 35:16 36:16,18 38:10 39:18 40:15 43:2,3,8,12 43:16 44:6,11 47:2,20 48:10 73:11 82:22 87:25</p> <p>2019 29:21 50:25 77:11</p> <p>2020 50:25 51:7</p> <p>2021 53:16</p> <p>2022 1:1 55:25 56:24 57:19</p> <p>22 21:9</p> <p>25 2:12 77:11</p> <p>29 90:7</p> <hr/> <p>3</p> <p>3 56:8 65:16 69:12 30 33:1 60:22</p>	<p>31 7:12</p> <p>34 52:2 55:18 56:22 59:13 61:8</p> <p>35 29:5,9 31:8 35:8 44:5 45:23 51:2 52:2 55:21 56:22 57:6,12,17,20 58:1,6,8,13 59:13 61:8,15 65:6 67:19 77:9 84:21 84:25 85:2,15 86:7,10 87:2,5,6 87:14,20</p> <p>35(1) 29:21 56:7 58:14 85:8,25</p> <p>35(2) 57:13 58:19 58:22 85:8 86:12 86:19</p> <p>35(3) 86:18</p> <p>36 91:15</p> <hr/> <p>4</p> <p>4.116 85:20</p> <p>48 21:3</p> <hr/> <p>5</p> <p>5 51:10 82:21</p> <p>50 69:18 76:25 82:21</p> <p>53 91:16</p> <p>55 82:21</p> <hr/> <p>6</p> <p>6 1:1 38:1</p> <p>60 23:11 44:2</p> <p>61 91:17</p> <p>61(3) 51:10</p> <p>69 91:18</p> <hr/> <p>7</p> <p>7 86:19</p> <p>74 89:16</p> <p>77 22:16</p> <p>78 21:3</p> <hr/> <p>8</p> <p>84 22:18</p> <p>87 40:17</p> <p>88 91:19</p>		
--	--	---	--	--