Wednesday, 6 April 2022
(10.00 am)
(Proceedings delayed)
(10.08 am)
THE CHAIR: Good morning. Thank you. Mr Bunting?
Closing statement by MR BUNTING
MR BUNTING: The BBC, chair is, the nation's public service broadcaster, it is impartial, and independent, it aims to inform, educate and entertain millions of people in the UK and around the world. It has played a role as a core participant in this inquiry so as to ensure that you, chair, have access to all relevant material and so that you are able to explore all of the public interest issues that the BBC's Panorama documentary "Undercover: Britain's Immigration Secrets" revealed.

This documentary was an example of the BBC's accurate, impartial and informative programming which is required under its charter and under its editorial guidelines. In these closing submissions, chair, the BBC makes two points, and both points go directly to the question of what evidence you can rely on when you are assessing the credibility of the allegations in this inquiry.

Those two points are as follows, chair: first, Callum Tulley's footage speaks for itself; second,

Callum Tulley was a witness of truth.

Starting with the footage, chair, throughout this inquiry, we have watched it again and again.

It has allowed us to see and hear what life in Brook House was actually like. It reveals incidents of the most troubling nature, including racist language, casually used in staff conversations and to detainees; a casual disregard for detainees, including as regards food refusal, petty, personal insults; violence praised in staff discussions and threatened in the most lurid of terms; and the disproportionate use of force, including, most graphically, the D1527 incident on 25 April 2017.

Callum Tulley's footage, chair, both that which was broadcast and that is which was not, is important, it is important because it vindicates the editorial decision to broadcast the Panorama documentary which revealed serious misconduct and which was a proper piece of public interest reporting. But it is also important because it goes directly to the heart of this inquiry's terms of reference. The inquiry wouldn't know the incidents it depicts but for that footage.

To make that point good, chair, you need to go no further than the inquiry's use of force expert, Mr Jon Collier, whose oral evidence explored the importance of video evidence. Where he had such

evidence, he could find a disproportionate use of force, and, where he didn't have any footage, he wasn't.

As he put it to the inquiry under questioning from Ms Townshend, video evidence emphasised two things in particular, "Video footage" as he put it, "is essential to get a true reflection of the incident, but also about the use of force report writing. It needs to be to a better standard and more descriptive of the actual events".

Callum Tulley's video evidence is, therefore, the best available evidence to enable you to assess the issues in the terms of reference, and it is no doubt for that reason, chair, that the inquiry has seen various attempts to undermine it. We had three suggestions during the evidence in phase 2 that the footage had been doctored, edited or dubbed. Those suggestions came from Yan Paschali, Derek Murphy and John Connolly.

Chair, those discussions were false.

All three men had good reason to insist that the footage was wrong because it revealed that they had committed serious misconduct -- Yan Paschali assaulting D1527; Derek Murphy swearing at and demeaning detainees; John Connolly using the most serious of racist epithets.

Indeed, chair, none of the three men were actually able to explain how or where the footage had been

edited. When he was asked where the footage had been edited, Derek Murphy had no answer. The best he could offer, chair, was that "the light changes in the background", and he confirmed under questioning that the timestamp on the footage hadn't been interfered with.

When he was asked how he said the footage had been dubbed, John Connolly sought to suggest that the footage had perhaps indicated that he had said N word in a lift. He then, immediately, accepted that he wasn't right about that. And then, when he was asked why he had said the footage was edited, John Connolly frankly admitted that "it was probably just hopefulness" on his part.

Chair, the BBC has made all relevant footage available to the inquiry. It is digital. It shows what happened with a continuing timestamp on the footage, and at no stage, chair, are there any unexplained breaks in that timestamp.

Finally, chair, in terms of the footage, as Callum Tulley confirmed in his oral evidence in phase 2, he didn't edit or doctor the footage, nor did he encourage anyone else to, and nor did anyone else in the BBC, chair.

That is the footage. Let me turn to my second point. The second point that the BBC emphasises is another simple one, Callum Tulley was a witness of

truth. You have heard some of the reasons for that submission elegantly adumbrated by Mr Armstrong yesterday, but the BBC emphasises four particular points to support that submission. The first, Callum Tulley gave evidence for the longest period of time of any witness: four days in phase 1 and another afternoon in phase 2.

At no stage during that long period of time chair, did he stumble, argue or seek to deceive.

Second, the evidence that Callum Tulley gave was consistent. His oral evidence reflected his own written witness statement which itself reflected his earlier written witness statements to the NMC and the police and which itself reflected his earlier contemporaneous video diaries.

More importantly chair, his evidence was also consistent with the video footage. The footage that he recorded not only supports his account of the incidents it depicts, but it also supports his account of the wider culture at Brook House over the wider period that he describes.

Third, chair, the manner in which he gave evidence was clear. His evidence was nuanced. He didn't seek to overegg the point. He didn't seek to make allegations that were unsupported by the wider evidence. He didn't

seek to make political points. Let me give one example of that, chair. Callum Tulley was careful in his witness statement for the Nursing and Midwifery Council to explain what Jo Buss would have been able to see and hear and what he was certain she was not able to see and hear. But, of course, Jo Buss was not satisfied with that and she still sought to unfairly criticise Callum Tulley in her witness statement. Chair, you will have seen how her criticisms and how her wider evidence unravelled during her oral evidence from Ms Simcock.

Then the final point to make this point good, chair, the criticisms that were made of Callum Tulley were baseless and, to develop that point, we can forensically examine some of the criticisms that the officers sought to make of him. I am going to give five examples in these closing submissions.

First, Chris Donnelly. He suggested in his second witness statement that Callum Tulley had a "preconceived political and professional agenda" and a "naive misunderstanding of the environment he worked in". He sought to stick by that extreme criticism in his oral evidence. This was Mr Donnelly's response, of course, to Callum Tulley's suggestion that Chris Donnelly had delayed in providing medical assistance to a detainee who had a ligature around his neck.

You may consider, chair, Mr Donnelly's response to that criticism to be somewhat extreme. When he was taken through that incident by counsel to the inquiry, Mr Donnelly, in fact, accepted that Callum Tulley's evidence about the delay was, to use his words, "accurate". Mr Donnelly also had no answer as to why he had never admitted that Callum Tulley had pointed out the ligature at the time.

The second example of unfair criticism; Dave Webb. He criticised Callum Tulley in suggesting that Callum Tulley was, in fact, the head officer during a use of force incident involving D149 on 31 May 2017, and that Callum Tulley was, therefore, responsible for not giving a warning about the use of a pain-inducing technique.

Of course, Mr Webb also had a motive for seeking to undermine Callum Tulley. Amongst other matters, Callum Tulley filmed Mr Webb telling colleagues to use a shield as an offensive weapon and alleging that he had badly injured D149. And of course, chair, the suggestion that Callum Tulley had been the head officer in that D149 incident, was as false as it was surprising.

The contemporaneous use of force incident shows that Callum Tulley wasn't even present during that incident,

and that was for good reason. The officers who were using force were seeking to transfer D149 because he was accused of having tried to steal Callum Tulley's keys.

Third criticism, chair; Yan Paschali. He made a number of false assertions about Callum Tulley.

Firstly, he alleged that Callum Tulley had failed to comply with his duties as constant observations officer as regards D1527, and yet the inquiry knows, because it has the constant observation records, that Callum Tulley wasn't the officer who was in charge of constant observations for D1527; Clayton Fraser was.

Second, Yan Paschali suggested, in the first time in oral evidence, that he had completed a use of force form in respect of the D1527 incident, but that Callum Tulley had taken that report and destroyed it. Simply to state that conspiracy theory, chair, is to undermine it.

There is not a shred of evidence to support it. Callum Tulley denied it, and of course he had no reason to make any such use of force form disappear.

Yan Paschali also suggested that Callum Tulley "had no duty of care". He sought to contrast that with his own "duty of care", which he said he had demonstrated in removing a ligature from D1527 during that central incident. There was, of course, a problem with Yan Paschali's evidence on this, chair, D1527 didn't

even have a ligature around his neck when Yan Paschali was on the scene.

The fourth criticism, chair, is that of Derek Murphy, and a number of the other officers who sought to suggest that they had told Callum Tulley tall stories because he seemed to have an appetite for them. It is striking, chair, that each of these officers should independently come up with this "telling Callum Tulley tall stories" excuse for their own apparent misconduct. Even yesterday, we had this allegation repeated by Nathan Ring in his closing submissions. In any event, chair, that suggestion cannot be sustained. We know that because we can see some of those tall stories being told on the footage.

Derek Murphy, number one, he suggested he had told Callum Tulley fairy stories when responding to footage of him calling a detainee a "little prick" and with Derek Murphy saying he was going to "come and smash the fucking shit out of you".

In fact, when we look at that footage, it shows that Derek Murphy wasn't telling the story to Callum Tulley but to DCO Andy Jennings. Callum Tulley's footage shows that he entered the conversation halfway through and that Derek Murphy wasn't even facing Callum Tulley at the time that he said it. Another tall story.

Derek Murphy's next suggestion: he said he had told tall stories to Callum Tulley when he was responding to an allegation that Derek Murphy had said to another detainee, "Tell him, if he keeps going, I am going to smash the fucking shit out of him" and "I am going to smash you right up". On this occasion, chair, we can see the footage, we can see who Derek Murphy was talking to, not Callum Tulley but Gary Croucher.

The last assertion, chair, the last criticism, which was made the most often of all, is the criticism that Callum Tulley had recorded the footage for his own professional advancement or financial gain. Of course, that assertion was made by officers and also, regrettably, by senior management. It was an assertion that was baseless. Callum Tulley explained to you, on a number of occasions, that he had no dream to become a journalist, but that he had felt compelled to speak to the BBC about what he had witnessed at Brook House and all of the evidence suggests, chair, that Callum Tulley acted in good faith and in the public interest.

The purpose of exploring that criticism is clear, chair. First, it doesn't stand up to scrutiny, as we have seen. Second, it provides evidence of the culture at Brook House. Callum Tulley told you, chair, that he always feared that if he blew the whistle, he would face

personal attack and that, chair, is precisely what has happened now that he has done so.

To conclude therefore, chair, Callum Tulley's footage speaks for itself. Callum Tulley was also, himself, a witness of truth. Unless I can assist you further, those are the closing submissions of the BBC.

THE CHAIR: Thank you very much, Mr Bunting, thank you.

We are now going to be hearing from Ms Mannion, which is going to be remotely, so we will hopefully be able to move to that smoothly.

Ms Mannion, can you hear me?

MS MANNION: Hello. Can you hear me, chair?

THE CHAIR: We can hear you and see you. Thank you very much.

MS MANNION: Firstly, thank you for letting me appear in this way, I am extremely grateful.

THE CHAIR: No problem, thank you.

Closing statement by MS MANNION

MS MANNION: Chair, you have heard powerful and important submissions yesterday on behalf of detained persons and other organisations as to the events within the relevant period and as to systemic issues. I hope I will be forgiven, in these oral submissions on behalf of Her Majesty's Inspectorate of Prisons, for addressing you more narrowly on four topics relating to inspection.

My first topic will be as to the important role played by inspection generally as a safeguard to protect against mistreatment; secondly, as to the 2016 inspection of Brook House in particular; and, thirdly, and very briefly, I will highlight the changes made following Panorama; and finally I am going to turn, again very briefly, to potential further improvements.

My first topic, safeguard -- inspection, sorry, as a safeguard. It is chair, well recognised in domestic and international law that independent inspection of places of detention provides a powerful safeguard to detect mistreatment. Independent visits to places of detention is a central tenet of OPCAT. Why? Dr Hindpal Singh Bhui, in his live evidence, was asked almost as his first question, "What was the purpose of an inspection?" He replied, and I quote:

"I think it has multiple purposes. One of the most important is to make sure that nothing is hidden, that what goes on inside immigration detention is open to public scrutiny and that the views of detainees, the experiences of people in detention are publicised. It is also about improvement. It is making sure that centres that aren't doing well enough in terms of keeping people safe, providing respectful conditions, providing enough activities and providing enough support

for them, that those things are highlighted and they have an opportunity to improve on areas where we think they are not doing well enough. These are the purposes, but, to evaluate inspection as a safeguard, it is also important to understand what an inspection is and what it does."

I highlight this because it would be wrong to treat as if they are limits or weaknesses or flaws of inspection matters which are outside of inspection, which are the responsibility of others.

It follows from your approach that you appreciate the distinction between the arrangements within Brook House and the role of external oversight bodies but that distinction is important. The first stage, chair, is local management, here by G4S and the Home Office. They are responsible for day-to-day running of the centre, including complying with individual Detention Centre Rules and processes and policies within the centre.

They are responsible for ensuring compliance in familiar ways, the adequacy and success of which you are investigating, such as training, guidance, systems, management, supervision and so on. At the second stage, the Home Office and G4S are also responsible for monitoring that compliance, including Home Office

contract monitoring and, again, chair, you are investigating the adequacy of that form of oversight. The third stage is internal audit. This is the provision of assurance. You will no doubt consider the extent to which this was being done and the effectiveness of governance structures within the Home Office and G4S.

HMIP's role sits beyond these three stages. It is wholly independent of the organisations it inspects and its function is not one of ensuring compliance with rules or regulations. As you know, HMIP undertakes regular inspections of immigration removal centres and reports on the treatments of detained persons and conditions in those centres as judged against its own human-rights-driven expectations for appropriate conditions for detained persons.

As was explained by Dr Bhui, HMIP's role, in essence, is "to do occasional deep-dive suspensions, to provide a good systemic analysis of what is happening in the institution and then we pass that information to others."

HMIP does this by bringing in an experienced and professional team of researchers and inspectors. They have a range of relevant specialisms and expertise and draw from their different complementary backgrounds and

experience. They decide what they will look at, including the paperwork and processes in the centre. They set out, in a number of ways, to hear the voice and find out the experiences of those held in detention centres. They have total access and they know what they are doing. If they pick up evidence of an issue or a problem -- for example, from intelligence or a disclosure in an anonymous survey or a confidential interview -- they follow it through. This is the triangulation method you have heard about.

As Dr Bhui explained in his live evidence, that method does not simplistically mean that information is only accepted if it is verified by multiple sources and discarded or ignored otherwise. Triangulation is about taking information received or obtained and seeing whether it is supported or verified by other sources, thereby strengthening the conclusion drawn from the information. As Dr Bhui put it, "All triangulation methodology really is, is making sure you have looked for as much evidence as possible to back up a finding."

Aiming to verify information by multiple sources is a strength of the process, giving HMIP reports the rigour which means they ought to be taken seriously. Single voices are not ignored or discounted, they can still found a conclusion, where appropriate, and

a prompt inquiry and follow-up, and contribute to the overall assessment, even if a specific finding is not able to be made. They are included in the process of feeding back to managers throughout the inspection, and they may appear, as I say, in the final report.

For inspections to act as a safeguard, it is important that HMIP reaches robust, well evidenced conclusions. And there are two core reasons, chair.

Firstly, HMIP expects inspected establishments to act on its findings. The inspectorate needs to be able to ensure those inspected, and the public, that its conclusions are sound and solidly based and, therefore, should be acted upon. To drive change, HMIP reports must be seen as authoritative.

Secondly, there is little value in a report which does nothing more than recount the various information it has obtained. Without a systemic analysis of the evidence and clear findings, a report is less likely to be understandable to the public, less likely to be acted upon by institutions and, ultimately, less likely to improve outcomes for detained persons.

In summary, the safeguard HMIP inspections provide is a strong and valuable one. Inspections are capable of driving change and improvements in the circumstances of persons who are detained, if used appropriately by

contractors and the Home Office.

It must, therefore, be understood that it is not a weakness of inspection that inspectors strive to support findings with multiple sources; it is a strength. This method gives the reports authority and demands a proper response to the findings. It is not a weakness that inspections only occur periodically. The role is not one of day-to-day monitoring or oversight, but deep and thorough spot inspection by a wholly independent body. External day-to-day monitoring is also, chair, a valuable safeguard, but it is one which offers different insights and it is provided by other bodies. It is not a weakness that HMIP does not have enforcement powers. Enforcement responsibility would interfere with HMIP's essential and fundamental independence from those inspected.

However, this does not mean that HMIP does not feel frustration if its recommendations are not acted upon, and meaningfully -- Dr Bhui made that clear in his evidence to you -- but this does not make HMIP recommendations futile or expose the limitation of inspections, it is a failure of implementation.

If a concern is raised by the inspectorate, the answer to it must come from those responsible for the management, running, compliance and oversight of the

establishment. The inspection report provides a detailed analysis of the state of an immigration removal centre. It is then for the contractor and the Home Office to consider and take any appropriate action.

As a final point before I leave this topic, chair, I should add that it should not be understood that HMIP recommendations are routinely ignored. They are not. For the most part, they are accepted and taken seriously by establishments, and this leads to improvements. Also, HMIP reports provide a rich source of information to the public and non-governmental organisations, who can themselves use the evidence in those reports, and HMIP's recommendations, to seek to bring about improvements.

Chair, I turn now to my second topic, and from the general to the specific and the question of whether the 2016 HMIP inspection itself was able to detect mistreatment.

For the reasons I will shortly develop, HMIP will invite to you make the following key findings. First, because of the sparsity of the evidence and because of some significant differences between the conditions at Brook House in November 2016 and in the relevant period, you cannot safely find that HMIP missed a subculture of abuse or mistreatment as seen on Panorama during the

2016 inspection.

Second, for the same reasons, there is no proper basis to find that there was a failure in the adequacy of inspections as a mechanism to detect mistreatment in 2016.

Third, there are important and relevant findings which were made in 2016 and which should have led to consideration, review and improvements, and I will take you, chair, to a small number.

Fourth, and without stepping back from the submissions I have just made to you, you can confidently conclude that HMIP is an organisation which listens, responds to feedback, has improved and continues to proactively improve.

Turning then to 2016, chair, there is at least one material difference between Brook House in November 2016 and during the relevant period. That is staffing levels. As you know, between September 2016 and April 2017, staff from neighbouring Tinsley House were relocated to Brook House. The Home Office witness, Michelle Smith, confirmed there were no understaffing days as against contract minimums in October and November 2016, and, I quote:

"It was only upon the reopening of Tinsley House did staffing hours become a problem."

It was more than a matter of just meeting contracted levels. Steve Skitt of G4S confirmed that staffing in the 2016 window was "Very high, as you essentially had two centres' worth of staff working at one centre."

Callum Tulley's notebooks, whilst mentioning a feeling of hostility in the centre, acknowledged that many of the consequences of understaffing were absent from the centre in the window up to the inspection, recording, on 10 October 2016, that this was "somewhat softening the impact of the Brook House population increase". You will note, of course that notwithstanding the relatively high staff levels at the time of the inspection, the report nonetheless mentions that staff were still "under pressure and busy".

Dr Bhui was challenged by counsel to the inquiry as to why the report did not include a finding that there was a lack of staff. Dr Bhui did not agree that such a finding should have been made, explaining as to understaffing, and I quote:

"I think almost certainly, in my view, it would have emerged quite strongly from other evidence if that was a big concern at the time we inspected."

Chair, understaffing also wasn't a feature of the window running up to the inspection. The relatively high-level of staff had been in place since

the September. In 2016, at the time of the HMIP inspection, the average length of detention in Brook House was 48 days and 78 per cent of detainees had been in the centre for less than two months.

This means that the great majority of those who were detained in Brook House at the time of the HMIP inspection will have not known anything other than the higher Tinsley House supplemented staffing numbers. The 22 per cent who had been in Brook House longer had still benefited from higher staff levels for some weeks before inspectors arrived.

The difference in staffing levels is important because of the evidence you have heard from detained persons and from staff about the consequences of understaffing. Activities could not be opened, courtyards stayed shut, everyday queries and requests from detained persons, for cleaning products or paper or any other small thing, went unanswered. You have heard that this increased levels of tension among detained persons, which itself was capable of triggering incidents of aggravation or apparent aggression. Such incidents drew staff time and attention and thereby exacerbated the cycle as staff numbers and time were yet further reduced.

Staff, too, were caught in the cycle. You have

heard a great deal of evidence about tiredness, frustration and short fuses amongst the staff, consequential upon the understaffing situation. For example, Owen Syred stated in his written evidence that shortages left staff feeling overwhelmed, undervalued and absolutely worn out, and it negatively impacted on the welfare of detainees, including the mental health of detainees, because of the lack of staff available to listen.

Of course staffing levels are not the only important factor, but in this case, the higher staffing levels may have made a contribution to the information which HMIP obtained at the time of the inspection, including during group interviews, at which detained persons described relationships with staff as a strength of the centre. Likewise, 77 per cent of detainees surveyed said that staff treated them with respect, and that increased to 84 per cent amongst those who did not speak English.

Overall, therefore, there are good reasons to conclude that the better staffing levels at the time of the 2016 inspection meant that, at that time, the centre was in a better state, affecting positively the data received by HMIP and the evidence accrued in respect of, most obviously, the safety of and respect for detained persons.

This undermines the suggestion that HMIP missed a culture of abuse, active in November 2016, and it also undermined any suggestion that inspection is, in conjunction with other safeguards, an inadequate safeguard to detect such abuse.

Chair, I now turn to important findings which were made in 2016 and draw out a small number of matters which have taken up time in the evidence, and these are understanding, firstly, the healthy establishment test scores; secondly, the physical environment at Brook House, including the additional 60 beds; thirdly, the use of force; and, fourthly, healthcare.

Firstly, understanding HMIP's four healthy establishment test scores. In each of these tests in 2016, Brook House was given a score of "reasonably good". This phrase does not mean the centre was reasonably good. What it means is set out in the report itself, and I quote:

"There is evidence of adverse outcomes for detainees in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place."

The then chief inspector, Peter Clarke, made clear that the 2016 inspection was an encouraging one. This comment should not be divorced from its context. In his

written evidence, Owen Syred, who first worked at Brook House in 2009, stated that, in 2010, Brook House was a "dreadful place", and he remembers, at that time, that HMIP inspectors did not feel safe. Dr Bhui explains in his second written statement that the 2010 inspection report, Brook House received the worst possible rating for safety, one of "poor", and it was assessed as "not sufficiently good" for all other tests. And in the 2013 report, the preparation for release test was "not sufficiently good".

That history makes clear that things were better at the time of the inspection, in 2016, compared to earlier reports.

The report clearly explains that the four sections of the report dealing with each of the four healthy establishment tests contain "a detailed account of our findings against our expectations".

A proper read of these findings makes clear that the report is densely packed with information which should have led to a consideration, review and action by the establishment and the Home Office.

It has, therefore, been disheartening to hear witnesses for organisations with responsibility for compliance, monitoring or governance refer to HMIP as somehow having given Brook House a clean bill of health

following the 2016 inspection. It should not have been possible to read the 2016 findings and conclude that Brook House had no work to do.

My second point from the 2016 report, HMIP has been highly critical of the physical environment at Brook House. You have heard a lot of evidence from witnesses at all levels about this and you may find in due course that the physical environment at Brook House was facilitative to some of the ill-treatment you are investigating. If you do do this, it is important that when you then come to consider the effectiveness of the safeguard of inspection, it being appreciated that these points were raised powerfully and promptly by HMIP. The introduction to the report noted:

"The residential units very closely resembled the conditions found in prisons and these were exacerbated by poor ventilation and unsatisfactory sanitary facilities."

And within the key findings, it was stated:

"The residential units remain stark and impersonal in design. Apart from paintings by detainees, the environment had not been softened. Many cells lacked curtains and many in-cell toilets were not curtained off. Many cells had ingrained dirt, especially in the toilets, and those on C wing were in the worst

condition. The lack of ventilation was the most common complaint and many cells were too stuffy overnight."

The condition of the residential units led to one of the two main concerns and recommendations in the 2016 report.

Dr Bhui underlines the significance of these recommendations in his evidence, explaining that Brook House "is a centre which looks and feels like a prison and it is designed like a prison. As we have said many times, that is inappropriate for a detainee population."

The chief inspector also said in the introduction to the 2016 report that the proposal to bring in the third beds installed already in two-person cells into use "has the potential to adversely affect the conditions in which some detainees are held". And the inspectors agreed it would lead to a decline in living standards.

As to this, Dr Bhui explained that a formal recommendation was not appropriate because the change had not yet happened, or even been approved, but this was a caution in stark terms. It is hard to see how, at that stage, HMIP could have put its concern more clearly or prominently.

My third point, I want to draw out HMIP's conclusions on the use of force because this, too, did

not get anything like a clean bill of health. HMIP made a number of findings about the use of force which was observed during the 2016 inspection, including: one, use of force had increased in the six months up to the inspection window as compared with the six months running up to the 2013 inspection; two, use of force was used proportionately and as a last resort in most, but not all, cases; three, echoing evidence you have recently heard from Jon Collier, HMIP inspectors found that video footage revealed mixed practice: some incidents took too long to resolve once force had been initiated and a description was given of an inappropriate use of force, and that was the use of a shield to restrain a passive detainee; fourth, video footage also revealed that waist restraint belts may not have been used as a last resort by Tascor; and, five, a use of force observed during the inspection itself was described as "chaotic".

These findings led to a recommendation by HMIP that all use of force should be necessary, proportionate and competently applied. There should be no confusion, this recommendation was made because it was the view of inspectors that this was not always happening in Brook House in November 2016, as indeed Dr Bhui also confirmed to you in his live evidence.

The report also noted as to governance of use of force that managers reviewed all incidents to learn and disseminate lessons and it was described as "very good". At this distance, little more detail is available within HMIP as to the exact systems in place during the inspection period as opposed to the relevant period. The inquiry has heard that improvement of use of force governance had been a focus for Lee Hanford during his period as director in 2016, March to July, and that use of force matters were often escalated to the SMT and other specific leadership team meetings.

The answer is not clear, but these matters might indicate that governance had deteriorated subsequent to the HMIP inspection.

Dr Bhui was asked whether HMIP might have missed evidence of abuse in light of the contents of the anonymous detainee survey. In 2016, the survey included responses from four detained persons that they had been physically assaulted by a member of staff. Of course this is a piece of evidence to be taken seriously, but that survey result is not enough on its own to safely conclude that there was a culture of abuse of the type seen on Panorama. Some of these responses may have been describing what were, in fact, lawful uses of force, the survey responses alone don't give us enough to know, but

as I have already mentioned, what they do do is prompt further research and inquiry.

My fourth and final point on the topic of the 2016 inspection. In relation to healthcare, the 2016 report raised relevant concerns. Rule 35 reports "did not provide an adequate safeguard for detainees with post-traumatic stress disorder (PTSD)", and recommended that "where a detainee claims they have been tortured, the rule 35 report should include an assessment of PTSD."

The report also raised concerns about the healthcare complaints system, compromising medical confidentiality and in relation to the need for reasonable access to translated information about health services and health and wellbeing. Nonetheless, Dr Bhui was asked about a small number of other areas where, candidly, he accepted that findings might have been more critical or would now have been more critical.

These were in respect of reporting detainee feedback more strongly, whether the specific criticism which HMIP made in 2019 about the lack of rule 35(1) and (2) reports might also have been made in 2016, and whether it was too positive to describe half the staff having received mental health training as "commendable". He accepted these points, though you may conclude that this

is good evidence of HMIP's ongoing willingness to improve, but these observations do not undermine the overall validity of the 2016 report.

Chair, my third headline topic is the changes which were made in response to Panorama. In HMIP's opening statement, I explained a little about the enhanced methodology which HMIP brought in following Panorama. As Dr Bhui explains in his first statement, HMIP reviewed its methodology with a view to whether it could increase the likelihood of identifying individual incidents of mistreatment and systemic risks in IRCs. You have detailed evidence about the changes in Dr Bhui's witness statement and how they came about, as well as the careful review of the efficacy which followed.

The enhancements were designed to encourage greater engagement and so obtain more information from detained persons, staff and third party organisations. There is now a greater opportunity for detained persons and staff to tell inspectors in confidence about concerns over safety or treatment. First, every detained person is now often interviewed with an inspector, using interpretation where needed. This opportunity is also extended to persons who were recently detained in the centre in question, as Dr Bhui explained in his live

evidence, and I quote:

"We offer every single detainee an interview. We have no systematic way of ensuring that every person who is vulnerable speaks to us, but they have certainly got the opportunity to come forward. We identify people through other means as well. So, for example, the safeguarding inspector might identify someone through a rule 35 and we might make a point of going to speak to that person."

Second, all staff are now given the opportunity to respond to an anonymous survey that they can complete outside the establishment and, where staff identify themselves, they can follow up discussions and interviews may be arranged. A range of access to staff allows HMIP to better identify problems in leadership, staffing levels, morale and culture which may affect outcomes for detained persons.

In view of the evidence concerning the difficulty that staff faced in coming forward with concerns, you may consider that an anonymous staff survey is a valuable tool in assessing the state of affairs at an immigration removal centre.

Third, NGOs are now proactively contacted by inspectors at the outset of inspections and expressly invited to contribute information and put detained and

formerly detained persons with whom they are in contact in touch with HMIP inspectors. Systematic contact with non-governmental organisations strengthens flows of communication and intelligence, assists in giving leads to follow and further works to ensure that the voices of detained persons are heard by inspectors.

Overall, HMIP's enhanced methodology provides greater opportunity for inspectors to identify potential concerns. HMIP believes the enhancements will better enable it to detect a culture or subculture of abusive practice. These changes were designed and driven by HMIP and they were already in place by mid October 2017. You may consider that HMIP reacted commendably swiftly to Panorama. In his evidence in phase 1, Nathan Ward stated that HMIP was, "the only organisation following Panorama to actively want to learn and sit down", which we did, and we met following Panorama.

Since that time, HMIP has also introduced a focus on leadership when undertaking inspections. In his witness statement, HMCIP, Charlie Taylor, said this would be carefully considered in view of the importance of good leadership at an immigration removal centre for outcomes for detained persons.

Most recently, HMIP has consulted on changes to the ways in which it makes recommendations. The suggestion

is to replace around 30 recommendations per inspection with a smaller number of key concerns. These concerns will still identify what must be resolved by the centre, and the Home Office, and an action plan will be required that sets out exactly how and when identified problems will be remedied. As Dr Bhui explained in his evidence, the idea is to reduce the scope for expected establishments to claim success in responding to recommendations, when they had just picked off low-hanging fruit. The new key concerns would all be important matters and demand action, but the body of the inspection report will remain replete with other information which establishments will be inspected to study carefully.

Chair, my final topic, very briefly, further improvements. As I indicated to you back in opening in November of last year, HMIP is listening and following this inquiry closely. It always strives to improve. I draw out four short examples which were raised during the hearings.

Firstly, the receipt of intelligence. Under the enhanced methodology, HMIP now proactively approaches non-governmental organisations and advocacy groups, ahead of inspections to ask for information and to help in making contact with those who may wish to speak to

the inspectorate. HMIP also makes it clear that it is willing to receive intelligence and information through other means; its email address and phone number are already advertised in places of detention and during inspections. However, more could be done here to ensure that HMIP consistently receives information which might be relevant, firstly, to assessing when a further inspection is required of a particular place, and, secondly, informing inquiries and findings during an inspection.

HMIP will continue to reflect on what information, and in what form, would most be useful to it to achieve those aims.

Secondly, the voice and reported experience of the detained person. I have explained the triangulation methodology and its value, but this does not mean that the voice of detained persons should not be clear from the report. Dr Bhui candidly expressed his view that there was value in giving more space to this within the healthcare sections of the report and, chair, this is already under discussion within HMIP.

Thirdly, Professor Bosworth suggested that HMIP might have a role in the training of DCOs. It would not be appropriate for HMIP to be involved in the management or oversight of DCO training or have any other type of

involvement that might harm its independence. However, as Dr Bhui confirmed, HMIP will reflect upon whether DCO training can be considered as part of its thematic work.

Finally, HMIP will consider whether the evidence presented during the inquiry can form a useful training case study for its own inspectors, particularly in relation to reviewing use of force incidents and assessing the effectiveness of rule 35 reports.

Chair, I conclude these closing remarks by saying this. Independent inspection is an essential and effective safeguard to detect abuse. The inspection of Brook House Immigration Removal Centre in November 2016 was delivered by a professional inspectorate, committed to, and effective in, improving outcomes for persons held in detention. Even though there may have been relevant differences in the conditions in 2017 from those during the inspection in 2016, HMIP made findings and recommendations which should have led to changes and improvements.

In the wake of Panorama, HMIP reacted promptly to the possibility it might have missed something during the 2016 inspection, making sensible and meaningful enhancements to its methodology.

It continues in the same vein to this day, building on what it does well but open to changes which will help

it do better and set out what it always sets out to do: improve outcomes for detained persons.

Chair, thank you very much.

THE CHAIR: Thank you very much, Ms Mannion. Mr Dixey?

Closing statement by MR DIXEY

MR DIXEY: Chair, I make this closing statement on behalf of the Independent Monitoring Board. In addition, we will provide you with written submissions which will address, in greater detail, the issues which have arisen from the evidence that has been adduced.

As I said in our opening remarks, the IMB welcomes this inquiry. As anticipated, it has provided an opportunity to formerly detained persons to speak openly about their experiences whilst at Brook House.

The inquiry has posed fundamental questions of how the immigration detention system operated in 2017, and continues to operate today.

As the Brook House IMB said in its 2017 annual report, it was horrified by the behaviour shown in Panorama. It is now apparent that the mistreatment and abuse within Brook House was even more widespread than was shown during Panorama. The conduct which this inquiry has revealed is reprehensible and inexcusable. There can be no doubt that, in light of the evidence which you have seen and heard, at least some formerly

detained persons were subjected to treatment that was inhuman and degrading. Some behaviour went well beyond even that.

This inquiry has uncovered a culture of -- amongst Brook House staff and management that failed to secure the safety and basic dignity of detained persons. That culture went beyond isolated incidents by a small number of staff. The inquiry has revealed evidence that unacceptable conduct and attitudes had become normalised within the staff at Brook House. There was a culture amongst staff of not reporting concerns about their colleagues internally, as well as to the IMB and other external bodies.

Indeed, there is a substantial quantity of evidence which supports a finding that some members of centre staff acted so as to keep abuse hidden. Uses of force were not reported, paperwork was not completed, or was completed inaccurately, body-worn video was not activated and, as Callum Tulley explained, abuse frequently occurred out of the sight of CCTV.

It is difficult to accept that such behaviour was limited to a small number of junior staff. The evidence clearly suggests that some frontline managers accepted or colluded with this behaviour and that senior management did not exercise effective oversight. On

Day 6 of the inquiry, Mr Tulley gave evidence, amongst a number of other days. During that evidence, he agreed with counsel to the inquiry that mistreatment might be considered to arise in three ways: first, the deliberate acts of physical and verbal abuse of the kind shown on Panorama; second, the harms caused by the nature of the immigration process, including the uncertain length of detention; and, third, the impact of the physical environment or conditions of detention.

In 2016 and 2017, the IMB had reported on, and raised concerns about, the second and third of those factors. However, it is now painfully apparent that the IMB, along with other oversight bodies and the onsite Home Office contract monitors did not identify and prevent the abuse and mistreatment of the first kind.

The IMB is not unique in not identifying the deliberate acts of physical and verbal abuse of the kind shown on Panorama. Along with HMIP, you have received evidence from Anton Bole of the Forward Trust, Dr Dominic Aitken and Jamie MacPherson of the Gatwick Detainee Welfare Group, all of whom were unaware of the abuse shown on Panorama. The fact that all of these people and organisations were unaware of what was revealed indicates that the reasons why this abuse remained hidden are complex and multi-factorial. These

were people in organisations external to, and independent of, the centre and Home Office. Therefore, we submit that the reason why abuse was not identified is not simply a question of independence.

It is clear from the perspective of the detained population that there were significant barriers to reporting concerns to the IMB and others. Again, the causes of those barriers are complex, but they include: firstly, a concern that, if a complaint were made, it might prejudice a detained person's immigration status or that they would otherwise be subject to reprisals; second, a lack of awareness of the IMB and its role; third, the misconception that the IMB was part of the centre management or Home Office; and, four, language barriers. All are matters of concern to the IMB and it is working hard to address these barriers.

Before turning to the criticisms which have been made of the IMB in 2017, it is important to set out the role and purpose of the IMB. It is important to do so because the evidence from certain witnesses to the inquiry has revealed a significant misunderstanding of the IMB's role.

We recognise that that misunderstanding is at least in part because of the way in which some board members summarise their role when interviewed by Kate Lampard

and Ed Marsden. You will recall that Professor Bosworth was asked about the quoted comments that the IMB were, "monitors really, rather than resolvers of problems."

As Professor Bosworth put it, such a description oversimplifies the IMB's role. We agree; it does oversimplify the IMB's role. Ms Colbran addressed this exact point in her witness statement, at paragraph 188. She explains that the way she expressed herself during the interview with Ms Lampard and Mr Marsden was demonstrably inaccurate. She and the board spent a considerable amount of time in Brook House resolving problems for detained people. As she puts it, "We saw that as a major part of our role."

This characterisation also does not accord with the material which has been placed before you. As the 2017 annual report shows, in that year, the IMB received 123 written applications; in 2016, it received 87 such applications. During rota visits, board members dealt with a much higher number of concerns raised with them orally. There are, within the papers, many instances of board members seeking to resolve the problems of the detained men which were raised with the IMB.

It is, we submit, to misunderstand the IMB's role, to suggest that members only concerned themselves with the heating, cleanliness and the absence of complaint

forms. These are important matters to detained persons; however, the evidence before the inquiry clearly shows the IMB was engaged in much more besides this.

IMB members were far more than passive observers within the centre and regularly raised matters of concern with those responsible for the care of those detained.

As members of the local community, IMB members are the public's eyes and ears within places of detention. Board members' regular presence in an establishment gives them a unique insight into the day-to-day experience of detained persons. Their work complements, but does not replicate, the work of other members of the National Preventive Mechanism, such as HMIP and the PPO. As Professor Bosworth explained in her evidence, there is great value in having transparent and reliable information of what happens within closed environments such as Brook House.

IMB members, who are a regular, albeit not permanent, presence, bring their varied life experience to bear on what they see and find, to record the actual outcomes for those in detention. Their reports form a crucial part of the civic dialogue concerning detention and the experiences of those who are detained.

You have received two statements from the chair of

the NPM -- the National Preventive Mechanism -- John Wadham. The IMB notes and agrees with Mr Wadham's observations in his second statement. I quote:

"The external oversight [as he outlines] offered by national and international bodies cannot, alone, prevent all ill-treatment occurring in detention. As identified by leading academics, it is not realistic to presume that one institution, whether that be the SPT [the UN Subcommittee on the Prevention of Torture], at the international level, or the NPM, at the national level, will be able to achieve this single-handedly. It needs to be placed within the broader context of factors that play a part."

Boards do not have a regulatory role. They can alert managers to problems and can offer advice and recommendations to the centre management, the Home Office or the minister. However, they are not responsible for the running of the centre or the oversight of contractual responsibilities.

They can alert those who are responsible, the minister and the department, to any concerns. They do so weekly through their rota reports, monthly in meetings with centre and Home Office managers, periodically to senior Home Office officials or ministers, where there are issues of particular concern,

and annually in their annual reports.

Addressing, if I may, the IMB's 2017 annual report itself, the IMB accepts that the 2017 annual report should have been more critical and challenging. The IMB accepts that, in light of what is now known, it was plainly wrong to say that the centre kept detained persons as safe as it could. Whilst the IMB's 2016 and 2017 annual reports were broadly positive, it is wrong to read them as raising no issues about the safety of the centre or the treatment of detained persons during those respective reporting years. In both the 2016 and 2017 annual reports, the IMB identified serious issues which required the attention of the minister, the Home Office and the centre.

To refer to just some of those issues within the 2016 and 2017 annual reports only, in 2016, the board raised concerns about delays in access to mental health treatment. It raised concerns about locating those with mental health issues on the CSU. In 2016, the board raised concerns and required a response on the use of night transfers, because the board did not believe that the impact on the care and welfare of individual detained men was being taken into account.

In 2016, the board specifically challenged the length of time people were detained at Brook House. In

2016, the board recorded its concerns about the preparations to add the additional 60 beds and acquire three men to share one room. It raised similar concerns in 2014 and 2015. In 2016, the board highlighted that it was concerned by the handling of rule 35 requests and reports. In 2017, the board identified as areas for improvement to increase staffing levels, to improve the operation of the Adults at Risk policy, to implement advanced mental health training for staff who interact with vulnerable detained persons.

In 2017, the board recorded concerns about the availability of drugs and alcohol within the centre.

In that context, the IMB has become increasingly concerned to hear the evidence in this inquiry from some senior members of the Home Office and G4S as to the reliance placed upon both the IMB and HMIP to identify and report matters of concern up to and including abuse. To mention just three examples, if I may, first, you heard evidence from Michelle Smith. During the relevant period, she was the service delivery manager within the Home Office and responsible for overseeing performance under the contract at Brook House.

You may think, having heard her evidence, that the Home Office had contracted out not just the running of the centre, but also its contractual oversight. That is

notwithstanding the fact that the IMB were not privy to the contract which the Home Office contract managers were meant to be monitoring, nor were the IMB members a permanent presence on site.

Second, you heard evidence from Peter Neden, Jerry Petherick and Gordon Brockington, all of whom sought to rely on parts of HMIP and IMB reports or, as counsel to the inquiry suggested to Mr Brockington, seeking refuge in Peter Clarke's finding that Brook House was "reasonably good". Mr Neden accepted that G4S overrelied on the reports of external organisations.

You may wonder how it is that a company the size of G4S, employing as many people as it did, operating a contract valued in the millions, say they came to rely quite so heavily on occasional HMIP visits and the nine unpaid members of the IMB.

Third, you heard evidence from Philip Dove, who sought to rely on the IMB, HMIP and CQC, to monitor healthcare provision at Brook House. Putting to one side that the IMB does not have access to healthcare records, the IMB did raise concerns about healthcare provision, including about the application of rule 35.

In respect of the IMB, arguably, the most serious criticisms are those which have questioned its

independence, in particular those made within the Verita report and by Professor Bosworth in her first report and oral evidence.

As to the criticism made in the Verita report, the IMB took, and continues to take, seriously the suggestion that the board was overempathetic. This criticism appears to have been formed primarily on the basis of accounts of interactions between the IMB and GDWG, to which I will come shortly, and comments within the Verita interviews which were themselves not reflective of the totality of the board's role.

As Dame Anne Owers has explained in her first statement, based on the evidence available to Ms Lampard and Mr Marsden, she can understand why they concluded there was a tendency to overempathise with centre managers and Home Office staff.

However, we submit the board was independent, albeit the perception that it was not is a matter of great concern and did prompt action.

Turning to Professor Bosworth's evidence, I make these submissions conscious that Professor Bosworth is an eminent academic with considerable experience and expertise on the issues which you, chair, will consider; however, it is you who has read, seen and listened to all evidence in this inquiry. We invite to you approach

with caution Professor Bosworth's criticisms of the IMB in 2017, as set out in her report and oral evidence.

First, it is not clear to us that Professor Bosworth had read the three statements submitted to you by Dame Anne Owers, Ms Colbran or Ms Molyneux.

Second, Professor Bosworth had watched some of Ms Molyneux's oral evidence but none of Ms Colbran's. As you will recall, it was Ms Colbran who was the chair during the relevant period.

Third, as Professor Bosworth explained when questioned by counsel to the inquiry, she was wrong about certain factual matters upon which she had relied in her statement; in particular, Professor Bosworth wrongly attributed to certain IMB members apparent criticism of some detained men and was wrong to say that IMB members "sat on a variety of centre committees."

Those factual matters are important because it is those factual matters which led Professor Bosworth to conclude, in her first report, that there was a shared culture between officers and the 2017 board, and that the organisation was, "not fully independent and thus not performing adequately as a safeguard for human rights".

During her oral evidence, John Connolly's observation in respect of the IMB, that "most of them

were ex-prison officers", was put to Professor Bosworth. Putting to one side any reservations one may have about relying upon Mr Connolly as a reliable historian, this is plainly not correct. One of the then board was a former prison governor, there were no ex-prison officers. There were, amongst those, people with backgrounds in the law, teaching, and nursing.

We accept that the use of language is important. We accept that, within the documents created by the IMB members in 2017, there are instances where the language used was inappropriate. One such example was put to Ms Colbran during her evidence. She immediately accepted such language was not appropriate.

As for the IMB's relationship with GDWG, it is now clear that both organisations were -- it is clear, now clear, that both organisations were unclear about each other's respective roles, objectives and working methods. We submit that the IMB's engagement with GDWG was well intentioned but was open to misinterpretation and misunderstanding.

The IMB has since been shocked to learn of the extent to which the relationship between GDWG, G4S and the Home Office had broken down. James Wilson's evidence about his treatment by G4S and Home Office managers is particularly troubling.

This was not known to the IMB at the time. Further, as Ms Molyneux accepted in her first witness statement, the IMB was too affected by the criticisms made by the centre and Home Office managers of GDWG. She has explained the steps which have been taken since to improve the two organisations' relations.

We invite you to reject the criticism that the IMB had a shared culture with officers and was not fully independent.

I turn now to the present and future. We have placed before you evidence as to the current position, both locally within the Brook House IMB and nationally. Both locally and nationally, IMBs have reflected on what Panorama showed and then what Ms Lampard and Mr Marsden concluded. There is now a much greater focus on training, specific to immigration detention, focusing on separation, Adults at Risk and mental health.

That training draws on the expertise and experiences of those outside as well as within the IMB, including those with lived experience of immigration detention. The Brook House IMB, in particular, refocused on monitoring vulnerable detained persons, Adults at Risk and staff culture and behaviour.

In addition to quarterly chairs' forums, there are weekly calls between the chairs of the IMBs for

immigration removal centres. These have proven to be an excellent opportunity to share experiences and learning amongst the chairs of the boards for IRCs.

This permits boards, through their chairs, to better contextualise their experiences and compare what they are observing against best practice and the practices in other establishments.

You will have seen that in Professor Bosworth's first report, she recommends that the IMB develops a rights-based approach and scrutiny document rather than one based on the layout of the centre.

You have received evidence from Dame Anne Owers and Mary Molyneux as to the new template developed for both rota and annual reports. This focuses on four areas set out in the national monitoring framework, which reflect international and domestic human rights standards for the treatment of those in detention. The rota template requires boards to make a judgment against each of these. This steers boards towards placing their detailed findings within that human-rights-based context.

Both before and since the relevant period, the Brook House IMB and the National Chair have reported on and made recommendations at Brook House and more widely. By way of example, the 2019 and 2020 Brook House annual

reports criticised the pre-Brexit charter flights; failures in the Adults at Risk policy and rule 35 policies and practices; Home Office DET staff not serving removal directions in person during the Covid-19 pandemic; and delays relating to providing bail accommodation.

You will be aware that in October 2020, the chairs of the Brook House IMB and the charter flight monitoring team wrote to the Minister for Immigration Compliance and Courts under rules 61(3) and (5) to raise serious concerns about the inhumane treatment of detained persons.

The IMB is not afraid to challenge, where appropriate, and will continue to do so. This inquiry offers an opportunity not only to cast light on the reasons for the appalling treatment in one immigration removal centre, but also to reshape the immigration detention system in a way which better promotes humane and decent treatment for those living within it.

You have received a range of recommendations which you will consider with care. In our written submissions, we will provide our observations on the reforms which might be made. At this stage, however, we confine ourselves to three.

First, it is imperative that the safeguards against

the inappropriate use of detention, which appear to have broken down at Brook House, the use of rules 34 and 35, and the Adults at Risk policy, must be strengthened. The IMB will, in any event, continue to focus carefully on how these operate in practice.

Second, to ensure that detained people have access to meaningful support in dealings with those in the Home Office who are making decisions affecting their lives. Caseworkers should be on site, on at least a periodic basis. There should be meaningful access to legal advice, including significant improvements to mobile telephone reception, IT facilities, and access to interpreters for legal appointments.

Third, the IMB reiterates a recommendation made by it for many years, that because of the profound impact which detention has on individuals, a time limit for immigration detention should be introduced.

Chair, unless I can assist further, that is the closing statement on behalf of the IMB.

THE CHAIR: Thank you very much, Mr Dixey.

Thank you. I am going to suggest we take our 15-minute break now and then we will be returning when we will hear from you, Ms White.

Thank you. We will return at 11.35. Thank you.

(11.20 am)

(A short break)
(11.42 am)
Closing statement by MS WHITE
MS WHITE: Practice Plus Group, PPG, welcomes the work of this inquiry and the significant benefit it has given PPG as the incoming provider of healthcare services at Gatwick IRC in informing the current and future practice.
PPG fully recognises the significant issues in the provision of healthcare at Brook House in the relevant period which have been revealed by this inquiry. PPG supplies this statement with a view to showing what work has been done to date to address those issues and what work remains outstanding.
Since assuming responsibility for healthcare in September 2021, PPG is endeavouring to firstly improve the level of staffing at Brook House, by increasing the volume and variety of clinical roles within the combined nursing service, mental health and primary care and within the team of healthcare assistants; secondly, to increase the provision of mental health care, through, for example, low- and medium-intensity trauma-based psychological interventions, led by a psychologist and an assistant psychologist; thirdly, to improve the availability of

translation services by agreeing an additional contract with thebigword in addition to LanguageLine, which can be used during patient consultations; fourthly, to improve the level of training at Brook House, by offering all clinical staff the opportunity to undertake the introduction to Health In Justice Course delivered by Stafford University; and, fifthly, to maintain the continuity and stability of GP care via its sub-contracted provider DoctorPA Limited. This has avoided short-term disruption to the service, although as you know, chair, PPG is working towards a model incorporating more employed GPs.
In addition, all staff are required to complete two online training sessions on self-harm and suicidal thought as part of their induction. PPG has introduced multi-professional complex case clinics, MPCCC, involving clinical leaders and multidisciplinary members in a weekly discussion of patients with complex needs. These discussions feed into weekly vulnerable persons meetings to ensure the full clinical picture is taken into account when considering a detainee's ongoing fitness for detention.
All detainees placed on constant supervision undergo a mental health assessment to ensure that mental health needs are identified and, wherever possible, met.

Finally, PPG provides trauma-informed training for the mental health team and bespoke mental health assessment training for secure environments.
The intention is for all healthcare staff at Gatwick to be given a trauma-informed training package to ensure greater awareness of the prevalence and impact of trauma on detainees and to reduce the risk of accidental retraumatisation.
In spite of these improvements, PPG recognises that many of the issues raised by the inquiry are not amenable to quick-fix solutions and require longer-term change. As Dr Bromley explained, significant further work is ongoing. In particular, firstly, PPG is developing bespoke reception screening training for teams assessing new arrivals. This will emphasise the purpose and importance of the initial screening and of communicating this to patients and of encouraging better attendance at rule 34 appointments.
It will also train all staff in the identification of conditions which may be detrimentally affected by detention, and which require assessment under rule 35, to encourage a more proactive approach to identifying patients who may be at risk due to detention. This bespoke reception screening training is due for roll-out by the end of May 2022.

Secondly, PPG is reviewing the initial reception screening template to ensure that vulnerabilities are properly identified and is working with Serco to pilot second reception screens as a further opportunity to pick up any needs not identified on the initial screening, including any Adults at Risk or individuals who may need to be considered for a rule 35(1), (2) or (3) report. Any individual identified as vulnerable becomes the subject of a supported living plan and is discussed at the weekly vulnerable persons meetings chaired by Serco and attended by healthcare and the Home Office.
Thirdly, PPG is working with external training organisations to develop bespoke training on suicide intervention, which is called Assist, on mental health assessment, and on healthcare responsibilities in control and restraint. That is training specifically designed for secure and detained settings, recognising that staff knowledge across these areas is in need of improvement.
Fourthly, PPG is in the process of developing bespoke rule 34 and rule 35 training for GPs, to ensure high-quality assessments and reports. This training is due for delivery in July 2022 and will be delivered, both as part of the induction of new GPs and as

an annual refresher. It will cover the Adults at Risk guidance and signs and symptoms of trauma and torture, drawing on guidance from the Faculty of Forensic and Legal medicine. PPG is also planning to develop a new quality audit, which will be peer reviewed, to examine the quality of rule 35 reports.

Finally, PPG is working with Stafford University to develop a more bespoke version of their calls for staff working in IRCs as opposed to prisons, using learning from the first six months of its contract to identify current gaps and training and induction.

As for rule 35, PPG recognises the disconnect between the absence of rule 35(2) reports in recent months as in the relevant period and the significant number of detainees who have been on constant supervision due to suicidal thoughts or self-harm.

The intention is for the approach to rule 35 at Gatwick to be subject to wholesale review, alongside Heathrow IRC in April 2022, so that both sites operate a robust rule 35 pathway which has had the benefit of peer review and redesign to meet the needs of detainees at those sites.

PPG also fully appreciates your concern, chair, to ensure that some immediate action is taken in respect of those currently in detention who may be vulnerable

and/or in need of a rule 35 report.

To that end, Dr Bromley has supplied a further short witness statement in which she has confirmed, in answer to your questions and those of your counsel, that both GPs have been reminded by the head of healthcare, Sandra Calver, of the need to complete rule 35 reports wherever indicated and have been actively encouraged by both Ms Calver and Dr Bromley to undertake rule 35 assessments.

The joint letter from the Home Office and NHS England received last Friday, 1 April, has been shared with the GPs. As a temporary solution, until a rule 35 pathway is developed, firstly, when an ACDT is opened, a rule 35(1) appointment will be booked for that day or the following day. Additionally, all patients are reviewed by the mental health team when an ACDT is opened.

Secondly, DoctorPA Limited have been instructed to undertake rule 35(2) assessments for all patients on constant supervision. As of this last Friday afternoon, only one patient was on constant supervision and he was due to be seen for a rule 35(2) appointment the following day, Saturday, 2 April.

Despite these interim steps, Dr Bromley remains of the view that there is a need to challenge and change

custom and practice, which will require further discussions, training and clinical supervision, as outlined in her evidence to this inquiry.

In terms of broader objectives, PPG is committed to the continual improvement of its service at Gatwick, whilst recognising that there are some factors outside its control. These include the physical capacity of the site, the policies and procedures developed and owned by other bodies, such as the Home Office and Serco, and the paucity of education and training materials nationwide which are bespoke to the environment of an IRC.

To date, it has been very difficult to obtain and deliver training on rule 34 or rule 35. PPG continues to work with providers across the country to develop bespoke training for IRCs and in particular for the site at Gatwick which has not hitherto been available.

Beyond these objectives, PPG recognises the need for cultural change at Brook House, including on the part of healthcare. PPG hopes and anticipates that better training will promote better understanding and awareness of vulnerabilities on the part of detainees and the safeguards which must be upheld in an IRC in order to detect detainees from harm.

PPG regards clinical supervision, reflective practice groups and peer reviews as essential routes for

all healthcare staff to reflect on their attitudes and approach to the delivery of care, including delivery of desensitisation and compassion fatigue highlighted by Dr Hard. The overall goal is to develop a more integrated patient service, and this is the subject of sustained effort on the part of PPG.

PPG also places particular reliance on strong and effective leadership in progressing the objectives outlined in this statement and hopes that the focus supplied by this inquiry will enhance these efforts.

Just finally, chair, PPG is well experienced in the provision of healthcare and has only been in possession for a relatively short period. PPG recognises, firstly, the opportunities for improvement as the new provider and is ready and willing to accept the challenge and make changes in line with its contract and the inquiry's findings. Secondly, that with a programme of continued improvement and feedback, high standards can and will be obtained.

Thank you, chair.

THE CHAIR: Thank you very much, Ms White. Thank you.

Mr Blake, I believe you might want 30 seconds to get the lectern?

MR BLAKE: Thank you very much.

THE CHAIR: Thank you.

MR BLAKE: Thank you, chair.

Closing statement by MR BLAKE

MR BLAKE: The inquiry hasn't yet produced its report, but it has already achieved a great deal. The inquiry has helped to shine a light on issues, the importance of which may not have been fully appreciated or fully understood. The questioning by Ms Simcock on the issue of rule 34 and rule 35, for example, has identified problems with the interpretation and application of those rules.

As you know, the Home Office, together with the NHS, have written to the healthcare commissioners and providers to provide urgent clarification arising from what we have heard over the past few weeks. The Home Office is committed to reviewing rule 35 and the ACDT process.

There are other areas which were known to the Home Office but which the inquiry has made even clearer: understaffing; the lack of a contractual power to penalise mistreatment; the imbalance between penalties for escape and penalties for harm; the imbalance in the weighting between commercial and operational objectives; and the imbalance that is caused by an overreliance on self-reporting and insufficient auditing.

We hope that the inquiry will recognise that the new

contract, the new provider, will go some way to address these historic problems that arose from an old contract that was based on an outdated approach. Improved staffing, improved contract, improved focus on welfare. We hope that the inquiry will recognise the work on staff culture that has been undertaken by Mr Riley, and the wide range of other changes, from improving auditing, the recommendations, including data gathering, regarding complaints against DCOs, improvements in the physical estate, and improvements in training.

The Immigration Minister described the treatment shown on Panorama as "appalling" and Mr Riley has delivered a clear apology to this inquiry.

Having recognised and been open to the problems that the inquiry has exposed, there is a good story to tell in many respects and we ask that the inquiry considers this alongside identified problems. For example, the Home Office does not shy away from scrutiny; the PSU got it absolutely right when it substantiated complaints against Nathan Ring, Yan Paschali, allegations of collusion and of derogatory comments by G4S staff in the case of D1527.

There are legitimate questions to ask about why the complaints system didn't lead to an earlier complaint to the PSU, but once it reached them, it undoubtedly was

acted upon. You heard from Mohammed Khan, who emotionally said at the end of his evidence that his parents were immigrants and that he sees it as the PSU's role to uncover wrongdoing and get to the bottom of it. You might think that the PSU is in good hands with him at the helm.

Similarly, the IMB, HMIP and others, the fact that you have heard critical comments about the Home Office from some of their reports is itself evidence that the systems of oversight are working and, indeed, are improving. The fact that the problems were not spotted by those organisations during the relevant period was not used by the Home Office in some way to shift the blame -- that is a misunderstanding there and I would like to clear that up. It was simply to show how challenging it can be to uncover mistreatment. How differently staff may have been acting around the Home Office, around the inspection bodies, to how they act amongst themselves in the corridor before they use force, or in the staff areas.

The Home Office welcomes scrutiny from those bodies and others. You heard from Mr Riley that he has previously asked Professor Bosworth to come in and look at the culture of different areas, since he has taken up post. The Verita report, whose transcripts have been

heavily relied upon in this inquiry, was another example of scrutiny that has been welcomed by the Home Office. And your own non-statutory inquiry was a further example of the Home Office opening up its doors.

When you consider the Home Office as an institution, which you have been urged to do by the representatives of those who were detained, we ask you to consider all of this, because an institution that invites such scrutiny is not an institution that intends to do wrong. And, of course, the Home Office does not so intend. When considering institutional issues, at the Home Office, you will no doubt consider the position of Tinsley House, which has been held up by some witnesses as an example of the high standards that are implemented by the Home Office. Reverend Ward described it as a "much calmer environment". He said Tinsley staff were very different. Tinsley House is run by the same team at the Home Office as Brook House. You will also consider the evidence of Owen Syred, who we know cared, and cares a lot, for the welfare of detained persons.

He worked with the Home Office on a secondment. He said he had a unique insight into his Home Office colleagues, he got on with them and they always behaved professionally. He said that the Home Office had a difficult job to do but acted with compassion. You

might think that his honest and open evidence is at odds with some of the overblown rhetoric that was obtained in some of the speeches that have been given yesterday.

As I said in my opening speech, some of the changes that you are likely to recommend are likely to be more mundane and less political. The change to rule 35 is one of those which might have profound changes for detained persons, even if one of the recommendations is simply improving the form that is completed or allocating more time to those appointments.

The Home Office's full submissions will be set out clearly in our written submissions, and I don't want to take up much more time today simply for the purpose of speaking. I should make it clear that we do not agree with the various submissions that have been made to you regarding the role that article 3 should play in your determination, and we will set that out more fully in our written submissions as we have been invited to do so.

Putting those legal submissions to one side, we know that you will approach the evidence that you have heard carefully, conscientiously and fairly.

Our primary objective throughout this inquiry has been to make sure our witnesses are treated fairly and have the opportunity to give their best evidence,

sometimes in response to demanding timeframes or in the face of criticism and cross-examination.

All I want to do, at this stage, is highlight five headline points for you, chair, to bear in mind when considering the evidence. First, a great deal of evidence has been heard in the form of witness statements that have been read and that have not been tested. The Home Office doesn't see it as its role to play the role of the defence, akin to a trial or civil litigation. That is not the purpose of a public inquiry. Probing questions that we proposed in phase 1 were not accepted because that is the approach that the inquiry wanted to take and that is certainly within your discretion, chair. But what we do, is ask you to apply appropriate care in your consideration of untested allegations.

Look, for example, at what happened in phase 1, where D1581 had previously relied on a written statement of someone we know as D390, who said he was beaten with batons. That simply was not right. We saw the footage, and that shows the danger in making conclusions based on written accounts alone.

Second, and consistent with the approach that has been taken with the evidence of those who were detained, GDWG, Medical Justice and others, I ask you to bear in

mind that it is the careful, considered and reflective evidence coming from the mouths of witnesses, not simply the acceptance of propositions that have been put to them, that really counts.

Phil Riley was a good example on Monday of a witness who has been asked and been able to give considered and properly answered questions and I ask you to consider the honest and open evidence, also of Paul Gasson in relation to his dealings with GDWG. Importantly, when you look at the evidence, I ask you to consider whether evidence, where a witness has simply said yes, or that they couldn't recall in response to repeated propositions, is useful evidence and we say it is not.

Third, I ask that you are mindful of the complexities in certain decision-making processes that you simply don't have the evidence to address. It has been repeatedly suggested, for example, that certain individuals would not have been detained if they had had a rule 35 form completed. That doesn't, in our submission, necessarily follow.

Do you know the countervailing immigration factors, including the detail in relation to their offending and the need to protect the public from harm? That is something you will have to ask yourself.

Fourth, I ask that you are mindful of any potential

unintended consequences of recommendations. We heard on Monday about Stephen Shaw's recommendation following the fire in Yarl's Wood, that the physical infrastructure needed to be strengthened and that that resulted in Brook House being built to its specification. As Phil Riley said, there is a balance to be struck between listening to what is said by experts and balancing it against other factors. There is no simple solution, and pulling in one direction might affect something else.

Fifth, and finally, I will end where I began and ask you to be mindful of what is achievable: end to immigration detention or the imposition of a definitive time limit is simply not achievable, even if it were within the terms of reference, and we say it isn't. As I said in my opening, this inquiry, an inquiry that makes focused but important findings, is just as important, just as valuable, in fact more so, to the wellbeing of those who were detained. The one that makes bold but unrealistic proposals.

The Home Office has full confidence that you, chair, will approach what is a very difficult task with the careful, thoughtful and sensitive manner that you have personally shown to witnesses throughout this inquiry. Thank you very much.

THE CHAIR: Thank you, Mr Blake.

Mr Sharland, thank you.
MR SHARLAND: Good afternoon, chair. My microphone is flashing red. Ah, I have a functioning microphone.
Closing statement by MR SHARLAND
MR SHARLAND: Good afternoon, chair. I make the following closing statement on behalf of G4S Care and Justice Services (UK) Limited as well as G4S Healthcare Service (UK) Limited. It will be supplemented, in due course, by G4S's written closing submissions, which will address the details of the matters under consideration by the inquiry. The written closing submissions will address the correct approach to article 3 of the European Convention on Human Rights. On this, G4S disagree with the suggested approach as set out in CTI's note, but we understand that the appropriate time to address this is in our written closing submissions.
The written closing submissions will also address each of the 50 or so incidents of concern, detailed in the inquiry's spreadsheet provided at the outset, as well as the various broader issues relating to both the provision of custodial and health services during the relevant period.
In this oral statement, however, I would like to address a number of key themes that have emerged in the course of the inquiry hearing a wide range of evidence,

covering life in Brook House, as well as the conduct of staff who worked there during the relevant period.
It is important, however, for me to start today, as I did in my opening statement on behalf of G4S, with an apology. These are not just my words, but the words of G4S's corporate witnesses to this inquiry. Mr Gordon Brockington, in particular, spoke about being personally appalled by what he saw on Panorama and that he, and G4S itself, were exceptionally sorry for the shocking mistreatment that was shown on that programme.
That sense of contrition was not, of course, limited to Mr Brockington. Mr Peter Neden, during the relevant period, the regional president for the UK and Ireland at G4S, explained that he was deeply sorry for there having clearly been a failure in the system that did not uncover the mistreatment of detainees.
He added that it was absolutely clear that he and the management team of G4S failed in their responsibility to keep people safe in Brook House.
Mr Jerry Petherick, who was, during the relevant period, managing director of G4S Custodial and Detention Services, too, also accepted his own responsibility for what had happened, because he was, as he put it, "at the top of the pyramid and there is no one tougher on me than myself".

The inquiry should be under no illusion that G4S, its staff, personally and as a corporate body, had been undertaking substantial soul searching since the conduct shown in Panorama came to light. As its senior witnesses made plain -- indeed, as well as many of the more junior staff, including DCOs and DCMs -- all feel a true duty of care towards detained persons, not simply in the legal sense but in the practical and moral one too.
What the Panorama documentary showed was that the company had let down a number of those individuals, let down a number of those individuals very badly. More than that, had been unaware of having done so. It is both those elements which have caused the company and its staff, of all grades, serious concern and regret.
As such, more than just recognising that conduct as abhorrent behaviour and apologising on behalf of G4S to those who suffered mistreatment, Mr Brockington pointed out that G4S looked forward to receiving the conclusions of the inquiry, and I add, in particular, it looks forward to the recommendations that the inquiry may make to ensure no such conduct occurs again at Brook House or indeed at any other IRC.
The inquiry's lens is, by its terms of reference, focused on a particular IRC and a particular period in

time. Its findings will necessarily be set by those parameters, but its recommendations will no doubt be of substantially wider application than to one particular IRC. Of course, G4S no longer operates Brook House or any of the other IRCs, but it is responsible for a number of other environments within the broader detention estate. It is for that reason in particular that it looks forward to learning from this inquiry.
A consistent theme of the evidence heard by the inquiry is the effect that "most staff were hard working but ..." or "the vast majority of use of forces were appropriate but ..."
The focus of this inquiry is, understandably, not on those majority of cases when staff were working hard in difficult circumstances, when detained persons were treated with dignity and respect, and where force was used appropriately and as a last resort. G4S appreciates that the inquiry was not established to concentrate on those cases, even if they applied to the majority of personnel or instances.
By its terms of reference, the inquiry is to "reach conclusions with regard to the treatment of detainees where there is credible evidence of mistreatment."
The focus of the inquiry's lens in those instances and cases where there is credible evidence and

mistreatment, its focus is not a holistic assessment on the performance of any individual staff member or G4S or any other contractor or the Home Office. However, with that said, the vast majority of cases of interaction between staff and detained persons that are characterised by respect and dignity should not be forgotten and are important context to the findings that the inquiry may make in respect of those instances where there is credible evidence of mistreatment, to recognise that such instances were the exception and not the rule.

As the 2017 report on Brook House from Her Majesty's Chief Inspector of Prisons recorded:

"In our survey, about three-quarters of detainees had a positive view of the attitudes and behaviour of staff and the proportion was higher for those who did not speak English."

Yesterday, Mr Stanton, on behalf of Mr Syred, stated, in relation to the issue of balance:

"There was a small minority of staff who conducted themselves as Yan Paschali and Derek Murphy did. By and large, staff at Brook House behaved well and treated residents with care, dignity and compassion. There are no recordings of officers and detainees chatting, having a coffee, sharing a joke or playing pool. However, these were everyday occurrences at Brook House."

G4S agreed with Mr Syred that this should not be forgotten. This is not just a matter of fairness, or balance, but it will inform the inquiry's approach to the recommendations that it may make, to maximise the effectiveness of those recommendations. There has been a debate between witnesses as to the extent to which poor conduct at Brook House was down to "a few bad apples". The relevance of any misconduct being set in the proper context of a wider pattern of genuinely hard-working, fair and compassionate staff is an important one.

The inquiry, when making recommendations to the future, will need to consider those measures which will properly identify any relevant bad apples as distinguished from the good or, in relation to some issues, where the problem is more systemic, such that more root and branch change is required either at Brook House alone or, perhaps more likely, across the IRC estate.

Many of the questions that the inquiry will seek to answer are not easy. G4S know this is first hand, as it has turned its mind to a number of those issues or similar ones, both before and after the airing of Panorama. A key theme of the evidence heard by the inquiry, the evidence the inquiry has heard, has been

about the issue of culture at Brook House, and the inquiry has heard much about a macho environment and a "man up" attitude. Neither of which were, of course, conducive to the operation of a safe centre.

Further, when it comes to culture, the answer is simply not a raft of new policies. Indeed, when the inquiry comes to consider a number of key areas, such as complaint handling and whistleblowing, whilst there may be room for lessons to be learned in the formulation of these policies, on paper, at least, many of them were sound, not least G4S's "Speak Out" whistleblowing policy, which was advertised, and utilised independent, external investigators to minimise any disincentive to report.

However, as the inquiry has been shown, however well intentioned or well designed on paper, these channels did not work at Brook House. The process of translating well designed policies into a healthy culture of not only good practice, but of reporting concerns, is difficult, but it is critical.

In the context of an operation which has been outsourced by central government, no doubt much scrutiny will be focused on the contractual arrangements between G4S and the Home Office and, where relevant, the health contract.

Even though the contract for the operation of Brook House between G4S and the Home Office is no longer in force, and the Serco operation is governed by a new contract on different terms, some important recommendations can be made on issues of principle, in particular, no doubt, as to how service levels and penalty regimes can be designed to ensure they operate as an effective means to incentivise compliance and, more than that, that they do so effectively; for example, minimising the extent to which a contractor marks their own homework, at the very least, without proper oversight by the Home Office.

Of course, the inquiry will recall that G4S did not agree or negotiate the terms of the contract that were in force during the relevant period but, rather, took over the contract that had been agreed between the Home Office and GSL.

The terms of that contract were set by the procurement exercise designed by the Home Office. The inquiry will no doubt recall evidence from a number of witnesses, including Mr Riley, that, at the time the initial contract was procured, the focus was very much on minimising the cost to central government. This is quite clear from the government's decision to have 50 per cent of the bidding scoring based on the cost of

the contract to the Home Office. Such an approach to procurement inevitably leads bidders to focus on costs in an attempt to be awarded the contract in line with what was essentially being asked for of them by the awarding body. This was recognised by the Home Office documentation, in relation to the procurement, exhibited to Reverend Ward's witness statement, which noted that the winning bid from GSL, which was the lowest yearly price, was 35 per cent below the relevant budget.

Such an approach can be contrasted with that taken in relation to the 2019 contract where only 25 per cent of the bid scoring was based on cost.

This differential approach to the procurement process inevitably led to very different bids, with more focus on the quality of provision.

G4S did not think it appropriate to bid at the low level adopted by GSL in the original procurement exercise, but it was nonetheless bound by the terms of the contract with the Home Office based upon GSL's bid after it purchased GSL. As a matter of procurement law, the terms of G4S's bid became irrelevant once the Home Office accepted GSL's bid. This remained the case as a matter of law when G4S subsequently took over GSL. The procurement law regime prevented G4S from seeking to substantially renegotiate the terms of the contract with

the Home Office once it was signed by GSL.

The inquiry should not, however, view the operation of the penalty regime under the contract as a key factor in why the behaviour of concern at Brook House was not brought to light. Although the contract provided for G4S to self-report on certain aspects of contractual non-compliance, and the National Audit Office found that G4S did so accurately self-report, that regime did not focus on the kinds of behaviour captured on the Panorama programme. There were, however, a number of other mechanisms, in addition to the complaints and whistleblowing frameworks, that should have picked up on any mistreatment through the Home Office's monitoring of the centre, both on the ground and centrally, as well as through the IMB and Her Majesty's Inspectorate for Prisons.

The fact that these bodies did not identify such problems on the ground -- and, indeed, IMB witnesses were surprised, for example, by what was seen on Panorama -- demonstrates the difficulty in creating effective oversight and monitoring structures which will both disincentivise misconduct before it occurs and also identify it when it has taken place. Any criticism of G4S that such misconduct did not come to the attention of G4S must be understood against the backdrop that it

was not identified by the regulatory and oversight bodies whose role it was precisely to look for and find evidence of it.

It is appropriate to say something about the proper scope of the inquiry. As I have already observed, the terms of reference of this inquiry quite properly set the boundaries of its investigation around a particular period of time at a particular institution. That does not prevent its recommendations and conclusions being of broader application, which is part of the reason why G4S will be listening carefully to them. However, as the chair previously recognised, in your determination on scope, for example, this inquiry is not a policy forum on immigration detention, nor has it been tasked with addressing questions on whether time limits should be placed on immigration detention.

Certain elements of the architecture of the immigration infrastructure, particularly those set out by law, are reference points by which the inquiry will need to frame its recommendations.

Other elements of the Brook House environment are not inherent within the immigration detention estate or its underpinning legal framework and are open to the inquiry's comments, criticisms and recommendations, particularly where the inquiry has heard evidence of

differing practice, either at other IRCs or subsequently at Brook House itself.

By way of example, and returning to the point that what lies at the heart of the operation of an IRC and which is difficult to measure and even to regulate, is its culture, the inquiry has heard that Brook House was, to a very considerable extent, defined by its oppressive physical architecture, built to the specifications of a category B prison, albeit without the education facilities and space for activities that would be available in such a prison.

Space, generally, and particularly outside, is in short supply. Its location, only 200 metres from one of Gatwick's runways, with the associated noise, further increased the oppressive and stressful environment. For an environment which is not intended to punish but rather to house and to do so for a short period only, the inquiry may well conclude that the austerity of the physical architecture had deleterious effects on those inside it.

That final point is an important one, understanding the position of those, as pointed out by G4S in its opening statement, to be at the heart of this inquiry, namely, those persons detained in Brook House.

What was striking throughout much of the evidence

heard by the inquiry was the consistent account of what were the primary concerns of those detained in Brook House during the relevant period, as recalled by various and varied witnesses. It was chiefly, and understandably, their immigration case rather than treatment within Brook House. Recalling that detained persons were held at Brook House prior to their removal, many not wishing to be removed, it is quite reasonable that many detainees would be anxious and stressed about their immigration case; the question of if and when they would be removed, as well as difficulties obtaining information from decision makers about those issues.

The inquiry will recall that the average length of detention at Brook House had increased prior to the relevant period, placing additional stress on detainees.

In that context, it is important for the inquiry to recall that G4S did not determine who was detained at Brook House, nor did it determine how long they would be detained for. It was not responsible for escorting detained persons as part of the removal directions and was not involved in casework regarding detained persons' immigration status. These were the key issues for detainees and their primary sources of concern and, sometimes, distress. G4S was not responsible for these matters, often knew nothing of them, yet it was G4S

staff who found themselves dealing on the front line with detained persons and queries, often simply unable to assist and in an understandable position of ignorance.

Another aspect of the culture of Brook House as an IRC was its challenging environment. Staff in a position of authority were present among a detained population understandably concerned about their immigration cases, often frustrated by a lack of progress or knowledge of the same, and including a considerable proportion, at least at the relevant time, of time-served foreign national offenders who had come to the IRC from the prison estate. As Mr Hanford explained in his oral evidence to the inquiry, as a result of government austerity shortly prior to the relevant period, prisons were closing and the prisons estate was no longer able to accommodate a large number of time-served foreign national prisoners. The proportion of such time-served foreign national prisoners at Brook House increased from approximately 5 per cent in 2013 to between 50 and 55 per cent in 2017. This increase coincided with a spice epidemic which had started in the prison estate and had then migrated to the IRCs, in part as a result of the transfer to IRCs of such prisoners from the prison

estate.

Such a change created a perfect storm during the relevant period which it is clear both custodial and healthcare struggled to cope with. This of course does not in any way justify the abhorrent behaviour by a small number of G4S staff but it is important context to consider when considering what happened in Brook House during the relevant period.

In that regard, the physical architecture of Brook House again plays an important role. Time-served offenders were transferred from a prison to an environment which looked remarkably similar to the prison from which they had come and but where staff lacked the powers of prison officers and, crucially, lacked the ability to incentivise good behaviour and disincentivise bad behaviour through a system of privileges or removing privileges. To a detained population that could already be frustrated by the stresses of their immigration cases, the inability of staff to use carrots and sticks could, and from the evidence heard by the inquiry did, lead to numerous instances in which detained persons not only challenged the staff but abused them verbally and physically.

To be clear, that does not in any way at all justify or excuse any mistreatment of detained persons by staff.

There is of course an inherent power imbalance between those in authority and those detained persons in their care, with staff who were responsible to look after detained persons and not vice versa. However, it does demonstrate the inherently challenging nature of the detained environment, particularly in respect of matters over which G4S had no control.

These considerations, understanding which are inherent in a system where individuals may be detained against their will and those which are perhaps exacerbated by matters which are not pre-determined by immigration law and policy, will be central to the inquiry's process of making recommendations which will have a real impact on the detained population.

This inquiry has heard extensive evidence on various matters relating to healthcare, and in particular care of detainees with mental health problems. It is not possible to address such matters in the detail necessary in these short oral closing submissions. However, I would like to touch on one particular issue, namely rule 35 of the immigration Detention Centre Rules.

G4S accepts that during the relevant period, and indeed both before and after the relevant period, the approach adopted by healthcare staff, and in particular the GPs, did not accord with the language of rule 35; in

particular, G4S, that there was a failure to complete reports under the first two limbs of rule 35 where detainees met the criteria under these two limbs. The inquiry will of course need to determine where primary responsibility for this failure lies.

When considering this issue, the inquiry will no doubt bear in mind a number of matters, including, first, the fact that the number of rule 35(1) and 35(2) reports completed at Brook House during the relevant period was not dissimilar to the number completed at other IRCs at this time. Further, it appears from the oral evidence to the inquiry that, fives years later, under the new provider PPG nothing has really changed.

Secondly, healthcare staff and G4S raise the lack of training of rule 35 with the Home Office on more than one occasion. However, there were real challenges to obtaining such training from the Home Office. This was not a new problem, nor does it appear to be limited to Brook House. Stephen Shaw in his 2016 report at paragraph 4.116 noted that one of the concerns healthcare staff at IRCs generally had was that "on site teams were not sufficiently trained to complete them."

Thirdly, Ms Calver in her oral evidence confirmed that the Home Office had not raised concerns about the lack of rule 35(1) or (2) reports during the relevant

period, or indeed before or after the relevant period, notwithstanding that they were well aware of the number of incidents of self-harm, suicide attempts and the number of detainees placed on ACDTs at Brook House during that period. Further, the Home Office did not generally raise concerns about the content or quality of the rule 35 reports that were completed.

Fourthly, Ms Calver in her oral evidence to the inquiry explained that she had set up an IRC forum to discuss rule 35 issues with the healthcare staff at other IRCs. The Home Office attended this forum and approved the rule 35(2) pathway drafted by Ms Calver. Ms Calver understood that, as a result of that approval, this pathway document was rolled out elsewhere in the IRC estate.

Fifthly, and finally, the relevant Home Office guidance, namely DSO09 of 2016, focuses to a considerable extent on rule 35(3) reports rather than 35(2) and (1) reports. For example on page 7, the guidance states that:

"It is important that nurses and other healthcare professionals are aware that they must report to an IRC medical practitioner any detainee who claims to have been a victim of torture or gives an indication that this might have been the case."

There is no such similar guidance to healthcare providers on the first two limbs of rule 35 in that guidance.

When considering whether the failure to complete rule 35 reports on every occasion that the threshold set out in rule 35 was met led indirectly to any mistreatment, it is important to bear in mind the very low release rate following submission of such reports to the Home Office, which according to Stephen Shaw in his 2016 review was in the region of 10 to 20 per cent.

Again, G4S does not suggest that any of these matters, either individually or collectively, negate its responsibility or that of the medical staff to act in accordance with rule 35, and other relevant Detention Centre Rules. However, it does believe that such matters are highly relevant when considering the context and who else shares responsibility for the way in which Brook House healthcare staff, like staff at other IRCs during the relevant period and subsequently, operated rule 35.

To conclude where G4S began in its opening statement to the inquiry, it is the detained persons who are, as much as any government or corporate body, the true audience for the inquiry's reports and conclusions to ensure that those detained in Brook House in 2017 have

been heard and listened to, and to ensure that the lessons of Brook House are learned so that those in the detention estate at present and in future should not suffer the kind of treatment witnessed on Panorama.

G4S, again, apologises for the conduct of its staff where they carried out that mistreatment and, more broadly, for its own deficiencies in failing to identify the mistreatment before or after it occurred. It recognises that, while learning lessons is vital, that may be of little comfort to those who have already suffered. G4S is grateful to all those who have given evidence to the inquiry, in particular those who have been detained at Brook House, as well as to the chair, her legal team and all those staff supporting the inquiry.

Thank you, chair.

THE CHAIR: Thank you, Mr Sharland.

Closing remarks by THE CHAIR

THE CHAIR: That concludes phase 2 hearings in this inquiry.

I would again like to thank you all the core participants and their legal representatives, as well as the inquiry staff for ensuring the smooth running of the hearings.

I would also like again to thank the IDRC for hosting us, as well as RTS for their technical support

and I am grateful to the transcribers and the evidence handler for their assistance throughout the hearings. Finally, thank you to the ushers and the staff from Hestia for their support.

I am very grateful for the high-levels of engagement that there has been before and during the inquiry hearings.

The inquiry received a number of statements from formerly detained men, four of whom were able to give live evidence. Many of these men are highly vulnerable and have provided detailed statements giving their accounts of mistreatment and other experiences at Brook House and elsewhere. I appreciate just how challenging this must have been for them and each will be considered for the purposes of my report.

The inquiry has also heard live evidence from 74 other witnesses and for each person that gave evidence to the inquiry I recognise that it has not been an easy experience but it has been of considerable value to me and to the whole inquiry.

I wish to express my gratitude to all of the witnesses who have come to give evidence over the past seven weeks.

Whilst it has not been possible or necessary to call each person who has provided a statement to give

evidence in person, each of those will be considered when preparing my report, alongside the rest of the evidence received in the course of the inquiry.

I have listened very carefully to the oral submissions that I have heard over last two days and I look forward to receiving the written submissions by 29 April, which I will of course also consider with great care. The inquiry team will then provide an update on the overarching timetable in due course.

Finally, I would like to say this. We have heard at times some very technical information regarding the contract, the systems, the rules and the processes in place at Brook House. We have also heard evidence about the role and the structures of oversight and monitoring mechanisms in place for IRCs.

In the course of these inquiry hearings, we have heard evidence in person or read in and seen footage of men suffering mistreatment and in distressing situations. We have also heard directly, or read transcripts of, swearing and abusive language directed at detainees.

So, although for reasons of necessity we have had to refer to those formerly detained men at Brook House using ciphers, I want to emphasise that at the very centre of this inquiry are the men who were detained at

Brook House.

I would like to conclude my remarks by acknowledging that behind each and every one of those ciphers is a human being who should have been treated with respect and dignity. Neither I nor the wider inquiry have lost sight of that.

Thank you.

(12.37 pm)

(The inquiry concluded)

I N D E X